Mapping the multiple intersectoral spaces for civil society participation and responsiveness strengthening in the South African health system – focusing on the Western Cape

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Abstract

Since the Alma Ata Declaration of 1978, community participation in health policy development and health system functioning has called for a collaborative intersectoral approach, engaging civil society as a pivotal agent for improving policy-makers' responsiveness in the public health system. Intersectoral approaches are widely accepted and research has shown the value in engaging communities in the improvement of their health. However, astonishingly little is known about the overall configuration, nature, and focus of the 'spaces' where civil society are participating in health system-relevant engagement, or their contribution towards improved system responsiveness.

This study describes a local provincial health system, the Western Cape province in South Africa, mapping the intersectoral spaces where civil society participates in the health system, provides feedback to the system (towards responsiveness), and contributes to health system improvement decisions. A mixed method case study was conducted, integrating desk-based review of multiple forms of openly available data, with verification from experts in the field. Sixteen intersectoral spaces in the Western Cape health system were mapped and compared, with analysis focussing on current governance practices in these spaces, evidence of accountability measures and civil society participation within the broader goal of improving health system responsiveness.

Multiple spaces exist for intersectoral engagement in the Western Cape of South Africa, but there is a lack of any 'system-wide' integrative approach – which creates overlap, a focus on vertical programming, and parts of civil society remain 'disconnected' from the system. Feedback from civil society back into national or provincial policy-making processes is sporadic due to fragmented tiered governance. New efforts towards 'whole-system' intersectoral collaboration need to be initiated and actively protected, if they are to succeed.

This study demonstrates that while 'intersectoral action for responsiveness strengthening' is broadly encouraged in this health system, it needs to be more fully assessed and operationalised in terms of multi-level governance, accountability and civil society empowerment. In doing so avenues can be identified for improving civil society's feedback into the public health system, and ensuring adequate system's response to this feedback, in health policy and practice.

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Acronyms and abbreviations

CBOs	Community based organisations
CDD	Community driven development
CMHF	Cape Metro health forum
CHC	Clinic health committee
CoCT	City of Cape Town
CoCT HIV / TB	City of Cape Town HIV / Tuberculosis committee
CS	Civil society
CSOs	Civil society organisations
CSP	Civil society participation
DHA	Department of home affairs
DHC	District Health Committee
DoH	Department of health
DSD	Department of social development
GBV	Gender-based violence
HESP	Health systems strengthening through strategic partnerships
HPCA	Hospice palliative care association
ISC	Intersectoral collaboration
LMICs	Low and middle income countries
LN	The Learning Network
MSATs	Multi-sectoral action teams
NGO	Non-governmental organisation
NHI	National health insurance
PCA	Provincial AIDS council
PCB	Provincial consultative body
PHC	Provincial health council
PPHF	Public-private health forum
PRSP	Poverty reduction programs
RRO	Refugee reception office
SALGA	South African local government association
SANAC	South African national AIDS council
SANGOCO	South African non-governmental organisation coalition
SDHC	Sub-district health committee
SGJ	Sonke Gender Justice
TAC	Treatment Action Campaign
UNAIDS	United Nations AIDS
UNDP	United Nations Development Plan
WC	Western Cape
WC-NACOSA	Western Cape networking HIV AIDS community of South Africa
WHC	Ward health committee
WHO	World Health Organisation
WoSA	Whole of society approach

Glossary

Civil society	"…a social sphere separate from both the state and the market … [with] CS organizations (CSOs) [as] non-state, not-for-profit, voluntary organizations formed by people in that social sphere" (Greer et al. 2017)
Civil society participation	"…the process by which members assume greater responsibility for their health needs and engage in health planning and "promotion, policy priority and standard setting, allocation of resources and monitoring of quality of care" (Zakus and Lysack, 1998) (Loewenson, 2000) .
Intersectoral	Intersectoral collaboration considers the roles of all actors in the system and aims to strengthen coordination between these actors- in such that their collective efforts work for one common purpose. Communication and purposive coordination between all actors is essential in achieving intersectoral collaboration and ultimately responsiveness (Adeleye and Ofili, 2010).
Vertical intersectoral collaboration	Intersectoral collaboration exists on horizontal and vertical dimensions. Horizontal intersectoral collaboration implies collaboration across sectors- such as Health, Education, Agriculture, Public Works and Housing. Vertical intersectoral collaboration, on the other hand, refers to the intersectionality of actors involved in those spaces- such as government departments and bodies; public-private engagements; civil society organisations and communities (Lindau et al. 2016)
Accountability	"the means by which individuals and organizations report to a recognized authority (or authorities) and are held responsible for their actions" (Edwards and Hulme, 1996).
Collaborative space	Space for…"planned or spontaneous engagements that take place between individuals or teams of individuals, whether in-person or mediated by technology, where information is exchanged in some way…and often occur across different roles" (Eikey et al. 2015).
Health system responsiveness	"Health system responsiveness has been identified as one of the intrinsic goals of health care systems, alongside health outcomes and fairness of financial contributions… Responsiveness relates to a system's ability to respond to the legitimate expectations of potential users" (Robone et al. 2011).
The public health system	the state-governed national health service, and inclusive of varied government institutions and actors

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Research Protocol

Mapping the multiple spaces for civil society participation in the South African health system – focusing on the Western Cape

Introduction

A health system's performance is determined by the complex and dynamic relationships within and between its hardware and software (Goudge et al. 2009). No longer can a health system's strength be measured solely by its resources and clinical outcomes, but we also need to take other concerns into consideration, such as health system responsiveness (Adesanya et al. 2012). The 'responsiveness' of a health system is a key objective of health systems everywhere, and the World Health Organization (WHO) recommends this "as a measure of how well a health system responds to the legitimate expectations of its citizens" (population or individuals), and how effectively and timeously policy-makers and service providers (mostly governments), respond to the needs of individuals within the system (Mirzoev and Kane, 2017, pg 1). Responsiveness is thought to occur when a health system is designed to incorporate the voices of the people receiving health services into its broader policy-making structures (Mirzoev and Kane, 2017) and respond effectively and timeously to issues and needs emerging within the system (Robone et al. 2011). By incorporating the voices of people into the health system, with influence on high-level decision-making, and thereby also holding government to account - a health system's responsiveness can be strengthened (Barker, 2012). A health system which does not respond, or does not include people in its policy-making processes, can negatively affect people's utilization of health services and how effective a health system will be (Coyne, 2000). Particularly for services that require follow-up, patients who are not adequately responded to are more likely to discontinue health-seeking behaviour; and health systems are most likely to be effective if they meet a 'need'. These needs can best be understood by combining government opinion and policy with the voices of non-government groups and individuals within the health system (Coyne, 2000).

There is a broader framing of health systems responsiveness beyond patients – where a whole-systems approach is taken and the interest is in responsiveness of the health system to citizens, the 'community', the broader population, not just a patient-centred approach (Gilson et al. 2017). This is in line with systems thinking, where all health systems actors and groups of actors are considered important and part of the health system (Marchal et al. 2009). In this framing, 'civil society' is understood as having an important role in providing extensive feedback and strengthening health system responsiveness (World Bank, 2005).

There are multiple definitions of civil society, but in this case, can be defined as "…a social sphere separate from both the state and the market … [with] civil society organizations (CSOs) [as] non-state, not-for-profit, voluntary organizations formed by people in that social sphere" (Greer et al. 2017, pg 8). Civil society is understood to have the potential to strengthen the responsiveness of a health system in multiple ways. Civil society's key asset is the ability to increase the voice of non-government actors by bringing together representatives from many subgroups and communities; creating unification across participants from varying backgrounds with differing perspectives (Portal, 2016); and assisting health systems in establishing good governance by amplifying the voices of non-government actors when accountability is not being realised (Roy, 2008). The *United Nations 2030 Agenda for Sustainable Development* suggested that by building alliances across all levels of governance; voicing the needs of the people and holding policy-maker to account, *civil society* is a key factor in building responsive health systems (Storeng and De Bengy Puyvallée, 2018). Civil society participants in the system "are the people who need the public health system to work, so they are the

first to notice when it doesn't" (Heywood, 2009, pg 9). Civil society, therefore, has a powerful role to play in voicing relevant and timeous feedback to government- and ultimately strengthening responsiveness (Heywood, 2009).

Although civil society's potential in supporting health system's responsiveness is endorsed in the literature – it is widely observed that there are challenges in achieving full civil society participation in health system governance (Martinez and Kohler, 2016; Greer et al. 2017). 'Spaces' for civil society participation are either lacking; dysfunctional or inhibited (Adesanya et al. 2012).[1] Civil society's common point of entry and space to participate in LMIC health system is predominantly through mechanisms such as committees and forums (Bennett et al. 2018), but the *nature* of these spaces and where they are situated within the power dynamics and network of the health system are seldom understood or effective (Abimbola et al. 2014).

Civil society may be present in a health system, but with little influence on health system governance. It is therefore important to understand *how* civil society participates in a health system and whether or not it has the spaces and power to influence (government-led) health system responsiveness (Storeng and De Bengy Puyvallée, 2018). Collaboration and strong relationships between civil society and government institutions (and in turn the public health system), cannot be achieved without adequate intersectoral collaboration in place (Adeleye and Ofili, 2010). There is a need to build bridges and create dialogue between separated civil society and government actors (McQueen et al. 2012). Intersectoral structures allow actors from government and non-government to collaborate across all levels and with open lines of reporting and feedback (Coyne, 2000). 'Intersectoral collaboration' is defined in different ways – but here, we mean the interaction and intentional collaboration between government and non-government (civil society) actors in the health system.

The idea of 'intersectoral collaboration' is well accepted in LMIC health system's contexts, but has proved challenging to implement effectively (WHO, 2012). Little is understood about the operationalisation of intersectoral collaboration, which engages both government and civil society actors effectively (Greer et al. 2017).

Literature review

A need for intersectoral collaboration exists in order to ensure civil society has spaces to participate in the health system. These spaces should be interconnected, well-organised and link civil society to the necessary government decision makers in the system (Adeleye and Ofili, 2010). However, little is understood about intersectoral collaboration and how to achieve this *effective* civil society participation (Greer et al. 2017).

Even the term 'intersectoral' is challenging, and is sometimes used interchangeably with 'multisectoral' (WHO, 2011) – the WHO (2011) arguing that 'intersectoral' collaborative approaches have an advantage over 'multisectoral' approaches. Multisectoral approaches are efforts to address health issues by strengthening each actor and domain in parallel to one another (Adeleye and Ofili, 2010). However, intersectoral collaboration considers the roles of all actors in the system and aims to strengthen coordination *between* these actors - in such that their collective efforts work for one common purpose (WHO, 2011). Communication and purposive coordination between all actors is essential in achieving intersectoral collaboration - making spaces for civil society participation more effective and ultimately strengthens the responsiveness of a health system (Adeleye and Ofili, 2010).

[1] We unpack the concept of 'space' in more detail below

Lindau et al (2016) usefully differentiate between 'horizontal' and 'vertical' intersectoral collaboration: with horizontal being collaboration across sectors - such as Health, Education, Agriculture, Public Works and Housing; and vertical referring to the intersectionality of *actors* involved in collaboration – actors such as government departments and bodies; private organisations; civil society organisations and communities (Lindau et al. 2016). Vertical interactions, which are seldom understood in LMIC health systems (Portal, 2016), will be important to be look at in this study.

Since The Alma Ata Declaration of 1978, *vertical intersectoral collaboration* for health system strengthening (Botes and Van Rensburg, 2000) has been widely accepted in policy. The WHO shows intersectoral collaboration as a long-held conviction in their guidelines to achieving the Sustainable Development Goals (SDGs) (WHO, 2011). Although policy has long endorsed the role of intersectoral action for health system strengthening (McQueen et al. 2012), today intersectoral collaboration remains largely untested and imprecise (Lindau et al. 2016).

Within their contexts, each health system contains its own set of unique cultural, historical, political and economic structures which can complicate and inhibit intersectoral structures from operating effectively (Botes and Van Rensburg, 2000). Health systems are "locality-bound rather than universally definable" (Botes and Van Rensburg, 2000, pg 50). With this locally-bound and dynamic nature of a health system in mind, it is clear that there can be "no blueprints, nor ready-made recipes of participatory processes that can be applied" in order to achieve intersectoral collaboration (Botes and Van Rensburg, 2000, pg 50). A systematic review of literature on intersectoral collaboration for health in LMIC's showed limited evidence on the operationalization and impact of intersectoral efforts, and attributed this to the challenge of measuring intersectoral collaborations which are frequently changing and impact health through multiple inter-related, complex channels (Bennett et al. 2018). Actors within each health system behave differently depending on the health system context and it may be necessary to strengthen certain relationships or spaces in one system and entirely different ones in another to achieve a collaborative, intersectoral approach that is responsive (WHO, 2011).

According to a WHO (2012) report; "only a small number of countries and cities have so far been successful in initiating intersectoral action. One of the reasons is that there are few easily replicable models of successful intersectoral structures to follow" (WHO, 2012, pg 25). The World Bank Development Report of 2004 acknowledged the challenge of creating a replicable model for intersectoral collaboration and stated there is "no one size fits all" when considering intersectoral collaboration. The reports suggests that there should be multiple, adaptable approaches to intersectoral collaboration and approaches or 'sizes' need to be adjustable, "like waistbands" (World Bank, 2004, pg 1691). This issue was addressed through expert consultations in Helsinki and a Global Forum on Urbanization and Health in Kobe where academics and policy-makers documented a "path for policy makers to implement effective intersectoral action without an operational model", but rather 'adaptable waistbands' termed key lessons (WHO, 2011, pg 16). These included: 1) creating multi-level governance structures, 2) utilising accountability opportunities, and 3) opening spaces for civil society participation and empowerment.

The potential of multi-level governance in improving intersectoral collaboration

According to a WHO consultation in 2012, multi-level governance is key to achieving intersectoral collaboration (WHO, 2012). Multi-level governance involves governance from local, provincial and national government bodies and all levels of non-government, such as small and large civil society groups.

Civil Society Organisations (CSOs) range from small, informal, community-based organisations to large, high-profile (non-government organisations) NGOs (UNDP, 2016). By definition, therefore these groups can be highly diverse, with varied constituencies, functions and structures. Their reach or geographical footprint; governance potential and access to resources can be minor to significant. For the sake of this study, it is necessary to unpack what we mean by 'small' or 'large' CSOs, but the very nature of CSOs (varied and complex) makes this task challenging. Multiple definitions in the literature have been considered and small CSOs are commonly believed to be organisations with local reach and footprint (village / community); local governance and small constituency (< 100 members) and resources. Large CSOs are then those with provincial, national or international reach and footprint or governance; large membership (>100 members) and resources allowing for salaries, meetings and programs for 100+ individuals (SANGOCO, 2008).

Actors from multiple levels of government and civil society, working in collaboration, have the greatest success at strengthening health system responsiveness (Lindau et al. 2016). Multi-level governance involves a "cross-section of interest groups to collaborate as partners in jointly defining development needs and goals, and designing appropriate processes to reach these goals" (Botes and Van Rensburg, 2000, pg 49). In order to achieve responsiveness, the WHO's 2011 review revealed that political will and commitment from actors across these multiple levels of government and civil society was "required to allow a shared policy framework for concrete actions and policies to be established and applied" - large and small civil society groups needed to be included equally in governance structures (WHO, 2011, pg 6). Moreover, it was necessary to highlight which actors were key to the health system and how willing they were to invest time in collaborative processes before planning started on intersectoral programs (Herringshaw, 2017).

As with the notion of 'adjustable waistbands' - multi-level governance had to be approached differently across differing countries and context. The 2003 World Bank Development Report showed evidence that LMICs implementing Poverty Reduction Programs (PRSP) adopted measures to prioritize engagement of *local* civil society groups as this enhanced consultation and lead to better budget distribution in countries involved in the program (World Bank 2003). Conversely, in the case of livelihood strengthening in India, strengthening of *national* government actors and senior administrative liaisons was necessary in order to achieve multi-level governance (Davies and Hossain, 1996). As can be seen from these two examples, multi-level governance translated differently between these two programs (in the case of PRSPs) local level, civil society actors were key and in the case of livelihoods strengthening in India - national actors were more important than smaller, local bodies. When addressing intersectoral collaboration in these two cases, the 'waistband' was adjusted according to contextual differences and key actors from different levels were prioritized (WHO, 2012). Population studies in Thailand confirmed the success of engaging both local and national levels of actors in governance structures in order to strengthen intersectoral collaboration - direct links were established in the Thai Health system between local non-government actors and national political figures. These links were facilitated by the involvement of political participants on local committees (Portal, 2016). Similarly in India, participatory development became possible through political actors' involvement on livelihoods committees - giving them an understanding of institutions' underlying rules and an ability to reform these with the help of non-state stakeholders (Davies and Hossain, 1996). Studies on African cases also show promise of incorporating civil society into governance structures at multiple levels to create intersectoral collaboration. The African Regional Forum on Tobacco is an encouraging example, where "high-level officials from ministries of finance, trade, health, and customs from 14 Southern African countries gather together with civil society to

address tobacco control" (Marques, 2012, pg 12). This forum showed that reaching out to actors from multiple levels is not only possible but imperative to advance the intersectoral action agenda (Marques, 2012).

The World Bank Guidelines on Intersectoral Collaboration advise participation with global, country, regional and district level civil society organizations, but fail to mention and include smaller, local civil society organizations in these guidelines (World Bank, 2005). Extensive efforts have been made to engage multiple levels of *government* bodies in LMICs, but few attempts are made to understand and include the roles of smaller *non-government* actors in governance structures, despite their potential for strengthening responsiveness (Abimbola et al. 2014). Case studies in LMICs show evidence of informal indigenous organisations being "more or less ignored by international actors during authoritarian regimes and in the run up to democratisation, being undermined by state authorities" (Davies and Hossain, 1996, pg 42). In sub-Saharan Africa, larger more formal and elite civil society groups are favoured and have more direct influence on government than voices of smaller, more marginalised civil society participants (Davies and Hossain, 1996). In order for multi-level governance structures to succeed there needs to be participation and empowerment from *multiple* levels, including smaller, informal civil society groups and community members (Davies and Hossain, 1996).

The potential of utilising accountability opportunities for responsiveness strengthening

The second 'adjustable waistband' emerging in the literature, towards achieving intersectoral collaboration, is the utilisation of *accountability opportunities*. Within the context of intersectoral collaboration and responsiveness literature, 'accountability' refers to inputs from civil society channelled to government; analysed; and active measures taken by government to respond to and address these inputs (Herringshaw, 2017).

Particularly in LMIC settings, accountability has been shown to be strengthened by members of the public and civil society holding government actors to account (Berlan and Shiffman, 2012). The United Nations Development Plan of 2006 shows that accountability opportunities with open and functional reporting lines and feedback loops form part of the pieces that constitute effective intersectoral collaboration and strengthen responsiveness (UNDP, 2006). Governments are not necessarily more accountable and responsive to the demands of civil society where civil society are proactive and involved (Roy, 2008). Rather, where civil society are correctly positioned within an intersectoral structure to exploit government conflict and forge alliances with a section of high level decision makers, they are better able to influence the health system (Roy, 2008).

Intersectoral collaboration has the potential to strengthen accountability mechanisms and health system responsiveness by giving civil society representatives a seat at the table during decision-making processes (World Bank 2003). However, case studies in developing countries show a break-down in government processing of the inputs they receive from civil society and poor channelling of inputs with little or no responsive action taken (World Bank, 2004; Herringshaw, 2017).

One of the major inhibitors to accountability found in the WHO 2011 health review was civil society's lacking 'voice' in LMICs (WHO, 2011). Seven Information and Communication Technology (ICT) projects for women's health in South Africa, Tanzania, Nigeria and Indonesia were conducted to strengthen civil society's voice and improve accountability (Hrynick and Waldman, 2017). Studies conducted on these projects revealed that channels for civil society voice were lacking and without pre-existing will to respond governments were ignoring those few voices that *did* reach them (Hrynick and Waldman, 2017). Accountability opportunities

without voice meant that governments were not answerable to civil society and hence limited or no enforceability of civil society's needs occurred (World Bank, 2004; Herringshaw, 2017).

In many LMICs, citizens had only a weak hold on politicians - even in health systems with robust functionality and fair government systems, impoverished people were not able to influence government about public health policy as they did not have the financial, legal and political backing (WHO, 2011). In Uttar Pradesh, India, citizens "know that government services are dismal, and know that everyone else knows that—and yet most do not feel free to complain" (World Bank, 2004, pg 1698). According to the UNDP report, in reality, accountability relations are not working properly in most LMICs, and are sometimes distorted or corrupt.

> *"Public institutions are captured by the powerful and resourceful, and resources are diverted to serve them. In such case, the poor are not represented by public institutions. The system becomes dysfunctional and is likely to be incapable to reform itself from within due to an ingrained architecture of vested interests and power differentials"* (UNDP, 2006, pg 30).

In LMICs, under the duress of power differentials, corrupt and distorted systems, accountability is severely lacking and civil society do not have the spaces and power to hold government to account (UNDP, 2006). In order for accountability to be enforced, it is not civil society's direct relationship to health providers that needs to be improved - but rather the formal spaces (such as committees and forums) that give them direct interaction with policy-makers to encourage and complain about health system issues (World Bank, 2004).

In South Africa the Treatment Action Campaign (TAC) believe that their ability to have an impact on the HIV strategies in South African have been hindered by a lack of formal accountability opportunities - where civil society do not have organised spaces to engage with government (Friedman, 2006). Evidence from South Africa reveal that civil society's power to participate in the health system implies that "power is, somehow, a capacity which can be transferred from those who have it to those who do not, by a technical process" (Gaventa, 2008, pg 3). This implies that "the 'poor and marginalized' can attain power only if the technicians find the appropriate 'participatory process' to grant it…but the 'power' bestowed in this way was far more likely to try to remake the poor in the planners' image than to open the frontiers of choice" (Friedman, 2006, pg 37). The World Bank 2004 report shows in many LMICs both subtle and blatant forms of coercion are being used by governments to impose obligations on civil society and these have proved much more powerful than the ability of civil society to impose discipline on politicians and policymakers (World Bank and Relations, 2003). Individuals in the North West Province of South Africa reiterate the frustrations civil society experience by being disempowered by government decision-makers: "What we resent is the high-handed way the planners go about ramming proposals down our throats. This is our community and we want to be part of decisions affecting us" (Botes and Van Rensburg, 2000, pg 48).

Accountability in LMIC countries has the potential to be strengthened by involving government and civil society (Lodenstein et al. 2017). However, in practice, spaces for accountability monitoring and actioning are overlapping or absent; reporting lines are blurry; roles and responsibilities unclear and civil society unable to exert their power in influencing policy-makers (Lodenstein et al. 2017). Therefore, despite accountability efforts, in many LMICs there is a severe lack of 'enforceability' of the needs of civil society (World Bank, 2004). The United Nations 2006 Development Plan confirms this notion, claiming that in LMICs either civil society do not have the spaces to voice their opinions about health services; or they feel powerless or fearful to do so (UNDP, 2006). Even if concerns *are* voiced within formalized spaces these are seldom acted upon and enforced by government (UNDP, 2006).

Civil society participation towards more responsive LMIC health systems

In order to achieve accountability, multi-level governance and intersectoral collaboration the health system should be structured such that civil society has spaces to participate - but more importantly - enough power to effect change at policy level (UNAIDS, 2011). In 2004 the World Bank development report acknowledged a movement toward engaging civil society in intersectoral structures through 'Community-driven development' (CDD). This aimed to give voice to civil society and empower communities to participate in health systems (World Bank 2003). The CDD framework represents about 10% of the World Bank's portfolio, highlighting the importance of including civil society in participatory decision-making (World Bank and Relations, 2003) and enhancing this power through community consultation and establishing committees and forums as platforms for engagement (WHO, 2011). The community-driven development approach shifts away from reaching immediate resolution and places importance instead on the 'process' of consultation (Botes and Van Rensburg, 2000). Similarly, the 2012 UNAIDS guidelines for civil society participation, highlights the importance of involving community and civil society in health system decision-making and gives a model of *how* successful overlaps and relationships between government and civil society should look in Figure 1 below.

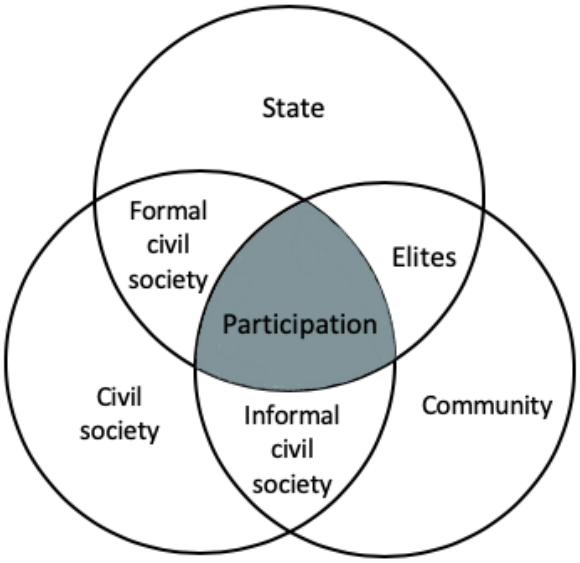

Figure 1. UNAIDS guidelines for partnerships with civil society (Davies and Hossain, 1996)

The participation at the centre, is the desirable relationship in order to achieve intersectoral collaboration – where participation between all three actors[2] occurs in a shared, collaborative dimension. Small, informal civil society groups and community therefore need to be given platforms and spaces to be included in collaborations in order for responsiveness to be achieved (Davies and Hossain, 1996).

> *"The closer civil society is to the state, the more formalised it becomes. Civil society is informal where it overlaps with community but not the state. Where the state and community overlap, it is usually via the participation of elites"* (Davies and Hossain, 1996, pg 51).

[2] The three actors in this case being individuals or groups in the form of state, civil society and community.

Participation and collaboration between community, civil society and the state is desirable for intersectoral collaboration and occurs in the centre of the diagram (Davies and Hossain, 1996).

This civil society participatory model should also be viewed as an 'adjustable waistband'. It has been shown to be the case in countries where the state is ineffective (as in many LMICs), that more formal civil society groups function well at filling the gaps in policy development or service provision (Valentine et al. 2003). Informal civil society groups, within the context of poorly run governments may struggle to engage- where weak structures for their participation exist (UNAIDS, 2011). These smaller, informal civil society groups are shown to be effective where governments are well-established and can more easily include smaller groups into their institutional governance (Ackerman, 2005). In Guatemala, the Democracy Trust formal civil society group, in the climate of volatile politics, helped to establish continuity in the country's health services by facilitating development efforts (Herringshaw, 2017). Large, formal civil society groups proved instrumental in strengthening responsiveness in Brazil, where government was less supportive and functional- health councils initiated collaboration between civil society groups and government officials and opened discussion around health policies and resource allocation (Martinez and Kohler, 2016). In Kenya, funds given for facility health committees assisted civil society in voicing opinions on facility spending, leading to effective prioritisation of resources (Opwora et al. 2009) (World Bank, 2004). Governments channelling money through these community committees, gave civil society a point of entry to participate in the health system with decision-making power and voice (Haricharan and The Learning Network, 2012). This is evidence of how 'formal civil society' can participate in a system where government structure is threatened and strengthen its functioning (Martinez and Kohler, 2016).

In Bolivia, a law was passed enforcing popular participation in policy and decision-making within high level government. The law has fundamentally improved informal civil society's engagement in policy making and fundamentally reframed rules with donors and foreign aid organizations. Since Bolivian parliament passed the law, civil society participation in governance within the health system has increased significantly (Herringshaw, 2017). A study done across six well-governed LMICs showed informal civil society groups who were included in broader governance structures had solved nutrition, health, forestry management and irrigation crises by forming local user groups and committees (World Bank, 2004). In Benin, Guinea and Mali community financing was introduced, giving community representatives power to decide on prioritisation and allocation of fiscal funding (WHO, 2013). Governments were required to negotiate financial decisions with informal civil society- rather than the converse (WHO, 2013). Today in all three countries, equity in health finance between poor and rich has improved drastically as a result (World Bank, 2004).

In many LMICs, civil society have exercised a right to be active and involved in ensuring appropriate health services and conditions are provided for, better health is sustained and that communities are empowered and supported to contribute to health development (Adesanya et al. 2012). Review of recent literature across 15 LMICs conducted on health provider responsiveness has given insight into the impact that civil society can have on strengthening government responsiveness (Lodenstein et al. 2017). This research reviewed cases of collective civil society action and advocacy. By initiating formal political and bureaucratic accountability channels, civil society were able to directly influence health provider responsiveness, improve health outcomes and fundamentally change the system within which they received healthcare (Lodenstein et al. 2017).

Barriers to civil society participation in LMIC health systems

Although civil society have proven successful at improving responsiveness in some regions, many civil society individuals, groups, and institutions face barriers to inclusion in national health responses (UNAIDS, 2011). The consultative process between government and civil society is sometimes viewed as time-consuming and may conflict with government agendas. Governments therefore often neglect the opinions and advice of civil society (UNAIDS, 2011). This is particularly detrimental in LMICs where health spending is more constrained than high income countries and resources need to be directed to highest priority areas (Abimbola et al. 2014). In these circumstances, governments need to be held accountable for health prioritisation and patiently endure the consultative process of listening to civil society's needs and opinions on where best to direct health resources and services. The UNAIDS 2015 statement on civil society participation states;

> *"…true political commitment will never be mobilized and achieved without civil society generating demand, and resources will not be directed to highest priority, effective and evidence-based programming without direct intelligence from communities about real needs and behaviours, and what works best"* (UNAIDS, 2011, pg 44).

Although some cases point toward civil society's value in participation in the intersectoral structure of a health system as a proposed manner of strengthening responsiveness, there is limited evidence regarding the *nature* of such engagement within government entities (Storeng and De Bengy Puyvallée, 2018). Empirical evidence is lacking on the overall, interconnecting structures of governance created by spaces for civil society participation; the processes, actors and strategies for such responsiveness are seldom understood (Storeng and De Bengy Puyvallée, 2018). Due to a lack of organised, collaborative structures; well-organized, larger civil society groups seem to benefit from attempts at intersectoral collaboration, while smaller community-based health councils and committees are excluded from broader structures of intersectoral collaboration, creating fragmentation, overlaps and gaps (Marques, 2012). According to the World Bank report in 2004, very often it was only the most visible and vocal civil society representatives- those who were educated and wealthy- who were partners in decision-making without serious attempts to identify less obvious, marginalized civil society representatives (Botes and Van Rensburg, 2000; World Bank, 2004). One such example is in Zambia, where the UN AIDS promoted a framework that encourages civil society organizations to coordinate with one another and provided a platform for such engagement: these spaces or platforms served mostly larger, established civil society groups and those smaller Civil Society Organisations (CSO's) and Community Based Organisations (CBO's) were not included in Zambia's advocacy (UNAIDS, 2011).

The WHO (2011) policy for intersectoral action highlighted the challenge some LMICs experience in opening lines of communication between civil society participants and governments.

> *"Adequate and continuous disclosure of information and the creation of feedback channels to convey concerns and potential grievances once the policy has been implemented are essential to sustaining community participation and ensuring accountability, but severely lacking in developing countries' health systems"* (WHO, 2011, pg 15).

'Participation', means not only that civil society are present at meetings and sit on committees and boards, but also that they are informed and government have transparent policies which are shared openly with these groups (WHO, 2011). Information that informs civil society of financial allocations for health; service delivery conditions and policy-maker behaviour can serve a powerful purpose in overcoming politicisation (World Bank, 2004). Unfortunately, civil society groups- especially smaller, informal ones- are often left in the dark

when it comes to high level information. In South Africa a lack of sharing of political knowledge with civil society groups is a major stumbling block to achieving intersectoral collaboration - misinformation about HIV/AIDS and poor political leadership compound the barriers to engaging civil society effectively in the health system (Ward, 2007). One particular study of youth policy in South Africa showed that youth groups at grassroots level did not participate in the National Youth Development forum, because they were unaware that the forum was open to them (Friedman, 2006). Perhaps it is, 'consultation fatigue' that stops policymakers from sharing information with civil society organisations and excludes them from the consultation process (Herringshaw, 2017). Due to a lack of streamlined formulation of spaces for public consultations, overlaps exist where policymakers need to attend multiple meetings- creating fatigue in the sometimes repetitive process of consultation (Herringshaw, 2017). Although the language in committees, assemblies and consultations may be one of 'participatory decision-making'; when it comes to finalising decisions, the power remains within a closed, small circle and civil society's articulated viewed are seldom taken into account (Herringshaw, 2017). The City of Johannesburg council committed its policy to strengthening civil society participations and engagement with multiple stakeholders in all aspects of the council, but in practice a consultative process with civil society and public stakeholders was not happening during the policy planning phase (Birdsall, 2013). According to the council,

> *"a strategic agenda and indicative budget allocations were agreed some five months before the consultation process–citizens were not allowed to comment directly on an Independent Development Plan (IDP)– time constraints ensured that not even the metropolis's ward committees learned of the contents of the draft IDP. Instead, ward councillors were given the responsibility 'of cascading the information to their committees and communities"* (Friedman, 2006, pg 29).

The South African context

In the past three decades in South Africa, collaborative action for justice has been taken on by civil society as some of the drivers behind responsiveness strengthening (UNAIDS, 2011). Within the context of apartheid, the "value of channels to enable civil society to communicate with government has been a canon of governance thinking in the new democracy (Friedman, 2006, pg 30). In their fight against apartheid's exclusion of the majority from decision-making, activists frequently demanded 'people's power'"(Friedman, 2006, pg 30). Many activists believe the decision to end apartheid and create a more equitable health system was considerably driven by civil society (Friedman, 2006). These drivers have been champions or leaders, who themselves have committed to use their voices to transform South Africa and bring about change (UNAIDS, 2011). One such example of the change these efforts brought about, is the greatly improved service provision of Antiretroviral treatment which today forms a huge part of South Africa's successful legacy in addressing the AIDS crisis and is largely attributed to these civil society groups (Heywood, 2009). Without the voices and legal advocacy of civil society, equitable access to medication and healthcare for all races in South Africa may have been far slower to initiate, if in existence at all (Heywood, 2009).

Civil society in South Africa have mobilised and held to account reluctant leaders through their commitment to affecting transformation of policies (UNAIDS, 2011). Responding to these efforts, in 2003, the South African government legislated and provided resources to open up spaces for civil society to consult with government and participate in health system decision-making- these spaces include health committees and national councils (Padarath, 2009). Today consultations in these spaces drive forward and inform many national strategic health plans in South Africa (UNAIDS, 2011). The post-apartheid South African health system has

shown signs of encouraging these progressive spaces which support communities and were initiated and championed by civil society movements as part of a larger attempt to build collaboration (Padarath, 2009).

Although an intersectoral approach to engage civil society was included in the 2007 National Strategic Plan in South Africa, there still exists the divide between policy and practice and major barriers to achieving responsiveness. Intersectoral collaboration is said to be a 'buzz' word "often mentioned but rarely defined or critiqued, with increased expectation for this undefined approach to augment a response that involves other actors" (UNAIDS, 2015, pg 27). From a study done in South Africa on intersectoral collaboration, a government department member commented:

> *"All directorates have focal areas, and most times the other is not aware about programs undertaken in other directorates. This limits ability to identify synergies and deliver programs in a more efficient manner"* (Mahlangu et al. 2018. pg 305).

A lack of collaboration between government health committees, NGO-HIV/Aids committees, civil society coalitions, multi-sectoral teams and smaller community organisations has perpetuated fragmentation in the South African health system (Friedman, 2006). Today many spaces exist performing the same functions, including the same actors- creating gaps in *whole-system* mandated spaces (Mahlangu et al. 2018). Reporting lines between civil society groups and government decision-makers are often unclear and feedback loops for responsiveness have become dysfunctional as government actors have too many spaces to attend and respond to (Friedman, 2006). Due to the prevalence of HIV/Aids and TB in South Africa, the prioritisation of single disease spaces has had a detrimental effect on the broader ability of strengthening responsiveness for the whole *system* (Lindau et al. 2016). The strategic response to the HIV epidemic did not give consideration to other domains of the health system, the multitude of overlapping roles and actors are ignored and single-diseases given primary attention which creates vertical programs and fragmentation (Friedman, 2006; Bennett et al. 2018) .

The Western Cape case

The Western Cape Province of South Africa has a mixed urban/rural population of 6.2 million people with a reasonably well governed, established health system compared to South Africa's other eight provinces (Schneider and Nxumalo, 2017). Civil society participation in the health system was acknowledged in the Western Cape as early as 1995 when the Provincial Health Plan included "a commitment to community participation in the planning of local health services" (Glattstein-Young and London, 2010, pg 2). For the next two decades, health governance was not clearly spelt out and roles and responsibilities of civil society not included in policy (Glattstein-Young and London, 2010). In 2015 the Bill on Health Facility Boards and Committees was a first attempt at amending this (Zwama, 2016). The Bill legislated health committees at district, sub-district, ward and facility levels in the Western Cape and aimed to open spaces for civil society participation in health system decision-making (Blecher et al. 2017). At the same time numerous Non-Government Organisations (NGOs), civil society coalitions, committees and forums were being established in the Western Cape (SANGOCO, 2015). In some of these spaces civil society has been a major driver of change in the Western Cape- a civil society organisation- Treatment Action Campaign (TAC) has mobilised the Western Cape government to make instrumental changes to policy and practice in the health sector (Heywood, 2009). Government-mandated spaces, such as WOSA (Whole of Society Approach) have forged collaborations between steering committees and government ministers from all sectors to improve service delivery in the Western Cape (WCDOH, 2018).

Although there is evidence of civil society participation and responsiveness strengthening- the Western Cape case is not dissimilar to the LMIC and South African cases mentioned above when it comes to barriers to intersectoral collaboration (Zwama, 2016). The numerous overlapping spaces and roles in the Western Cape suggest that since 1995 civil society groups and government committees have been established with little or no collaboration and largely single-disease focus (Friedman, 2006). The Provincial AIDS Council (PCA), the Treatment Action Campaign (TAC), WC-NACOSA (Western Cape-National Aids Council of South Africa), MSATS (Multi-sectoral Action Teams) and the City of Cape Town HIV/TB are some of the many overlapping single-disease spaces in the Western Cape (Blecher et al. 2017). A report conducted in 36 districts in the Western Cape on responsiveness, showed these siloed approaches to lead to a lack of health system responsiveness from government on prevailing issues, leading to the multitude of service delivery issues (Heywood, 2009). Spaces mandated with a *systems* approach, such as SALGA (South African Local Government) and SANGOCO (South African NGO Coalition) have since been introduced in the Western Cape and begun to curb the issue of fragmentation (Herringshaw, 2017). So too, government health committees in the Western Cape are mandated to address all health issues, instead of dealing exclusively with HIV/TB (Blecher et al. 2017). However, civil society are unable to participate successfully in a number of Western Cape health committees as meetings are infrequent and policy-makers are often absent (Birdsall et al. 2007). Despite an attempt to formalize clinic committees and hospital boards and include community representatives – current evidence suggests these groups remain dysfunctional in the majority of Western Cape facilities (WCDOH, 2019a). Data collected in the Western Cape as part of a study on the right to health revealed a number of civil society committee members were unaware of the Boards and Committees policies and felt their inputs at committee meetings were "neither valued nor considered in the planning or provision of health services" (Glattstein-Young and London, 2010, pg 2).

Matters of fragmentation of spaces and governance; dysfunctional committees; unclear accountability and reporting lines and a lack of 'voice' for civil society in the Western Cape echo the cases mentioned above in LMICs and South Africa (Blecher et al. 2017). However, no evidence could be found on these issues in their *entirety* in the Western Cape. Spaces for intersectoral collaboration have been researched in isolation- owing to the need to holistically *map* these spaces. A map of intersectoral collaboration and its contribution to health system responsiveness needs to be better understood, including multi-level governance structures, accountability lines and spaces for civil society participation. Gaps and overlaps need to be considered, as well as the Western Cape context before planning can start on how better to distribute spaces; forge relationships between government and civil society actors and utilise accountability opportunities. Collaboration needs to be considered as an 'adjustable waistband', taking into consideration the political, social, cultural and economic nuances of the Western Cape health system.

Problem statement and purpose of study

Although efforts have been made in South Africa to establish spaces aimed at strengthening civil society participation in the health system and improving health system responsiveness, research is showing that many of these spaces are absent or overlapping - in many cases roles of civil society are not formalised or reaching higher level decision-makers (Mdaka, 2014). There is strong acknowledgement that intersectoral collaboration is required in order for a health system to become more responsive, but evidence is lacking on how intersectoral collaboration can be operationalised to create streamlined reporting lines and feedback loops between all levels of government and civil society (Ackerman, 2005). The WHO intersectoral guidance policy calls for a self-assessment where a health system's "existing relationships with and participation in relevant

intergovernmental bodies are mapped out" (WHO, 2011, pg 7). This initial phase of description is needed before consideration can be given to methods for strengthening responsiveness. The study will map out legislated and informal spaces where civil society participates in the health system and where government policy-makers contribute and connect to these spaces. The mapping process will visually display overlaps and gaps occurring, illustrating current intersectoral collaboration; showing *where* and *how*[3] civil society is participating in these intersectoral spaces in the Western Cape health system.

Objectives

1. Outline the current landscape of civil society participation in the public health system in the Western Cape province of South Africa, with particular focus on health system responsiveness.
2. Describe current successes and shortfalls of intersectoral collaboration in South Africa and the Western Cape.
3. Descriptively map all relevant, existing intersectoral spaces in the Western Cape - depicting collaborative opportunities, actors and institutions (e.g. committees and forums) within those spaces.
4. Analyse across all intersectoral spaces to report on 'whole system' responsiveness based on governance, accountability and civil society participation.

Research question

What is the current nature and configuration of intersectoral collaborative spaces involving civil society in the Western Cape provincial health system, and do these support or inhibit health system responsiveness?

Sub-questions

1. Are there gaps and overlaps in intersectoral collaboration configuration of spaces in the Western Cape Health System?
2. How are intersectoral collaboration structures in the Western Cape facilitating or inhibiting accountability and therefore responsiveness?
3. Where and how does civil society participate in the governance of the Western Cape Health System?

Sub-study to broader responsiveness study in South Africa and Kenya

This study will form part of a broader responsiveness mixed-method study being conducted by researchers from the University of Cape Town, University of the Western Cape, Kenyan Medical Research Institute and local government partners. The broader study runs from 2017-2021, and is addressing the question: *"What policies and mechanisms (formal and informal) work for receiving and responding to citizen feedback on health systems in South Africa and Kenya? How can health systems responsiveness be strengthened towards the development of learning, equitable health systems?"*[4] *(See appendix 4) This* study forms part of the first of three phases of the broader responsiveness study and contribute to the initial 'mapping' component which aims to provide a national policy review and Western Cape province mapping.

[3] Referring to civil society's 'voice' and influence on policy-making

[4] Olivier, J., Molyneux, S., Schaay, N., Schneider, H., Tsofa, B., Barasa, E., Gilson, L. (2017). *Strengthening health system responsiveness to citizen feedback in South Africa and Kenya.* Grant application. MRC Joint Health Systems Research Initiative (Round 4 2017)

Methodology

The study is a mixed-method case study using a desk-review of multiple sources of openly available data. It will involve case reporting on embedded cases- intersectoral spaces- in the Western Cape and a cross-case descriptive mapping of intersectoral collaboration and responsiveness in the Western Cape health system.

Theoretical framing

The study deals with an intersection of multiple concepts and frameworks, therefore theoretical framing was necessary to establish the 'lens' through which the case will be researched and how each of these concepts fits within the responsiveness directive. The literature review was used to operationalise terms: 'civil society, *inter*sectoral and *vertical* intersectoral collaboration'. These definitions will be referred back to when conducting the case study.

Table 1. Research definitions from multiple sources

Civil society	"Civil society refers to the space for collective action around shared interests, purposes and values, generally distinct from government and commercial for-profit actors. Civil society includes charities, development NGOs, community groups, women's organizations, faith-based organizations, professional associations, trade unions, social movements, coalitions and advocacy groups" (Seddon et al. 2011).
Intersectoral	Intersectoral collaboration considers the roles of all actors in the system and aims to strengthen coordination between these actors- in such that their collective efforts work for one common purpose. Communication and purposive coordination between all actors is essential in achieving intersectoral collaboration and ultimately responsiveness (Adeleye and Ofili, 2010).
Vertical intersectoral collaboration	Intersectoral collaboration exists on horizontal and vertical dimensions. Horizontal intersectoral collaboration implies collaboration across sectors- such as Health, Education, Agriculture, Public Works and Housing. Vertical intersectoral collaboration, on the other hand, refers to the intersectionality of actors involved in those spaces- such as government departments and bodies; public-private engagements; civil society organisations and communities (Lindau et al. 2016)
Accountability	"the means by which individuals and organizations report to a recognized authority (or authorities) and are held responsible for their actions" (Edwards and Hulme, 1996).
Collaborative space	A collaborative space is a space for…"planned or spontaneous engagements that take place between individuals or teams of individuals, whether in-person or mediated by technology, where information is exchanged in some way…and often occur across different roles" (Eikey et al. 2015).
Health system responsiveness	"Health system responsiveness has been identified as one of the intrinsic goals of health care systems, alongside health outcomes and fairness of financial contributions… Responsiveness relates to a system's ability to respond to the legitimate expectations of potential users" (Robone et al.2011).

As noted above, three *approaches* to understanding responsiveness and vertical intersectoral collaboration emerged from the literature[5], which were included in 15 secondary studies; the WHO 2011 Guidelines to Intersectoral Action for Health (WHO, 2011) and the World Bank 2004 Development Report (World Bank, 2004). These approaches were synthesized and adapted to create the framing in Figure 1 below, which will be used as the framework through which the Western Cape Health system will be researched.

[5] Three approaches mentioned in the literature review are multi-level governance, accountability and civil society participation and empowerment (WHO,2012).

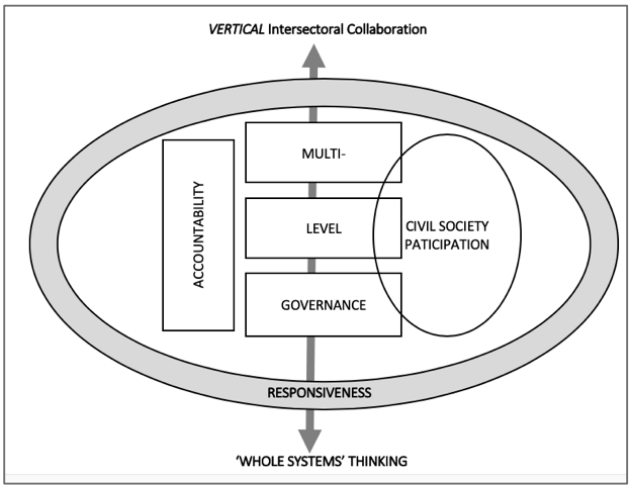

Figure 2. Approaches to vertical intersectoral collaboration (author, adapted from WHO, 2004; World Bank, 2004)

Case study design in six phases

A scoping review was conducted (reported in the literature review above), to initiate an understanding of intersectoral collaboration in LMICs and South Africa; how civil society participates in these spaces and where inhibitors to responsiveness exist (Wilson et al. 2012). This review showed a lack of research or comprehensive mapping of intersectoral spaces in the Western Cape and suggested that literature on health system responsiveness is likely to spread across multiple disciplines and sectors.

A case study design was selected, drawing on Yin's recommendation of case studies as appropriate for studies whose purpose is *descriptive,* and is considering a case "within its real-life context" (Yin, 2009, pg 26). As this is a case study design, context mapping of the South African and Western Cape health system will be conducted to describe the context and situate the study. During this process *policy analysis* of the South African and Western Cape Health System provides the basis of information for context reporting. Context reporting uses the three approaches from the framework outlaid in *figure 2* to situate the case: Governance, accountability and civil society participation.

Once the case context is understood, embedded cases from the Western Cape Health system can be selected. Individual intersectoral spaces will be selected - these are expected to consist predominantly of committees and forums. Intersectoral spaces will be identified from the scoping review and context reporting on the Western Cape as well as a further search of published and grey literature for spaces meeting inclusion criteria[6]. Data on each space will then be extracted from a variety of published and unpublished sources (*see Table 5* below). It is expected that a high volume of grey literature will be required during this phase- such as meeting minutes, unpublished reports, committee websites and unpublished strategic documents. This assumption comes from the lack of published literature on the operationalisation of intersectoral collaboration as spelt out in the literature review. To achieve triangulation at least three different data sources for each space will be used. Data for each space will be analysed separately, giving a multitude of small reports with qualitative and quantitative outcomes reported for each space. Spaces will serve as 'embedded cases'- which

[6] Inclusion criteria will be unpacked further on in the methodology section

collaboratively make up the entire 'case': intersectoral collaboration in the Western Cape Health System. Individual case reports will be thematically analysed- looking *across* spaces for emergent themes. Spaces will be mapped out showing where they are situated; their participants; reporting lines and their relationships to each other. The map will depict the overall 'case' of intersectoral collaboration in the Western Cape Health System. Individual reports on each space and overall descriptive mapping will be checked by experts in the Western Cape health policy and planning profession. Feedback on errors from experts will be used to adjust reports on individual spaces and descriptive mapping. These amended reports and map will undergo a second and final analysis. This process of reporting on individual spaces, followed by overall analysis and expert checking allows for a rigorous chain of evidence to build the case in question and through multiple sources of data collection and iterative analysis provides a more in-depth understanding of the case than a scoping review (Yin, 2009).

This study is a meso level investigation. It will look at a case at provincial level and the embedded cases (intersectoral spaces) within it consist of meso and micro-level spaces as they engage actors and representatives from the level of community to provincial ministries. The study will use smaller, embedded or nested cases[7] and look at their relationships to create a 'map' of intersectoral collaboration in the Western Cape at meso level.

The study design is a flexible, mixed-method study - it will rely on emerging themes to direct the course of enquiry and analysis. Data collection from multiple sources will be used "to further develop and understand the case, shaped by context and emergent data" (Egerton, 1995, pg 57). Using an iterative process will allow for flexibility in the search, reviewing and descriptive mapping. A flexible approach will be important to follow as this area of inquiry is not well-defined and, as a result, important literature may be overlooked if a prescriptive design is followed (Wilson et al. 2012).

The study is a single-embedded case study where the 'case' is the state of intersectoral collaboration between civil society and the Western Cape health system, and the embedded or nested cases are individual 'spaces' of intersectoral collaboration. As already noted in the above review, some evidence does exist about particular types of intersectoral collaboration in the Western Cape, although this is disjointed, and tends to be focused on particular programmatic areas (such as HIV/AIDS collaboration), rather than taking a systems lens. Our initial context mapping suggests that there is sufficient existing and accessible data available to conduct this case study - through synthesis and secondary analysis of existing data (see *appendix 5: Table 1* for available evidence).

The Western Cape has been chosen as the focus of the study, following an initial scoping revealing peculiarity in the Western Cape Health System- whereby intersectoral collaboration is mentioned throughout policy documents, but is failing to be operationalised. These kinds of peculiarities are the foundations on which case studies are built (Egerton, 1995). Further to being peculiar, intersectoral collaboration in the Western Cape is challenging- as it consists of complex relationships and overlapping spaces- which makes for significant, interesting results (Yin, 2009). The author of this study is currently enrolled at the University of Cape Town in the Western Cape and has a number of established contacts in the field of health systems, making it possible to access experts for expert checking of the research conducted.

[7] Intersectoral spaces - e.g. Committees and forums

This study's qualitative approach will "explore a real-life, contemporary case through detailed, in-depth data collection" (Hyett et al. 2014, pg 2). As this is a mixed-method design, quantitative data will also be collected to improve rigour through triangulation. Mixed methods research integrates qualitative and quantitative methods and combines the power of stories and numbers (Hyett et al. 2014).

The study will consist of six phases (unpacked below): Context mapping; selection and reporting on 10+ intersectoral 'spaces'; descriptive mapping of intersectoral spaces; cross-case analysis; expert checking; second analysis based on expert feedback; synthesis and write-up. See *figure 1* below for detailed study design phases.

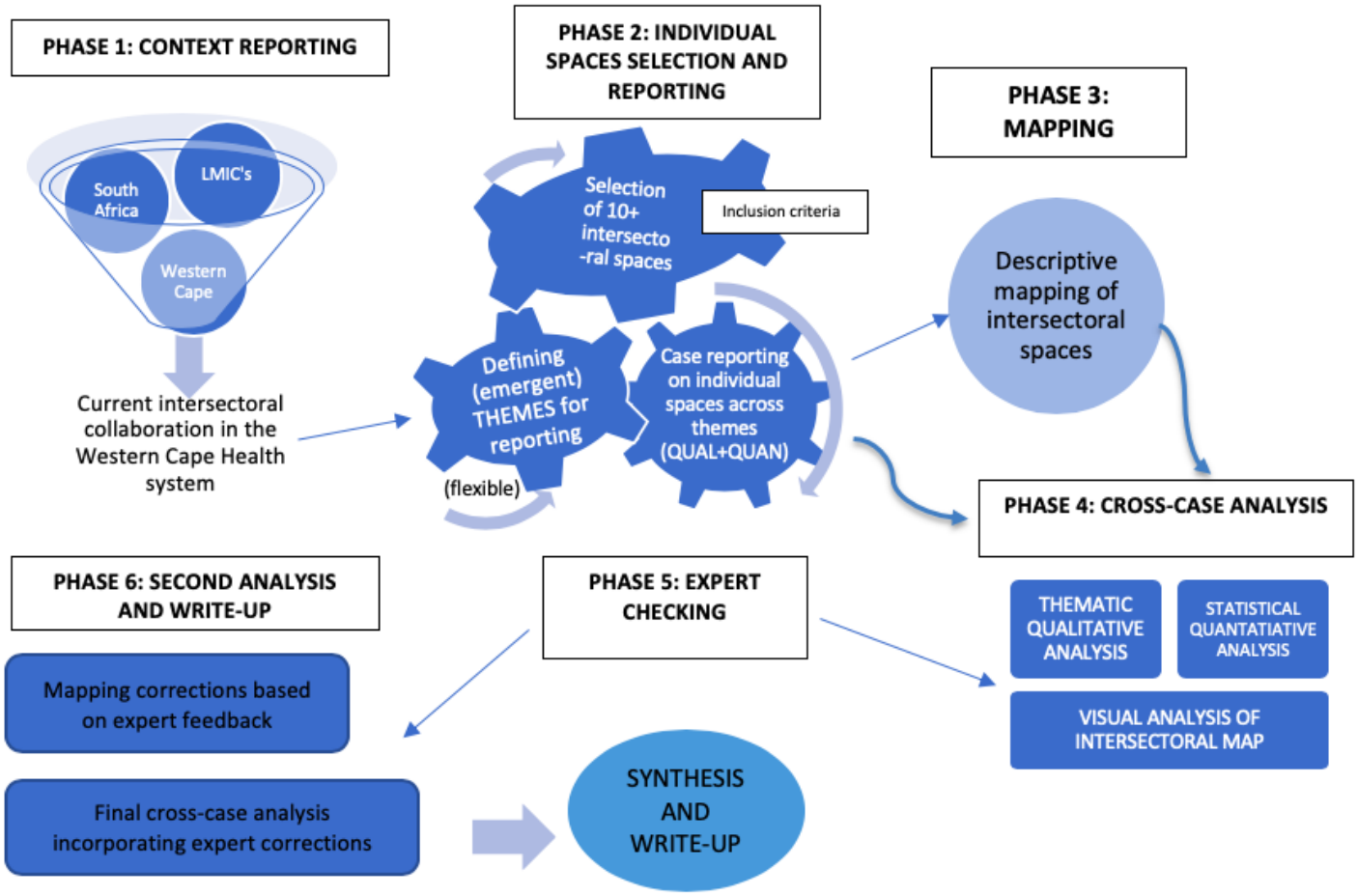

Figure 1. Study design phases (author)

Phase 1: Context mapping

Context mapping will be conducted for current intersectoral collaboration in LMIC health systems and the South African health system with a case-focus on the Western Cape. Context mapping is a necessary component of this, and other, case studies- as it "involves careful and in-depth consideration of the nature of the case, historical background, physical setting, and other institutional and political contextual factors" (Hyett et al. 2014, pg 2), "…we need to contextualise the case to understand experience (Robson, 2011, pg 12)". Context mapping will be conducted using a desk-based search of PubMed, Embase, Google scholar, University of Cape Town departmental resources and unpublished literature.

Table 2. Key search terms (context mapping of ISC in LMICs, South Africa and the Western Cape)

Term	Variation
Intersectoral collaboration	Intersector* ; intersector* collaboration; multisector* ; multisector* collaboration; partnership
Civil society participation	Civil society; community, community-based; public; civic; participat*; engag*;
Responsiveness	Responsive*; accountab*; governance ;
Health system	Health; health sector; health system; health system strengthening; health system performance ;
LMICs	Developing; less developed; low income; middle income; East Asia; Pacific; Latin America; Caribbean; Middle-east; North Africa; sub-Saharan; (including complete list of LMIC country names)
South Africa	South Africa; southern ; sub-Saharan Africa
Western Cape	Western Cape; Cape Town; Cape Winelands; Cape Metro

An initial search brought up 531 papers - 123 with relevant tiles for abstract review. After review, 39 of these multiple and varied sources of data appeared suitable for context mapping (see *appendix 5: Table 1*). The context mapping process will unpack current intersectoral successes and shortfalls; gave a theoretical framework on which the case will be built (see *figure 2* above); will situate the case within its real context (the Western Cape health system) and give substantive relevance to the study.

Phase 2: Selection of intersectoral spaces and individual case reporting

In phase 2 of the case study design, a search for intersectoral spaces in the Western Cape will be conducted; data will be extracted on each of these cases and individual reports will be compiled according to emergent themes (themes described below). A desk-based search will be conducted to select 10+ intersectoral spaces in the Western Cape Health system. This number is expected to give sufficient data to make a 'case'. "Case study research is an investigation intended to capture the complexity of the object of study" (Egerton, 1995, pg 57) and therefore the total number of spaces researched will be limited to less than 20 to allow for thorough and in-depth case reporting on each. Intersectoral spaces are expected to be predominantly committees and forums - but are not limited to these. Spaces should currently be functional or have been functional in the past 2 years and be organised to function on more than one occasion - for example; once-off protests, marches, rallies, campaigns and conferences will be excluded from the study. Spaces should be mandated directly or indirectly to address *health* issues in the Western Cape and have participation from government and / or non-government actors. *Table 3* provides a list of inclusion and exclusion criteria to be used in selection of intersectoral spaces:

Box 2: Single embedded case study clarification:

Case: Intersectoral collaboration in the Western Cape Health System

Embedded cases: Individual intersectoral spaces - such as committees and forums - in the Western Cape

Table 3. Inclusion / exclusion criteria for selection of intersectoral spaces (author)

Inclusion criteria	Exclusion criteria
Exists within the Western Cape health system, public or private	Exist within globally or national health system only
Direct or indirect health mandate	Is mandated to another sector with no connection to health issues
Currently an active, functional space or recently (2 years) discontinued	Was discontinued more than 2 years ago

Formal or informal, structured space which is legislated or unlegislated	Informal rallies, protest and marches
Sufficient literature and evidence for data collection and analysis of emergent themes	Literature and evidence missing for more than three emergent themes

A desk-based search of secondary data for intersectoral spaces in the Western Cape will be conducted using the above inclusion criteria and key search terms (*table 2 and 3)* with additional criteria.

Databases - PubMed, Embase, Google scholar, University of Cape Town departmental resources for responsiveness studies - and grey literature will be searched. The study will rely heavily on unpublished sources such as institutional reports, meeting minutes, strategic documents, WHO databases and institutional websites. Due to this reliance on unpublished sources, expert checking will be a necessary component of the study design (more below). At least three sources from varying origins will be used for each space to ensure varied sources of literature are used and therefore varied opinions are accounted for. As this is a case study, perspectives matter and by using a number of sources from different perspectives, rigour can be enhanced for the study. If sufficient information cannot be found for an individual space, that case will be excluded from the study (Yin,2009). *Table 4* below gives a comprehensive list of sources of secondary data expected to be used:

Table 4. Data sources for selection of intersectoral spaces and individual reporting and availability

Type	Name	Data type, Source / Location, and Availability
Secondary literature: empirical studies	1.South Africa's Treatment Action: Law and social mobilisation campaign to realise the right to health. 2.Multisectoral inaction towards effective mainstreaming of HIV in public sector departments in South Africa 3. Implementing a multi-sectoral response to HIV in South Africa-Mpumalanga Province	Qualitative Openly available published peer reviewed journal articles *Have (will refresh)*
Reviews	1.Scoping review: Community-based organisations in the health sector 2.Systematic review: strengthening intersectoral collaboration in primary health care in developing countries. 3.Literature review: Community voice and role in district health systems in East and Southern Africa	Qualitative Openly available published peer reviewed journal articles *Have*
Theses	1.MPH-Civil society's role in health system monitoring and strengthening- a study in Khayelitsha, WC 2.MPH-Training health clinic committees: a vehicle for improving community participation in health 3. MPH-Improving health care provider-health committee working relationships 4.The status of clinic committees in three provinces of South Africa	Qualitative and Quantitative Openly available published journal articles and unpublished (available through UCT portal) *Have*
Evaluation reports	1.South African health review 2017 2. International development services: unlocking the power of partnerships 3 South African Private Practitioners Forum https://www.mm3admin.co.za/ 4.City Of Cape Town and District health collaboration report https://pmg.org.za/committee-meeting/26452/	Qualitative Openly available on the web *Have*
Policies	1.World Health Organisation Intersectoral Action on Health 2011. 2. World Health Organisation 2012: Intersectoral governance for health in all policies 3.SANGOCO constitution 1997 http://cab94.tripod.com/sango00.htm 4.Western Cape health facilities boards and committees act https://pmg.org.za/committee-meeting/26109/ 5.South African Patient's Rights Charter 2014 6.The regulatory framework of the SA health system	Qualitative and quantitative Openly available published peer reviewed journal articles or Openly available on the web *Have*
Reports	1.HIV/Aids and TB Plan 2009-City of Cape Town	Qualitative

	2.Challenges of health committees and meaningful structures for community participation. Cape Metropole 3. State of provincial healthcare system: Spotlight	Openly available or Openly available on the web *Have*
Institutional (CSO) websites	1.Aids Foundation South Africa: https://www.aids.org.za/ 2.South African National Aids Council http://www.sanac.org.za 3.South African NGO coalition http://www.sangoco.org.za/ 4. Learning network for health and human rights http://www.salearningnetwork.uct.ac.za/ 5.People's health movement https://www.phm-sa.org/health-committees/	Qualitative Openly available on the web *Have*
Institutional (gov) website	1.Western Cape Department of Health https://www.westerncape.gov.za/dept/health 2.South African local government association http://www.salga.org.za/ 3.South African youth council http://www.sayc.org.za/	Qualitative Openly available on the web *Have*
Surveys	1. Estimating responsiveness level and distribution in 191 countries	Quantitative Data openly available in WHO reports *Have*
UNAIDS databases	1.United Nations civil society participation- including qualitative data 2. UNAIDS Data 2019 https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf	Qual, Openly available within journal article Openly available on the web *Have*
Media	1.Multisectoral action teams Cape Town-Plainsman news https://www.plainsman.co.za/news/funding-not-enough-says-msat-5854060 2. National health insurance coalition- Section 27 http://section27.org.za/2011/12/insurance-coalition-gives-civil-society-voice/	Qualitative Openly available in the web *Have*
Guidelines	1.UNAIDS 2011 guidelines for partnerships with civil society including people living with HIV and key populations 2.Western Cape Annual Performance Plan 2019-Department of Health	Qualitative Openly available *Have*
Annotated bibliography	Social power, participation and accountability in health (EQUINET & COPASAH)	Openly available published peer reviewed journal articles Have
Books	1.Civil society and the public sphere (South Africa) 2. Ward Committees Resource: Provincial and Local Government-Republic of South Africa	Qual, Openly available online, published, *Have* Qualitative, Available online, *have*

In this case study, the research *design* will determine the process to follow - including determining which sources of data and themes are relevant to the study, deciding how to collect the data and which type of analysis technique to use on the individual case reports (Philliber et al*.* 1980). Themes emerging from context mapping will help identify the relevant information. Without these "one might be tempted to cover "everything" about the individual spaces which is impossible to do" (Yin, 2009, pg 26). As this is a flexible design, the context mapping phase will be used to begin identifying emergent themes which will constantly be re-looked at during the study and used to guide extraction of data on spaces for individual reporting. A review of over 200 articles relating to community organisations (Wilson et al. 2012) was adapted and used to compliment the selection of emergent themes from the context mapping phase and give rigour to the data extraction process. *Table 5* below gives preliminary information and initial themes to be used for data collection on each intersectoral space.

Table 5: Preliminary information and initial themes for data extraction and reporting of individual spaces (Author, adapted from Wilson et al. 2012)

Basic information	**Themes**
Name of intersectoral space	Government activity in space
Geographical level or catchment	Civil society activity in space
Mandate	Government response to meeting content
Structure	Government action taken to address response
Legislation	Voice
Reporting lines	Participation
Functionality	Ownership
Frequency of meetings	
Funding	

Case reports on individual spaces will be compiled using data from multiple sources (see *Table 5*). Reports will consist of qualitative data on each theme and quantitative data where themes can be reduced to numerical totals (Yin, 2009). Microsoft Excel will be used for inputting of case report data. Data falling outside of preliminary themes but found interesting by the researcher will be captured on case reports for further investigation. Researcher's thoughts on emerging data will also be recorded and referred to during the analysis phase. Once individual reports on all spaces are complete, the mapping phase will commence.

Phase 3: Descriptive mapping of intersectoral spaces

Individual case reporting on embedded cases is not enough to understand the complexity of their relationships and give a whole picture of intersectoral collaboration. "A complex system is not constituted merely by the sum of its components, but also by the intricate relationships between these components" (Anderson et al. 2005, pg 671). The Western Cape intersectoral collaboration case is about the relationships among spaces and the system's actors (Anderson et al. 2005). Capturing the complexity of intersectoral spaces using a case method will provide a useful map of the system - rendering the study more informative by revealing characteristics of a complex adaptive system (Anderson et al. 2005).Individual case reports will be used to piece together a descriptive map of intersectoral collaboration in the Western Cape.

Each space will be displayed on the map and situated according to geographical level or catchment (from local to national) and mandate (from single-disease to whole systems focussed). Participation from civil society and government will be depicted for each space and reporting lines between spaces and actors will be drawn *(See figure 2 below).* Participation and reporting lines will be shown as either functional or dysfunctional. Reporting lines will be shown using arrows and participation will be shown using lines. Solid lines will represent reporting or participation which is functional and dotted lines will represent that which is dysfunctional. The figure below may change fundamentally depending on findings during the research process.

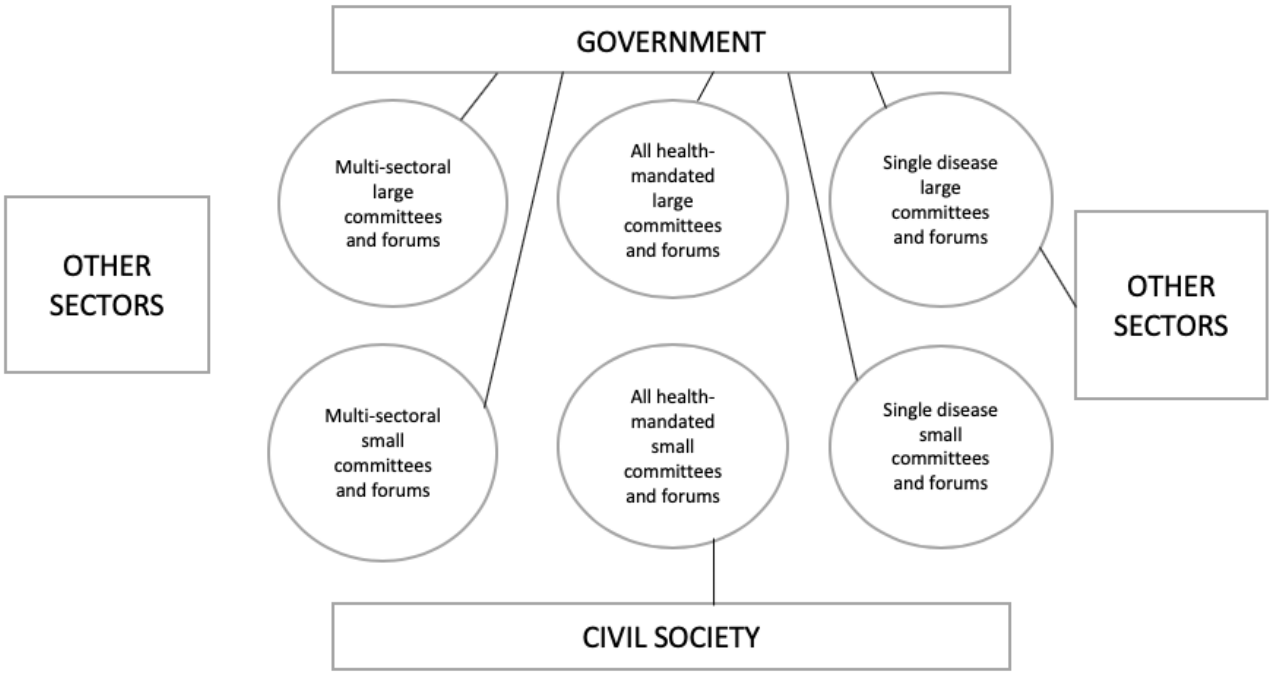

Figure 2: Example map for Phase 3 descriptive mapping (Source: Author)

Phase 4: Cross-case analysis (analysis of all intersectoral spaces)

Individual case reports on intersectoral spaces will be analysed across each theme and reported on accordingly. As this is a flexible design, thematic analysis will be iterative - during the case reporting process, emergent themes may be added for analysis and current themes may be adapted or removed (Wilson et al. 2012). The final analysis will present outcomes of individual case reports according to each space and outcomes across spaces according to each theme. Case report data will then be used to extract quantitative data. Where themes can be reduced to numerical totals this will be done in Microsoft Excel and these numbers will be statistically analysed to give cross-case averages and percentages. This mixed-method approach combines the strengths, and compensates for the limitations, of using qualitative and/or quantitative data (Pluye and Hong, 2014).

Cross-case analyses outcomes of individual case reports will be kept in mind when conducting visual analysis of the descriptive map. The map will be analysed according to gaps and overlaps apparent between spaces; clusters of spaces according to geographical level/catchment; number of single-disease versus whole-system spaces present; functional and dysfunctional reporting lines and participation in spaces by government versus civil society actors. As mentioned previously, the flexible nature of the study allows for these themes of visual analysis of the map to be added to and adapted throughout the analysis process, as “spaces and actors interacting in a nonlinear fashion may self-organize and cause system properties to emerge” (Anderson et al. 2005, pg 629).

Phase 5: Expert checking

This is a desk-based case study and draws mainly on publicly available data sources. It is therefore important that the synthesis and interpretation of this secondary data is checked by experts to enhance rigour. Expert consultation can add rigor by checking insights, provide useful additional resources, and shed light on other possible avenues for exploration (Booth and Carroll, 2015).

Experts from the public health system and from civil society will be approached: their selection will be based on their experience of the health system and knowledge of intersectoral spaces (*See Table 6* for list of experts). Experts will be sent draft case reports. *Appendices B, C and D* give a full description of the expert checking process and documentation which will be used. (Note limitations on expert checking process as a result of COVID19 in 2020, see risks and benefits below).

Table 6: List of experts to be approached

Position	**Expertise Area**
Western Cape Government health employee	Western Cape Dept of Health
Non-governmental media / advocacy member	Health Journalist
Civil society committee executive	Health – Western Cape
Health systems researcher	Health systems Western Cape
Local government committee member	Western Cape Department of health

Note: these experts are drawn from the existing broader study (mentioned above) and are also covered by the ethical clearance from that study.

Phase 6: Synthesis and write-up

Once expert checking is complete – feedback from experts will be used to correct errors on the descriptive map; insert additions and review the visual analysis. Qualitative and quantitative data from case reports will be amended according to expert feedback. A second and final thematic and statistical analysis will be conducted on amended case reports. Final analyses and expert feedback will be synthesised and used to create a holistic picture of the case. The write-up will take a whole-systems approach, with the aim to understand holistically and in context, the complex nature of intersectoral collaboration in the Western Cape Health System. This phase of the study is designed as a result of complexity theory whereby one recognises that intersectoral collaboration has “elements, but it is the interdependencies and interactions among these elements that create the whole” (Anderson et al. 2005, pg 629).

Rigor

In the case of qualitative studies rigor cannot be reduced to a list of technical procedures, but instead is embedded in a broader understanding of the rationale and assumptions behind the research (Yin, 2009). Consideration for this study is therefore given to the appropriateness of study design, the rigor of data searching and extraction processes and the use of multiple expert checking. A case study design was chosen as intersectoral collaboration is a complex and detailed system, requiring rich description. To ensure rigour the ‘case’ has been clearly and adequately defined as intersectoral collaboration in the Western Cape health system and this system has been unpacked and represented by smaller nested /embedded cases which have been clearly defined using thorough case selection criteria and strategy. As well as being clearly defined, transparency will be used when showing how embedded cases were chosen. By using multiple search engines, published and unpublished literature and predefined inclusion criteria, cases are ensured to be representative

of embedded cases (intersectoral spaces) that exist in reality in the Western Cape health system - this strengthens the validity of the study.

To ensure rigorous data collection, a number of search engines will be used give credibility and confirmability to the study (Yin,2019). Because many government and civil society reports, agendas and minutes are highly relevant to the study, but often unpublished, many forms of grey literature will be reviewed. These include student theses, minutes from meetings received from the Western Cape Department of Health, social media posts, news articles and online reports. Information relating to each forum will be collected from multiple sources, to avoid bias.

In iterative research design, new ideas feed into studies, hypothesis testing occurs and modification of themes emerges through replication (Rolfe et al. 2008). The flexible design of this study allows for these emerging themes to be captured during the process of data collection and analysis and to be fed back into the research process. This multi-stage data analysis develops decision-making narratives and allows for careful case examination (Abelson et al. 2003).

In intersectoral spaces where uncertainty of information is present, expert checking will confirm or correct data. All data will be sent to health system experts for checking. “Case study research includes procedures central to all types of research methods, such as protecting against threats to validity” and investigating and testing ‘rival explanations’ (Thomas, 1998, pg 308). A threat to validity and a blind spot to rival explanations may be due to the researcher’s personal perspectives. These researcher roles, perspectives and the personal intentions will be made apparent through reflexivity (Thomas, 1998) and given alternative views by experts.

Risks and benefits

This is a no (or minimal) risk study, as it will be based on secondary desk-based review of publicly available materials, with no human subjects.

The disseminated information may benefit governments and civil society, giving them insight into avenues to strengthen intersectoral collaboration. Civil society may draw information from the study on where and how to participate in the Western Cape Health System. Government policy-makers may consider re-distributing their actor-participation in intersectoral spaces or decide to open spaces for civil society to participate and intersectoral collaboration to occur. The study may serve as a catalyst for further, more elaborate research and mapping of intersectoral collaboration in health systems.

Box 3: Risks and potential limitations in relation to Coronavirus in 2020

This ethics application is being submitted in early 2020, in the midst of the global COVID19 pandemic. We are starkly aware of the limitations placed on research conducted at this time and in this context – especially health systems research. We have assessed the risks and adapted this study to suit the ‘desk-based’ requirements of this particular time.

However, the expert-checking process described above might not be possible within the time-frame of the study. That is, these health systems experts are deeply immersed in COVID19 response, and may not have the time to respond (indeed, it might be unethical to even ask). It is unclear when/if they would have the capacity to respond.

We have considered these risks and have retained this part of the study design – but will reassess the conditions when the time for expert-checking arises. It may be necessary to ensure checking and rigor in other ways (e.g. through more detailed triangulation) or give experts an extension on their timeline to respond. This decision will be made with support from the study supervisor.

Ethics

The study is a desk-based mixed method study which synthesizes multiple forms of data (as is standard in a case study), including literature, policy, grey literature such as reports, theses, surveys, and media resources. The study draws on multiple forms of evidence but does not include any human subjects, and therefore does not pose significant ethical risks. Any sensitive or personal information, even if sourced in public documentation, will be considered carefully before inclusion.

Risks to the health system may emerge during the research process - these may be unintentional risks and will be dealt with immediately if and when they arise during the study. Adequate measures will be taken swiftly to adapt or discontinue the study if risks to the health system arise.

All data will be collected from open access materials, either published or unpublished and stored on a password protected private computer. Experts will be required to sign a confidentiality clause prior to receiving data for checking (See *appendix 7*). The expert checking process is to review data and search for inconsistencies, it does not constitute drawing new information from participants and therefore experts are not considered 'participants' (See *appendix 7* for expert checking forms). Experts' review process will be entirely voluntary, and experts may opt out of reviewing data and or remove their inputs at any stage before the study is finalised. The time required to review and comment on study data is minimal and experts will be given at least 4 weeks to complete checking - this should not put any added stress to their current roles - if experts feel they are unable to complete checking in the time frame stipulated, they may either opt out or discuss an extended time frame *(see also COVID-19 limitations - box 2)*.

The expert checking process is not an interview process - as the data will be already be captured from desk-based searches. Expert checking is aimed at ensuring data is correct rather than providing new information. Data will be sent electronically to experts to review and sent back to the researcher via email, no recordings or note-taking of experts words verbatim will occur. Experts will be asked if they would like to be acknowledged (named) in any published outputs emerging from this work.

The study aims to benefit government and civil society, as well as intersectoral spaces and not cause any harm to these individuals and organisations. As such it will be ensured that the study does not directly implicate any individual or organisation to poor functioning of intersectoral collaboration in the Western Cape - but rather gives suggestion as to where relationships and spaces can be strengthened.

Dissemination of findings

When complete, this study will be made available on the open access database of theses supported by the University of Cape Town. It is hoped that the article will be submitted for publication in an academic journal. Internal case reports will be developed (as is normal in case study research), and these will be shared with the experts involved in the expert checking process (unpacked below). Early drafts of the journal article will also be made available to these experts and other interested health professionals.

Data on individual intersectoral spaces and their case reports will be shared as a 'filtered' spreadsheet in Microsoft Excel, depending which space /(s) apply to the particular expert. Experts in government fields will not receive data on civil society-only spaces and vice-versa. Experts will receive a PDF version of the descriptive map, displaying all spaces and their interactions. Once the study has undergone a final synthesis and write-up, experts will receive a draft version of the article by August 2020.

The data collected, and all outputs will be provided to the broader linked study (on health systems responsiveness in SA and Kenya). Members of the broader linked study team will receive a full draft of the article, before final submission takes place.

A final version of the article will be sent by email to the Western Cape Department of Health; all intersectoral 'spaces' (organisations, committees, board members) included in the study and the University of Cape Town Public Health students.

The author will use a platform provided by the David and Elaine Fellowship to disseminate findings. The study outcomes will be disseminated during a one-day seminar at the University of Cape Town to fellowship donors and invited delegates from various health professions.

Expected timeline for study

2019 / 2020	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Protocol										
Literature review draft	X	X								
Methods section draft		X	X							
Article										
Embedded case selection and reporting			X	X						
Mapping				X	X					
Cross-case analysis					X	X				
Expert checking of case reports and mapping							X			
Editing based on expert feedback								X		
Final write-up and analysis								X		
Article draft									X	
Finalized for submission										X

Budget

The study is self-funded. The research requires access to online literature and an internet source. Unlimited internet is currently available to the author at no further cost. No primary data collection will occur and therefore no funding is required for this. Assistance in generating a digital map may be out-sourced and cost incurred:

Table 8: Breakdown of costs for research study

Item	**Total Cost over study duration**
Internet costs	R0
Digitizing map / diagram: service cost	R500
Total	**R500**

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Journal article

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Mapping current intersectoral spaces for civil society participation in the Western Cape province of South Africa, focusing on health system responsiveness: a mixed methods case study

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Abstract

Since the Alma Ata Declaration of 1978, community participation in health service improvement and health policy development has called for an intersectoral approach - usually by the engagement of civil society as a pivotal agent for improving health system responsiveness. However, astonishingly little is known about the overall configuration, nature, and focus of spaces where civil society are participating and intended to be providing feedback into the health system.

In South Africa, with the mainstreaming of HIV/AIDS and TB prioritization, and the global drive to operationalize intersectoral collaboration, there is a sense that spaces for civil society participation are often siloed and guidelines for intersectoral collaboration do not take locally bound, dynamic health systems into account.

This study describes a provincial health system, the Western Cape province in South Africa, mapping the spaces where civil society (is intended to) participate in the local health system, provide feedback, and contribute to health system improvement such as policy decisions.

A mixed method case study was conducted, integrating desk-based review of multiple forms of openly available data, with verification from experts in the field. 16 intersectoral spaces in the Western Cape health system were mapped and compared, with analysis focusing on current governance practices, accountability and civil society participation within the broader health system responsiveness goal.

The current configuration in the Western Cape consists of multiple overlapping 'spaces'. Informal, non-elite civil society groups remain disconnected, lacking the political capital to engage with health system decision-makers. The Western Cape health system actors evidence historic and ongoing efforts to involve and integrate civil society organizations into the public health system, primarily through the establishment of more intersectoral spaces (such as multi-sectoral action teams, networking AIDS communities, and the newer whole-of-society approach). However, more deliberate 'whole system' efforts are needed, including the routine mapping of adaptive spaces for civil society engagement and the changing actors and networks within those spaces; and adjusting intersectoral approaches according to updated context-specific criteria in order to improve system responsiveness.

Keywords*:* health system, intersectoral collaboration, civil society participation, responsiveness, South Africa, multi-level governance, accountability

[1] Journal instructions for authors in appendix 13.

[2] For the purpose of thesis examination, the student is the sole author of the work.

Key messages

- Multiple overlapping spaces for actor collaboration exist in the Western Cape health provincial system, although parts of civil society still lack access to these mainly 'vertical' intersectoral spaces. There is a need to remove redundancies (spaces with overlapping functions), open new spaces, and streamline intersectoral processes.
- Vertical intersectoral collaboration has proven challenging to achieve through a one-size-fits-all model due to the context-specific nature of health system. Instead, an 'adjustable waist band' approach should be used, considering governance, accountability and civil society participation within each individual health system's context.
- Local, non-elite civil society groups are often alienated from public health system decisions. To ensure responsiveness equity they can be legitimised and absorbed through intermediary bodies and government leaders with political will.
- Further efforts are required to measure the effectiveness and impact of intersectoral collaboration (for example, towards health system responsiveness) to attract long-term sustainable funding for collaboration. Routine and holistic mapping of a health system's current configuration is useful to see where the avenues for civil society engagement lie, towards improved health system responsiveness.

Introduction

The World Health Organisation (WHO) acknowledged in 2007 that a health system's performance can no longer be measured solely on availability of finances, workforce, technology or clinical outcomes – but consideration also needs to be given to non-health related performance concerns such as health system responsiveness, as a measure of success (Adesanya et al. 2012; Gilson et al. 2017). Responsiveness has been broadly defined as how timeously and effectively health system decision-makers such as policy-makers respond to the legitimate expectations of the population, or people within the system (Robone et al. 2011; Mirzoev and Kane, 2017). A mapping review of literature relating to health system responsiveness organizes relevant materials into three broad categories or framings; the first and second relate to feedback inputs from patients (users) into health services for the purpose of *service* quality improvement; the third categorization clusters materials more focused on responsiveness framed as a form of accountability, involving inputs from 'community', inclusive of users and non-users, as well as community-representative civil society (Khan et al. 2020). We focus on the third categorization/framing of responsiveness, in particular 'civil society', which (broadly defined) constitute all non-government individuals and groups, including citizens, community, and the general public (Greer et al. 2017; Khan et al. 2020). Within this categorisation health systems should then also be responsive to civil society's input into service improvement as well as health *system* policy and planning (Khan et al. 2020).

It has been widely noted that there are benefits to including the broader public in health system decision-making – as non-government actors' non-political, non-partisan subgroups have the potential to come together as a collective, amplified voice, especially when government accountability is not being realised (Roy, 2008; Portal, 2016; Storeng and De Bengy Puyvallée, 2018). In low- and middle-income countries' (LMICs) health systems, where resources are limited, and accountability often strained, the participation of civil society becomes even more pertinent (Martinez and Kohler, 2016). In such settings, civil society can act to direct scarce resources to highest priority areas, and can also ensure that vulnerable and marginalised people are included more often in health policy; contributions from these actors in the system improves responsiveness equity (Darby et al. 2000).

When considering *how* civil society participates in a health system, the literature shows that engagement by non-government actors in the health system is impossible without enabling intersectoral structures being in place (McQueen et al. 2012). Intersectoral collaboration is defined in different ways, but in this case we mean what is usually termed 'vertical intersectoral collaboration': "building bridges and creating dialogue between separated civil society and government actors at all levels" (McQueen et al. 2012, g 24). It is important to note that in this particular paper, we do not use the term to indicate collaboration between sectors (such as health, development and education), unless indicated, as it is also used in other publications. Instead we focus on collaboration across the vertical domain: *actor* collaboration. Informal avenues are commonplace for civil society to put external pressure on government, such as rallies, campaigns and protests - but this study focuses on the more formal 'spaces', relational spaces, mechanisms and platforms where civil society engage with government - such as committees and forums. More often than not collaboration does not always occur in the same physical location, therefore, by 'intersectoral collaborative spaces' we mean more than the geographic locations in which engagement occurs *(see Box 1)*.

The broader global health and development policy shows wide acceptance of the importance of intersectoral action in spaces, but also indicates how little is understood about their overall configuration and nature – making genuine participation from civil society and system responsiveness challenging to achieve (WHO, 2012; Greer, Wismar, & Kosinska, 2017). The WHO acknowledged that this poor operationalization of intersectoral collaboration could come as a result from implementing a 'one-size-fits-all' strategy for health systems which are context-specific (WHO, 2012). In 2012, global consultations on a *Path for intersectoral collaboration in health policy* recommended instead an 'adjustable waistbands' approach, to use and adapt according to each health system context (World Bank, 2004). Three adjustable approaches were identified: 1) creating multi-level governance structures, 2) utilising accountability opportunities, and 3) opening spaces for civil society participation and empowerment (WHO, 2012).

Box 1: Defining 'intersectoral collaborative spaces' between civil society and the public health system

The terminology in this terrain is varied.
In this study, we define:
- vertical 'intersectoral collaboration' as collaborative approaches which consider the roles of all actors in (this case) the public health system and aim to strengthen coordination between these actors, so their collective efforts work for one common purpose
-horizontal 'intersectoral collaboration' as collaborative approaches across sectors (such as health, education, agriculture and finances). This form of intersectoral collaboration will not be used for this particular study
- **'spaces'** as the formal, institutional, or policy mandated committees and forums for civil society participation in intersectoral collaboration
- **'civil society'** as individuals and institutions who are non-state/non-government mandated
- '**the public health system**' as the state-governed national health service, including the various government institutions and actors
See Methods section for more operationalisation of key terms

A scoping review of 531 documents highlighted the current challenges in addressing the three 'adjustable waste bands' in LMIC and South African contexts. Multi-level governance is largely being addressed using a tiered system and in many contexts is failing as some levels are weaker than others. Accountability is seldom realised in LMIC health systems where government are not legally mandated to attend committee meetings. Finally, civil society voice is often silenced in government-owned or government-funded spaces.

All of this calls for more context-specific research on intersectoral collaboration between civil society and the public health system, and we include a particular interest in how such collaboration, when effective, might potentially improve health system responsiveness. We have selected the Western Cape province of South Africa as the particular health systems context in which to conduct this descriptive study in which we 'map' collaborative 'spaces', considering in particular the relevance of an adjustable waistband approach.

Background: Responsiveness and civil society in South Africa

In the context of South Africa, it has been widely noted that civil society's ability to participate in the public health system at multiple levels of governance has been impeded by fragmentation between the national quasi-federal government (run by the ruling African National Congress) and the individual provinces, in particular the Western Cape province, for years operated by the main political opposition party, the Democratic Alliance (Bennett et al. 2018). In certain domains of the Western Cape health system power and process is centralised and national government determines policy and practice down to local level (WCDOH, 2019).

> *"Provincial governments are now responsible for the provision of all health services; local governments, for a package of 'municipal PHC services'; and national government, for developing overarching health policy and health legislation, and support for specified prevention and disease control services" (Gilson et al, 2017, p229).*

In service delivery the provincial Western Cape government remains fairly autonomous from national strategy. This was demonstrated by the restructuring of the Western Cape health system according to a 'District Health System' (Rahim et al. 1992). This meant instead of local level health institutions operating under national centralised policy and reporting directly to them, they now operated and reported through a decentralised, tiered system- from local, sub-district, district to provincial level (DOH, 2016). Decentralised health systems are believed to improve efficiency and local accountability, but studies done in Ghana, Uganda, Zambia and the Philippines showed little evidence of decentralised structures improving health system performance and equity of resource allocation (Bosert, 2020). For the sake of this study, when considering the overall configuration of intersectoral collaboration (the gaps and overlaps in spaces) and the levels of governance in the Western Cape health system it is important to note the 'decentralised' nature of the Western Cape health system and how configuration of spaces and governance between them is implicated by such structure. Findings from Western Cape. .

Gaps and overlaps within the health system are represented not only by spaces' level or footprint, but also by the absent or overlapping *functions* performed in these spaces. The HIV/AIDS epidemic in South Africa and global response efforts have been predominantly centred around creating spaces with single disease functions, creating siloed structures – largely ignoring the need for a 'systems approach' (Global Fund to Fight Aids, 2016; Lindau et al. 2016). Due to political fragmentation (and hence lacking collaboration) and siloed programming, it appears that in the South African context, intersectoral efforts are often disjointed and happening in multiple different spaces, at times excluding smaller, non-elite civil society from broader public health system decision-making (Birdsall, 2013).

While it is important to assess the effectiveness of individual collaborative approaches (such as clinic committees), what is currently missing is an overview of all of the collaborative spaces in which civil society engages with the public health system – so that the current collaborative context can be properly understood (Blecher et al. 2017). Furthermore, to holistically map intersectoral spaces in a specific context (in this case, the Western Cape provincial health system), according to the three adjustable 'waistbands', to better understand where avenues for improving collaboration and responsiveness may exist (Okeyo et al. 2020). In this paper, we ask the question: What is the current nature and configuration of intersectoral collaborative spaces involving civil society in the Western Cape provincial health system, and can these be seen to support or inhibit health system responsiveness?

Methodology

A mixed-methods embedded case study using primarily desk-based review of varied documents was conducted. Mechanisms such as committees and forums comprised embedded cases, analysed in parallel to form the overall case of 'intersectoral collaboration in the Western Cape' (*see box 2)*. The study was conducted in six phases (*see appendix 1*).

Box 2: Single embedded case study clarification
The case: Intersectoral collaboration in the Western Cape health system
Embedded cases: Individual intersectoral spaces (geographic, institutional and relational), such as committees and forums, in the Western Cape

An initial scoping review (*see Protocol Literature Review*) showed that there was sufficient openly available data to conduct the study; and operationalised concepts such as 'civil society', 'participation' and 'collaboration'. The review also resulted in the development of theoretical framing which provided the lens through which the case was analysed and how concepts fit within related topic areas such as health system responsiveness. *Figure 1* shows this framing, where the three 'adjustable waistbands'; multi-level governance, accountability and civil society participation are analysed to understand vertical intersectoral collaboration and how this relates to responsiveness (World Bank, 2004; WHO, 2011).

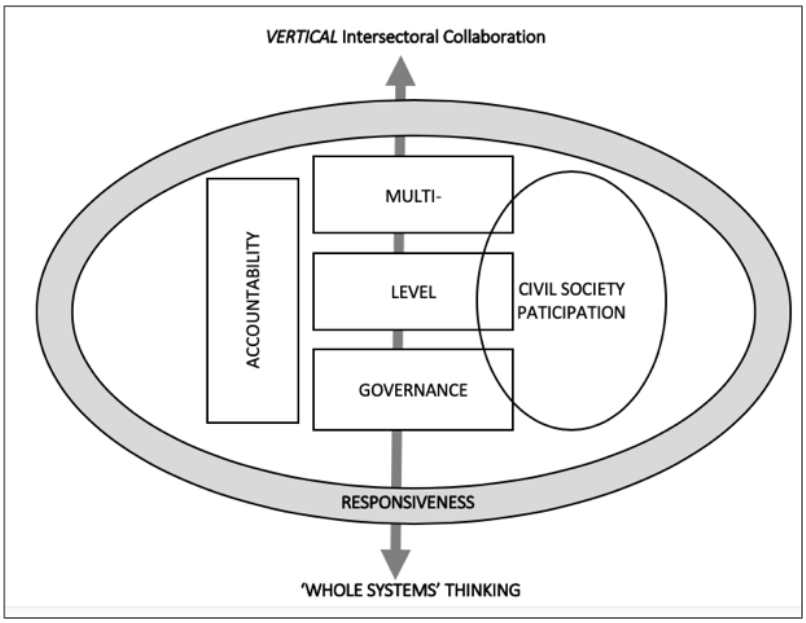


Figure 1. Approaches to vertical intersectoral collaboration (author, adapted from World Bank, 2004; WHO, 2011)

The case was built on this scoping review as well as further desk-based review. Databases such as PubMed, Embase, Google Scholar, University of Cape Town library platforms, and institutional platforms (such as the WHO and World Bank databases, Department of Health publication lists, and university thesis repositories) were scanned using sets of search terms (see *appendix 5*). In addition, relevant databases of civil society institutions, websites, and media repositories were scanned (see *appendix 6* for full list of included materials and their locations). In total, 531 relevant materials were gathered and assessed for relevance; and full text review was conducted on 52 journal articles, reports and theses, on 37 policies and 26 institutional websites (*appendix 6*). In total, this case is built on the close review and utilisation from 115 secondary items.

Embedded case selection of 16 intersectoral spaces emerged out of context reporting data, based on the inclusion criteria of relevance to the case description (health-relevant mandate within the Western Cape) and availability of 'reliable' evidence (see *appendix 7)*. Because the focus of this study is on *current* intersectoral collaboration in the Western Cape, cases which had data from the last five years were prioritised, although earlier evidence was gathered as part of case description and context (*appendix 8* shows included and excluded cases).

The author searched all selected literature to extract pieces of information that related to emergent themes and group these together to build a chain of evidence. Literature (published and unpublished) shown in appendix 6 is the main reference material, but the smaller pieces of extracted information within the literature serve and the study 'data' and is depicted using unique identifiers and page numbers where pieces of evidence were found. Results show where conclusions were drawn from (and the diversity of data sources) by referring back to unique identifiers (*see appendix 6*) and their page numbers (p) coded in *Box 3*.

Box 3. Data unique identifiers
S#(p): Secondary Literature
P#(p): Policies
R#(p): Reviews
T#(p): Theses
E#(p): Evaluation Reports
F#(p): Forums
G#(p): Government Reports
N#(p): Non-government Reports
C#(p): Institutional (CSO) Websites
I#(p): Institutional (Gov) Websites
W#(p): Wikipedia
D#(p): Databases
M#(p): Media
A#(p): Guidelines and Strategy Documents
H#(p): Annotated Bibliography
B#(p): Books

From thematic analysis of data qualitative case reports and quantitative summaries on each embedded case were compiled, synthesizing all available data *(see appendix 6)*. Qualitative descriptive analysis and quantitative trend analysis was conducted simultaneously, and iteratively adjusted as trends emerged during cross-case analysis *(see appendix 10 and 11).* This mixed-method approach compensated for the limitations of using qualitative or quantitative data in isolation and increased opportunities for triangulation (Pluye and Hong, 2014).

As the desk-based study drew on publicly available data sources, and relied on researcher interpretations of such, additional expert verification was included after the initial analysis phase. Three experts from public health and civil society were selected to give feedback and report errors in a final checking process (see *appendix 2*).

Limitations

We have noted that this is an under-explored terrain, so this descriptive mapping approach is necessary as a first step towards understanding these intersectoral spaces. However, the desk-based approach, while suitable for this first stage of research, in future would need to be supplemented by primary research (for example, interviews and observation of these spaces). We see this as an important later step to this research (see Conclusions) and this study forms part of a first phase of broader study which will employ these field-based techniques *(appendix 4*). The multiple forms of data synthesized, provides opportunities for triangulation, but also creates challenges, as there was rarely one form of data consistently apparent across all cases (making a cross-sectional approach impossible). One of the main challenges of researching intersectoral networks and engagement, is that such spaces are massively complex and changeable – this study is limited as a 'snapshot' of what can be as assessed in the current literature. Generalisable claims are therefore are limited. All of this points to the need for further, deeper research approaches to address this complex issue.

As this case study is based on review of secondary data, it is not useful to separate findings into primary results and then reflection against secondary resources. As is increasingly common in case study reporting, the next section reports on the cross-case analysis, which is inclusive of researcher analytics, and gives reference to secondary literature as well.

Results

The study describes 16 intersectoral spaces currently active in the Western Cape health system (*see box 4*). Results consider their 1) configuration and development, 2) current functionality, 3) governance and accountability, and 4) actor-participation, with a specific focus on responsiveness.

Box 4. Intersectoral space acronyms: the study analyzed 16 intersectoral spaces (mainly committees and forums) in the Western Cape health system

1	PCA	Western Cape provincial AIDS council
2	MSATs	Multi-sectoral action teams
3	WC-NACOSA	Western Cape- networking HIV and AIDS community of South Africa
4	DHC	District health councils
5	SDHC	Sub-district health committees
6	WHC	Ward health committees
7	CHC	Clinic health committees
8	LN	The learning network
9	WoSA	Whole of society approach
10	SALGA	South African local government association
11	SGJ	Sonke gender justice
12	CoCT HIV/TB	The city HIV/TB coordinating committee
13	HPCA / HESP	Hospice palliative care association / Health system strengthening through strategic partnership
14	PCB	Provincial consultative body
15	PHC	Provincial health council
16	PPHF	Public-private health forum (PPHF)

Gaps and overlaps in the directive of intersectoral spaces

This study sought out spaces which were engaged in health, but it is still interesting to understand, within that sample, what their main focus is. We mapped spaces according to their 'main directive', that is whether they were mandated to address a single disease, health or all sectors; and their geographical footprint, including at what level of the health system they were mandated to operate (*Figure 2*), and how substantial the network appears to be. Figure 2 organises these embedded cases against these criteria – noting that the Figure does not indicate the number of spaces, only the location of type - that is, at the lower levels in particular, this represents multiple spaces (such as multiple ward-based teams).

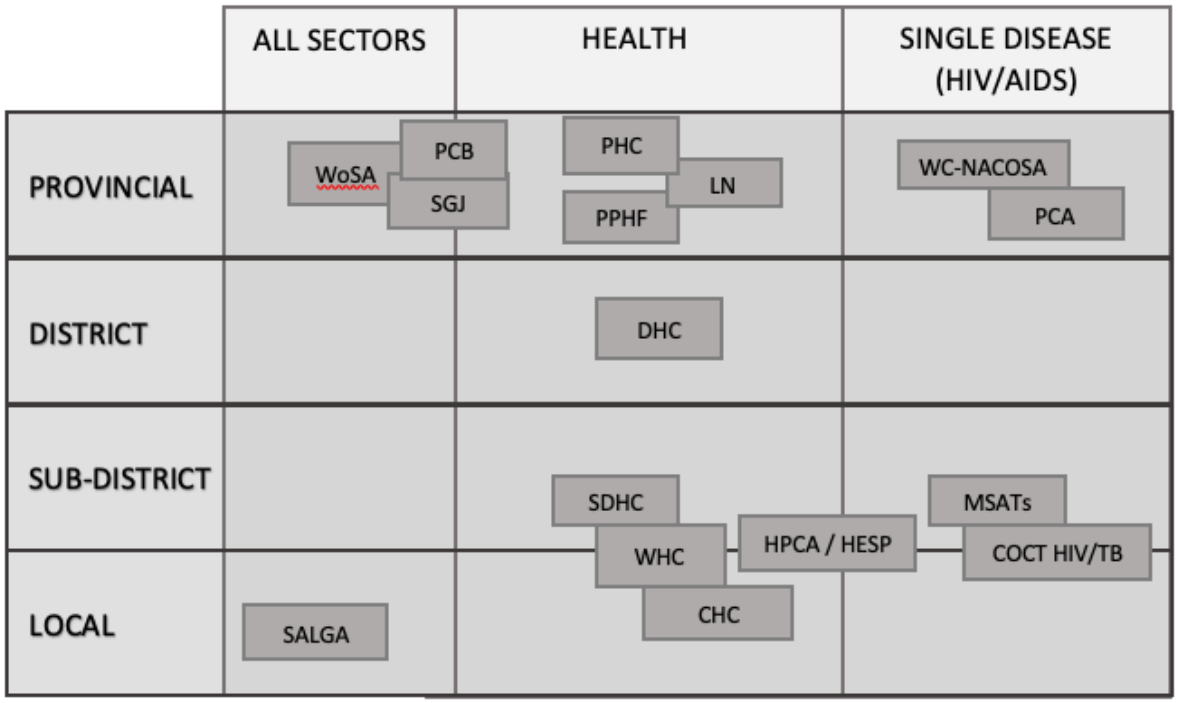


Figure 2. Mapping of intersectoral spaces according to original directive and footprint (author analysis).

Figure 2 above was compiled using data from appendix 6: A1(10,26,37,99); A5(1,3); A6(1); A8(4,9,24); C5(2); C6(1); C7(1); C8(3); C11(1); E2(13,28,32,34); E3(1); E11(4); I7(2); P2(46); S6(1); S7(13,16,59,110); S8(3); T2(99); T4(44,64,65); R5(541); R7(38,39,41); W1(1).

The cases primarily mandated to engage on a 'single disease', were mostly focused on HIV/AIDS. This is not surprising given the global attention and funding epidemic efforts received post-1994 in South Africa. However, more recently funders such as USAID/PEPFAR and Global Fund have specific funding given for intersectoral collaboration and civil society engagement (Friedman, 2006; Olivier, 2014). The evidence gathered for this study substantiate the observation that "there are a lot of overlapping and competing structures that should be reformed" in intersectoral collaboration in any particular system (Spotlight, 2020a, pg 1), data source: appendix 6, A1(37); E2(32); S6(1); S8(3); T4(65) . For example, while there are multiple intersectoral spaces operating in the same spaces (in terms of level, geography and mandate) at provincial and sub-district levels, but there appear to be many gaps at the district level (see figure 2 above, supported by Mahlangu 2017 - who noted the absence of spaces for intersectoral engagment at district level).

Most of the other spaces we mapped had broader 'health' directives – but also often overlapped in their function (appendix 9 shows this overlap by spelling out directives spaces are mandated to address). For example the Learning Network and the Public-Private Health Forum are both mandated to address civil society's right to health (see appendix 9), data source appendix 6, C6(1); I8(1); S7(16); T2(99)

It is important to note that Figure 2 only maps out the included cases in this study – which is selective, not inclusive of all intersectoral spaces in the Western Cape. In fact, this 'map' would be massively populated if we had included all 'spaces' mentioned in the literature, such as gender-based violence spaces and others that did not have sufficient data. It does however, confirm the observation in the South African and Global literature, that intersectoral spaces tend to be established without consideration of what other spaces are

already available (Spotlight, 2020a), resulting in gaps and overlaps. Nxumalo, 2013 notes that collaboration between districts in a province are required when establishing intersectoral spaces. We noted earlier that common barriers to integrated and effective intersectoral collaboration are identified as the 'siloing' of spaces, 'single-disease focus' and 'vertical programming' – and this does appear to be apparent in the Western Cape health system (appendix 9 shows the multiple HIV/AIDS mandated spaces to support this claim).

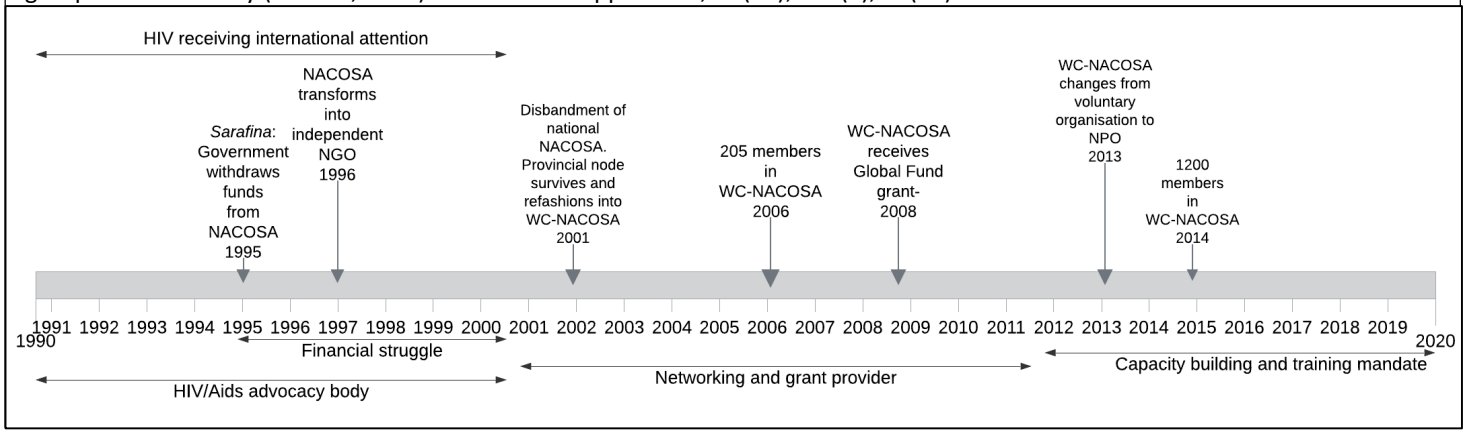
The current presence of intersectoral spaces in the Western Cape

The above section sought to map out the *directive* of these spaces, however, it is widely acknowledged that intersectoral engagement occurs on two planes (horizontal and vertical) and is complex in nature (WHO, 2012). In the Western Cape, it is observed that the directive of such spaces (horizontal, *sector* engagement) does not necessarily correlate with their *actor* engagement. For example, even single-disease spaces, such as HIV/AIDS Councils, usually engage all actors (government and civil society) in the health system, across multiple levels – and the nature of HIV/AIDS in South Africa (as a disease of society) means that the topical engagement in such spaces is often more wide-ranging than it would at first appear. Similarly, many of the Multi-sectoral Action Teams (MSATs) have recently broadened their scope of engagement to broader health and development activities (literally changing their name from Multisectoral AIDS Teams, to Multisectoral Action Teams) (City of Cape Town, 2019), data source: appendix 6, A1(76); A5(1); E2(28); R5(548). We need to take care with drawing conclusions from this. In the first account, most of these intersectoral spaces are still mandated to act as what could be labelled as spaces of 'vertical intersectoral collaboration'. However, in implementation, the situation is more complex, and in these spaces, broader actors are included, and more 'horizontal collaboration' is sometimes undertaken. Care must therefore be taken in assuming that in implementation, such spaces are 'siloed' because they have a mandated single-disease focus (more on this below). Most of these spaces in the Western Cape demonstrate a shift towards a broader more 'systemic' approach over the last two decades. That is, since the 1990s, there is evidence of more diversely inclusive spaces, and more open communication between diverse parts of civil society and government *(appendix 12)*, data source: appendix 6, A1(24,99); C11(1); E2(30); T4(68,88)

Box 5 provides an example of the changes Western Cape Networking HIV and AIDS community of South Africa (WC-NACOSA) has undergone since its establishment in 1990 - shifting to include smaller civil society groups through training and capacity building. This does not imply WC-NACOSA encompasses intersectoral collaboration entirely (horizontal and vertical collaboration - see box 1 above), but merely that the change of WC-NACOSA's mandate has had a role in absorbing and representing small CSO's to government (requiring systems thinking), an important *part* of intersectoral collaboration.

Box 5: WC-NACOSA's development

WC-NACOSA's development over time evidences how a space's ability to adapt its mandate and shift according to a changing health system, has an effect on longevity. NACOSA began as a national advocacy body for HIV/AIDS (NACOSA,2000). Following unsteady relationships with government and funding withdrawals in 1996 it transformed into an independent, self-funded NGO. In 2002, the national space disbanded; HIV/AIDS was now well known and advocacy became less of a priority (Vos, 2015). Perhaps in recognition of the saturated HIV/AIDS advocacy spaces, NACOSA restructured itself as a networking body in the Western Cape. The need to link small civil society organisations into the larger 'system' was prioritised (Birdsall, 2007). Currently, to further strengthen this vertical intersectoral collaboration WC-NACOSA provides training and capacity building to these (sometimes) side-lined individuals and groups of civil society (Powers, 2020). Data source: appendix 6, A1(99); C11(1); T4(68)



The current functionality of intersectoral spaces in the Western Cape context

Multiple narratives were collected on as many individual committees as possible and an 'overall' analysis done for each type of space. Policy documents and reports were used to determine whether membership was mandatory or voluntary (Mandatory spaces required attendance from members based on provincial policy); whether spaces were open to attend by anyone or closed (invited members only) and who 'owned' spaces (this is discussed in more detail below). Recent comments from meetings minutes or reports used to populate *table 2*.

Table 2: Results on functionality of 16 intersectoral spaces

Intersectoral space	Open (public members allowed)	Closed (only invited members allowed	Gov owned	CS owned	Membership mandatory	Membership voluntary	Meetings happening according to mandate	Sufficient funding for required activities
PCA	X	√	√	X	X	√	X	X
MSATs	X	√	√	X	√	X	√	X
WC-NACOSA	X	√	X	√	√	X	X	√
DHC	X	√	√	X	X	√	X	X
SDHC	X	√	√	X	X	√	X	X
WHC	X	√	√	X	X	√	X	X
CHC	X	√	√	X	X	√	X	X
LN	X	√	X	√	X	√	√	√

WoSA	X	√	√	X	√	X	√	√
SALGA	X	√	√	X	√	X	√	√
SGJ	X	√	X	√	-	X	√	√
CoCT HIV/TB	X	√	√	X	-	X	√	√
HPCA / HESP	√	X	X	√	X	√	X	√
PCB	X	√	√	X	√	X	√	√
PHC	X	√	√	X	√	X	X	√
PPHF	√	X	X	√	X	√	√	√

Key: √ means yes, sufficient evidence shows | X means no, sufficient evidence shows | - means unknown, insufficient evidence to determine

Table 2 above was populated using data sources: appendix 6, A1(57,62,65); A5(3); C5(2); C7(11); C11(1); E2(23,45,50); E3(1); E4(13); E11(4); G1(3); G2(3,4,9); I5(7); N9(12); P2(28,83,100.125); R5(540,548); R9(5); S4(2); S7(19,31,38,54,64); T4(39,68,92); W1(1). Although functionality tends to change over time; *table 2* shows that currently (within the past 2 years) intersectoral spaces in all cases had mandated meeting frequencies in their policies. However, for many, meetings were not happening according to these mandates. Analysis showed that many actors in intersectoral spaces were struggling to find sufficient funds to conduct the activities described in their policies; "…the central issue highlighted at the provincial level was that the activities listed in the implementation plan were unfunded and, as a result, likely to remain a wish list" (Mahlangu, 2017, pg 8), data source: appendix 6, I3(1); S8(5); W1(1). Many spaces reported over-stretched, 'shoe-string' budgets and lacking finances for basic costs of participation and committee administration, including MSATs, District (DHC), Sub-district (SDHC) and Clinic Health Committees (CHC) (City of Cape Town, 2019), data source: appendix 6: A5(2); S7(31,38,60). Spaces with funds specifically for meetings, including transport and catering (stipulated in their budget) were more likely to adhere to holding regular meetings (Birdsall, 2013). For WC-NACOSA and the South African Local Government Association (SALGA), membership fees, a reliable board and the ability to raise long-term funds keep their intersectoral meeting spaces functioning effectively (SALGA, 2017; Networking HIV AIDS Community of South Africa, 2019), data source: appendix 6, A1(57); C11(1); I3(1); T4(39); W1(1).

Comparison of mandatory and voluntary spaces showed the former to be more functional: meetings requiring 'compulsory' attendance from members often had a constitution, set agenda and minute-taking, whereas more voluntary spaces were informal, covering topics as they arose (Mahlangu, 2018). Voluntary spaces showed evidence of including members on a short-term basis; when these members left, some spaces' meetings discontinued (SANAC, 2020). One of the challenges of making voluntary spaces more mandated, is that governments often fail to find 'measurable' value or impact of intersectoral collaboration (Mahlangu et al. 2017). Some government representatives attending intersectoral spaces in the Western Cape have been reported to convey an attitude of "I'm not supposed to be here" (Vos, 2015, pg 18). As intersectoral collaboration may not be written into their government actor's deliverables, there may be a sense that these collaborations are not valued as an important part of a government members job. Data source: appendix 6, A1(39,98); A5(1); E4(45); N10(7); R7(36); S7(31,32); S8(6); T4(100).

The nature of governance and accountability in the 16 intersectoral spaces

We reviewed annual performance plans and reports to descriptively map governance connections at multiple levels of civil society and government, across the 16 spaces - showing at which levels civil society *report* (provide a reporting-type of feedback) 'up' into government structures (*appendix 9 and 13)*. Figure 4 shows a sample (of these 16 spaces) where civil society successfully reports inputs up to government (solid lines) or has barriers to reporting (dotted lines).

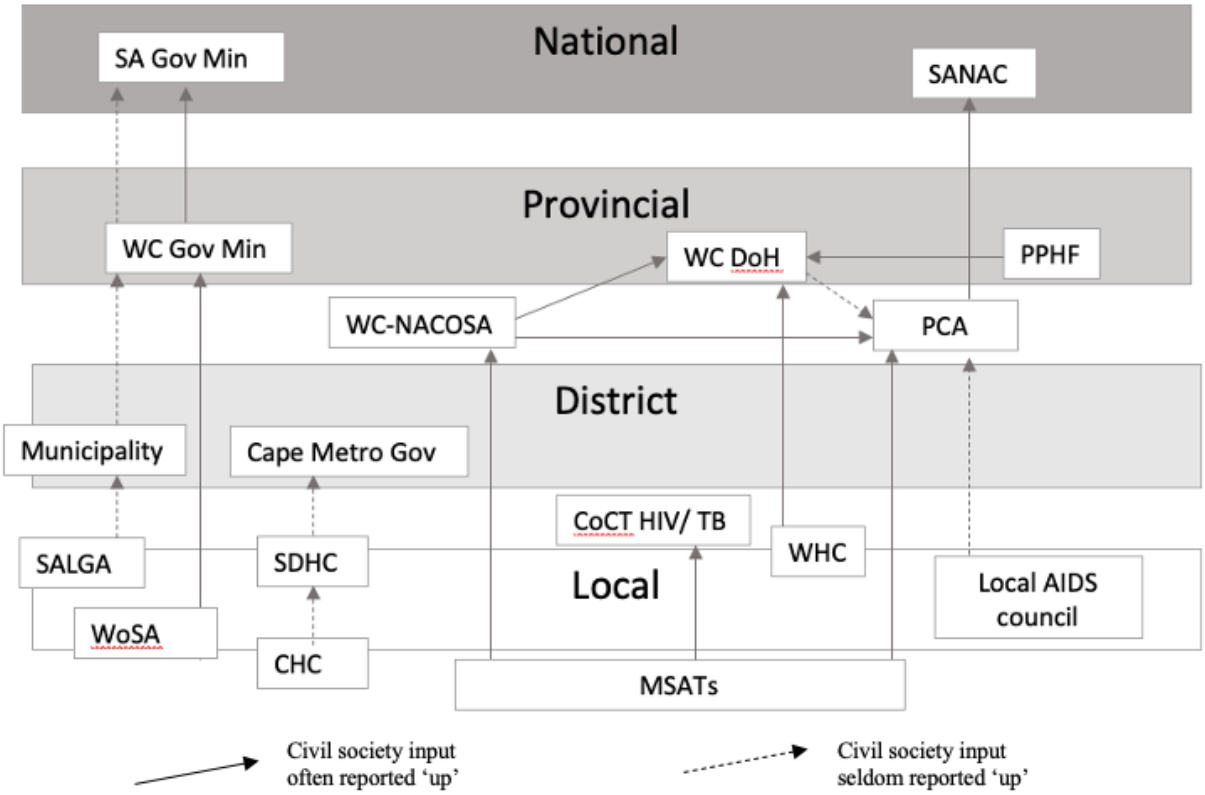


Figure 4: Governance levels and reporting for intersectoral spaces in the Western Cape

Figure 4 above was populated using data sources: appendix 6, A1(8,9); A5(1); C10(2); I3(1); I6(1); N10(3); R7(37); S4(15); S7(22,80,123); S8(5); S11(304); T4(79). There was evidence across the cases of tiered reporting structures where local level civil society actors potentially report through to provincial policy-makers. Provincial AIDS council (PCA), SALGA, CHC, SDHC, DHC and the Provincial Health Council (PHC) established spaces at local, (sub-district) district, provincial and national level to create tiered governance (*appendix 13)*. However, smaller, local individuals and groups often faced barriers in upward reporting for various reasons. In the case of PCA, local and district councils did not exist in the Western Cape. For example, "the lack of representation of some sectors in District AIDS Councils and Local AIDS Councils contradicts the purpose for which AIDS councils were established, resulting in poor coordination and omission of the work of stakeholders from multiple sectors" (Mahlangu et al. 2017, pg 8). In the case of SALGA, cross-boundary municipalities meant local actors were not clear on where to report to, impeding the flow of information to district and then provincial level (Parliamentary Monitoring Group, 2019a). For clinic committees, absent ward counsellors meant feedback from health committees often does not reach sub-district and district level government

(Mahlangu, 2018). In six of the cases reporting lines to government were not required, and instead other forms of communication such as advocacy or media were used or civil society actors reported to their respective funders (see appendix 9), data source: appendix 6, A1(8,9); A5(1); C10(2); I6(1); N10(3); R7(37); S4(15); S7(22,123); S8(5); T4(79).

Figure 4 depicts a situation where reporting is mainly happening through the expected 'tiered' system, where feedback is expected to flow from local, to sub-district, to provincial then national-level decision-makers. However, again, there appears to be a difference in mandate and implementation, and in many cases, that tired flow 'up' the system encountered barriers. Unexpectedly, in the Western Cape, the spaces showing the strongest most (currently) functional flows of feedback were those reporting directly from local to provincial level, such as civil society members of MSATs reporting directly to the Western Cape provincial department of health (City of Cape Town, 2019). The key to the success of local-provincial linking appears to be, firstly, a space (such as MSATs) that served as a 'clearing house' for small, local civil society organisations – advocating on their behalf to government and mapping out the CSO landscape; and, secondly, a space (such as WC-NACOSA) to train and support small, local civil society groups so they could effectively account for and report to government funders. (Vos, 2015). Not only do these spaces serve a 'boundary spanning' function between local and provincial level, they also address the common issue of alienation and side-lining of local, small civil society (CSOs) from the public health system by absorbing these groups into broader structures (Storeng and De Bengy Puyvallée, 2018).

However, little evidence was found of spaces situated at a district level successfully reporting feedback to provincial government. Also striking was the lack of *integrated* feedback flows from these various spaces to the provincial health system policy and decision-makers.

Mapping reporting-related feedback gives some hint of governance conditions, it also raises the question as to whether multi-level governance should include all levels of the tired structure to support civil society inputs up to provincial level government. The Western Cape case shows evidence that multi-level governance can be successful, even if the district level is 'bypassed'(Vos, 2015). The World Bank's *Guidelines on Intersectoral Collaboration* advise participation simultaneously at global, country, regional and district level (World Bank, 2005). However, in the study, evidence has shown promising collaboration occurring from direct links between local and national-level actors. This contradicts the common 'tiered' multi-level governance structures, suggesting that 'adjustable waistbands' are useful to apply for each differing health system to determine 'weak spots' in governance levels. In the Western Cape case this applications points to the fact that district level governance should either be strengthened or 'bypassed'.

The model shows some success in reporting 'up' (the first process of a feedback loop) - where civil society, through engagement in these spaces, give their input and provide feedback into the system through reporting. However, what remains unclear is the further feedback loop process: how the system (in this case provincial-level decision-makers) respond to this feedback.

Feedback loop functionality - from feedback to response

Functional feedback loops are a component of a responsive health system – they ensure that civil society's voice is incorporated in the health system and active measures are taken by government to respond (enforce inputs) and action to by government (Herringshaw, 2017; Khan et al. 2020). A collection of minutes, reports and narratives (*Table 4*) shows that most of the 16 intersectoral spaces had communication channels available, for civil society to provide feedback (of various forms, not only reporting) into the public health system, but

there was little evidence of routine or complete feedback loops where government then responded to that feedback (by response we mean action, not acknowledgement of feedback). Table 4 below was compiled using data source: appendix 6, I3(1); N9(18); S4(2); S8(9); T4(80); W1(1).

Table 4: Feedback loops and responsiveness in 16 intersectoral spaces in the Western Cape

Civil society gives feedback to	**Information passed on to**	**Response by**	**Feedback loop currently functional**	**Example**
PCA	WC DoH (through district AIDS council)	WC DoH	Partially	"Through the mayor's involvement, we mobilized stakeholders to participate in the AIDS council, and also brought investors who funded some activities….when there is something needing action, the mayor ensures that it become a success" (Mahlangu et al. 2017)
MSATs	WC-NACOSA, City Health Directorate	City Health Directorate	No	"The MSATs coordinator is not actually linked into the government system" (Olivier, 2014a)
WC-NACOSA	WC DoH, SANAC, PCA	SANAC, PCA	Partially (Not direct government feedback)	"Quarterly consultative meetings would start with feedback on how joint input to documents were taken upstream and feedback from SANAC and AIDS Council meetings were provided" (Vos, 2015)
DHC	Provincial health council	*Insufficient evidence*	*Insufficient evidence*	"CS members angrily voiced their opinion on draft PSP- they had no support from DoH and had had the same meeting about the PSP the year before" (Powers, 2020)
SDHC	City Health	City Health and WC DoH	Yes (for bigger committees)	"Some of these (bigger) forums had representatives from City Health and the provincial Department of Health, ensuring that there was a link between community participation and the health system" (Haricharan and The Learning Network, 2012)
WHC	Ward counsellors	WC DoH	No	"There is inadequate public participation and poorly functioning ward councilors" (Western Cape Department of Health, 2019a)
CHC	Sub-district committees	Sub-district government	No	"14% of health committees were involved in dealing with complaints"…of these only half of the committees actually addressed complaints or found solutions (Haricharan and The Learning Network, 2012)
LN	The Cape Metro Health Forum	*Insufficient evidence*	*Insufficient evidence*	
WoSA	Inter-ministerial government	WC Gov	Yes	"(face-to-face meetings) become one of the most cited advantages of the WoSA process, which offer a safe platform to discuss complexity" (Okeyo, 2017).
SALGA	Open WC Gov online portal	WC Gov online	Partially	"it is difficult to get provincial and national sector departments to respond … often due to the limited number of senior officials available for the task" (SALGA, 2017)
SGJ	WC Gov	WC Gov	Yes	"The DA congratulates South Africa's vibrant civil society sector for its tireless efforts in holding the DHA to account for the RRO closures … the RRO was reopened on 31 October 2018" (Violence Prevention Alliance, 2020)
CoCT HIV/TB	CoCT Gov	City of CT Gov	*Insufficient evidence*	
HPCA / HESP	MSATs and WC DoH	WC DoH	No	"… this is not really collaboration, it is the department telling us what to do and reporting information … there is an attitude of 'we are funding you, so just shut up and listen" (Olivier, 2014a)
PCB	WC Gov	*Insufficient evidence*	*Insufficient evidence*	
PHC	WC Gov	*Insufficient evidence*	*Insufficient evidence*	

PPHF	WC Gov	WC Gov	Yes	The forum opened channels for members of the public to submit their opinions for a draft discussion document, which is used annually to contribute to the Western Cape government's five-year strategy toward health (Western Cape Department of Health, 2019c)

Key: WC DoH: Western Cape Department of health; WC Gov: Western Cape government; CoCT: City of Cape Town

We noted earlier the challenge of evidencing the *response* part of responsiveness and acknowledge that in some cases action may have been taken, but not documented. However, from the available outputs, it can be said with some confidence that civil society's feedback is often fed into a vacuum - and others have noted the same, noting this is often a 'political vacuum' (Mahlangu et al. 2018). Civil society members from MSATs, DHC, Ward Health Committees (WHC), CHC, SALGA and Health System Strengthening through Strategic Partnership (HESP) reported insufficient government response to issues raised in collaborative spaces (Haricharan, 2012; Birdsall, 2013; Vos, 2015; National Aids Council of South Africa, 2019), arguing that civil society "…inputs are neither valued nor considered in the planning and provision of health services" (Glattstein-Young and London, 2010, pg 2), data source: appendix 6, I3(3); N9(18); S8(9); T4(80); W1(2). For the majority, the absence of senior government actors within these spaces, meant that civil society voices could not be communicated 'up', or responded to by decision-makers and incorporated in policy. This may speak to the multitude of overlapping meeting spaces for senior government to attend: for example the same provincial government representative is expected to attend PCA, MSATs, WC-NACOSA, DHC and HESP meetings, while the same ward councillor is expected to attend DHC, SDHC, WHC and CHC meetings. Data source: appendix 6, A1(36); A5(1,2); A8(28); E2(12); E4(15); C7(1); C8(1); E2(12); E4(15); G1(3); G2(3); I3(1); M4(6); S7(59); S8(8); S11(308); T4(60); W1(1).

Despite the above-mentioned barriers to feedback-response, the Western Cape case showed many examples of government responsiveness. For example, the role-out of ART treatment; the improvement of municipal water and sanitation services; the provision of funding for provincial AIDS councils and incorporating of civil society's voice in the planning of health services (WCDOH, 2019; SANAC, 2020; Friedman, 2006; SALGA, 2017; Glattstein-Young, 2010).

The main facilitator of this seemed to be the presence of champion government leaders who were receptive to civil society feedback, and (appeared to have) political will. Receptivity of health providers and government decision-makers relies on individual perceptions and attitudes (Lodenstein et al, 2017). Both the PCA and HESP cases showed civil society feedback being actioned by government due to mobilisation by individual motivated, passionate government leaders (Olivier, 2014a; Poolman et al. 2017). "When there is something needing action, the mayor ensures that it become a success. She is very hands-on, very much involved. She supports the coordinator, very much so, that's what makes them to succeed" (Mahlangu et al. 2017, pg 9), data source: appendix 6, E3(34); S7(8)When there is receptive and robust government leadership, feedback results in action (response); but where there is less receptivity or will from leadership, there are reports of frustration and disengagement by civil society (Haricharan and The Learning Network, 2012).

Formal, legislated authority relating to feedback and accountability

Government mandating the utilization of feedback from civil society in health system decision-making relies on a degree of accountability. Accountability is a major concern of health system responsiveness, ensuring that active measures are taken by government to respond to and address civil society inputs (Herringshaw, 2017). When civil society is correctly positioned within an intersectoral space to exert authority and forge alliances with a section of high-level decision makers, it is better able to strengthen accountability (Roy, 2008). However, "the creation of feedback channels to convey concerns and potential grievances…are severely lacking" (WHO, 2011, pg 7). Civil society's positioning in some of the study's intersectoral spaces proved challenging to legitimise and use to hold high-level government to account for a number of reasons – such as unlegislated spaces, unclear roles and inappropriate actor relationships or positioning. Unlegislated spaces showed evidence of accountability struggles (*box 6*). Where government are legislated and mandated to respond, they do so more frequently (Botha, 2018). In informal unlegislated spaces, such as SDHC, when a promise is made by one government member, but a punitive measure does not exist to enforce it, it is challenging to hold that government member to account (Mahlangu, 2017), data source: appendix 6, E11(4);

Box 6: Provincial AIDS Council's (PCA) accountability crisis
For the Western Cape Provincial AIDS Council, "lacking legislated authority can be associated with a lack of accountability, lack of ownership, low morale and lack of commitment … In the absence of a framework to guide their development and responsibilities, the roles of members are unclear, and there are no rules and regulations governing the way in which they operate" (Mahlangu et al.2017). Lacking legislation means measure cannot be taken against members who do not comply with meeting attendance and regulations (Friedman, 2006). Government are required to send a consolidated report to and from provincial AIDS councils – this accountability measure currently does not exist, and may be partially due to lacking formalised member roles to enforce this process (Mahlangu, 2018). Perpetuating this issue is the constant change of PCA members, who take with them the knowledge of roles and responsibilities when they exit, leaving new members without a clear understanding of their reporting lines (SANAC, 2016).

P2(125)

The quality of current actor-participation in 16 intersectoral spaces

Further to understanding civil society's 'positioning', the study sought to understand *how* civil society participates in a health system, considering excluded subgroups (inequity) and the power civil society has to influence (government-led) health system responsiveness (Storeng and De Bengy Puyvallée, 2018).

In order to achieve vertical intersectoral collaboration, there needs to be *genuine* actor participation (Davies and Hossain, 1996). This means participation in spaces by government and civil society actors from formal, informal, elite and non-elite representation.

In this study we considered actor-participation by reviewing meeting registers or reports to determine which actors were present in meeting spaces and situating the 16 spaces accordingly on the Davies and Hossain framework for *genuine participation (figure 7).* Also, referring back to the literature on system responsiveness, it is the inclusion of *all actors,* including the broader population (elite and non-elite civil society) that strengthens a health system's responsiveness (Gilson et al. 2017).

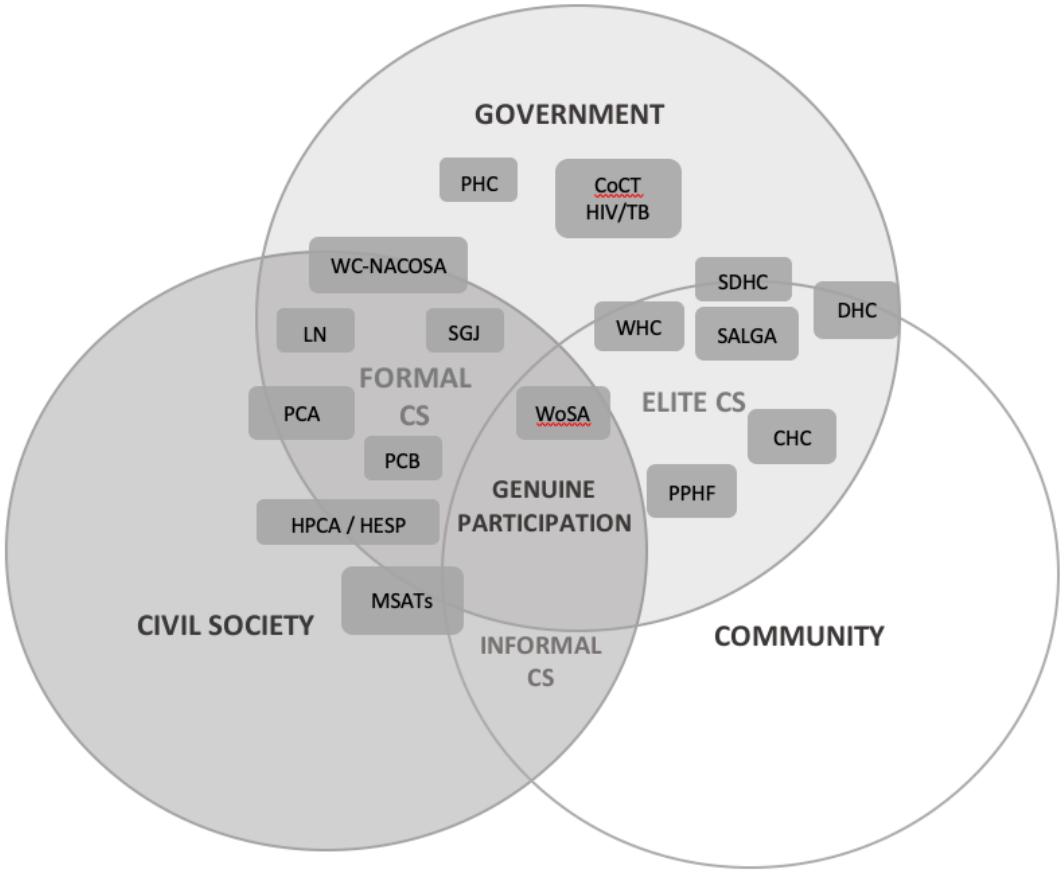


Figure 7. Situating 16 intersectoral spaces in the Western Cape health system on the Davies and Hossain 'genuine participation' model (author adaptation of Davies & Hossain, 1996)

Figure 7 above was populated using data source: appendix 6, A1(36); A5(2,4); E2(23); G1(3); G3(3); G4(2); I2(8); I3(1); I6(1); P2(54,100); R7(35,37,40); S7(102); S8(4); T4(52). As depicted in Figure 7 above, all but two of the study's intersectoral spaces have some form of participation from civil society or community. Whole of Society Appraoch (WoSA)[10] is the only space to fall in the cross-section of participation from all actors and thereby be classified as achieving 'genuine participation.). For many of these spaces civil society participation means the presence of NGOs, businesses, academics or medical professionals – what can be understood as 'elite' civil society (Vos, 2015; Mahlangu et al. 2018). It is very often only the most visible and vocal civil society representatives – those who are often more educated and wealthy than the 'norm' – who are partners in decision-making, without serious attempts being made to identify less obvious, marginalized representatives (Botes and Van Rensburg, 2000; World Bank, 2004). Eight spaces showed evidence of including non-elite civil society members at their meetings and the other 8 were represented by civil society by including NGOs, researchers or medical professionals (see appendix 9), data source: appendix 6, A1(36); A5(2); E2(23); G3(19); I3(1); I6(1). For example, in the case of the Western Cape's PCA, "the problem is the level of capacity in most AIDS councils. Some of them [members], especially from civil society, do not have much education" (Mahlangu

[10] WoSA is an approach to integrate municipal and provincial service delivery efforts in the Western Cape, South Africa across all sectors, by bringing together government with non-government actors in collaborative quarterly meetings. Civil society are included in these consultations through community-driven steering committees in three sub-districts (Cloete, 2018)

et al. 2017, pg 8). Provided reasons for side-lining these non-elite, less formal groups (unpacked below) were: education levels of non-elite civil society, government consultation fatigue, and the lack of finances.

Without community members having a level of 'policy language', there was evidence that government experienced frustrations with civil society feedback and consultation (Haricharan and The Learning Network, 2012). In collaborative meetings with DHC, WC-NACOSA, SDHC and MSATs it was noted that government left little time for civil society to discuss policy matters – and evidence from district health committees in the Western Cape shows government avoidance of long consultations with community at meetings (*See box 6 below)* (Powers, 2020).

As noted above, poor participation from non-elite, community-level and/or informal civil society was often owing to the lack of finances. Spaces such as CHCs do not commonly have a budget allowance for meetings and hence only those community members with their own transport and money for catering were able to attend meetings (Haricharan and The Learning Network, 2012). In DHCs, civil society members without access to the internet were reported to be excluded from reviewing (the PSP Draft) documentation and hence unable to give feedback on the policy during the meeting (Powers, 2012).

Civil society's inputs and feedback

Ownership of intersectoral spaces had a significant role to play in civil society's ability to genuinely participate in these spaces. Ownership was determined by reviewing reports and minutes of spaces to see which actors (government or civil society) established spaces, organised meetings, invited participants and hosted proceedings. In many government-owned intersectoral spaces, where civil society is 'invited in' governments often take control of meeting agendas and give little opportunity for civil society members to voice their opinions: "What we resent is the high-handed way the planners go about ramming proposals down our throats. This is our community and we want to be part of decisions affecting us" (Botes and Van Rensburg, 2000, pg 50). Civil society at times reported feeling fearful to raise honest concerns in case this lead to government cutting their funds or to civil society appearing 'ungrateful' *(box 6)* (Powers, 2020). In some Hospice Palliative Care Association (HPCA) meetings it was reported that government members tell civil society what to do during meetings, as they are the ones funding spaces, and civil society deeply resented being 'spoken at' rather than 'with' – resulting in them developing their 'own' spaces into which they could invite government representatives (Olivier, 2014a). Table 5 below was populated using data source: appendix 6, A1(77); E2(39); I3(1); I4(3); I8(1); R9(3); S4(14); S7(39); S8(9).

Table 5: Civil society's feedback in spaces owned by government versus civil society

	Government-owned spaces											**Civil society-owned spaces**				
	MSAT	DHC	SDHC	WHC	CHC	WoSA	SALGA	CoCT	PCB	PHC	PPHF	PCA	WC-NACOSA	LN	SGJ	HPCA /HESP
Gov gives feedback	X	X	X	X	**√**	**√**	**√**	**√**	X	**√**	**√**	X	X	X	X	X
Civil society gives feedback	**√**	**√**	X	**√**	**√**	**√**	**√**	X	X	X	**√**	**√**	**√**	**√**	**√**	**√**

In the Western Cape, SALGA and the Public Private Health Forum (PPHF) are seeking innovative mechanisms to overcome civil society's fear of giving honest feedback 'inside spaces' into the government public health system, by providing opportunity for civil society to voice concerns 'outside spaces' - for example using anonymous online portals and chat platforms open for public comment on health policy (SALGA, 2017; Western Cape Department of Health, 2019d). However, the concept of voice is complex and intertwined with issues of power which all requires more in-depth study.

Box 7: WC District Council's ineffective consultations in the development of 2020 Provincial Strategic Plan
As volunteer bodies, district health councils are seldom involved in high-level government processes and lack formal authority to feed civil society information back to high-level government policy-making (Haricharan, 2011). The case of collaborative efforts to engage civil society in the process of establishing a provincial strategic plan (PSP) was no different. A draft version of the PSP was supposed to be distributed to civil society to scrutinise before district council meetings, but this did not happen: "PSP was developed without civil society consultation. No one was able to look at the draft policy prior to the meeting" (Powers, 2020). During district council meetings members of civil society reported that government spoke *at* them in rushed, jargon-heavy language, leaving little to no time for discussion and feedback (People Health Movement, 2018). In one particular case, a civil society member told researchers they were worried about speaking openly with government. When members of civil society tried to raise concerns on the PSP they were told by government not to complain and be grateful for what they have (Powers, 2020).

For some of the study's intersectoral spaces there was evidence that civil society feedback is in fact reaching government and being responded to – and these are also the spaces in which 'genuine participation' is emphasised. In the Learning Network (LN) , Whole of Society Approach (WoSA) and Sonke Gender Justice (SGJ), evaluative research has shown that community members give input, actively participate in meetings and raise their concerns – for example, such concerns are written into future agendas and feedback taken seriously (Haricharan and The Learning Network, 2012; Okeyo, 2017; The Learning Network, 2019; Sonke Gender Justice, 2020), data source: appendix 6, A8(24); C8(1); N9(18); R9(3)Lessons are being learned from the Western Cape's WoSA, which, in the study, was the only space to fall in the cross-section of government and civil society to achieve 'genuine participation' according to the above criteria. WoSA "aims to encourage and put into practice a new way of working in partnership across all levels of government, as well as with civil society, business, NGOs, and intermediary organisations" (DOH,2019c, pg 5). The significance in this space is the level-playing field when it comes to power that government have created with community members and civil society (Okeyo et al*.* 2020).

Discussion

Responsiveness is thought to occur when a health system is designed to incorporate the voices of the people receiving health services into its broader policy-making structures and respond to issues and needs emerging within the system (Robone et al*.* 2011; Mirzoev and Kane, 2017). Formal spaces, such as committees and forums, where community (and community-representing civil society) can engage in the public health system are common in LMICs, but often analysed in isolation or in relation to specific disease events, seldom considering the broader, overall configuration and nature of such spaces (Bennett et al*.* 2018). This study aimed to holistically map the configuration and nature of multiple intersectoral spaces where civil society provides feedback into the Western Cape provincial health system in South Africa, and consequently government responds in a way that has a health improving or systems strengthening effect. Although the study uses a selective sample of 16 embedded cases and does not analyse all spaces that exist in the Western

Cape, and only addresses one local health system, it provides important suggestions of where gaps and overlaps may exist for the broader configuration of intersectoral collaboration in the Western Cape health system, and other LMICs, and suggests where further research should be focused.

A need to more holistically map intersectoral collaboration

The configuration of intersectoral spaces in a health system is important as it facilitates civil society's ability to participate, collaborate with government and influence the system in order to improve responsiveness (Coyne, 2000). There is a sense that often spaces (or operational structures) for civil society engagement are established with little planning or consideration of existing/other spaces, and limited coordination – which in turn results in overlaps and gaps which may impede the flow of feedback and response between system actors (Bennett et al. 2018).

The global attention around the HIV/AIDS epidemic in many LMICs seems to have resulted in numerous spaces with a single-disease focus, often overlapping in their functions (Mahlangu et al. 2017). This is not to say that all intersectoral spaces in LMICs should take on multi-sector functions - but rather that those numerous spaces addressing HIV/AIDS at the same level should attempt to forge synergies or fill gaps at other levels in order to 'iron out' the configuration of intersectoral spaces.

In this case study, we found that the collaborative spaces were highly adaptive, changing in form and function over time (and also sometimes frustratingly, frequent changes in actors and institutions). Findings from other LMIC contexts show that similarly such collaborative spaces tend to shift – for example, Seddon et al, (2011) note that in the last two decades, collaborative spaces have changed to be more inclusive of civil society in the health system and open dialogue with government (Seddon et al. 2011).

Systems are by nature complex and adaptive, and this ability of spaces to shift and transform their function should not only be seen as a challenge, but can also be said to lead to longevity and sustainability (Plsek and Greenhalgh, 2001). The key, throughout this transformative process is that regardless of a space's function (single disease or not), commitment is made to *vertical* intersectoral collaboration: actor collaboration – and more specifically: genuine participation, where spaces engage elite and non-elite members of civil society.

This case shows that effective *systems* collaboration does not come from each space performing all functions and activities, but rather from the coordination *across* their differentiated functions, and from the uniformity of actor efforts fitting into an overarching purpose. For example, in the case of WoSA, organisation with differing directives, such as HIV/AIDS, gender-based violence and economic development come together with their differing roles, but a shared understanding of the importance of intersectoral work, collaboration and partnerships (Adeleye and Ofili, 2010; Vos, 2015).

Approaching different health systems with 'adjustable waistbands'

Community participation in health system policy and decision-making in LMICs was emphasized from the 1970s and since then intersectoral collaboration for health systems has been widely endorsed (Zakus and Lysack, 1998). Policies in 2012 on intersectoral action for health and civil society participation attempted to provide a path for policy makers to incorporate civil society in the public health system (WHO, 2011; McQueen et al. 2012; Storeng and De Bengy Puyvallée, 2018). However, the operationalisation of such policy has been challenging for many LMICs because of locally bound differences across health systems (Botes and Van Rensburg, 2000). Attempting to apply a 'one size fits all' policy or standardized guideline to intersectoral action is therefore shown here, to likely be ineffective (Botes and Van Rensburg, 2000; WHO, 2012). This study

confirms this notion and reinforces that it may be more useful to firstly report on individual contexts of LMIC health systems and then apply three 'adjustable waistbands' to map out the nature of intersectoral collaboration specific to each health system. Adjustable waistbands provide a useful framework to understand local systems contexts, in terms of multi-level governance, accountability and civil society participation. Once an overall, contextual descriptive mapping of a health system's intersectoral collaboration is undertaken, then it may be easier to see obvious avenues for improving health system responsiveness.

Lessons from the Western Cape, South African context

The South African health system particularities are central to understanding intersectoral collaboration in the Western Cape case and shaping the context within which we are describing responsiveness. The country's health system issues date back to the apartheid era when governance and service delivery was highly fragmented, populations were segregated and discriminatory laws resulted in resources being unequally distributed across racial divides (Maphumulo, 2019). Giving voice to marginalised groups is a reform in South Africa, given the suppressive nature of apartheid that will take time to fully realise and hence affect civil society's ability to openly participate in government dialogue (Friedman, 2006). Besides entrenched institutional barriers, South Africa's triple burden of disease has not only put financial duress on the health system, but also redirected programming and resources to an HIV/AIDS and Tuberculosis response and away from other health-related issues, dismantling attempts at multi-sectoral engagement (Lindau et al., 2016). Further to historical and epidemiological barriers, South Africa's current challenge is addressing the lacking trust that exists by the public due to a decline in the quality of their health system (Maphumulo, 2019).

The avenues to improve health system responsiveness suggested from the Western Cape of South Africa's case may differ from other LMIC health systems, but some lessons are cross-cutting. There is a sense that the traditional multi-level governance 'tiered' structures (where civil society gives feedback 'up' through local, district, provincial and national levels) might only work well in systems where each level is already highly functional (SANAC, 2020). However, in many LMIC health systems, the absence of government political will, poor receptivity to feedback, and institutional barriers mean that civil society feedback 'up' into government structures often does not reach provincial and national policy-maker level (Lodenstein, 2017). Consideration needs to be given to 'bypassing' problematic levels - and evidence from the Western Cape shows the value in forging links for civil society feedback to go directly from local to provincial level, by means of intermediary bodies, boundary spanners or clearing houses (Vos, 2015). These intermediary spaces have shown value in many LMIC contexts as they strike a balance between understanding local needs and having the social capital to advocate to higher level government (Schneider et al. 2019). Governance therefore may not require engaging all levels, but rather ensuring that intersectoral collaboration occurring at micro, meso and macro levels are not working in opposition to each other, and that civil society feedback is reaching a level where decisions can be influenced and action can be taken.

One of the reasons for this attention to ensuring civil society feedback reaches government, is because of how instrumental active participation from civil society can be in holding government actors to account and improving responsiveness (Adesanya et al. 2012). Surprisingly, little is known about the actual response part of feedback loops - where governments action the inputs they receive. What is implied from this case and the broader scoping review conducted for this study is that LMIC governments seldom have the workforce and capacity to respond - in these contexts it often takes a passionate leader who is receptive to community and civil society feedback, and has the political will to push past these institutional barriers to effect change (Okeyo, 2017; Lodenstein, 2017). It has also been noted that leadership needs to be skilled and robust in

intersectoral collaborative efforts, to avoid the risk of government and non-government actors consulting incessantly without reaching agreement on joint action or finality on policy (Bennett et al. 2018). Consultation fatigue was widely reported in this case (from both sides) and is observed in other settings - and can lead to vital policies remaining unfinished, or implementation failures, which has been shown to be determinantal in failures of accountability (Olivier, 2014a; Powers, 2020). Lacking final long-term policy with clear roles and responsibilities communicated to all actors is shown to be a major stumbling block to improving responsiveness in LMICs – and appears to be a necessary focal point in relation to civil society collaboration (Vos, 2015).

Inhibitors and supporters of health system responsiveness

This case study sought to describe the nature and configuration of intersectoral collaborative spaces involving civil society in the Western Cape health system, and asked whether this configuration supports or inhibits health system responsiveness.

The system we described is a complex one – in which intersectoral collaboration is widely approved of, and for which spaces are available, some mandated by policy some not. However, these spaces are many, and have both obvious gaps and frustrating overlaps (the latter often resulting in collaboration fatigue).

However, there were major issues (in nature and configuration of these spaces), which acted as inhibitors to improved health system responsiveness. These inhibitors are not unique to the South African context. For example, in many LMICs it has been noted that a major inhibitor to intersectoral collaboration is sustained core funding for collaboration. Not only does unstable funding affect the functionality of meetings, but also their equity (Barker, 2012; Vos, 2015; Mahlangu, 2017) – as un/under-funded meeting spaces usually exclude vulnerable and marginalized groups as these members cannot always afford to attend. Civil society participation cannot be classified as 'genuine' if these informal non-elite groups are under-represented in these collaborative spaces (Davies and Hossain, 1996). In systems thinking, all formal and informal actors play a part in influencing health policy - yet often only large NGOs, academics or medical experts (elite civil society) are heard in intersectoral spaces (Blendon et al. 2001). There are many reasons 'voices' are not heard, and their feedback is not actioned. In fact, both elite and non-elite civil society representatives may be present in intersectoral spaces, but they may be silenced – as a result of issues of power, self-regulation, or government controlling meeting agendas (Glattstein-Young and London, 2010). The broader LMIC literature raises further concerns by governments, that civil society will raise conflicting issues (Barker, 2012). In some cases civil society regulate their own inputs as a result of fear and power dynamics - where often it is government who own and fund spaces and health services (Olivier, 2014).

The other main inhibitors already mentioned are firstly; the voluntary nature of spaces which affects functionality and accountability. Secondly, government versus civil society 'ownership' of spaces affects civil society's empowerment and ability to participate. Finally, lacking senior government presence in spaces as a result of a multiple overlap inhibits responsiveness. Brazil's Health Councils; Uganda's Health Unit Management Committees and Nigeria's Ward Development Committees reflect similar issues to those of the Western Cape case regarding the voluntary nature of intersectoral spaces. Studies have shown these committees are limited by their lack of formal, mandated authority, which reduces meeting functionality and weakens civil society's ability to government accountable, thus hindering the 'collaboration' mandate these spaces were originally established for (Martinez et al, 2016 and Brinkerhof, 2020). Village committees in rural India show evidence of power inequalities between government and civil society in spaces owned by

government. Researchers suggest disappointing outcomes of participation, were communities are silenced by external agendas and what they term 'quiet power'. Communities members expressed "fear to speak" as government own the space (Scott et al, 2017, p84). Lacking senior government presence in intersectoral spaces is referred to in the literature multiple times for community-based health committees in Kenya, Malawi and Tanzania. Poor attendance and the challenge of retaining these government decision-makers in intersectoral spaces creates the same 'political vacuum' referred to in the Western Cape case (Lowenson, 2014). However, there were also several cases showing successful intersectoral collaboration and functioning. Across the cases, the factors that were supportive of intersectoral collaboration can be summarized as: firstly; spaces taking systems approach (deliberately including actors directly and indirectly affected by the health system in policy and planning) (Gilson, 2012). Secondly, spaces exhibiting a level of adaptability to changing times, context and political or economic climate (Vos, 2015). Thirdly, the use of boundary spanners, clearing houses or intermediary bodies to network local non-government actors into the broader public health system. Finally, government leaders with political will to action inputs received from civil society feedback (WCDOH, 2019a).

A main supportive factor is when a more 'systemic' approach is undertaken and written into policy. This has been initiated in the Western Cape, for example the Wosa case – and is becoming apparent in recent policy documentation – such as the WCDOH's main policy document 'Healthcare 2030' which speaks of a whole systems and whole of society approach – and suggests a commitment to intersectoral collaboration, and routinely monitoring this engagement (WCDOH, 2017). A systems-wide approach would undertake to considera wider array of actors, across multiple levels of the system, to ensure overlaps and gaps are mitigated, and prioritize the integration (streaming) of multiple lines of feedback (Khan et al. 2020).

Related to this, is the support provided when the commitment from local government is 'genuine' in nature. This implies government actively attempts to collaborate with elite *and* non-elite members of civil society and incorporate their feedback into policy.

Although this case study described many 'friendly partnerships', it should not be forgotten that another enabler of responsiveness is when civil society is positioned to successfully apply external pressure on government to realize accountability – shown in this case and in the broader literature which suggests that civil society may be most successful at influencing power-holders by partnering and sharing power (which is advocated for in the Western Cape case), but in other cases by situating themselves as external bodies, 'forcing' government to respond - such was the case in South Africa in achieving ART treatment roll-out (Friedman, 2006; Nkandu Chikonde, 2012). There may be value in striking a balance between the two (as in the case of WC-NACOSA in the Western Cape), where civil society partners with government close enough to share planning, but not too close that they are compelled to follow government influences - a mix of persuasion and regulation (Friedman, 2011; Vos, 2015).

Given the desk-based nature of this descriptive study, it is entirely possible that we are missing the full extent to which civil society feedback is gathered and actioned in this provincial health system. For example, we may be under-representing government's level of responsiveness because barely any of this is routinely reported or recorded, and because of the main challenge of tracing and linking of feedback inputs to their actioned outputs. This is especially true in spaces which are voluntary and different government members appear at consequential meetings – so there are few clear lines of feedback between representatives from meeting to meeting (SANAC, 2020). Subtle improvements in services or systems performance may be happening as a result of collaboration - but going unnoticed. The ' impact' and 'effects' of collaboration are always difficult to

measure, and these links are even more obscure and less tangible in relation to health system responsiveness . A key lesson is that better approaches and measurement tools are needed to track the direct and indirect (tangible and intangible) impacts of intersectoral collaboration.

Conclusion

This case study descriptively mapped (a large part) of the civil society landscape in one local health system, focusing on the configuration and nature of current intersectoral collaborative spaces - where civil society's voice could/should be incorporated in the health system for improved responsiveness, and therefore health system strengthening. Using a desk-based flexible, mixed-methods case study design was useful in achieving a first phase description of the Western Cape case, but further longitudinal primary data collection is necessary for a more complete analysis and understanding of these spaces. The study relied heavily on open-source literature and grey literature. The author extracted pieces of literature relating to certain themes as the 'data' and linked these together to form a chain of evidence. Because literature was published in differing years and spaces constantly change in nature, membership and functionality the evidence gives a very general, 'snapshot' of the case. This approach can direct further enquiry, but cannot give a complete analysis of the *current* nature and configuration of such spaces. The expert-checking process accounted for some of the discrepancies in study data and reality, but only for those spaces the three experts were familiar with. Expert checking was highly successful at identifying issues the author had overlooked and shedding light on new angles to use to analyse case data. As this was a case with little previous exploration, the flexible study design allowed for themes and insights to emerge and for the author to identify avenues for further research. The Western Cape mapping study was unique in that through this exploratory, flexible approach the 'system' could be studied, rather than isolated spaces;

"Indeed, there has been relatively little evaluation of large-scale system transformation in South Africa at all... such evaluation is vital in developing an evidence base that can support continuing efforts to strengthen the public health system" (WCDOH, 2017, pg 7). More deliberate 'whole system' efforts are needed, including continual routine mapping of spaces for civil society engagement in public health systems and further understanding of how intersectoral spaces affect each other and the responsiveness of a whole health system (Olivier, 2014a).

If these efforts are to succeed they require a context-specific, adaptable approach - where the nature of spaces for intersectoral collaboration facilitates refashioning and transformation. Intersectoral collaboration needs to be more fully assessed in terms of multi-level governance, accountability and civil society empowerment. In doing so avenues can be identified for improving civil society's feedback into the public health system, and the system's response to this in health policy and practice.

The Western Cape case is evidence that health systems policy makers and researchers should re-think the 'way they do business' when it comes to intersectoral collaboration (DOH, 2017). Traditional tired governance structures may be failing to support feedback loops, imperative to the incorporating and responding to civil society inputs - further research is required on the success of alternative governance structures.

Civil society should take from this study their important role as active decision-makers in the public health system and use this research to find formal avenues where they can engage with government in the Western Cape and other LMIC health system contexts. Further primary research within individual intersectoral spaces should be done to give a rich description of *power* and *voice* of civil society actors participating in committees and forums; and how these dynamics can be supported through ownership and actor positioning.

The Western Cape health system case has shown intersectoral efforts have the potential to completely reform the responsiveness of a health systems if actors work together toward one common goal. “Collaboration – the ultimate intertwining of skills, passions and knowledge is what concocts the most shatterproof forms of change making” (Somerhalder, 2015, pg 1).

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Ethical clearance

This paper was approved by the Human Research Ethics Committee (HREC), reference: HREC 282 / 2020 SC

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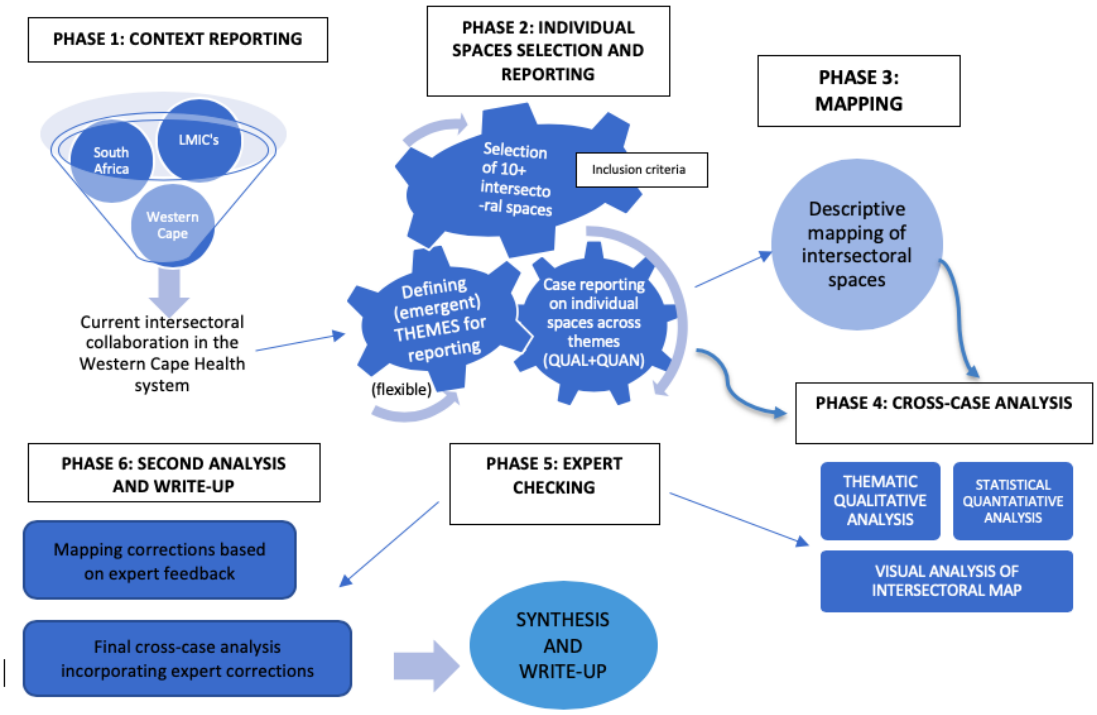
APPENDICES

Appendix 1: Study Design Phases (source: author)



Appendix 2: Expert checking consent and information sheet

Dear Sir / Madam,

My name is Amy Whiting. I am a student in the division of Health Policy and Systems at the University of Cape Town. I will be conducting a study as partial requirement of a master's degree in Public Health and request your expert assistance in a short checking process.

Study information

The study aims to descriptively map and analyse intersectoral collaboration in the Western Cape, looking specifically at civil society's participation in such spaces and the effect on health system responsiveness. The study forms part of a broader study conducted by the University of Cape Town and the Kenyan Medical Research Institute addressing responsiveness in the South African and Kenyan health system.

Procedures

To ensure all information in my master's study is correct, I would like to request your expert assistance in briefly reviewing data and a descriptive map on intersectoral collaboration in the Western Cape. This process should not take more than a few hours to complete and relies on your current expertise. It is not expected that you conduct any research to provide feedback and corrections for the study. Case report data and the descriptive map with instructions will be sent via email - it is required that a consent and confidentiality statement (attached) be signed and sent back before data can be disseminated. Feedback is required to be sent back by the 15th July. Given the current pressure on health professionals regarding the COVID-19 pandemic, this deadline may be extended at your request.

Risk

The study is a low-risk mixed-method case study of intersectoral collaboration in the Western Cape Health system and uses a desk-based review of multiple open-access data sources. You will not be put at risk during or after the expert checking of this study. Your review and contributions are entirely voluntary, and you may opt out of the process at any stage. If you would like statements or feedback removed from the final study, you may do so at any stage prior to the 15th August 2020.

Confidentiality

The expert-checking process will be anonymous, your details will not appear on any materials. Data will be stored on a password-protected computer. Names of experts and organisations will be removed from data and stored as generic terms. Should you wish to include your name on the final article you may request to do so through the primary investigator. Kindly complete and return the confidentiality statement below, before data is sent for expert checking:

- √ *My involvement in the study is voluntary - I may opt out at any stage or remove statement before the 15th August 2020.*
- √ *My contribution to the study is as an expert 'reviewer' of secondary data and not a study participant.*
- √ *I will not receive any monetary or other benefits for expert checking.*
- √ *I will keep the study data on a password protected computer and keep all information pertaining to the study confidential.*

√ *I will provide information which is true and accurate to the best of my knowledge.*

Signed: _____ Date: _____

Should you require any further information, or have concerns, please use the below contact details:

Information or concerns about the study

Amy Whiting – Researcher

Email: amywhiting1@gmail.com

Tel: +263 (0)783038135

Information or concerns about the researcher

Dr Jill Oliver – Principal Investigator & Supervisor

Email: jill.olivier@uct.ac.za

Tel: +27 (0)21 406 6489

Information or concerns about your rights and the ethical approval for the study

University of Cape Town

The Faculty of Health Sciences

Human Research Ethics Committee

E 52, Room 24, Old Main Building,

Groote Schuur Hospital,

Observatory, 7925

Telephone: +27 21 406 6492

Fax: +27 21 406 6411

Permission for the study

Ethical clearance has been obtained from the University of Cape Town´s Human Research Ethics Committee (HREC REF: TBC).

I thank you kindly for your time and contribution to what hopes to be a beneficial study for the Western Cape Health system.

Sincerely,

Amy Whiting

Appendix 3: Expert Checking Guide

EXPERT CHECKING GUIDE_____Name: (Optional)_____

Please complete the below information:

1. Current position / title

2. Organization

3. Number of years in current role

4. Number of years working in health-related position

5. Contribution or experience with health system responsiveness?

6. Please review the attached study draft article of intersectoral collaboration in the Western Cape health system and make any comments directly on the document regarding information you believe to be erroneous; adaptions of information and / or add additional information.

Thank-you very much for sharing your inputs, they are highly valued and appreciated.

Appendix 4: Responsiveness study brief

School of Public Health and Family Medicine
Isikolo Sempilo Yoluntu kunye Namayeza Osapho
Departement Openbare Gesondheid en Huisartskunde

UNIVERSITY OF CAPE TOWN
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University of the Western Cape
School of Public Health

KEMRI | Wellcome Trust

STRENGTHENING HEALTH SYSTEM RESPONSIVENESS TO COMMUNITY AND CITIZEN FEEDBACK IN SOUTH AFRICA AND KENYA

Responsiveness to citizen rights, needs, expectations and values is understood to be an essential quality of health systems. Responsiveness is necessary to provide inclusive, legitimate, participatory and accountable services and to ensure the social rights of citizens. It can support nation-building, state-legitimacy, public participation, and social cohesion, and contributes to HS goals such as improved access and acceptability of services, and ultimately improved health. Responsiveness can generally enhance the functioning of health systems, e.g. providing timely feedback, and ensuring HS leaders have evidence for decision-making. However, citizens in LMICs experience a range of problems with weak HS that display poor responsiveness: from lack of service availability, through poor quality of services, to ethical infringements including rights violations and commercial exploitation, inadequate procedures and rules for accountability, rigid bureaucratic norms, collusion and corruption. Health workers also express the need for more responsive health systems, e.g. facing threats to their security.

This study is being carried out by a collaboration of researchers from the University of Cape Town, the University of the Western Cape, the Kenyan Medical Research Institute (KEMRI), and partners from our local Departments of Health. We are working together with health leaders at a district and community level to better understand how the health system responds to different forms of feedback. This includes learning about different channels of feedback used by various citizens, or groups of citizens to give feedback to the health system, how feedback given to the system is integrated and processed and how the system responds.

Research Question: *What policies and mechanisms (formal and informal) work for receiving and responding to citizen feedback on health systems in South Africa and Kenya? How can health systems responsiveness be strengthened towards the development of learning, equitable health systems?*

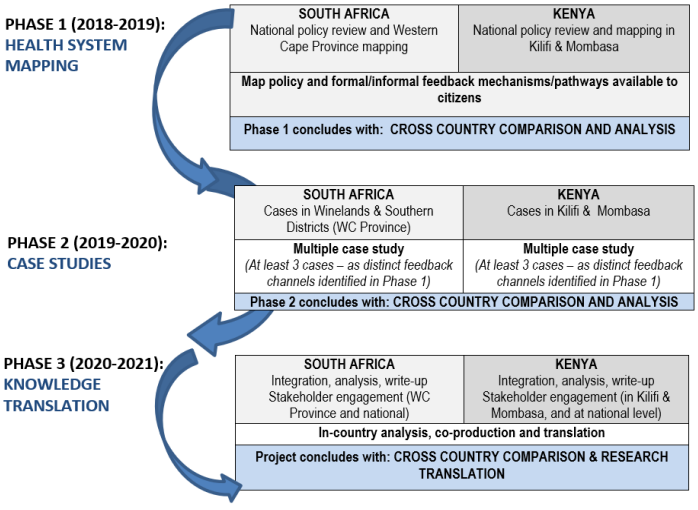
This is a mixed method, multiple case study, conducted in two countries, in three phases:

Phase 1 - 2018-2019: Desk based literature review, data collection, and policy analysis

Phase 2 - Late 2019-2020: Fieldwork, exploring health system responsiveness at a district and sub-district level

Phase 3 - 2020-2021: case comparison, write up, consultation

This work involves primarily talking, observing and working with district and sub-district health leaders and managers, health facility managers, and community/ civil society leaders. We will then integrate and synthesize this with multiple forms of other gathered materials, including (existing) surveys, policies, facility data, other research, and published literature.



For queries, or to hear more about the study, please feel free to contact us:

Principal investigator: AProf Jill Olivier
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Appendix 5: Key search terms (Context mapping of intersectoral collaboration in LMICs, South Africa and the Western Cape)

Term	Variation
Intersectoral collaboration	Intersector* ; intersector* collaboration; multisector* ; multisector* collaboration; partnership
Civil society participation	Civil society; community, community-based; public; civic; participat*; engag*;
Responsiveness	Responsive*; accountab*; governance ;
Health system	Health; health sector; health system; health system strengthening; health system performance
LMICs	Developing; less developed; low income; middle income; East Asia; Pacific; Latin America; Caribbean; Middle-east; North Africa; sub-Saharan; (including complete list of LMIC country names)
South Africa	South Africa; southern ; sub-Saharan Africa
Western Cape	Western Cape; Cape Town; Cape Winelands; Cape Metro

Appendix 6: Data sources used for selection of intersectoral embedded cases and individual reporting

DATA TYPES	Unique Identifier	Reference
Secondary literature: empirical studies	S1	Mamud (2003) Increasing Voice in the Health Sector in Rural Bangladesh: Is There a Role for Citizen Participation?
	S2	Martinez et al (2016) Civil society participation in the health system: the case of Brazil's Health Councils
	S3	Heywood (2009) South Africa's treatment action campaign: Combining law and social mobilization to realize the right to health
	S4	Glattstein-Young (2010) Community health committees as a vehicle for participation in advancing the right to health
	S5	Adesanya (2012) Exploring the responsiveness of public and private hospitals in Lagos, Nigeria
	S6	Global Fund (2016) NACOSA: OVC Community Systems strengthening model case study
	S7	Haricharan (2012) Extending Participation: Challenges of Health Committees as Meaningful Structures for Community Participation
	S8	Mahlangu et al (2017) Implementing a multi-sectoral response to HIV in South Africa-Mpumalanga Province
	S9	Meier (2012) Implementing community participation through legislative reform: A study of the policy framework for community participation in the Western Cape province of South Africa
	S10	Schneider (2019) The governance of local health systems in the era of Sustainable Development Goals: Reflections on collaborative action to address complex health needs in four country contexts
	S11	Mahlangu et al (2018) Multisectoral (in)action: towards effective mainstreaming of HIV in public sector departments in South Africa
Policies	P1	Stevenson (2019) The National Health Act Guide
	P2	Hassim et al (2003) The National Health Act 61 of 2003. A Guide
Reviews	R1	Wilson (2012) Community-based organizations in the health sector: A scoping review
	R2	Health Systems Trust (2004) South African Health Review 2003/04
	R3	Defillippi et al (2007) Promoting the Integration of Quality Palliative Care-The South African Mentorship Program
	R4	Sheikh (2003) Mapping the regulatory architecture for health care delivery in mixed health systems in low- and middle-income countries
	R5	Powers (2012) Institutionalising dissent: HIV/AIDS, the post-apartheid state and the limits of transnational governance in South Africa
	R6	Okeyo et al (2020) The impact of differing frames on early stages of intersectoral collaboration: the case of the First 1000 Days Initiative in the Western Cape Province
	R7	Friedman (2006) Discussion paper Participatory governance and citizen action in post-apartheid South Africa Steven Friedman Visiting Professor of Politics
	R8	Adeleye (2010) Strengthening Intersectoral Collaboration for Primary Health Care in Developing Countries: Can the Health Sector Play Broader Roles?
	R9	Okeyo (2017) Lessons for intersectoral collaboration from the First 1000 Days Initiative in the Western Cape Province
	R10	Baez et al (2006) Community voice and role in district health systems in east and southern Africa: A literature review
Theses	T1	Barker (2015) Civil society's role in health system monitoring and strengthening- a study in Khayelitsha, WC
	T2	Chikonde (2012) Training health clinic committees: a vehicle for improving community participation in health
	T3	Zwama (2016) Improving health care provider-health committee working relationships
	T4	Vos (2015) Critical factors in NACOSA ' s success as a network organisation in the HIV and AIDS Sector
	T5	Padarath (2009) The status of clinic committees in three provinces of South Africa
Evaluation reports	E1	Bletcher et al (2017) Health spending at a time of low economic growth and fiscal constraint
	E2	Olivier (2014) Evaluation of the Hospice and Palliative Care Association of South Africa's Health System Strengthening through Strategic Partnerships Project
	E3	Olivier (2014) HPCA Appendix A: Table
	E4	Padarath & Friedman (2008) The Status of Clinic Committees in Primary Level Public Health Sector Facilities in South Africa

	E5	Mahlangu (2019) Towards a framework for multisector and multilevel collaboration: case of HIV and AIDS governance in South Africa
	E6	Global Fund to Fight Aids (2012) Global Fund-Supported Community Systems Strengthening Programs in Cambodia : Evaluation Report
	E7	International Development Services (2016) Unlocking the Power of Partnership - A Framework for Effective Cross- Sector Collaboration to Advance the Global Goals for Sustainable Development
	E8	Matzopoulos (2014) The Western Cape Government's new Integrated Provincial Violence Prevention Policy Framework: Successes and challenges
	E9	Isandla institute (2007) Mainstreaming Local Government Responses to HIV / AIDS A Case Study of the City of Cape Town ' s HIV / AIDS / TB
	E10	South African Private Practitioners Forum https://www.mm3admin.co.za/
	E11	Ringheim et al (2009) Engaging men for gender equality and improved reproductive health.
	E12	Botha (2018) City of Cape Town & Department of Health collaboration; District Health Plan
Forums	F1	McQueen et al (2012) Health in All Policies: the social determinants of health and governance
	F2	NHA (2017) Thailand National Health Assembly
	F3	Abimbola et al (2014) Towards people-centred health systems: A multi-level framework for analysing primary health care governance in low-and middle-income countries
	F4	UNDP (2006) Mutual Accountability Mechanisms: Accountability, Voice and Responsiveness
	F5	WHO (2012) Uniting for health across sectors
	F6	SANGOCO constitution 1997 http://cab94.tripod.com/sango00.htm
	F7	Western Cape health facilities boards and committees Act https://pmg.org.za/committee-meeting/26109/
	F8	World Bank (2003) Working Together: World Bank - Civil society relations
	F9	World Bank (2005) Issues and options for improving engagement between the World Bank and Civil Society
	F10	DoH (2014) The Patients' Rights Charter Participation in decision-making
	F11	Gaventa (2010) A policy-makers guide to putting citizens at the centre
	F12	RSA DoH (1997) White Paper for the transformation of the health system in South Africa
	F13	The regulatory framework of the SA health system
Government reports	G1	Western Cape Department of Health (2018) : Annual report 2018
	G2	Western Cape Department of Health (2019) : Annual report 2019
	G3	Western Cape Department of Health (2019) WoSA Manenberg and Hanover Park Relationship Building Workshop Report
	G4	Western Cape Department of Health (2011) Western Cape health minister appoints NGOs on PCA.
	G5	Poolman et al (2016) Annual Progress Report 2015 / 16 Western Cape Provincial Aids Council
	G6	Department of Health (2006) Draft report of the National Consultative Health Forum
	G7	Western Cape Department of Health (2017): Whole system change in South Africa: Understanding the experience of health system transformation in the Western Cape province
Non-government reports	N1	HIV/Aids and TB Plan 2009-City of Cape Town
	N2	Herringshaw (2017) Addressing failure in ICT-enabled 'citizen voice – government responsiveness' interventions: unpacking core assumptions and essential components
	N3	Coyne (2000) World Health Report: Improving Performance
	N4	World Bank (2004) Making services work for poor people
	N5	Challenges of health committees and meaningful structures for community participation. Cape Metropole
	N6	Boulle et al (2008(Promoting partnership between Communities and Frontline Health Workers : Strengthening Community Health Committees in South Africa .
	N7	Taylor (2002) Inquiry into the various Social Security Aspects of the South African Health System
	N8	Birdsall (2007) Models for Funding and Coordinating Responses to HIV / AIDS
	N9	Sonke Gender Justice (2019) Sonke Annual Report 2018-2019
	N10	Poolman et al (2017) Annual Progress Report 2015 / 16 Western Cape Provincial Aids Council
	N11	State of provincial healthcare system: Spotlight
Institutional (CSO) websites	C1	Aids Foundation South Africa: https://www.aids.org.za/
	C2	South African National Aids Council http://www.sanac.org.za
	C3	South African NGO coalition http://www.sangoco.org.za/

	C4	Knysna Sedgefield Hospice (2020) Partnerships: https://www.hospiceknysna.org.za/about-us/partnerships/
	C5	Hospice Palliative Care Association of South Africa (2019) About HPCA: https://hpca.co.za/about-us/
	C6	Learning Network (2017) Learning network for health and human rights: http://www.salearningnetwork.uct.ac.za/
	C7	Sonke Gender Justice: https://www.who.int/violenceprevention/about/participants/sonkegenderjustice/en/
	C8	Sonke Gender Justice (2020) About Sonke Gender Justice: https://genderjustice.org.za/#
	C9	NACOSA (2019) Networking AIDS community of South Africa: https://www.saferspaces.org.za/organisation/entry/networking-hiv-aids-community-of-southern-africa-nacosa
	C10	People's Health Movement (2018) Health committees: http://phm-sa.org/health-committees/
	C11	National Aids Council of South Africa (2019) About NACOSA: http://www.nacosa.org.za/about/our-partners/
	C12	People's health movement https://www.phm-sa.org/health-committees/
Institutional (gov) website	I1	Western Cape Department of Health https://www.westerncape.gov.za/dept/health
	I2	Parliamentary Monitoring Group - Committee meeting: https://pmg.org.za/committee-meeting/17386/
	I3	Overview of SALGA innovation program: http://pmg-assets.s3-website-eu-west-1.amazonaws.com/171108salga.pdf
	I4	Parliamentary Monitoring Group - Call for comment: https://pmg.org.za/call-for-comment/927/
	I5	Open government partnership - Back to basics program: https://www.opengovpartnership.org/members/south-africa/commitments/ZA0018/
	I6	South African Local Government Association (2017) Stakeholder Relations: Stakeholder management framework: http://www.salga.org.za/About%20Us%20OS.html
	I7	National Government of South Africa (2018) SALGA: https://nationalgovernment.co.za/units/view/171/south-african-local-government-association-salga
	I8	Western Cape Department of Health (2019) The public-private health forum: https://www.westerncape.gov.za/general-publication/public-private-health-forum-pphf
	I9	South African youth council http://www.sayc.org.za/
	I10	Chatterji et al (2001) WHO Multi-country Survey Study on Health and Responsiveness GPE Discussion Paper 37
	I11	Economic Development Partnership (2012) About WoSA: https://wcedp.co.za/edp-programmes/#the_whole_of_society_approach
	I12	WHO (2003) Key Informant Opinion Survey
	I13	Robone et al (2011) Health systems' responsiveness and Its characteristics: A cross-Country comparative analysis
Wikipedia	W1	SALGA (2019): https://en.wikipedia.org/wiki/South_African_Local_Government_Association
Databases	D1	Silvana et al (2011) Health systems' responsiveness and Its characteristics: A cross-Country comparative analysis
	D2	District health barometer (HST)
	D3	Valentine et al (2003) Estimating Responsiveness Level and Distribution for 191 Countries: Methods and Results
Media	M1	Multisectoral action teams Cape Town-Plainsman news https://www.plainsman.co.za/news/funding-not-enough-says-msat-5854060
	M2	Treatment Action Campaign (2018) State of Provincial Healthcare System Spotlight on Western Cape May 2018
	M3	Wordpress (2016) The multi-sectoral action team: https://msatwesterncape.wordpress.com/
	M4	Spotlight (2020) Face to Face: Winde on HIV and Zille on tough choices
	M5	Ndaki (2017) Provinces make progress with AIDS plans
	M6	e Health news (2019) The public private health forum
	M7	National health insurance coalition- Section 27 http://section27.org.za/2011/12/insurance-coalition-gives-civil-society-voice/
Guidelines and strategy documents	A1	Birdsall (2007) Models for Funding and Coordinating Responses to HIV / AIDS
	A2	UNAIDS (2011) UNAIDS guidance for partnerships with civil society, including people living with HIV and key populations
	A3	WHO (2012) Intersectoral Action on Health
	A4	Botes (2000) Community participation in development: Nine plagues and twelve commandments

	A5	City of Cape Town (2011) HIV , Aids and TB PLAN 2010 / 2011
	A6	SANAC Trust (2014) Annual Performance Plan
	A7	City of Cape Town (2019) MSATs
	A8	The Western Cape Economic Development Partnership (2018): Doing development differently: A whole of society approach (WoSA)
	A9	DoH (2019) Western Cape Annual Performance Plan 2019-Department of Health
Annotated bibliography	H1	Loewenson (2013) Social power, participation and accountability in health (EQUINET & COPASAH)
Books	B1	Hassim et al (2003) The National Health Act 61 of 2003. A Guide
	B2	Gilson et al (2017) Health Systems Trust (2017) South African Health Review. Chapter 6
	B3	Calhoun (2014) Civil society and the public sphere
	B4	Freeman et al (2014) Law and Global Health: Current Legal Issues
	B5	Powers (2020) Sustaining Life: AIDS Activism in South Africa
	B6	Van Dyke (2010) HIVAIDS Care and Counselling: A Multidisciplinary Approach

Appendix 7: Inclusion / exclusion criteria for selection of intersectoral spaces (source: Author)

Inclusion criteria	**Exclusion criteria**
Exists within the Western Cape health system, public or private	Exist within globally or national health system only
Direct or indirect health mandate	Is mandated to another sector with no connection to health issues
Currently an active, functional space or recently (2 years) discontinued	Was discontinued more than 2 years ago
Formal or informal, structured space which is legislated or unlegislated	Informal rallies, protest and marches
Sufficient literature and evidence for data collection and analysis of emergent themes	Literature and evidence missing for more than three emergent themes

Appendix 8: Included and excluded EC (embedded cases)

INCLUDED	EXCLUDED	REASON
WC Provincial Health Council	South African National AIDS council (SANAC)	National footprint
WC Provincial consultative body	Treatment Action Campaign (TAC)	National footprint
WC-Networking HIV and AIDS Community of SA (WC-NACOSA)	South African NGO Coalition (SANGOCO)	National footprint
South African Local Government Association (SALGA)	Global Fund to fight AIDS oversight committee,	No direct links to Western Cape
Provincial Council on AIDS (PCA)	Desmond Tutu Peace Centre Open Dialogue	Informal dialogue- evidence lacking
The learning network	South African Migrants Forum	Forums in Johannesburg only- no Western Cape link
The public private health forum	Central Drug Authority	Narrow mandate to address drug issues- no health-related mandate
Whole of Society Approach (WOSA)	National health council technical committee	Data lacking
City of Cape Town HIV/TB Committee	South African Youth Council	No direct health mandate
District Health committee	Joint Primary Health Committee	No direct links to the Western Cape
Multi-Sector Action Teams (MSATS)	Resource mobilisation committee	No direct links to the Western Cape
Sub-district health forum	People's National Health Assembly	No record of current meeting
Ward health committees	People's health movement	Included in other committee and forum mandates
Clinic Committees	Aids Foundation South Africa (AFSA)	Grants are not given to the Western Cape
HESP forums	National Health Insurance Civil Society Coalition	Mandated only to address NHI
Sonke Gender Justice	Early Learning Resource Unit (ELRU)	No Health mandate
	Community Development Resource Association (CDRA)	No forum or committee
	iThemba Advocacy Campaign	Education mandate
	Social Justice Coalition	Human Rights mandate (not including Health)

Appendix 9: Description of embedded cases (committees and forums) in the Western Cape health system.

	Mandate	Performance	Coverage	Agents	Intersectoral collaboration	Sources
E1	*Identification:* **Provincial Aids council (PCA)** *Purpose:* Multi-sectoral body to coordinate and implement the Provincial Strategic Plan to respond to HIV/Aids, TB and STIs in the Western Cape. *Legislation:* National government under SANAC	*Age:* 20 years *Current functioning:* Mandated to host quarterly meetings – occurring twice annually. *Funding:* National government and Global Fund to Fight AIDS. Funding insufficient to conduct activities on implementation plan.	*Geographical footprint:* Provincial (Western Cape) *Governance reach:* National (SANAC) *Policy implementation:* Coordinate and implement Provincial Strategic Plan (PSP).	*Ownership:* Civil society. Lack of ownership due to volunteerism. *Membership:* Voluntary membership of government and civil society. Chairing by provincial premier since 2020. *Roles and reporting:* Local and district Aids councils (dysfunctional) report to PCA who reports to SANAC. Local government report to PCA-not happening.	*Networks:* Western Cape government, Treatment Action Campaign (TAC), community *Participation:* Senior government presence weak. Meetings dominated by civil society – severe lack of decision-maker presence at meetings.	(Friedman, 2006; Mahlangu et al. 2017, 2018) (Poolman et al. 2017) (South African National Aids Council Trust, 2014; Western Cape Department of Health, 2019a) (Ndaki, 2017; Spotlight, 2020b)(Mahlangu et al. 2019) (Poolman et al. 2017)
E2	*Identification:* **Multi-sectoral Action Teams (MSATs)** *Purpose:* Coordinating local HIV/AIDS activities, providing funding to small community organizations, and arranging training and capacity building *Legislation:* Government City Directorate	*Age:* 18 years *Current functioning:* Meeting attendance is a pre-condition for financial support-attendance varies across spaces. *Funding*: Global Fund to Fight AIDS. Previously funded by City Directorate. Overstretched budget.	*Geographical footprint:* Sub-districts (Cape Metro) *Governance reach:* Provincial (WC-NACOSA and DoH) *Policy implementation:* Endorse project proposals for City Directorate	*Ownership:* Government *Membership:* Government, civil society *Roles and reporting:* Took over role of local AIDS councils – report to PCA, HIV/TB coordinating committee and WC-NACOSA. Monitor activities of CBOs in their subdistrict through community liaisons (CLOs)	*Networks:* WC-NACOSA, NGOs, District government, churches, businesses, CBOs, City health government, City health HIV/TB coordinating committee *Participation:* Not adequately linked into government structures- therefore poor government participation	(City of Cape Town, 2011; Birdsall, 2013; Olivier, 2014a; Wordpress, 2016) (Powers, 2012; Ndaki, 2017; City of Cape Town, 2019; Powers, 2020)(Isandla institute, 2007)
E3	*Identification:* **Western Cape Networking HIV & Aids Community of South Africa (WC-NACOSA)** *Purpose:* A networking HIV/Aids and TB body, working towards capacity building and promoting dialogue between government departments, civil society and the private sector. *Legislation:* NACOSA- nationally legislated, currently WC node is an independent NGO	*Age:* 28 years *Current functioning:* Mandated to meet with partners every three months – evidence from district councils confirm meeting occurrence is infrequent: as issues arise – such as Provincial Strategic Plan Draft consultations. *Funding:* National DoH, DSD, City of Cape Town, Rockefeller Foundation & Chain Program and MSAT's	*Geographical footprint:* Provincial (Western Cape) District (Council collaboration) Local (Training and capacity building for CSOs and CBOs through MSATs) *Governance reach:* Provincial (Department of Health, Provincial AIDS council, Department of social development) *Policy implementation:* Channelling funds, training and capacity building from government department to small CBOs	*Ownership:* Non-governmental *Membership:* Civil society - director, rural and urban managers, finance manager, coordinator, administrator. *Roles and reporting:* Report civil society concerns to DoH and PCA. Quarterly reports submitted on district matters to provincial government.	*Networks:* Western Cape department of health, civil society, private sector *Participation:* Participant presence at meetings dominated by WC_NACOSA members - not representative of broader community.	(Birdsall, 2013; Vos, 2015; Global Fund to Fight Aids, 2016; National Aids Council of South Africa, 2019; Powers, 2020)

E4	*Identification:* **District health councils** *Purpose:* Bring community representatives together with health care providers and government representatives to ensure quality health care and communicate and support health campaigns. *Legislation:* National government (Health Act 2003)	*Age:* 17 years *Current functioning:* Meetings mandated every 3 months, but occurring ad hoc. *Funding:* Initially funded by provincial government, currently the responsibility of the Metro resulting in reduced budget.	*Geographical footprint:* District (Six districts of the Western Cape) *Governance reach:* Provincial (provincial health council), sub-district (sub-district forums) *Policy implementation* :Monitor effectiveness of subdistrict committees and use feedback for policy.	*Ownership:* Government – voluntary bodies with no formal status (CMHF) *Membership:* Local government counsellor, head of facility, elite community member (politicised process of selection) *Roles and reporting:* CMHF roles are informal: in Draft policy. District councils advise municipal and provincial health council. Not linked to clinic committees.	*Networks:* Western cape department of health, WC-NACOSA, CMHF *Participation:* Communities not adequately represented at councils – present community representatives silent at meetings. Community lack the ability to participate in government structure.	(Padarath and Friedman, 2008; Haricharan and The Learning Network, 2012; People's Health Movement, 2018; Western Cape Department of Health, 2019e)(City of Cape Town, 2011; Meier et al. 2012; Freeman et al. 2014; Stevenson, 2019; Powers, 2020)
E5	*Identification:* **Sub-district committees** *Purpose:* To coordinate and monitor the effectiveness of clinic committees and report these finding to district level councils. *Legislation:* National government (Health Act 2003)	*Age:* 17 years *Current functioning:* Monthly meeting legislated – occurring in two out of the eight sub-districts of the Cape Metro. *Funding:* Government-funded. Finances should come from district council, but seldom reach sub-district level.	*Geographical footprint:* Subdistrict (24 subdistricts in Western Cape) *Governance reach:* District (District health councils) *Policy implementation:* Coordinate and monitor the effectiveness of clinic committees.	*Ownership:* Government *Membership:* Provincial department of health, City health, community. *Roles and reporting* Report effectiveness of clinic committees to district level. In Cape Metro report to CMHF	*Networks:* CMHF, clinic committees, community *Participation:* Government present only in 'bigger' meetings. Community participation erratic. MEC and HOD absent.	(Haricharan and Learning Network, 2012; Mahlangu et al. 2017, 2018; Parliamentary Monitoring Group, 2019b; Powers, 2020)
E6	*Identification:* **Ward committees** *Purpose:* A representative structure of the community and citizens, to inform the municipality about health aspirations, potentials and problems of the people. *Legislation:* 1999 South African government	*Age:* 21 years *Current functioning* Monthly meeting legislated – occurring ad hoc. *Funding*: Municipalities and NGOs	*Geographical footprint:* Western Cape municipal wards *Governance reach:* City (Councils) *Policy implementation:* Inform municipalities on local health issues through Integrated development plans (IDPs).	*Ownership:* Government *Membership:* Local government counsellor, head of facility, community member *Roles and reporting:* Submit IDPs and budget proposals to provincial government.	*Networks:* Treatment Action Campaign (TAC) *Participation:* Inadequate public participation	(Friedman, 2006; Padarath and Friedman, 2008; Nkandu Chikonde, 2012; Western Cape Department of Health, 2018, 2019c)
E7	*Identification:* **Clinic (health) committees** *Purpose:* Engage public health care users by bringing community representatives together with health providers and government representatives to ensure quality health care and ensure accountability at local, district, and provincial levels. *Legislation:* National (Health Act 2003)	*Age:* 17 years *Current functioning* 55% of facilities in the Western Cape have functional clinic committees. *Funding: Government funded – funding accessed through sub-district. Several committees currently do not have access to these funds for administrative and operational meeting costs.*	*Geographical footprint:* Western Cape clinic facilities and their surrounding communities *Governance reach:* Sub-districts and Ward committees, clinic clusters (Overlapping governance) *Policy implementation:* Advisory bodies with no formal power.	*Ownership:* Government or community. Either facility manager takes ownership and defines the role of the committee or community takes ownership. *Membership:* Local government counsellor, head of facility, community members *Roles and reporting:* Report to sub-district council- not happening. Clinics under local or provincial government –	*Networks:* Community *Participation:* Lack of representation of community at committee meetings. Local government counsellor, MEC and HOD absent from annual meetings. Community inputs seldom valued and passed or passed on to government.	(Friedman, 2006; Padarath and Friedman, 2008; Glattstein-Young and London, 2010; WC DoH, 2011; Haricharan and Learning Network, 2012; Western Cape Department of Health, 2018; Learning Network, 2019)

				variation in roles, services, management and accountability. Unclear mandates		
E8	*Identification:* **The learning network** *Purpose:* Explore the role of CS organisations in realising the right to health and advance this right through strengthening community participation with research, training and advocacy. Empower organisations and their members to assert rights for health *Legislation:* Non-government	*Age:* 13 years *Current functioning:* Mandated to host quarterly meetings – currently happening. *Funding:* NGOs: SANPAD, NRF, OXFAM, DVV, PERC, EuropeAid, National research foundation, IDRC	*Geographical footprint:* Western Cape *Governance reach:* Cape Metro *Policy implementation:* **	*Ownership:* Non-governmental *Membership:* 5 CSOs, academics from 4 universities *Roles and reporting:* Annual strategic planning and reflection workshops with stakeholders	*Networks:* CMHF (training), NGOs *Participation:* Civil society participate in research and academic writing and have a strong voice in network through NGO representation	(Friedman, 2006; Haricharan and Learning Network, 2012; Nkandu Chikonde, 2012; Fick, 2013; Freeman et al. 2014; Learning Network, 2019)
E9	*Identification:* **Whole of society approach (WoSA)** *Purpose:* A collaborative endeavour between 13 provincial and local government departments piloted in 4 subdistricts in the Western Cape. WoSA is an approach rather than a program, using collaborative learning and adaption to negotiate silo bureaucracies and accompanying mandates. *Legislation:* Provincial government	*Age:* 3 years *Current functioning:* Meetings are scheduled every two months – these are adhered to with agenda and minute-taking *Funding:* Government funded through the Independent Development Plan budget. Sufficient funding to conduct activities.	*Geographical footprint:* Four sub-districts in the Western Cape *Governance reach:* National government *Policy implementation:* Independent development plan (IDP)	*Ownership:* Provincial government *Membership:* Provincial, subdistrict and local government, NGOs *Roles and reporting:* Municipalities report to provincial level and inter-ministerial team reports to national government.	*Networks:* NGOs *Participation:* Community consultations are effective through steering committees – feedback reaches provincial ministers and adaptations made accordingly	(Economic Development Partnership, 2012; Okeyo, 2017; The Western Cape Economic Development Partnership, 2018; Western Cape Department of Health, 2019b) (Matzopoulos and Myers, 2014) (Schneider et al. 2019)
E10	*Identification:* **South African local government association (SALGA)** *Purpose:* Positioning local governments to work better with provincial and national level, and advocating and enforcing rights on behalf of municipalities. *Legislation:* 1997 Organised local government Act	*Age:* 23 years *Current functioning:* Meetings mandated every two months – currently being adhered to *Funding:* Membership fees, donor donations, national fiscus.	*Geographical footprint:* Local government (Western Cape municipalities) *Governance reach:* National government *Policy implementation:* Inform local independent development plans (IDPs). Not present in provincial legislature	*Ownership:* Government, voluntary. *Membership:* Local government *Roles and reporting:* Legislation to be reviewed – roles unclear. Limited senior officials available to respond to Annual performance plan. Strategic plan developed by municipalities – reported to national minister.	*Networks:* Civic academy, public *Participation:* Meetings do not currently include health committees, hospitals boards and general public- a need to incorporate CS. Online Q&A platform for public – well-answered by government.	(SALGA, 1998, 2017; South African Local Government Association, 2017; Mahlangu et al. 2018; National Government of South Africa, 2018; Parliamentary Monitoring Group, 2019a, 2019b)
E11	*Identification:* **Sonke Gender Justice** *Purpose:* Uses a human rights framework to build capacity of government and CS to achieve gender equality, prevent GBV and reduce the spread of HIV	*Age:* 14 years *Current functioning:* Mandated to host annual meeting – currently adhered to. *Funding:* Western Cape Department of Health and international donors	*Geographical footprint:* Western Cape *Governance reach:* National government (South Africa) *Policy implementation:* Holds government	*Ownership:* Non-government *Membership:* Civil society *Roles and reporting:* Financial audits and donor reporting	*Networks: W*omen's rights organisations, social movements, trade unions, government departments, sports associations, FBOs, media, university research units and human rights advocates. *Participation:* Minister DHA attends meetings and responds to issues raised	(Ringheim and Feldman-Jacobs, 2009; Poolman et al. 2017; Sonke Gender Justice, 2020; Violence Prevention Alliance, 2020)

	Legislation: 2006 non-partisan, non-government		accountable for current policies			
E12	*Identification:* **The city HIV / TB coordinating committee** *Purpose:* Establish an enabling environment for civil society to engage in an intersectoral response to HIV/Aids and TB issues in the Western Cape *Legislation:* City of Health government	*Age:* 19 years *Current functioning:* Mandated to meet quarterly. *Funding:* City Health (government)	*Geographical footprint:* Cape Town City *Governance reach:* Sub-districts in the Western Cape *Policy implementation:* Coordinates City of Cape Town development plans	*Ownership: City of Cape Town g*overnment *Membership:* Mayoral committee member of health, directorates of subdistricts *Roles and reporting:* Hold subdistrict directorates accountable	*Networks:* MSATs, WC-NACOSA *Participation:* Poor participation from political actors.	(City of Cape Town, 2011, 2015; Botha, 2018; Parliamentary Monitoring Group, 2019b)(Isandla institute, 2007)
E13	*Identification:* **HPCA-Hospice Palliative Care Association forums (HESP project)** *Purpose* The Health Systems Strengthening through strategic partnerships (HESP) innovates new mechanisms for strengthening community systems and local partnerships around health and welfare, using current HPCA structures. *Legislation:* HPCA: 1987 Companies Act, HESP: Non-governmental	*Age:* HPCA: 33 years HESP: 11 years *Current functioning:* 70% of HPCA forum sites in the Western Cape still function. 40% of these meet regularly. *Funding:* PEPFAR and Anglo American chairman's fund for HESP. Funding is finished for 80 percent of sites.	*Geographical footprint:* National (including Western Cape) *Governance reach:* Western Cape Department of health *Policy implementation: **	*Ownership: Non-government* *Membership:* 7 regional association members from Western Cape. Development coordinator, hospice member and varying partners across 10 WC sites *Roles and reporting **	*Networks:* MSATs, Western Cape department of health. WC-NACOSA, PCA *Participation:* District and provincial government members are absent from some site meetings. Positive engagements with WC-NACOSA and government at other sites.	(Olivier, 2014a, 2014b; Hospice Palliative Care Association of South Africa, 2019; Knysna Sedgefield Hospice, 2020)(Defilippi and Cameron, 2007)
E14	*Identification:* **Provincial consultative body** *Purpose:* Promotes and facilitate the sharing of information on provincial health issues and include relevant stakeholders such as community health organisations. *Legislation:* National health Act 2003	*Age:* 17 years *Current functioning:* Required to meet annually – meetings are ad hoc. *Funding:* Government	*Geographical footprint:* Provincial *Governance reach:* National *Policy implementation:* Informs national policy	*Ownership:* Government *Membership:* Government, community health organisations *Roles and reporting:* Feedback from members reported to national body	*Networks:* Treatment Action Campaign (TAC) *Participation:* Work groups consist only of government members	(Department of Health, 2006; Van Dyk, 2010; Hassim et al. 2019; Parliamentary Monitoring Group, 2019b; Stevenson, 2019)
E15	*Identification:* **Provincial health council** *Purpose:* Determine health policy guidelines within provincial government and report to national health council. Inform District health plans within the Western Cape province. *Legislation:* National health Act 2003	*Age:* 17 years *Current functioning:* * *Funding:* Government	*Geographical footprint:* Provincial *Governance reach:* National *Policy implementation:* Determines guidelines for district health plans	*Ownership:* Government *Membership:* Metro and district counsellors, head of provincial department *Roles and reporting:* Incorporates feedback from district councils and reports to national council to incorporate into policy.	*Networks:* * *Participation:* *	(Van Dyk, 2010; Hassim et al. 2019; Stevenson, 2019)
E16	*Identification:* **Public-private health forum (PPHF)**	*Age:* 8 years *Current functioning:*	*Geographical footprint:* National (including Western Cape)	*Ownership: **	*Networks:* Western Cape Minister of Health, the Department of Health, public and private sector	'(Republic of South Africa Department of Health, 1997; Western Cape Department of Health,

	Purpose: To serve as a consultative body by including the Western Cape Minister of Health, the Department of Health, public and private sector in formal and informal open forums to strengthen health related-services. *Legislation:*	Mandated to meet annually – adhering to this with structured annual forums. *Funding:* **	*Governance reach:* National *Policy implementation:* Contribute to WC 5 year strategy towards health. Advise National Health Insurance (NHI) paper	*Membership:* Funders, health providers, NGOs, businesses, government, medical advisors *Roles and reporting* **	*Participation:* Civil society are on meeting agendas and speak during sessions	2018; Parliamentary Monitoring Group, 2019b; Western Cape Department of Health, 2019a, 2019d)

Appendix 10: Quantitative results of embedded case analysis: committees and forums in the Western Cape health system- E1-E16

Theme or EC	E1	E2	E3	E4	E5	E6	E7	E8	E9	E10	E11	E12	E13	E14	E15	E16	Govern legislated	Non-gov legislated	Govern owned	CS owned	Voluntary	Mandatory	Total
Multi-level governance	0	1	1	1	0	0	0	1	1	0	1	1	0	0	0	1	41,7	75,0	45,5	60,0	33,3	71,4	50,0
Local footprint	0	1	1	0	1	1	1	1	1	1	0	1	1	0	0	0	58,3	75,0	70,0		66,7	57,1	62,5
District footprint	0	1	1	1	0	1	0	0	1	0	1	1	1	0	0	0	41,7	75,0	45,5	60,0	33,3	71,4	50,0
Provincial footprint	1	0	0	0	0	0	0	1	1	0	1	0	0	1	1	1	41,7	50,0	36,4	60,0	33,3	57,1	43,8
Government owned	0	1	0	1	1	1	1	0	1	1	0	1	0	1	1	1	91,7	0,0	100,0	0,0	66,7	71,4	68,8
Civil society owned	1	0	1	0	0	0	0	1	0	0	1	0	1	0	0	1	16,7	100,0	9,1	100,0	44,4	28,6	37,5
Voluntary	1	0	0	1	1	1	1	1	0	1	0	0	1	0	0	1	58,3	50,0	54,5	60,0	100,0	0,0	56,3
Single-disease mandate	1	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	25,0	25,0	18,2	40,0	11,1	42,9	25,0
Health mandate	0	1	0	1	1	1	1	1	0	0	0	0	1	1	1	1	66,7	50,0	72,7	40,0	77,8	42,9	62,5
Systems approach'	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	16,7	0,0	18,2	0,0	11,1	11,1	12,5
Clear roles and responsibilities	1	1	1	0	0	0	0	1	1	1	1	0	1	0	0	0	33,3	100,0	27,3	11,0	44,4	80,0	50,0
Legislated by government	1	1	0	1	1	1	1	0	1	1	0	1	0	1	1	1	100,0	0,0	100,0	20,0	77,8	71,4	75,0
Functional	1	1	1	1	0	0	0	1	1	1	1	0	1	0	1	1	58,3	100,0	54,5	100,0	66,7	71,4	68,8
Age	1	0	1	0	0	1	0	0	0	1	0	0	1	0	0	0	25,0	50,0	18,2	60,0	44,4	14,3	31,3
Mandated meeting frequency per annum	0	1	0	0	1	1	1	0	0	0	0	0	1	0	1	0	41,7	25,0	45,5	20,0	44,4	28,6	37,5
Meetings happening according to mandate	0	1	0	0	0	0	0	1	1	1	1	1	1	0	0	1	41,6	75,0	45,5	60,0	44,4	57,1	50,0
Meetings happening infrequently or ad hoc	1	0	1	1	1	1	1	0	0	0	0	0	1	1	0	0	50,0	50,0	45,5	60,0	66,7	28,6	50,0
Government funded	1	1	0	1	1	1	1	0	1	1	1	1	0	1	1	1	100,0	25,0	100,0	40,0	77,8	85,7	81,3
Lost government funding	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	25,0	25,0	18,2	40,0	22,2	28,6	25,0

Donor-funded	1	1	1	0	0	0	0	1	0	1	1	0	1	0	0	0	25,0	100,0	18,2	100,0	44,4	42,9	43,8
Lost donor funding	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0,0	25,0	0,0	20,0	11,1	0,0	6,3
Self-funded	0	0	1	0	0	0	0	0	0	1	0	0	0	1	0	0	16,7	25,0	18,2	20,0	11,1	28,6	18,8
Funding has been stable	0	0	0	0	0	0	0	1	1	0	1	1	0	1	1	1	41,7	50,0	45,5	40,0	22,2	71,4	43,8
Sufficient funding for required activities	0	0	1	0	0	0	0	1	1	1	1	1	1	1	1	1	50,0	100,0	45,5	80,0	44,4	85,7	62,5
Government present at meetings	0	0	1	0	1	0	0	0	1	1	0	0	0	0	1	1	41,7	25,0	45,5	20,0	33,3	42,9	37,5
Civil society present at meetings	1	1	1	1	1	1	0	1	1	1	1	1	1	1	0	1	83,3	100,0	81,8	100,0	88,9	85,7	87,5
Informal CS or community present at meetings	0	0	1	0	0	1	0	0	1	1	1	1	0	0	0	1	41,6	50,0	45,5	40,0	33,3	57,1	43,8
Government speaks at meetings	0	0	0	0	0	0	1	0	1	1	0	1	0	0	1	1	50,0	0,0	54,5	0,0	33,3	42,9	37,5
Civil society speaks at meetings	1	1	1	1	0	1	1	1	1	1	1	0	1	0	0	1	66,7	100,0	63,6	100,0	88,9	71,4	75,0
Government responds to civil society	0	0	0	0	0	0	0	0	1	1	1	0	0	1	0	1	33,3	25,0	36,4	20,0	22,2	42,9	31,3
Government actions responses	0	0	0	0	0	0	0	0	1	1	1	0	0	1	0	1	33,3	25,0	36,4	20,0	22,2	42,9	31,3
Some attempt at intersectoral collaboration	1	1	1	0	0	0	0	1	1	1	1	0	1	0	0	1	41,6	100,0	36,4	100,0	55,6	57,1	56,3

Appendix 11: Summary analysis table showing case comparison

SPACE NAME	Space configuration	Space nature	'Ownership'	Intersectoral	Participation	Facilitates feedback	Engenders response from health system
PCA	Membership comprised of civil society, government and private sector	Unsupported by national level, unstable funding. Generally weak and failing to achieve ISC.	Nationally legislated by government, owned by civil society. Voluntary membership.	Tiered intersectoral structure from local, district to provincial. In the WC, MSATs should replace local & district AIDS councils	CS are passionate and attempt to participate, but lacking HIV education. WC mayor recently started attending meetings	Local government not providing feedback to PCA	No, for example CS are not listened to unless their request is endorsed by the mayor. (Lacking political support)
MSATs	Bringing together local civil society groups and City Health government in coordinating HIV/AIDS response	Functional, with stretched budgets, but consistent community activity	Government-owned: City Director of Health	Yes, systems approach. Links multiple level actors in the health system.	Strong participation from most actors except DoH in some spaces.	Incorporates CS from small organisations and reports to WC-NACOSA	DoH fairly unresponsive to invitations and feedback received
WC-NACOSA	Grant provider and supporter for small civil society organisations	Functional with stable funding	Non-government Organisation	Networks multiple informal, small CS actors into the broader health system	Small CS member organisations, DoH and PCA	Feedback from CS and AIDS councils at quarterly meetings	DoH attends meetings and responds
DHC	Health care providers, government representatives, community representatives	Unclear roles- draft policy for DHC and unstable funding from Metro government.	Government legislated, voluntary structure with no formal status	Tiered- connected to clinic and sub-district committees.	Lacking community representation.	CS invited to meetings on policy development but discouraged from giving feedback	No, PSP remains in draft form without input from CS
SDHC	Committees in 8 sub-districts	Insecure funding. Finances from District level not reaching sub-district committees	Government-owned	Engages with clinic committees at local level	Government members only present in bigger meetings	(No evidence)	Yes, in bigger spaces where government are present
WHC	Bringing together ward councils and the communities they represent	Inadequate public participation and poor attendance by ward counsellors	Government owned and legislated by WC Health Facilities Board and Committees Act	Mandated to engage residents with ward level government members	Lacking ward counsellor and community member presence	Citizens give feedback on integrated development plan (IDP)	(No evidence)
CHC	Clinic health providers, community representative collaboration	Only half mandated spaces exist in the WC. Many meetings cancelled or poorly attended	Government-owned	Activities directed at patients and service delivery	Low participation from local government and facility managers	Yes, complaints received at facilities from civil society	No, feedback seldom valued or responded to. Feedback

				rather than the health system			seldom reaches higher level government
LN	Collaboration between six civil society organisations, academics and local government	Currently functional	Civil-society owned	Yes, engages actors from CS and government	Participation from CS at monthly team meetings	(No evidence)	(No evidence)
WoSA	Iterative learning through collaboration between provincial government, municipalities and civil society in three sub-districts of the WC	Well-funded, meetings happening quarterly	Government-owned	Engages all government sectors and actors, including NGOs and civil society	Government presence strong, civil society participate through steering committees	CS give feedback to steering committees	Feedback used in high level policy and embedded in learnings
SALGA	South Africa's local government members, consisting of national, provincial executive committees and working groups	Currently well-functioning (evidence of CS-gov engagements online). Stable funding from membership fees and international donors	Government-owned, voluntary association	Connects municipalities to higher level government	CS engages on open platforms to create a critical mass of voices	CS able to engage with local government on open platforms and receive online feedback	No, CS input to flow to National Executive Committee, but SALGA not linked into provincial level legislature
SGJ	Strengthen government, civil society capacity for equity in gender and HIV/AIDS	Stable international funding	Civil society-owned, non-partisan, non-profit	Creates networks and coalitions between multiple spaces and actors	(No evidence)	CS gives feedback into government policy	Yes, Example-government actions response to CS feedback on refugee organisation closure
CoCT HIV/TB	Creating an enabling environment for civil society to hold government directorate accountable and advocate for resources	Meetings held quarterly in 2011, current functionality unknown	Government-owned	Brings together local government, MSATs and community	(No evidence)	CS give feedback at annual meetings	Response on feedback from the provincial department of health
HPCA / HESP	Collaboration and integration across established palliative care committees and local government	Funding has ceased, but all WC committees continue to function	Civil-society owned	Creates partnerships and networks between multiple government and non-government health-systems actors	Strong civil society attendance, weak local government presence	Monthly meetings for CS feedback to government	Poor relationships with DoH – power imbalance hinders response

PCB	Promotes sharing of information by municipalities and provincial government	Meetings are ad hoc and happen according to need	Government-owned	Mandated to included community health organisations but not CS in general	No evidence of CS presence	Annual meetings held for CS feedback	(No evidence)
PHC	Monitor and support district health councils	(No evidence)	Government-owned	(No evidence)	Provincial, Metro and district counsellors present, but not CS	(No evidence)	(No evidence)
PPHF	Bringing together local and provincial government, funders, formal civil society and the general public	Functional online forums	Government-owned	Allows all actors directly and indirectly involved in the health system to give online feedback	High level of online participation from public	Feedback from CS via online platforms on specific health policies	Response from WC minister of health

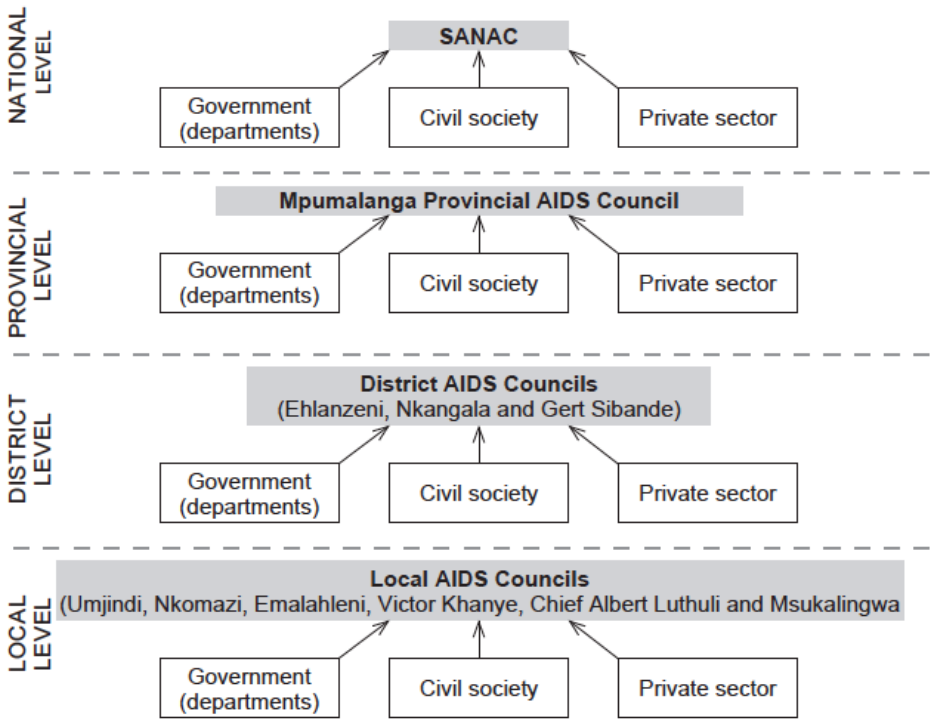
Appendix 12. Past and present actor-collaboration approach of 16 intersectoral spaces in Western Cape

Year	Intersectoral space	Actor-collaboration approach when established	Current approach (as apparent in 2020)
1990	National AIDS convention of South Africa (NACOSA)	A national advocacy body in response to HIV/TB, contributing to South Africa's HIV/AIDS strategic plan (Vos, 2015)	(N/A)
1997	South African local government association (SALGA)	Enforcing the rights and responsibilities of the local government sector in South Africa (SALGA, 1998)	Includes a broader range of stakeholders, such as civil society and advocates on behalf of these members and municipalities to higher level government (SALGA, 2017).
1999	Ward health committees	A cluster of clinic committees, including ward councillor, community representative and citizens who communicate to inform the municipality of health needs (Friedman, 2006).	No change (Western Cape Department of Health, 2019c)
2000	South African national and provincial AIDS councils (SANAC & PCA)	An intersectoral structure established by national government for government departments, private sector and civil society to partner and respond to the HIV/AIDS crisis (Poolman et al. 2017).	More deliberate attempt to include NGO representatives and high level government representatives in space (SANAC, 2020).
2001	Western Cape networking HIV & AIDS community of South Africa (WC-NACOSA)	The provincial node of a national advocacy body in response to HIV/TB, contributing to South Africa's HIV/AIDS strategic plan (Vos, 2015).	Move from advocacy to a networking and capacity building body, opening communication between small civil society organisations and government across all aspects of health (Mahlangu et al. 2019).
2002	Multi-sectoral action teams	Bringing together local government officials, churches, NGOs and CBOs to coordinate HIV/AIDS activities and provide funding and training to small organisations (Birdsall et al. 2007).	Broadened focus from HIV/AIDS to all work on health, wellness and welfare issues (Mahlangu et al. 2019).
2003	Provincial, district, sub-district & clinic health committees	Bringing together government members, health facility managers and community representatives to support and improve government health service quality (Gray and Vawda, 2014)	Strategic plans continue to emphasise community representation in spaces
	Provincial consultative body	Facilitating collaboration between government and community health organisations on health policy development (Gray and Vawda, 2014)	Continued collaboration
2006	Sonke gender justice	Involves civil society and citizens with government to challenge national policies in support of gender equality and reducing the impact of HIV/AIDS (Violence Prevention Alliance, 2020)	Higher level government actors now included in collaborative efforts
2007	The learning network	Bringing together five civil society organisations and academics from four universities to strengthen community participation towards advocating for the right to health (Haricharan and The Learning Network, 2012).	Continue engaging civil society through collaborative workshops.
(1987) 2009	HPCA / Health systems strengthening through strategic partnership (HESP)	Support and capacity building for hospices around South Africa (Defilippi and Cameron, 2007)	Establishing intersectoral collaborative networks beyond palliative care – to include community and local partners in 10 sites in the Western Cape (Olivier, 2014a)
2012	Public – private health forum (PPHF)	Bringing together NGOs, funders, academics, government and the public through open online forums (Western Cape Department of Health, 2019d)	Continual effort to harness feedback from the public using online portals
2017	Whole of society approach (WoSA)	Collaborative learning and experimentation between provincial government departments, NGOs and community members to improve service delivery in three sub-districts in the Western Cape (The Western Cape Economic Development Partnership, 2018)	Fairly recently established, continuing to engage actors across sectors and levels
(Unknown)	City of Cape Town HIV/TB coordinating committee	Creating an avenue for civil society to hold sub-district government in the Western Cape accountable for HIV/AIDS and TB policy (City of Cape Town, 2011)	Limited current evidence

Appendix 13: Reporting across multiple levels for 16 intersectoral spaces in the Western Cape

Intersectoral space	Reporting policy	Current actual reporting
PCA	Progress reports sent from local, district and provincial AIDS councils to SANAC (Mahlangu et al. 2017)	Local and district AIDS councils not functioning in the Western Cape. A consolidated report from the government sector currently does not exist (Mahlangu et al. 2018)
MSATs	Report to provincial aids council, City of Cape Town HIV/TB coordinating committee and WC-NACOSA. Send quarterly report from sub-districts on health statistics to local government (Birdsall et al. 2007)	As proposed (City of Cape Town, 2019)
WC-NACOSA	Reports to the Global Fund management committee, DoH and PCA. Sends quarterly reports from districts to executive committee (Birdsall et al. 2007)	As proposed (Powers, 2020)
DHC	Report to provincial health council (Stevenson, 2019)	No evidence of reporting occurring to higher level.
SDHC	Report effectiveness of clinic committees to district level(Haricharan and The Learning Network, 2012).	Reporting seldom done. In Metro region reporting more frequent and sent to CMHF (Parliamentary Monitoring Group, 2019b)
WHC	Submit Independent Development plan and report to provincial government (Padarath and Friedman, 2008).	As proposed, but overlap with sub-district reporting (Western Cape Department of Health, 2019c)
CHC	Report to sub-district council (Glattstein-Young and London, 2010)	Community members reported to be absent from annual report input meeting (Western Cape Department of Health, 2018)
LN	Internal reporting	Internal reporting
WoSA	Municipalities report to provincial level and inter-ministerial team reports to national government (Okeyo, 2017)	As proposed (Western Cape Department of Health, 2018)
SALGA	Reporting from municipalities to provincial working groups, to the national executive council (South African Local Government Association, 2017)	Cross-boundary municipalities impeding reporting (SALGA, 2017)
SGJ	Reporting to provincial government (Ringheim and Feldman-Jacobs, 2009)	As proposed (Sonke Gender Justice, 2020)
CoCT HIV/TB	Reports to the City of Cape Town (City of Cape Town, 2011)	No evidence of reporting happening currently
HPCA / HESP	Internal reporting	Internal reporting
PCB	Reports to national consultative body (Hassim et al. 2019)	Functional
PHC	(Insufficient evidence)	(Insufficient evidence)
PPHF	Reports to the WC minister of health (Western Cape Department of Health, 2019a)	As proposed (Western Cape Department of Health, 2019a)

Appendix 14: Provincial AIDS council (PCA) governance and coordination (SANAC, 2020)



Appendix 15: Ethics clearance letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room G50 -G Floor
Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 650 1236
Email: hrec-enquiries@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

11 August 2020

HREC REF: 282/2020

A/Prof Jill Olivier
Department of Public Health & Family Medicine
Room 1.42
Falmouth Building
Faculty of Health Science
Email: Jill.olivier@uct.ac.za
Student Email: amywhiting1@gmail.com

Dear A/Prof Jill Olivier

PROJECT TITLE: MAPPING THE SPACES FOR CIVIL SOCIETY PARTICIPATION IN THE WESTERN CAPE HEALTH SYSTEM-MASTERS CANDIDATE-AMY WHITING

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

This approval is subject to strict adherence to the HREC recommendations regarding research involving human participants during COVID-19, dated 17 March 2020 and 06 July 2020.

Approval is granted for one year until the 30th August 2021.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

The HREC acknowledge that the student, Amy Whiting will also be involved in this study.

Please also note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF in all your correspondence.

HREC REF 282/2020 SC

Appendix 16: Health Policy and Planning journal style guidelines

Instructions for Authors

Health Policy and Planning will be published online-only from May 2020. All print editions will be discontinued.

Health Policy and Planning improves the design, implementation and evaluation of health policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. *HPP* is published 10 times a year.

HPP has a double-blinded peer-review policy. All types of papers are peer reviewed and all article abstracts from each issue are translated into French, Spanish and Chinese.

Before you submit please make sure you have followed all the relevant instructions. A checklist for authors is available on the *HPP* webpage.

Please note that submission of a paper implies that it reports unpublished work and that it is not under consideration for publication elsewhere. Plagiarism, including duplicate publication of the author's own work, in whole or in part without proper citation is not tolerated by HPP. Submitted manuscripts are screened with iThenticate software, as part of the CrossCheck initiative to detect and prevent plagiarism.

Not sure which section to submit to? Read our Section Summaries.

- Guidance

i. Improving chances of publication

ii. Manuscript format and style for all articles

iii. Prior publication guidelines

- Types of papers
- Submission process

Guidance

Improving chances of publication

As well as the high overall quality required for publication in an international journal, authors should take into consideration:

- Addressing *HPP*'s readership: national and international policy makers, practitioners, academics and general readers with a particular interest in health policy issues and debates.
- Manuscripts that fail to set out the international debates to which the paper contributes, and to draw out policy lessons and conclusions, are more likely to be rejected, returned to the authors for redrafting prior to being reviewed, or undergo a slower acceptance process.
- Economists should note that papers accepted for publication in HPP will consider the broad policy implications of an economic analysis rather than focusing primarily on the methodological or theoretical aspects of the study.
- Public health specialists writing about a specific health problem or service should discuss the relevance of the analysis for the broader health system. Those submitting health policy analyses should draw on relevant bodies of theory in their analysis, or justify why they have not, rather than only presenting a narrative based on empirical data.
- Primarily focus on one or more low- or middle-income countries.

The editors cannot enter into correspondence about papers considered unsuitable for publication and their decision is final. Neither the editors nor the publishers accept responsibility for the views of authors expressed in their contributions. The editors reserve the right to make amendments to the papers submitted although, whenever possible, they will seek the authors' consent to any significant changes made. The manuscript will not be returned to authors following submission unless specifically requested.

Should you require any assistance in submitting your article or have any queries, please do not hesitate to contact the editorial office at hpp.editorialoffice@oup.com.

Should your manuscript require any English language editing, we recommend contacting AuthorAid, a free network which provides free mentoring and English-language editing for researchers in low-and middle-income countries.

Manuscript format and style for all articles

Only articles in English are considered for publication.

The journal follows Oxford SCIMED style. Please refer to these requirements when preparing your manuscript. More information on preparing your manuscript is available. Oxford English spelling style should be used consistently throughout your manuscript. (-ize/-ization), except in quotations and in references.

Prepare your manuscript, including tables, using a word processing program and save it as a *.doc, .rtf* or *.ps* file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left justified and not hyphenated.

The title page should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter
- Corresponding author's name, address, telephone/fax numbers and e-mail address
- Each author's affiliation and qualifications
- Keywords and an abbreviated running title
- 2-4 Key Messages, detailing concisely the main points made in the paper
- Acknowledgements
- A word count of the full article

In the acknowledgements, all contributors who do not meet the criteria for authorship should be listed. Sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material.

Please be aware that the requirements for online submission and for reproduction in the journal are different: (i) for online submission and peer review, please upload your figures separately as low-resolution images (.jpg, .tif, .gif or. eps); (ii) for reproduction in the journal, you will be required after acceptance to supply high-resolution .tif files. Minimum resolutions are 300 d.p.i. for colour or tone images, and 600 d.p.i. for line drawings. We advise that you create your high-resolution images first as these can be easily converted into low-resolution images for online submission.

Figures will not be relettered by the publisher. The journal reserves the right to reduce the size of illustrative material. Any photomicrographs, electron micrographs or radiographs must be of high quality. Wherever possible, photographs should fit within the print area or within a column width. Photomicrographs should provide details of staining technique and a scale bar. Patients shown in photographs should have their identity concealed or should have given their written consent to publication. When creating figures, please make sure any embedded text is large enough to read. Many figures contain miniscule characters such as numbers on a chart or graph. If these characters are not easily readable, they will most likely be illegible in the final version.

Certain image formats such as .jpg and .gif do not have high resolutions, so you may elect to save your figures and insert them as .tif instead.

For useful information on preparing your figures for publication, go to the Digital Art Support page.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

Manuscript file must include text body. Title Page, Figures and Tables should be uploaded separately.

Prior Publication Policy

[Based on a statement developed by a group of editors of journals that publish articles on health, health services, and health policy. Journals currently using this statement include: Health Affairs, Health Services Research, Inquiry, Journal of Health Politics, Policy and Law, Journal of Health Services Research & Policy, Medical Care, and the Milbank Quarterly.]

Background

The policy of the journals subscribing to this statement is to consider for publication only original work that has not previously been published. Questions about what constitutes previous publication are arising with increasing frequency because of the growth of electronic publishing and the increasing number of reports and papers being produced by organizations and agencies. This statement provides guidance on this issue.

There are legitimate reasons why research may be disseminated before submission to a journal. Active communication among researchers about preliminary findings or the circulation of draft reports for discussion and critique contributes to the eventual quality of published work. In addition, organizations that support or carry our research have an understandable interest in disseminating their work. From the perspective of journals, these reasons for dissemination must be balanced against two considerations. The first is the value of the peer review process. The rules against prior publication are intended to add some assurance of the credibility of published research.

Papers are often improved during the peer review process, with findings, conclusions, and recommendations sometimes changed in response to reviewers' comments. The public and policymakers might be confused or misled if there were multiple versions of a paper in the public domain. Second, from a more parochial viewpoint, journal space is limited, and much time and expense are involved in the evaluation, publication, and distribution of journal articles. Journals must make difficult choices about what to include; there is less value in publishing papers that have already been disseminated to their target audiences.

We discuss here several types of dissemination and provide guidelines with respect to the prior publication question. This discussion is essentially an elaboration of two rules, the first emphasizing previous dissemination of the material, the second stressing disclosure.

- Rule One: If the material in a paper has already been disseminated to a journal's audience, particularly in a format that appears to be a final product, then it is unlikely that a second version will be worth publishing in the journal.
- Rule Two: It is the responsibility of authors to let editors know at the time of submission whether a paper's contents have been previously disseminated in any manner so that the editors can determine whether to proceed with the review process.

Previous Presentations at Meetings

Presentation of a paper at conferences or seminars usually does not jeopardize the possibility of publication.

Working Papers

Dissemination of "working papers" to a limited audience will not ordinarily jeopardize publication. Working paper series are used by many organizations as a means of enabling researchers to obtain critiques from fellow researchers. Working papers covered by this policy are those that are released by the author or an organization rather than by a publisher, are not advertised to the public, and are marked as drafts that are subject to future revision. HPP will not publish papers for which a similar working paper is already available in the public domain.

Internet Postings

Release via the Internet may jeopardize journal publication under some circumstances. Presentation of the work as a final report is a marker of an attempt to reach a wide audience, particularly when combined with efforts to direct traffic to the work (e.g., via links on other sites) and efforts to attract attention (e.g., press releases). In contrast, if a document is posted on the Internet only to facilitate communication among colleagues with the aim of getting feedback, and if there has been no attempt to otherwise attract the attention of journalists, the public, or the broader research community to the document, then this is unlikely to preclude journal publication.
In general, when posting on the Internet serves similar functions as presentation at professional meetings - facilitating the development of papers and the improvement of the research, influencing future revisions, and not constituting a "finished" product - it would not be considered prior publication. On the other hand, when the Web site posting functions as a virtual version of a conventional publication, which may even be copyrighted by the posting organization, the benefit of an additional publication in the journal will be scrutinized carefully.

In cases where there has been little to no exposure at the time that a paper has been submitted to the journal, but the circumstances surrounding the posting make it likely that a high level of exposure (press coverage, etc.) might occur, then the author should remove a posting as a condition for further consideration of the manuscript.
Authors who post papers on a Web site and do not want it to constitute prior publication should also post a disclosure statement such as: "This draft paper is intended for review and comments only. It is not intended for citation, quotation, or other use in any form." This statement should be kept on the Web site throughout the review process and until the paper is actually accepted for publication in a journal. Once accepted, authors should post a message to the effect that: "A revised final version of this paper will appear in (Journal Name), volume, issue." Authors also should include this statement as a header or footer on every page of the paper.

Formal Reports from Foundations, Academic Institutions, Institutes, Trade Associations, and Government Agencies

The dissemination efforts of foundations, government agencies, research institutes, and other organizations that support or carry out research can complement publication in peer-reviewed journals. If publication in one of our peer-reviewed journals is desired, organizational publications should be timed to coincide with or follow journal publication, with appropriate copyright permissions having been obtained. This sequence ensures that the peer-review process will have an opportunity to correct deficiencies of method or presentation.
Formal, published reports that have gone through an editorial process, that have been intended to reach a wide audience, and that are publicized and available to any interested party (whether free or not) usually will not be considered for journal publication. A paper that is based on such a report might be considered for publication if it were sufficiently different in emphasis or intent. In such instances, the author should explain at the time of submission (or before) how the paper differs from the previously released report and why its publication would represent a distinct and important contribution beyond that version.

Policy briefs

If the findings of a piece of research have been published locally (i.e. in a specific country) with the aim of influencing policy debates in that country then even if the brief is available on the web we may consider publishing an article so long as (i) the brief has not had wide circulation outside the country and (ii) the brief is clearly targeted at policy-making audiences, and hence does not include the detailed discussion of methods and perhaps findings that one might expect in a journal article.

Media Publicity

If results reported in a working paper have become widely known as a result of media exposure (or even if the potential for widespread exposure remains during review), and that working paper is readily available to interested readers (e.g., through a Web site), an editorial judgment will be made whether journal publication would be appropriate. Authors can help protect their work from unwanted media exposure by making clear on working drafts, copies presented at conferences, and other versions that it is a draft that has not yet undergone peer review for publication and that findings and conclusions are subject to change. Authors also should request that any "stories" derived from interviews with the media be embargoed until the work is published or released by the publisher (see, for example, Fontanarosa, P.B., and C.D. DeAngelis. 2002. The Importance of the Journal Embargo. Journal of the American Medical Association 288: 748-750). Any accepted manuscript released to the media should contain the statement: "A revised final version of this paper will appear in (Journal Name), volume, issue." Journal policies involving author contact with members of the media may vary, depending on the issue or journal. Thus, authors should check with the editor before speaking with or distributing papers to members of the media.

Importance of Disclosure

In contrast to the editors' decision whether a certain paper has been disseminated too widely to warrant journal publication, there is very little judgment involved in whether an author should disclose previous dissemination. Prior to, or at the time of, submission of a paper that has been disseminated in any of the ways discussed previously, authors should bring this to the attention of the editor so that a determination can be made before the paper goes into the peer-review process. In so doing, authors should describe in what form and how the work was previously disseminated and how the submitted manuscript differs from previously disseminated versions. Editors might be receptive to a modified version of a paper that has been widely disseminated if the submitted version has a different focus (e.g., more emphasis on methods, more sophisticated analytic approach, or discussion of developments that have transpired since the initial dissemination). The key point is to let editors know about any dissemination that will have, or is likely to have, occurred before the journal article is published rather than have it discovered during or after the review or editorial process. As part of the submittal, authors should include copies of other related papers that might be seen as covering the same material.

Failure to disclose could preclude publication in the journal or, if already published, could result in a notice in the journal about the failure and may result in a retraction of the article.

Manuscript Preparation

Page 1: *Title Page* – as above.

Page 2: *Abstract.* The abstract should be prepared in one paragraph, no headings are required. It should describe the purpose, materials and methods, results, and conclusion in a single paragraph no longer than 300 words without line feeds.

Page 3: *Introduction.* The Introduction should state the purpose of the investigation and give a short review of the pertinent literature, and be followed by:

Materials and methods. The Materials and methods section should follow the Introduction and should provide enough information to permit repetition of the experimental work. For particular chemicals or equipment, the name and location of the supplier should be given in parentheses.

Results. The Results section should describe the outcome of the study. Data should be presented as concisely as possible, if appropriate in the form of tables or figures, although very large tables should be avoided.

Discussion. The Discussion should be an interpretation of the results and their significance with reference to work by other authors.

Abbreviations. Non-standard abbreviations should be defined at the first occurrence and introduced only where multiple use is made. Authors should not use abbreviations in headings.

All *measures* should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

References. References must follow the Harvard system and must be cited as follows:

Baker and Watts (1993) found...

In an earlier study (Baker and Watts 1993), it...

Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus:

Baker S, Watts P. 1993. Paper/chapter title in normal script. Journal/book title in italics *Volume number in bold* : page numbers.

Baker S, Watts P. 1993. Chapter title in normal script. In: Smith B (ed). *Book title in italics*. 2nd edn. Place of publication: Publisher's name, page numbers.

Tables All tables should be on separate pages and accompanied by a title - and footnotes where necessary. The tables should be numbered consecutively using Arabic numerals. Units in which results are expressed should be given in parentheses at the top of each column and not repeated in each line of the table. Ditto signs are not used. Avoid overcrowding the tables and the excessive use of words. The format of tables should be in keeping with that normally used by the journal; in particular, vertical lines, coloured text and shading should not be used. Please be certain that the data given in tables are correct. Tables should be provided as Word or Excel files.

Availability of Data and Materials

Where ethically feasible, *Health Policy and Planning* strongly encourages authors to make all data and software code on which the conclusions of the paper rely available to readers. Authors are required to include a Data Availability Statement in their article.

We suggest that data be presented in the main manuscript or additional supporting files, or deposited in a public repository whenever possible. For information on general repositories for all data types, and a list of recommended repositories by subject area, please see Choosing where to archive your data.

Data Availability Statement
The inclusion of a Data Availability Statement is a requirement for articles published in *Health Policy and Planning*. Data Availability Statements provide a standardised format for readers to understand the availability of data underlying the research results described in the article. The statement may refer to original data generated in the course of the study or to third-party data analysed in the article. The statement should describe and provide means of access, where possible, by linking to the data or providing the required unique identifier.

The Data Availability Statement should be included in the endmatter of your article under the heading 'Data availability'.

More information and examples of Data Availability Statements.

Data Citation
Family Practice supports the Force 11 Data Citation Principles and requires that all publicly available datasets be fully referenced in the reference list with an accession number or unique identifier such as a digital object identifier (DOI). Data citations should include the minimum information recommended by DataCite:

- [dataset]* Authors, Year, Title, Publisher (repository or archive name), Identifier

*The inclusion of the [dataset] tag at the beginning of the citation helps us to correctly identify and tag the citation. This tag will be removed from the citation published in the reference list.

Preprint policy

Authors retain the right to make an Author's Original Version (preprint) available through various channels, and this does not prevent submission to the journal. For further information see our Online Licensing, Copyright and Permissions policies. If accepted, the authors are required to update the status of any preprint, including your published paper's DOI, as described on our Author Self-Archiving policy page.

Types of papers

Health Policy and Planning welcomes submissions of the following article types:

- Original research
- Review articles
- Methodological musings
- Innovation and practice reports
- Commentaries
- 'How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and
- '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

Original Research

Manuscripts should preferably be a *maximum* of *6,000* words, excluding tables and figures/diagrams.

The manuscript will generally follow through sections: Title page, Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, Acknowledgements, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

For the reporting of statistical analyses please consider the following additional points:

- Focus the statistical analysis at the research question.

- Provide information about participation and missing data.
- As much as possible, describe results using meaningful phrases (e.g., do not say "beta" or "regression coefficient", but "mean change in Y per unit of X"). Provide 95% confidence intervals for estimates.
- Report the proportions as *N* (%), not just %.
- Report *P* values with 2 digits after the decimal, 3 if <0.01 or near 0.05 (e.g., 0.54, 0.03, 0.007, <0.001, 0.048). Do not report *P* values greater than 0.05 as "NS".
- Always include a leading zero before the decimal point (e.g., 0.32 not .32).
- Do not report tests statistics (such as chi-2, T, F, etc.)."

For acknowledgements, figures and measures see above.

Review Articles

Manuscripts should preferably be a *maximum of 10,000 words*, excluding tables, figures/diagrams and references.

Reviews may be invited. They generally address recent advances in health policy, health systems and implementation. *Systematic reviews are particularly welcomed,* but may not be appropriate for every topic. If authors are submitting a review article that is not a systematic review then the paper should explain why a systematic review was not feasible/desirable, and the review methods should be described in a way that is as clear and as replicable as possible.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

Checklists have been developed for a number of study designs, including randomized controlled trials (CONSORT), systematic reviews (PRISMA), observational studies (STROBE), diagnostic accuracy studies (STARD) and qualitative studies (COREQ, RATS). We recommend authors refer to the EQUATOR Network website for further information on the available reporting guidelines for health research, and the MIBBI Portal for prescriptive checklists for reporting biological and biomedical research where applicable. Authors are requested to make use of these when drafting their manuscript and peer reviewers will also be asked to refer to these checklists when evaluating these studies.

Commentaries

Short commentaries on topical issues in health systems are welcomed - *please email the editorial office prior to submission*. Most such commentaries are commissioned by the editors, but the journal will also consider unsolicited submissions. Commentaries should of broad interest to readers of *Health Policy and Planning*, and while they are not research papers, they should be well substantiated. Manuscripts should preferably be a *maximum of 1,200 words*, excluding tables, figures/diagrams and references.

The manuscript will generally contain a short set of key take-home messages. Tables and Figures should not be placed within the text, rather provided in separate file/s.

How To Do...Or Not To Do

This series is meant to explain how to use a particular research or analytical method (e.g. social network analysis, discrete choice experiment etc.). The research or analytical methods discussed should be well accepted and clearly defined: this category of paper is not meant to address methodological debates but rather to help disseminate and promote the use of well-accepted methodologies.

Manuscripts should preferably be a *maximum of 3,000 words* excluding tables, figures/diagrams and references.

- The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.

Tables and Figures should not be placed within the text, rather provided in separate file/s.

10 Best Resources

This 10 best is a series of articles that identify and outline the 10 most useful resources from a range of sources to help facilitate a better understanding of a particular issue in global health.

We often commission these articles but we also hear unsolicited suggestions.

For acknowledgements, figures and measures see Title page.

Methodological Musings

This series is meant to address methodological issues in health policy and systems research, where there is currently a lack of clarity about accepted research methods. This series is intended to support the development of the health policy and systems research field, through supporting methodological discussion.

Manuscripts should preferably be a *maximum of 3,000 words*, excluding tables, figures/diagrams and references.

- The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.
- For acknowledgements, figures and measures see Title page.

Innovation and Practice Reports

These short reports are narratives from the perspective of health managers operating at the national or sub-national level which focus on innovative approaches to strengthen health systems. Papers should highlight the practical experience of health managers or practitioners involved in taking action to strengthen health systems through innovative activities and new practices. The new activities and practices should preferably have been implemented for a sufficiently long time to allow authors to demonstrate the potential for sustained improvement or change in the health system. Examples might include practices to build capacity, develop new partnerships or restructure relationships within health systems. Papers should identify 2-4 key messages or lessons for consideration in other settings. We will not consider clinical and pharmaceutical innovations and practices. Manuscripts should be a maximum of 2,000 words.

The manuscript will generally follow through sections: Key Messages, Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s. In the main body of the paper, sub-headings may be useful to signal key elements of the experience reported. Reports must be led by local practitioners, managers or policy-makers.

Submission process

Pre-submission language editing

Authorship

Originality

Online submission

Pre-Submission Language Editing

HPP asks all authors to ensure that their papers are written in as high a standard of English as possible before submission to the journal. If your first language is not English, to ensure that the academic content of your paper is fully understood by journal editors and reviewers, you may want to consider using a language editing service. Language editing does not guarantee that your manuscript will be accepted for publication. For further information on this service, please click here. Several specialist language editing companies offer similar services and you can also use any of these. Authors are liable for all costs associated with such services. If your first language is not English, to ensure that the academic content of your paper is fully understood by journal editors and reviewers is optional. Language editing does not guarantee that your manuscript will be accepted for publication. Further information on the Language services is available. Several specialist language editing companies offer similar services and you can also use any of these. Authors are liable for all costs associated with such services.

Authorship

All persons designated as authors should qualify for authorship. The order of authorship should be a joint decision of the co-authors. Each author should have participated sufficiently in the work to take public responsibility for the content. Authorship credit should be based on substantial contribution to conception and design, execution, or analysis and interpretation of data. All authors should be involved in drafting the article or revising it critically for important intellectual content, must have read and approved the final version of the manuscript and approve of its submission to this journal. An email confirming submission of a manuscript is sent to all authors. Any change in authorship following initial submission would have to be agreed by all authors as would any change in the order of authors.

Originality

Manuscripts containing original material are accepted for consideration with the understanding that neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted for publication elsewhere. This restriction does not apply to abstracts or short press reports published in connection with scientific meetings. Copies of any closely related manuscripts should be submitted along with the manuscript that is to be considered by HPP. HPP discourages the submission of more than one article dealing with related aspects of the same study. For further information on the prior publication policy see Prior Publication Policy.

During the online submission procedure, authors are asked to provide:

- information on prior or duplicate publication or submission elsewhere of any part of the work;
- a statement of financial or other relationships that might lead to a conflict of interest or a statement that the authors do not have any conflict of interest;
- a statement that the manuscript has been read and approved by all authors (see also section on authorship);

- name, address, telephone and fax number of the corresponding author who is responsible for negotiations concerning the manuscript;
- copies of any permissions to reproduce already published material, or to use illustrations or report sensitive personal information about identifiable persons.

All papers submitted to HPP are checked by the editorial office for conformance to author and other instructions all specified below. Non-conforming manuscripts will be returned to authors.

If authors are unsure about the originality of their manuscript or any part of it, they should contact the editorial office at hpp.editorialoffice@oup.com.

Online Submission

Prior to submission please carefully read instructions on each type of paper and closely follow instructions on word count, abstract, tables and figures and references. This will ensure that the review and publication of your paper is as efficient and quick as possible. The Editorial Office reserve the right to return manuscripts that are not in accordance with these instructions.

All material to be considered for publication in Health Policy and Planning should be submitted in electronic form via the journal's online submission system. Once you have prepared your manuscript according to the instructions below, instructions on how to submit your manuscript online can be found by clicking Manuscript Submission.

Conflict of Interest

Authors must declare any conflicts of interest during the online submissions process. The lead author is responsible for confirming with the co-authors whether they also have any conflicts to declare.

Ethical Approval

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