

Evaluating the influence of the TB Think Tank on South African policy

Produced by: [Dr. Bey Schmidt](#), Dr. Chanelle Mulopo, Ms. Lilian Mayieka

bschmidt@uwc.ac.za

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Executive Summary

This evaluation aims to enhance the capacity of the TB TT in producing quality evidence and supporting its uptake and use in national TB policy and practice decision-making. A Knowledge Translation Platform (KTP) framework (Bennett and Jessan, 2011), comprising knowledge exchange, dialogue, and capacity building as domains, guided the evaluation. A mixed-methods design was used to collect data through in-depth interviews, a survey, a document review, and participant observation.

The findings indicate that 83% of survey respondents were involved in TB TT task teams and working groups, with over 50% expressing satisfaction. The TB TT members participate in a range of activities, and while the National Tuberculosis Programme (NTB) is the primary user of the TB TT outputs, members also utilise them to inform their research and practices. Over 70% of survey respondents were satisfied with outputs, such as the Targeted Universal Testing for TB Policy, Paediatric Standard Treatment Guidelines, and the TB recovery Plan. Outputs were disseminated to different audiences through various channels, including social media, websites, webinars, and meetings.

Key strengths include strong leadership with the TB TT, an ongoing relationship with the NTP, diverse member expertise fostering collaboration, and a shared vision to combat TB in South Africa. However, limitations such as suboptimal use of evidence and bureaucratic constraints affecting rapid decision-making were noted. Recommendations include establishing mechanisms for tracking feedback and impact of outputs submitted to the ExCo and NDoH, managing conflicting priorities of the NTB and funders, and creating feedback loops on evidence usability and dissemination formats.

In summary, the TB TT is instrumental in shaping South Africa's TB strategy, with strong leadership and a collaborative network driving its achievements. However, addressing challenges like evidence use and bureaucratic inefficiencies will be key to maximising its impact. Strengthening these areas will ensure the TB TT continues to contribute meaningfully to the fight against TB.

Description of the TB Think Tank

Background:

Tuberculosis (TB) is an infectious disease primarily affecting the lungs, caused by the bacterium *Mycobacterium tuberculosis*. Despite being preventable and treatable, TB remains one of the top ten causes of death globally. It is particularly prevalent in low- and middle-income countries, like South Africa, where health systems may be less equipped to handle the disease, and where social determinants of health—like poverty, overcrowding, and malnutrition—exacerbate its spread. There are several challenges when it comes to TB control, including multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB) which are harder to treat, lack of early and accurate diagnosis of TB, poor adherence to TB treatment, and poorly resourced health systems lacking infrastructure, funding, and trained personnel needed to effectively manage TB cases.

In this context, a TB think tank serves as a vital knowledge translation platform for bridging the gap between research, policy, and practice. It facilitates the synthesis and dissemination of scientific evidence to inform decision-making, ensuring that the latest advancements in TB diagnosis, treatment, and prevention are effectively communicated to health decision-makers, such as policymakers, healthcare providers, and the public. By bringing together stakeholders from various disciplines and sectors, a think tank can translate complex research findings into actionable strategies that are contextually relevant and accessible. This process not only accelerates the implementation of innovative solutions but also fosters collaboration across disciplines and sectors, ultimately enhancing the global and local response to TB.

The TB Think Tank (TB TT) was established in 2014 at the 4th South African TB Conference in an effort to strengthen the government's programmatic TB response. It is a network of TB experts who are dedicated to driving innovative and effective solutions to combat TB by advising the National Department of Health (NDoH) on evidence-based

TB prevention and control policy and programmes. The objectives of the TB TT are (i) to collate, review, synthesize, and evaluate evidence related to policy and implementation (ii) to specify and request evidence, and if necessary, research to inform policy and implementation (iii) to identify and prioritise research questions, and (iv) to advise the NDoH on policy implementation. Through these efforts, the TB TT aims to be a catalyst for change, ensuring that South Africa leads the way in the global fight against TB.

Structure and Governance:

The TB TT is an independent entity with its secretariat housed within the Aurum Institute. The TB TT functions through an executive committee (ExCo) responsible for delivering its mission and mandate. The ExCo is made up of a chair and co-chair as well as a secretariat which is responsible for the day-to-day management of the TB TT and provides administrative support to the task teams and working groups. The secretariat consists of the TB TT lead, programme manager, programme coordinator, task team and working group leads and co-leads, and two scientists. The TB TT's chair is the Chief Director of the National Tuberculosis Program (NTP), while the co-chair is the Director of the Office of AIDS and TB Research at the South African Medical Research Council. The TB TT lead dedicates a portion of her time overseeing the secretariat's activities. The programme manager is employed full-time to manage and track the day-to-day activities of the TB TT. Similarly, the programme coordinator is employed full-time to handle logistics and administrative tasks of the TB TT. One of the scientists is employed part-time, while the other is employed full-time. They provide research support to the task teams, working groups, and consultants commissioned to carry out various projects of the TB TT. The team also benefits from the guidance of a senior advisor who offers technical support on a limited basis.

The NDoH identifies annual priorities for the TB TT and its members through individual task teams and working groups, thereby prioritising activities. Each task team and working group is responsible for the execution of specific workplans and facilitates widespread stakeholder involvement within the TB TT. The TB TT has a very strong connection to the

NDoH through the chair, and currently the programme manager meets with the chair and works at the National Department of Health weekly. Members of the secretariat meet monthly to get updates on the progress made by task teams and working groups on workplans and activities. This also serves as a monitoring and evaluation of the task team's activities.

Activities and outputs:

The TB TT members are involved in different activities in various capacities, primarily guided by the NDoH priorities outlined in the task team and working group workplans. Members of the TB TT are involved in task team and working group meetings, synthesising existing evidence, conducting research, drafting and reviewing policy and guidelines, providing expert advice, presenting at conferences, etc. The TB TT produces various outputs such as webinars, academic peer-reviewed publications, newsletters, policy briefs, briefing notes, PowerPoint presentations, annual reports, standard operating procedures, and policy and guideline recommendations. The outputs are disseminated using various channels, including champions within the NDoH, stakeholder meetings, mailing list, public webinars, institutional websites, and social media platforms such as YouTube and LinkedIn.

Stakeholders:

The TB TT consists of a wide range of TB and TB-HIV stakeholders, including representatives from the NDoH, public-sector health practitioners, researchers, implementing and donor organisations, civil society and private sector.

Evaluation Objectives

1. To describe the characteristics of the TB Think Tank, including its scope, activities, processes, outputs, stakeholders, strengths, and limitations.
2. To ascertain perceptions of and experiences with the TB Think Tank among relevant stakeholders.
3. To determine the effectiveness/influence of the Think Tank in translating TB evidence into national policy and recommendations.
4. To determine if policy recommendations are appropriate for implementation in various South African contexts.
5. To identify any preventable delays in policy uptake and/or implementation.
6. To assess the participation and willingness of stakeholders relevant to policy development and implementation.
7. To evaluate the TB Think Tank's efforts to disseminate research findings to relevant audiences.
8. To provide recommendations for strengthening the TB Think Tank.

Methodology

To guide the evaluation, we used an existing Knowledge Translation Platform (KTP) framework by Bennett and Jessani (2011) consisting of knowledge, dialogue, and capacity as key components (see **Figure 1**). Knowledge refers to the role of a KTP in defining and identifying knowledge, and then harvesting, preparing, and synthesizing it. Dialogue refers to the ability of a KTP to deliberately facilitate discussions around prioritized questions and topics. Capacity in the context of a KTP means providing evidence users (e.g., policymakers) with support in acquiring, assessing, adapting, and applying research in decision-making. The KTP framework was used to systematically assess various aspects that enable or hinder the successful functioning of the TB TT.

We conducted a process and outcome evaluation to assess the overall effectiveness, influence, and functioning of the TB TT in translating TB evidence into national policy and recommendations. Data was collected using mixed methods, including a document review, observations, survey, and key informant interviews.

Figure 1: KTP framework (*Bennett and Jessani, 2011*)

Knowledge	Dialogue	Capacity
Determine knowledge availability and gaps	Broker stakeholder meetings	Train researchers on policy-making processes
Stakeholder analysis and mapping	Research-specific stakeholder engagement	Train researchers on participation in KT activities
Synthesise, package, and or tailor outputs for various audiences	Provide safe harbours	Train decision-makers & other stakeholders on acquiring, accessing, and applying research
Host clearing house for one-stop-shop	Contribute to research and or policy agenda-setting	Undertake advocacy to disseminate and support the use of research evidence
Provide rapid response services		
Be a center for excellence		

Data collection and analysis methods

Study Participants

The TB TT has a database of about 380 members representing different stakeholder groups. Of the 380 members on the database, over 280 are volunteering to the TB TT's five task teams and two working groups.

Document review

Internal data sources provided by the TB TT's secretariat, such as meeting notes, recordings, and presentations, were reviewed. Outputs published on the TB TT's website, such as webinars, newsletters, and strategic documents, were also reviewed. The document review was conducted by two researchers (CM and LM) using thematic and numerical analysis, which entailed coding information relevant to the evaluation objectives and counting the type and frequency of available outputs.

Observations

Two researchers (CM and BMS) attended the TB TT annual meeting and observed people and events at the meeting. We observed presentations, task team and working group discussions, and interactions between members. We did not participate in any discussions or actions at the annual meeting.

Survey

A survey consisting of 26 questions (14 close-ended questions, 12 open-ended questions) was disseminated by the TB TT programme manager to all members via an email mailing list (**Appendix 1**). The survey (and in-depth interviews) collected demographics of participants and their role within the TB TT, as well as information on the activities, processes, outputs, purpose, function, stakeholders, positioning, funding, strengths, limitations, and monitoring and evaluation of the TB TT. Sixty-five members of the TB TT responded to the survey (**Box 1**). Survey data were manually analysed using descriptive statistics and thematic content analysis.

Box 1. Survey respondents

What is your sex?	<ul style="list-style-type: none">• Female – 43 (66%)• Male – 21 (32%)• Prefer not to say – 1 (2%)
Which stakeholder group do you belong to?	<ul style="list-style-type: none">• National government (e.g. manager or policy maker) – 9 (14%)• Provincial government (e.g. manager or implementer) – 6 (9%)• Health professional (e.g. nurse, doctor) – 8 (12%)• Non-governmental organisation – 11 (17%)• Research council or university – 14 (22%)• Private sector (e.g. medical aid scheme, consultancy) – 0 (0%)• International organisation (e.g. health agency, university, non-profit organisation) – 8 (12%)• Donor or funding agency – 2 (3%)• Civil society or advocacy groups – 4 (6%)• Other – 3 (5%)
Are you involved in any of the task teams and/or working groups?	<ul style="list-style-type: none">• Yes – 54 (83%)• No – 11 (17%)
How long have you been involved with the TB Think Tank?	<ul style="list-style-type: none">• 0-5 years – 38 (58%)• Greater than 5 years – 16 (25%)• Greater than 10 years – 11 (17%)

In-depth interviews

Potential interview participants were identified from the member database. Initially, one researcher (BMS) purposefully invited the lead or co-lead of each task team and working group, and two other members representing different stakeholder groups to the lead or co-lead to participate in interviews. Purposeful sampling aimed to ensure representation of different stakeholder groups and potentially different levels of involvement. Invites were sent via email, including an information sheet and consent form (**Appendix 2 and 3**). Potential participants were asked to read the information sheet, sign the consent form if they agreed to be interviewed, and provide their availability for the interview within a two-week date range. BMS followed up with potential participants who did not respond to the invite after one week. If she still did not receive a response, she purposefully selected a new stakeholder from the database to invite for an interview.

An interview guide (**Appendix 4**) consisting of 14 open-ended questions was used to interview fourteen people (**Box 2**) over two months (June and July 2024), in English via Microsoft Teams. Most interviews lasted between 50-60 minutes (the shortest being 30

minutes and the longest being 120 minutes). Researchers asked participants to record the interviews and all participants agreed to be recorded. Interview recordings were transcribed verbatim and were coded using Atlas.ti, a qualitative data analysis software, to identify key themes and patterns. Data was coded and synthesised in Atlas.ti software using an inductive thematic approach. We followed Braun and Clarke's six steps of analysis: 1. familiarization, 2. generating initial codes, 3. generating initial themes, 4. reviewing themes, 5. defining and naming themes, and 6. writing the report.

Box 2. Interview participants

Participants	Gender	Task team / working group	Duration
1	Female	TB Prevention	8 Years
2	Male	TB Epidemiology, Modelling and Health Economics	<10 Years
3	Female	TB Prevention	3 Months
4	Male	Data Systems and Innovations	2 Years
5	Female	Optimising Treatment Outcomes	7 Years
6	Male	Childhood and Adolescent TB	1-2 years
7	Female	Finding Missing People	2 Years
8	Female	Optimising Treatment Outcomes	<10 years
9	Male	Data Systems and Innovations	2 years
10	Female	TB Epidemiology, Modelling and Health Economics	8 years
11	Female	Data Systems and Innovations	7 years
12	Male	TB in the Mines	5 years
13	Male	Data Systems and Innovations	3 years
14	Male	TB in the Mines	<10 years

Ethical Considerations

All participants in the evaluation were informed of the purpose of the study, the voluntary nature of their participation, and the confidentiality of their responses. Written and verbal informed consent was obtained from all interviewees. Data were anonymised to protect the identities of participants, and all information was securely stored and only accessible to the evaluation team.

Limitations

A limitation of this evaluation is that participants did not have the same level of knowledge and understanding about the objectives and activities of the TB TT, regardless of the number of years they were involved in the TB TT. This limitation was especially noticeable

with the interviews and survey. Hence, the information provided by participants varied in richness, although resulting in similar patterns and themes in the data.

Evaluation results

The evaluation results are organised into 11 sections.

Members and stakeholders of The TB Think Tank

As described earlier, the TB TT has a database of about 380 members, with over 280 individuals volunteering to the five task teams and two working groups. Most survey respondents (83% of 65 respondents) were involved in a task team or working group and expressed that they were very satisfied (20% of 65 respondents) and satisfied (32% of 65 respondents) with their involvement in TB TT activities. The distribution of volunteers across the task teams and working groups varies (**Box 4**). When it comes to the task teams, the *TB Prevention* task team has the most members, while the *TB Epidemiology, Modelling and Health Economics* had the least members. The *Childhood and Adolescent TB* and *TB in the Mines* working groups were formed over a year ago, each with a similar number of members.

Box 3. Number of members in each task team and working group

Five task teams	
Finding Missing People	55
Optimising Treatment Outcomes	41
TB Prevention	58
Data Systems and Innovations	34
TB Epidemiology, Modelling and Health Economics	28
Two working groups	
Childhood and Adolescent TB	38
TB in the Mines	32

Most members of the TB TT, besides the secretariat, fill multiple roles as contributors to and/or users of evidence and policy within and outside of the TB TT. For example, the chair of the TB TT is a contributor (he is involved in the *TB in the Mines* working group), while he is also a user (he uses outputs produced within the TB TT to inform his NDoH work). Interview participants agreed about who the users of the TB TT are. Most said that

key outputs produced within the TB TT are for the NDoH and provincial implementers. One participant said: *“The biggest consumer of the Think Tank is the NDoH because it is the one who gives direction to the province, the clinics, and so on.”* Another participant said: *“The users are hugely government, right? Provincial government, the national government, especially when it comes to implementing policy”*. Documents produced within the TB TT, such as strategic plans, reports, standard operating procedures, and guidelines, are critical for government, but a participant also noted: *“The [non-governmental organisation] NGO’s and implementing partners benefit a lot from the documents that we develop”*. Further, researchers were identified as users of the TB TT as well, as noted by one participant: *“Researchers too...because it guides what they do in their practice because they guide basically what the country ought to be doing”*.

In addition to the membership of the TB TT and the roles of individuals, we also collected information on the diversity of stakeholders represented in the TB TT. Stakeholders included managers and programme implementers from various levels of the NDoH, academics and researchers, and representatives from funding agencies, non-government organisations (NGOs), civil society (South African National AIDS Council) and the private sector. Most respondents (77% of 65 respondents) said that the TB TT includes a diverse range of stakeholders in its decision-making processes. The remaining respondents (23% of the 65 respondents) said that some stakeholder groups were underrepresented, including district and provincial health practitioners (e.g. nurses and doctors), patient and advocacy groups, basic scientists, and representatives from other relevant government departments (e.g. information systems, education, social services).

An interview participant noted that the TB TT intentionally seeks out relevant stakeholders: *“We try to source based on their expertise and to try and bring the best from the country. So, there's good representation from academia, from NGO, and we do have private sector as well in a number of these groups, working groups.”* Interview participants recognised the importance of having provincial implementers and patient and public advocates involved in the decision-making processes to ensure that policies are developed with practical implementation in mind. One participant said: *“I think that*

bringing the implementors in is something that has shifted in recent time that's important, because you can't, you shouldn't be developing policy without actually understanding the implementing perspective. And then the other group that's become more prominent, the TB advocates, so things like TB Proof and Rural Health Advocacy Project. And they bring a different perspective, they bring the more community perspective, the more equity perspective." And another said: "... *bringing together a body of stakeholders that are invested in and working on progressing the TB agenda forward.*" These reflections speak to the effectiveness of the TB TT in bringing together individuals who are committed to the TB agenda. Those who responded to the survey belonged to different stakeholder groups; for example, 22% of the respondents were researchers, 17% were NGO representatives, and 14% were national government officials.

The role and function of the TB Think tank

Interview participants reported that the TB TT's primary role is to generate and apply evidence for developing national TB strategies. Most survey respondents (82% of 65 respondents) said that the TB TT is prioritising the right things in terms of its role and function. As such, the TB TT's role and function complements the NDoH's efforts to combat TB, particularly through the development and implementation of the TB Vision 2023-2028 TB Recovery Plan. One interview participant described the TB TT as "*a platform for building consensus on how to improve policy and practice of the TB Programme nationally.*" One role of the TB TT is that it brings together top TB experts in TB from various fields to develop new and review existing policies and guidelines, to support policy and practice decision-making, to disseminate policies and guidelines, and to address previously neglected policy areas, such as paediatric and occupational TB.

Another role of the TB TT is that it generates evidence to inform policy; another participant said: "*The main purpose, is to be a knowledge and a policy translation bridge or instrument... the success is that most of the policies that are proposed by the TB Think Tank are adopted by the National TB Programme*". It serves as a platform for synthesising international and local research findings, assessing their applicability to the South African

context, and providing the NDoH with evidence relevant for policy updates. Another participant emphasised that the TB TT "*puts these activities into place, generates the evidence which informs policy change,*" stressing its role in translating research into actionable policies. The TB TT packages evidence in a way that facilitates easy understanding and adoption by the National TB Program. Participants generally agreed with this sentiment, with one participant saying: "*If you just look at the amount and the speed at which guidelines are now out...these are guidelines that are not done by one person, they are reviewed thoroughly and there's rigorous critique and review.*"

Further, the TB TT plays an important role in the agenda setting of strategic plans and advocating for policy changes. By involving researchers, the platform serves to "*give researchers a more prominent role*" in contributing to the National TB Programme's (NTP) priorities, resulting in more effective and responsive TB strategies.

The TB TT also serves as a platform for sharing research findings and fostering collaboration among stakeholders. The platform excels in networking and stakeholder engagement, bringing together diverse stakeholder groups. Participants said:

- "*Networking is really, really critical, and different modelling projects that come out of that group are incredible.*"
- "*The right people are the guiding voices in setting the TB strategy for the country.*"
- "*This is the most effective technical forum in South Africa between the scientists and the researchers and the implementers.*"

Activities and outputs of the TB Think Tank

Survey respondents and interview participants named a wide range of activities facilitated and outputs produced by the TB TT, which are the same as those listed earlier under the *Description of the TB TT* section. Many survey respondents were very satisfied (31% of 65 respondents) and satisfied (40% of 65 respondents) with the quality of the of evidence and recommendations. When it comes to the quantity of outputs, many survey respondents were satisfied (42% of 65 respondents) and neutral (29% of the 65 respondents) about the quantity of outputs. Survey respondents mentioned

various examples of influential, useful, or impactful outputs over the past year. Some of those examples included the Targeted Universal Testing for TB Policy, Paediatric Standard Treatment Guidelines, and TB Recovery Plan. Interview participants shared the same sentiments regarding activities and outputs:

- *“The Think Tank basically managed the drafting of the Vision 2028 policy, so the national strategy for TB which has just been published... we also actually draft guidelines for the department, so the TPT guidelines were drafted in the Think Tank and now the paediatric guidelines have been drafted in the Think Tank.”*
- *“The Think Tank, they launched the TB Recovery Plan.... That document is literally the TB Think Tank’s work, and a huge part has been funded... it’s one of our really great deliverables.”*
- *“We’ve just developed a standard operating procedure for the use of digital chest x-ray for TB screening... that’s going to be implemented shortly.”*
- *“We’re working with occupational health and sort of seeing how those engagements translate as well, there’s workshops that have come out of engagements in modelling work and increasing training for people who are involved in the sector.”*

Other examples that interview participants highlighted were related to:

- The TB TT’s pivotal role during the COVID-19 pandemic by integrating TB and COVID-19 screening guidelines, demonstrating its ability to respond to emerging public health challenges. It recommended that individuals with an acute cough be evaluated for both TB and COVID-19. These guidelines provided a practical example for dual-disease screening.
- The TB TT’s ability to commission new research projects to inform national policy. For example, it commissioned studies on digital chest x-rays, adherence to TB treatment, and the evaluation of data systems such as Tier.Net.
- The TB TT’s contribution to developing a home-grown TB model to simulate the spread of TB, help evaluate the impact of different TB interventions, and predict

future trends in TB incidence and prevalence. This model is the result of collaborative efforts, including work by PhD students.

- The TB TT's role in sharing new evidence and recommendations with provincial and district health departments. For example, the TB TT shared algorithms for finding missing people with TB with provincial health departments to gather feedback before finalising them. This was highlighted by a participant who said, *"There was a process of sharing that with the provinces and getting their feedback and with national and then finalising it."*
- The TB TT's recent contribution is to the development of a standard operating procedure (SOP) for the use of digital chest X-rays in TB screening, which has been approved and is set to be implemented. These efforts, supported by different task teams, shows the TB TT's significant contributions to TB control, with a focus on generating actionable guidelines and strategic documents that drive progress in the TB field.

Sources of evidence for the TB Think Tank

Interview participants said that outputs were produced using evidence from various sources, including existing World Health Organization documents, available literature, commissioned primary studies, and expert consultations. Researchers involved in the TB TT play a crucial role in sharing their research results, and when additional research is needed, the TB TT commissions research studies. The development of the urine lipoarabinomannan (LAM) assay policy provides an example of an output where various sources of evidence were collected, including conducting a primary study and expert consultations to translate results into actionable policy. One interview participant said: *"What the Think Tank lady did was bring together all of that data and use the data from the multiple studies to come up with a urine LAM policy"*.

Evidence production for, and use in, TB policy and practice decision-making

Most survey respondents were very satisfied (33% of 65 respondents) and satisfied (29% of respondents) with how effective the TB TT has been in collating, reviewing, synthesising and evaluating evidence related to policy and implementation. Similarly, survey respondents were very satisfied (31% of 65 respondents) and satisfied (32% of respondents) with how effective the TB TT has been in soliciting and requesting evidence, and when needed research, to guide policy and implementation. Most respondents were satisfied (37% of 65 respondents) and neutral (26% of 65 respondents) about how effective the TB TT has been in identifying and prioritising research questions. An overwhelming majority (97% of 65 respondents) said that the TB TT has been effective in advising the NDoH on policy and implementation.

Interview participants agreed that the TB TT was effective in producing relevant and timely evidence to support the NDoH. However, all except for one participant said that they did not know how evidence was used in decision-making processes once it was shared with the NDoH. The participant was able to fully describe the process for using research evidence in TB policy and practice decision-making. They said that the research needs to be protocol-driven, peer-reviewed, and published in a peer-reviewed journal. As a starting point, appropriate evidence syntheses are identified from the literature, and if not available, new research is commissioned. Then experts are consulted to provide their insights and advice, especially when research is limited, or research results contradict each, or there is uncertainty about the robustness of the research, or research is outdated. The expert consultation process can take long, as it is iterative and many people and NDoH stakeholders are involved in approving the outputs. One participant expressed a lack of understanding about how outputs are used in decision-making: “...*once our outputs are out and we have submitted them to the NTP we don't quite directly follow it up, but they are followed up by the management, the cluster management*”. Another participant said: “*I haven't been involved in the final step. The TPT guidelines, I wasn't involved in that, I know it was very complicated and went all wrong*”. After expert

consultations, the research is consolidated into policy and recommendations and submitted as a tailored output to the NTP.

Engagement, dissemination, and communication

Outputs are disseminated and communicated via the TB TT website, its mailing list, monthly newsletters, seminars, face-to-face meetings, webinars, social media, and the annual TB conference. Researchers are asked to report on new scientific publications on a quarterly basis and they are provided with an opportunity to present their research results. Outputs are also disseminated via civil society organisations across their networks. Additionally, the chair of the TB TT has a technical support unit at the NDoH that assists with disseminating outputs to provincial and district levels.

When it comes to stakeholder engagement, the TB TT is well-connected to the NTP via its chair. His background as a clinician contributes to a positive attitude towards research. Members of the TB TT engage on an ad hoc bases through virtual and in-person meetings and workshops. The TB TT also have a global footprint that is attributed to members who have relocated to other countries. Stakeholders from across the country are usually invited to attend virtual meetings where outputs are shared, but most participants noted that district and sub-district practitioners and managers hardly attend these meetings unless they are directly involved in a project. One participant mentioned that: *“you’re not going to necessarily find a...some maybe, like a district or a sub-district TB manager necessarily, unless they’re involved in a project and they’re not the most frequent attendees”*. Nevertheless, other stakeholders, such as NDoH representatives and provincial managers are usually well-represented.

Funding the TB Think Tank

The TB TT provides valuable services to the NDoH, sustaining its operations primarily through donor funding, with various funders supporting different aspects of its work. An interview participants explained: *“Initially, the Think Tank was funded by the Bill and*

Melinda Gates Foundation. Their catalytic funding from 2014/2015 helped establish the Think Tank, leading to additional support from USAID and CDC". Initial funding from the Bill and Melinda Gates Foundation helped the TB TT gain traction, and later, the United States Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC) joined in as funders. Currently, the TB TT 's secretariat is primarily funded by USAID and CDC. Additionally, the TB TT receives funding from the South African Medical Research Council (SAMRC) and the Bill and Melinda Gates Foundation also returned as a funder in August 2023 after a brief break between 2021 and 2023.

The Gates Foundation has committed to a three-year grant from 2023 to 2026, with USAID and CDC providing matching funding and renewing their grants annually. SAMRC, although the smallest funder, provides indefinite, government funding of approximately R600,000 per year. Funding from the SAMRC shows that the South African government sees value in the TB TT's work, even though the most funding still comes from international donors.

A few interview participants mentioned that there are discussions about the NDoH eventually needing to fund the TB TT, as its work is aligned with national health priorities. Securing long-term sustainability through government funding would ensure that the TB TT continues to play its vital role in supporting TB policy and practice in South Africa. Another participant stated that: *"So yeah, it's quite good. We had made an application to Global Fund to include it because Global Fund is funding a large sum of money for the TB programme and we believe that it would be good at this stage in that Global Fund funding. But probably for sustainability, perhaps the government itself should consider starting to put some resources because it's a structure that is very useful to the running of government services"*.

Operational gaps in the TB Think Tank

While the operations of the TB TT are generally considered sound, some participants feel there are gaps. One participant expressed this sentiment, stating, *“I don’t think there’s anything wrong with the design, but the effectiveness could definitely improve”*. One gap that participants spoke about related to lack of clear pathways for evidence and recommendations to be shared with and used by the NDoH. One participant gave an example of this gap by saying that *“...policy briefs that have been produced and sent on, but are not followed up with concrete actions”*, and another participant suggested a clear pathway *“making sure that there’s follow-through from the TB Think Tank chairs, to the exco and from the exco escalated to NDoH or escalated to research institutions...is a function that could improve”*. Another participant gave an example about ongoing work on a TB occupational health policy: *“There is one that we’ve been working on and it’s just not gaining any traction within the Department of Health... it’s going to be a decade just now, I think, which is unfortunate, right, because it is so important to protect healthcare workers”*.

Another gap that participants mentioned was that HIV stakeholders, public finance officials, and the private sector are not widely involved in the operations of the TB TT, which could hinder comprehensive policy development. A participant said: *“I’ve been trying since I started in the TB Think Tank to get people from the HIV cluster included... there’s no point in us developing guidelines and they’re developing their own and then they don’t talk to each other”*.

Furthermore, limited capacity to produce outputs was mentioned as a gap in the TB TT’s operations. One participant was concerned about outputs not being timely and complete: *“So last year we had half an output, it is still not finalised, that’s all. I have been thinking quite a bit about it. Is it time that the treatment outcomes task team dies, has it outlived its use?”*. Other participants were concerned about members’ capacity to contribute: *“And it is a lot of work, it is a huge amount of work and I don’t know, last year was very difficult, just nobody in my task team had the time and capacity and bandwidth to do anything”*.

Additionally: *"Why get us to do the work if somebody else is going to do it. I don't actually have time to spend hours. We worked, we did a lot of work on an adherence policy, I would say it took me ten working days over a time, but ten full working days to come up with that thing".*

Participants also spoke about a gap between the TB TT's priorities and the NTP's implementation needs. One participant described this issue: *"So how do we ensure research priorities align with the needs of the TB programme, because as you know I'm sure, that we are a high burden TB country, we've got massive research capacity but we need to strengthen implementation research because if you look at our cascade we're still losing most of the patients along the way right, and as such our overall performance in my view is sub-par, given the capacity that we have."* Another participant linked this implementation issue to the complexity of addressing TB in South Africa: *"I think what we've learned now working in TB over the last three years is that it's deceptively simple but incredibly complicated, when you look at the cascade it's like you have to find the people, you treat the people, you must keep them in care and then they're cured and everything is great, but in practice when it meets reality and decision making, it's incredibly complex and there's very little information".*

It was also noted that the TB TT lacks a system for monitoring and evaluating its influence on national policy, which could be an area for future improvement.

Evolution of the Think Tank over time

The TB TT has shown significant evolution over time. It was initially funded as a pilot project from 2014 to 2017, aimed to demonstrate its potential in supporting government policy-making through evidence-based methods. That pilot project grew significantly by the end of 2017 and expanded its scope to include TB experts and task teams (and more recently working groups). Additionally, the TB TT became more inclusive, incorporating a diverse range of stakeholders. This shift helped it address a broad range of topics and produce outputs more aligned with the needs of the NTP. One participant said: *"I'm an*

epidemiologist but my work in South Africa has been a lot of social science as well, and there were no social scientists, there were only clinicians, clinical scientists in the room and it just seemed very dis-representative of everything that was going on out there, that's changed a lot over the years". Another participant commented positively on the TB TT's evolution: "One of the nice changes is that previously it was very much a heavy focus on researchers, whereas now it is more implementers and there are also TB advocates that are part of it. I think all of those groupings bring different perspectives which I think is important".

The TB TT's pivot from a pilot project to a fully operational platform resulted in increased visibility and recognition. Another participant expressed how well the TB TT is working: *"I think it's just evolved, it's more effective, each of the task teams, it's doing important work and there's a very nice culture of cooperation and there isn't conflict, there isn't competition you know, we just get together, focus on the TB issues, try to help the department to be more effective, and then with more funding we can do more you know".*

From its inception to present, the TB TT's evolution has highlighted substantial improvements in both its structure and influence on policy and practice. It has become more structured, with a stronger secretariat and a broader range of expertise, including epidemiologists, social scientists, health systems analysts and others. One participant confirmed that: *"When it started, it didn't have a strong Secretariat. Aurum was doing it on an ad hoc basis, so I think strengthening the operations and the governance made a difference to the way it operated. It also meant that the National Department of Health started playing a more strategic role in it".* The shift towards a more participatory model, particularly post-COVID, has enabled quicker responses and better integration with the NDoH. Enhanced funding from multiple sources has also allowed for more comprehensive outputs and improved cooperation among task teams and working group, leading to significant advancements in TB policy and practice.

Strengths of the TB TT

One strength of the TB TT is that it has buy-in and is supported by the NDoH and many other reputable organisations. One participant confirmed this by saying: *“I think it’s more of the enhanced support by the National Department of Health because I think that’s what gives the Think Tank it’s credence because you realise that the Think Tank doesn’t have more of a legal power on issues, rather it has more of an influential power”*. A second strength is highlighted by participant who said that: *“It is a community that provides a space where one is kept up to date on key priorities in the TB communities it also provides opportunities to connect and network”*. The stakeholders within the TB TT come from different parts of the country, bringing with them different experiences and knowledge, and thereby making the evidence and recommendations produced more credible and representative of different South African contexts. The current diversity of the TB TT members in race, gender, culture, and job title is a third strength of the TB TT compared to the past when members of the TB TT were mainly white male clinical researchers. This diversity has broadened the trust, respect, transparency, and competency of the TB TT and given it an added advantage in working closely with the NDoH.

A fourth strength of the TB TT has to do with the leadership of the TB TT’s chair. One participant said that: *“So Dr. Ndjeka is excellent, I don’t think other countries have such a responsive TB programme manager”*. Another participants attributed an increase in outputs within the TB TT to the chair: *“the level of engagement of the chief director with the Think Tank has strengthened the Think Tank and we’ve seen a big, an increase in the number of outputs”*.

Further, collaboration between members of the TB TT is noted as a fifth strength. Members share common goals and are driven by their commitment to those shared goals in the absence of remuneration. It is beneficial that the task teams and working groups have good leadership and consist of highly skilled individuals. One participant mentioned that the outputs produced by the TB TT are of high quality and go through a rigorous review process: *“if you just look at the amount and the speed at which guidelines are now out, and these are guidelines that are not done by one person, they are reviewed thoroughly and there’s rigorous critique and review of those guidelines”*.

A final strength mentioned by participants has to do with the reputation of the TB TT. It is a respected entity that researchers and other people who are interested in or working with TB want to be associated with. The TB TT's good reputation comes from it being flexible and adaptable to the local context; it has good leadership through the ExCo and secretariat; it can attract funding and maintain a good relationship with funders; and it has been sustainable for over ten years. One participant said: *"The good part again is that we've been able to attract and retain some of these key stakeholders within the TB Think Tank so they are also involved in some of the activities, they are involved in some of the Task Teams and there are people that also have invested interest in some of the work that we do"*.

Limitations of the TB TT

While some task teams and working groups are functioning well, others are experiencing challenges with keeping momentum and getting their members to commit. A few participants expressed this issue: *"Last year I just couldn't get people to do anything, and I wasn't the only task team that had that problem"* and *"people are just very busy"*. Although participation in the TB TT is on a voluntary basis, one participant raised an issue about the TB TT not compensating or recognising its members. The participant said that the TB TT receives a significant amount of money from funders that goes to the secretariat, while the sustainability of the TB TT through the task teams and working groups is dependent on voluntary work. Additionally, the participant suggested that discontinuing certain task teams could improve resource efficiency.

Some participants reported that the evidence produced within the TB TT was not optimally translated into suitable formats, and once submitted to the NDoH was not tracked for progress on implementation. One participant said: *"Having a guideline that doesn't impact anyone on the ground, what is the value of a deliverable if it is not reaching the people on the ground, an algorithm exists but doesn't impact every person walking into [Primary Health Care] PHC"*.

On the one hand, participants reported that producing evidence and developing guideline recommendations within the TB TT was slow. One participant expressed that: *“on the prevention side the guideline took too long to do, but it was done, and it was a useful guideline, but it didn’t go fast enough”*. On the other hand, participants also reported that the uptake of evidence and approval of guideline recommendations was slow. For example, with the Targeted Universal Testing for TB Policy was developed within a year, however the approval of the policy took long. One participant expressed frustration with the approval processes: *“I find that process of approvals frustrating, but equally sometimes I think that things sit at the Think Tank for too long like the digital chest x-ray SOP... there could be a year where national policies are out but provinces aren’t implementing it”*. A few participants noted that low participation of provincial TB managers in TB TT meetings, where TB related priorities are discussed and decisions are made about specific policy and recommendations, negatively impacts their implementation.

Another limitation of the TB TT relates to juggling national TB priorities and the priorities of funders. A participant explained that: *“at times it’s difficult to negotiate between what the real priority is, versus what the funder is willing to fund; at times we find ourselves giving into the demands of the funder for something that maybe we would have not gotten to do at that particular time”*. Hence, the TB TT is faced with managing expectations and conflicts of interest amongst stakeholders. One participant expressed *“I just think we’re supposed to be independent right, the funders are supposed to give us the funding to allow the task teams to decide what the priorities are, so it feels there are certain funders where that becomes quite challenging”*.

The bureaucratic nature of both the TB TT and NDoH was perceived as a constraint, hindering the efficiency of the TB TT's activities. For example, one participant said: *I think the main limitations are the bureaucracy of the – in approvals you know – of some of the outputs, the process that it takes, the time that it takes and that becoming unnecessarily long, because ja, it just needs to go through that process”*. Some participants said that the TB TT has not sufficiently explored how to effectively navigate the NDoH system.

They suggested that the secretariat needs to investigate the various forums within the NDoH where TB TT representation is required and establish the necessary feedback loops to its members. However, participants also shared that they were concerned about the additional expectations this would place on already-busy members.

Another challenge faced by the TB TT is accessing relevant NDoH data. The NTP does not manage its own data, and although efforts to engage with the division responsible for data management have been ongoing, these efforts have encountered numerous challenges. One participant explained this challenge: *“we are struggling with data management, we have a data management task team but you know it’s struggling because, well probably like a much bigger problem with data management in the health services, we don’t have access to TIER data if we want data from TIER we need to request it from another department in the NDoH, but we have a whole ongoing review at the moment looking at how to interact with that whole reform process”*.

Furthermore, most interview participants reported a lack of understanding and clarity regarding the processes that occur after outputs are reviewed within the TB TT and submitted to the NDoH. One participant said: *“that process is not very clearly defined, and if the process is clearly defined, the process is not very effective”* Another participant noted that there is clarity on the different approval levels within the NDoH: *“Because the guideline process is so drawn out eventually you get to hear that something has been accepted but it is a bit convoluted, nobody writes to the person who has presented it and says, thank you so much it has gone to this stage. Or just to let you know that it has now progressed from stage one to stage two, there is none of that”*.

Participants identified a dual challenge with the meeting structure of the TB TT. They felt that having only one in-person annual meeting was insufficient and suggested increasing it to two meetings per year, as building relationships online proved difficult. Conversely, they also found the frequent online meetings to be problematic, suggesting that some communication could be handled via email. Coordinating online meetings was

challenging due to difficulties in finding suitable times that accommodate all interested individuals.

Monitoring and Evaluation

All participants reported that there are no measures put in place for monitoring and evaluating the influence and impact of the TB TT on national policy and practice, except for this and a previous evaluation. There are no specific stakeholder engagement, dissemination and/or community strategies in place.

Task teams and working groups develop annual workplans, which the ExCo use to monitor progress of activities and outputs. The ExCo meets quarterly where tasks team and working group leads provide updates. One participant explained: *“You know, like we’ll have an exco meeting and everybody will report, it will be documented in the minutes, but that’s not what you’re talking about, you’re talking about a more formal monitoring and reporting on the successes and failures”*. Another participant said that implementing mechanisms for monitoring and evaluation the TB TT could cause issues: *“I don’t want to force it too much into a rigid structure, we’re not an institution, we’re a forum of volunteers...a voluntary association of highly functioning people you know, the moment you start putting too many boxes and rules then it could work against you”*.

Recommendations

Gaps identified	<u>Recommendations made</u>
Slow production of evidence and uncertainty about the uptake of recommendations	<ul style="list-style-type: none"> • Establish a mechanism to ensure that outputs submitted to the ExCo and NDoH are followed up for feedback and impact assessment.
Evidence produced within the TB TT is not optimally translated into suitable formats.	<ul style="list-style-type: none"> • Enhance the TB TT’s support in decision-making processes at NDoH and establish a feedback loop on the usability / usefulness of evidence and appropriateness of dissemination formats. • Strengthen methods and capacity for conducting systematic searches and reviews and knowledge translation. Explore collaborations with evidence synthesis organisations, such as Cochrane or Joanna Briggs Institute.
There is minimal representation of some relevant stakeholders in the TB TT activities.	<ul style="list-style-type: none"> • Seek to include representation from additional universities, research institutions, and various levels of government in the country to ensure inclusivity and that research is well-contextualised. • Investigate why some stakeholders have opted not to participate in the TB TT and address these concerns. • Explore opportunities for collaboration with HIV stakeholders, specifically, to ensure comprehensive policy and recommendations.

<p>Conflicting priorities of the NTB and funders</p>	<ul style="list-style-type: none"> Promote a balanced approach to funding by leveraging both global funders and local government support, ensuring priorities are clearly defined and managed.
<p>Bureaucratic constraints within both the TB TT and NDoH, hindering efficiency and clarity in processes.</p>	<ul style="list-style-type: none"> Consider how the secretariate can more effectively use its capacity to support task teams and working groups. For example, the secretariat could distribute a survey to task team and working group members to identify current gaps in support and communication, as well as gather suggestions on how to address these issues. The secretariat can then review and update its support and communication accordingly and seek opportunities to increase its capacity. However, there is also a need for the secretariat to clarify its purpose and set realistic expectations regarding the level of assistance that can be provided to task teams and working groups.
<p>Difficulty accessing relevant NDoH data, hindering data management efforts.</p>	<ul style="list-style-type: none"> Explore solutions with the NDoH to access and retrieve data efficiently, e.g. develop a joint data portal. This portal could include features for real-time data access, monitoring data requests, and tracking the usage of shared data.
<p>Insufficient in-person meetings and challenges with coordinating online meetings.</p>	<ul style="list-style-type: none"> Review and update support and communication, potentially increasing in-person meetings to two per year while addressing challenges with online communication.

<p>Lack of monitoring and evaluation of the TB TT's impact on national policy and practice.</p>	<ul style="list-style-type: none"> • Implement Integrated Knowledge Translation and Communication Strategies to systematically and intentionally engage stakeholders, disseminate and communicate outputs, and monitor and evaluate impact on policy and practice.
<p>Lack of momentum and commitment within task teams, with voluntary participation not being sufficiently recognised or compensated.</p>	<ul style="list-style-type: none"> • Explore mechanisms for recognising individuals who have made significant contributions to specific outputs by formally acknowledging and attributing efforts to them, particularly for work within the TB TT that extends beyond regular duties.
<p>Lack of clarity on the TB TT's role in Implementation Research.</p>	<ul style="list-style-type: none"> • Clarify or agree upon the scope of the TB TT in policy and guideline implementation, particularly in engaging with provincial and district implementers.

Conclusion

The TB TT has emerged as a key player in South Africa's fight against tuberculosis, successfully bridging the gap between research, policy and practice. Over the past decade, the TB TT has made significant progress by aligning itself with the NTP's priorities. Through a well-structured governance system, inclusive stakeholder engagement, and its capacity to generate timely and relevant evidence, the TB TT has advanced the development and implementation of TB strategies through outputs such as the TB Vision 2023-2028 and the TB Recovery Plan.

Efforts to ensure the TB TT's long-term sustainability are already underway, with increasing support from the NDoH as an important advisory body. This collaboration, alongside continued funding from national and international partners, ensures the TB TT's ability to drive national TB strategies effectively. While reflecting on these successes, a recent evaluation of the TB TT highlights a few operational challenges that, if addressed, could further enhance its functioning and influence on national policy and practice.

The TB TT's evolution over the past decade demonstrates its growing influence in South Africa's public health landscape. As it continues to adapt to emerging challenges, it remains well-positioned to contribute to the national TB agenda, supporting evidence-informed strategies that improve health outcomes and ensure equitable care for those affected by tuberculosis.

Acknowledgements

We would like to thank all TB TT members who initiated, supported and/or participated in this evaluation study.

Appendices

Appendix 1: Survey questions

1. Do you agree to participating in this evaluation (research study)?
1. What is your sex?
2. Which stakeholder group do you belong to?
3. Are you involved in any of the task teams and/or working groups?
4. Describe your role in the TB Think Tank.
5. How long have you been involved with the TB Think Tank?
6. On a scale of 1 to 5, how satisfied are you with your involvement in the TB Think Tank's activities?
7. Do you feel that the TB Think Tank includes a diverse range of stakeholders in its discussions and decision-making processes?
8. If you answered 'no' to the question above, which stakeholder group(s) do you think is/are underrepresented?
9. On a scale of 1 to 5, how effective do you think the TB Think Tank has been in collating, reviewing, synthesising and evaluating evidence related to policy and implementation?
10. On a scale of 1 to 5, how effective do you think the TB Think Tank has been in soliciting or requesting evidence, and when needed research, to guide policy and implementation?
11. On a scale of 1 to 5, how effective do you think the TB Think Tank has been in identifying and prioritising research questions?
12. On a scale of 1 to 5, how effective do you think the TB Think Tank has been in advising the National Department of Health on policy implementation?
13. What does the Think Tank do particularly well?
14. What activities or initiatives of the TB Think Tank do you find most effective in producing evidence or influencing policy and practice? Please explain.
15. On a scale of 1 to 5, how satisfied are you with the quality of the evidence and recommendations produced by the TB Think Tank?
16. On a scale of 1 to 5, how satisfied are you with the quantity/frequency of the evidence and recommendations produced by the TB Think Tank?
17. Can you provide an example of a research output or recommendation that you found particularly influential, useful, or impactful in past year?
18. Do you think the TB Think Tank should be organised or positioned differently to advance its work?
19. If you answered 'yes' to the question above, how do you think it should be re-organised and re-positioned differently?
20. Do you think the TB Think Tank is prioritising the right things?
21. If you answered 'no' to the question above, how do you think the TB Think Tank can improve how it prioritises its work?
22. List internal and external barriers that affect the TB Think Tank's functioning and impact.

23. In light of the barriers you have listed above, how can the TB Think Tank be improved or strengthened?
24. List internal and external facilitators that affect the TB Think Tank's functioning and impact.
25. Are there any new areas or issues you think the TB Think Tank should address in the future? Please explain.
26. Is there anything else you would like to share about your experience with the TB Think Tank? Please elaborate.

Appendix 2: Information sheet

Topic: Evaluating the impact of the TB Think Tank on South African policy

What is the study about?

Dr Bey Schmidt at the University of the Western Cape and her team are conducting an evaluation of the TB Think Tank. This evaluation includes describing the characteristics of the TB Think Tank; determining the effectiveness/influence of the Think Tank in translating TB evidence into national policy recommendations; and providing recommendations for strengthening the TB Think Tank.

Why are you being invited to participate in this study?

The researcher is inviting you to participate in this study because you are a key staff member of the TB Think Tank.

What will you be expected to do in this study?

You will be invited to a virtual interview. During the interview, you will be asked about the activities, processes, outputs, purpose, functions, models, stakeholders, positioning, funding, strengths, limitations, monitoring, impact, and status of the TB Think Tank.

We will follow these steps for the virtual interview:

1. Before the interview you can contact the researcher with any questions you have before you agree to participate in the study, via email, phone call, or text message.
2. If you are willing to voluntarily participate in this study, you will be asked to complete verbal (with recording) or written informed consent.
3. The researcher will contact you to schedule the interview.
4. The interview will be held on Microsoft Teams.
5. The duration of the interview will be approximately one hour.
6. Some of the topics that may be discussed are:
 - Your role or involvement with the TB Think Tank;
 - Your experiences with people, activities, and processes of the TB Think Tank;
 - Your perspectives on the functions, strengths, and limitations of the TB Think Tank;
 - Your perspectives on whether/how the TB Think Tank is successful in influencing policy and practice; and
 - Your suggestions for improving and strengthening the TB Think Tank.

7. The interview will be audio-recorded with your permission.
8. After the interview, you are welcome to ask any questions.

What are the potential risks involved in this study?

All human interactions and talking about self or others carry some amount of risk. The researcher will minimize such risks and act promptly to assist you if you experience any discomfort or psychological distress 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 potential benefits involved in this study?

A potential benefit of this study is that you and other stakeholders of the TB Think Tank will be asked about mechanisms for strengthening it. You will collectively be providing solutions to challenges you face within the TB Think Tank. Additionally, this study will make recommendations for the TB Think Tank and other knowledge translation platforms. Another potential benefit has to do with conducting virtual interviews. You will not incur financial costs (e.g. transport fare) or lose time (e.g. travel time) as is the case with face-to-face meetings.

Will my details be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution.

To ensure your anonymity:

- All data for the study that are captured in documents will use participant codes instead of participants' names.
- All articles, reports, and presentations will not state participants' names and pseudonyms will be used instead.

To ensure your confidentiality:

- Any hard-copy documents will be stored in locked cabinets by the researcher and her
- team.
- Any soft-copy documents will be saved on an online storage platform (Dropbox) accessed via password-protected computers.
- Transcribers will be asked to sign confidentiality agreements stating that they will not disclose participants' identities or information that they shared.

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), please note additional information:

What type of personal information will be collected?

Your name and age

Who at UWC is responsible for collecting and storing my personal information?

Dr. Bey Schmidt will be responsible for collecting and storing your personal information.

Who will have access to my personal information outside of UWC?

Dr Chanelle Mulopo and Ms Lilian Mayieka who will be assisting with this evaluation study.

How long will my personal information be stored?

Electronic data will be kept on the researchers' password-protected computer, for five years and deleted thereafter. Hard copies will be kept in a locked drawer for five years and shredded thereafter.

How will my personal information be processed?

Only personal information that is necessary for this project will be collected, we will not collect information more than what is needed.

Who do I contact for further information?

Should you require any further information, please do not hesitate to contact me Dr. Bey Schmidt on my cell phone (079 070 3631) or via email (bschmidt@uwc.ac.za).

To report any adverse or unexpected effects emergent from this research, please contact the ethics committee below:

Biomedical Research Ethics Committee
Research and Postgraduate Division
University of the Western Cape
Private Bag X17
Bellville 7535
Tel: 021 959 4111
Email: research-ethics@uwc.ac.za

This information sheet is for you to keep so that you can be aware of the purpose of the study. With your signature on the attached consent form, you indicate that you understand the purpose of the exercise.

Appendix 3: Consent form

Topic: Evaluating the impact of the TB Think Tank on South African policy

Researchers: Dr. Bey Schmidt, Ms. Lilian Mayieka, and Dr. Chanelle Mulopo

Please initial the boxes to show your agreement and understanding of what is expected for this study.

1. I confirm that I have read and understood the information sheet explaining the above research project and I have had the opportunity to ask questions about the project.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I wish to withdraw, I may contact the lead researcher at any time to do so).
3. I understand my responses and personal data will be kept strictly confidential.
4. I give permission for members of the research team to have access to my responses without revealing any part of my identity.
5. I understand that my name will not be linked with the research materials, and that I will not be identified or identifiable in the reports or publications that result from the research.
6. I hereby agree that my anonymized responses collected through the questionnaire can be used for this research.
7. I agree for the **anonymized** data collected to be used in future research

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), personal information will be collected and processed:

- I hereby give consent for my personal information to be collected, stored, processed and shared as described in the information sheet.
- I do not give consent for my personal information to be collected, stored, processed and shared as described in the information sheet.

Name of Participant
(or legal representative)

Date

Signature

Name of person taking consent

Date

Signature

Appendix 4: Interview guide

Topic: Evaluating the impact of the TB Think Tank on South African policy

Consent:

- Ask participant to provide verbal (with recording) or written consent.
- Ask participant permission to be recorded.
- Ask if the participant has any questions.

Basic information:

- Gender
- Job title
- Years of TB Think Tank operating
- How long have they been working for the TB Think Tank

Interview Questions:

1. What is your **role** within the TB Think Tank?
2. What is the **purpose, function, structure and model** of the TB Think Tank?
3. How is the TB Think Tank **funded**? How are its operations sustained over time?
4. Who are the key **collaborators and/or users** of the TB Think Tank? What is their role?
5. Has the TB Think Tank **changed over time** (in activities, processes and outputs), e.g. from when it started to now, or before and after the COVID-19 pandemic?
6. What **activities and processes** are carried out within the TB Think Tank?
7. What kinds of **outputs** does the TB Think Tank produce?
8. How is **evidence** produced within the TB Think Tank used in policy and practice decision-making processes?
9. What is the TB Think Tank's approach to **strategically engaging** relevant stakeholders, and **disseminating and communicating** evidence and outputs produced within the TB Think Tank?
10. What makes the TB Think Tank work well? What are its **strengths**? Can you share a situation or story.
11. What makes the TB Think Tank not work well? What are its **weaknesses or limitations**? Can you share a situation or story.
12. How can the work of the TB Think Tank **be improved or strengthened**?
13. Do you think that the TB Think Tank should be organised or **positioned differently** to advance its work?

14. Do you have processes in place to **monitor and/or evaluate** whether or how the TB Think Tank is successful in influencing policy and practice? Are you tracking outcomes at the **individual and clinical level**?