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From process to priority: Improving responsiveness in South African health research

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The extraordinary human and financial costs associated with intensive care in Africa have been well documented.[1] However, few studies have described the long-term health outcomes of critical illness survivors in Africa.[2] Most existing knowledge about recovery trajectories, disability and post-ICU quality of life originates from high-income countries, whose health systems, social support structures and resource contexts differ substantially from our own.[3] Locally, we spend millions annually on ICU care,[4,5] yet we have little evidence about what happens to survivors after discharge, whether they regain functional independence, or how survivors and families cope with the enduring consequences of critical illness. This evidence gap has direct consequences for patient care. Critical illness does not end at ICU discharge: survivors frequently face prolonged physical deconditioning, cognitive impairment, psychological sequelae and social disruption that require coordinated management across the full continuum of care - from the acute phase through post-acute rehabilitation, community reintegration and long-term follow-up.[6] Without locally relevant evidence spanning this continuum, clinicians are left to navigate complex care transitions and rehabilitation decisions with limited evidence, unable to draw on data that reflects the realities of their patients and health systems. The scarcity of local ICU research, spanning in-hospital outcomes, multicentre trials and long-term follow-up, underscores the urgent need to generate locally relevant evidence that can support holistic patient management. Yet the systems meant to enable this work are, too often, the very systems slowing it down.

Timely, rigorous and multicentre research is essential not only to advance scientific knowledge but also to support evidence-based, holistic management of critically ill patients across the full care continuum - from acute stabilisation in the ICU through post-acute recovery, rehabilitation and community reintegration. In critical care, where multicentre designs are often necessary to achieve adequate sample sizes and longitudinal follow-up is essential to understand recovery trajectories, the cost of procedural delay is especially high. The costs of procedural delays are not borne by researchers alone: without timely evidence, clinicians lack the data needed to guide patients through the transition from the ICU to the ward, from the ward to rehabilitation to community reintegration. Furthermore, teams planning and motivating for post-acute care programmes cannot justify service design decisions. Lastly, the complex, multi-disciplinary co-ordination that holistic recovery demands is left to operate in an evidence vacuum.

For many South African (SA) clinician-researchers, the path to conducting research remains obstructed by procedural complexity. One obstacle, seldom discussed but deeply consequential, is the requirement for reciprocal ethics approval, commonly arising when researchers are affiliated with more than one institution or when a study involves multiple institutions, health facilities or collaborative research teams. Despite prior approval by the primary ethics committee, parallel approval may still be required by the employing or host institution. Although intended to promote accountability and oversight, the process often results in unnecessary duplication, delays and confusion, which are particularly problematic in time-sensitive fields such as critical care research, where procedural barriers may impede the knowledge generation needed to support patients through the full journey of recovery from critical illness.

The tension between participant protection and research facilitation is not new. SA research ethics committees (RECs) operate within a complex and sometimes fragmented regulatory landscape that has been criticised for variability, limited capacity and procedural inefficiency.[7,8] Several authors note that while independence of review is important, over-regulation or redundant approvals can restrict research productivity without improving ethical safeguards.[9] Differences between institutions, shaped by their histories and independence, mean that national guidelines are applied unevenly and inefficiencies persist.

Reciprocal ethics reviews, though designed to ensure institutional accountability, often reproduce prior assessments rather than add substantive value.[10, 11] In most cases, such re-reviews yield no meaningful change to methodology or participant protection.[12] Instead, they create administrative bottlenecks that can extend for months, jeopardising doctoral projects, research funding timelines and the translation of evidence into practice. Similar challenges have been described across Africa, where inconsistent REC capacity and a lack of mutual recognition impede the pace and quality of health research.[13,14]

RECs carry a dual mandate: to protect participants from harm while enabling socially valuable, ethically sound research. Too often, the second responsibility receives insufficient emphasis.[15] In a field such as critical care, where rapid knowledge generation can improve outcomes, timeliness itself is an ethical concern.[16] Ethics systems must evolve from duplication to collaboration, recognising the legitimacy of peer review processes across accredited institutions and fostering reciprocity and trust between committees.[9,17]

At the national level, the National Health Research Ethics Council (NHREC) has a pivotal role to play. The principle of mutual recognition is already supported within the SA National Department of Health's Ethics in Health Research: Principles, Processes and Structures (2024), which explicitly provides that "*To prevent unnecessary duplication of work, RECs may, at their own discretion, recognise the review and approval of a research protocol granted by another registered South African REC.*"[18] However, in practice, this provision remains largely underutilised. There is still no consistent process for implementing mutual recognition between accredited committees, leaving each to decide independently. Without coordination, institutional caution and fear of liability often result in repeated reviews for multisite or inter-institutional projects.[8,10,12]

Achieving consistency will require leadership at national level. A national reciprocal ethics framework could provide a constructive solution, allowing RECs to recognise one another's decisions under

defined conditions while maintaining participant protection. Such a system could also include expedited pathways for research of demonstrable public health importance, as highlighted during the COVID-19 pandemic.[16] Streamlining ethics review aligns with national science and health policy priorities such as the National Development Plan 2030, which emphasises the generation of locally relevant evidence to strengthen health systems and improve population health outcomes.

The call, therefore, is not for less ethics but for smarter ethics. The principles of autonomy, beneficence and justice are not served by processes that delay urgently needed research. When low-risk, ethically sound studies remain in administrative delays for months, beneficence is compromised and justice is denied to those who might benefit from the results.[9] The moral cost of inaction, measured in delayed innovation, lost capacity and potentially even preventable deaths, cannot be justified by rigid adherence to institutional silos.

Reform requires leadership and collaboration. The NHREC, universities and hospitals must collectively develop systems of trust, shared accountability and mutual recognition. Ethics committees themselves must embrace their dual identity as protectors and facilitators of ethical research. The alternative - a system of duplicated reviews and procedural delays -threatens the progress of critical care science in SA.

Ethics committees are not merely custodians of caution; they are stewards of possibility. Their work is vital to safeguard human dignity and maintaining public trust in research, yet this protection must not come at the expense of progress. By embracing collaboration, proportionality and mutual recognition, SA can build an ethics ecosystem that upholds integrity while enabling the research needed to improve lives. In the end, ethics is not about bureaucracy, it is about humanity. Every unnecessary delay in research represents an ethical cost as real as any procedural risk, and reducing these delays is a shared responsibility. Until the processes that govern our research catch up with the urgency of the questions being asked, SA patients affected by critical illness, and the clinicians who care for them, will continue to operate in an evidence vacuum, deprived of the locally relevant data needed to inform care, guide recovery and understand outcomes.

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