

**Civil Society's role in health system monitoring and strengthening: Evidence
from Khayelitsha, South Africa**

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Declaration I JESSICA BARKER (BRKJES004) hereby declare that this is my original work and has not been presented before for the award of a Masters' Degree in Public Health.

Date: 13th February, 2014

Signature.....

Signed by candidate

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Abstract

Introduction: Historically in South Africa, civil society has played a key role within the health system, including advocating for equitable and quality health care services. The purpose of this research is to explore the implementation of a pilot health systems strengthening intervention in primary health facilities in Khayelitsha, South Africa. The study is built on Treatment Action Campaign, a civil society organization, which has recently implemented a health system monitoring tool within health care facilities in Khayelitsha. Specifically, this study considers the functioning and potential impact of the monitoring tool introduced as a community accountability mechanism at the local level. The development and implementation of the monitoring tool can also be seen as part of a policy implementation process.

Methods: Using an action research approach, the researcher engaged with implementing actors in the development and implementation of the monitoring tool. Qualitative methods were used to explore: the understandings of various stakeholders about the tool, their interests or concerns, potential positions, power and influence on its implementation. Quantitative data allowed for the ability to track potential improvements in clinic performance in terms of operational research. The challenges during tool development and implementation and how these were overcome were also explored.

Results: Analysis of the stakeholders demonstrated how actors exerted their power in various ways to influence the development and implementation of the tool. Results suggest it can be an empowering process for members of civil society and there is a role for civil society in improving health system performance. Findings have highlighted the need for civil society organization monitoring tools to be not only methodologically sound but, more importantly, accepted by the activist. If carefully considered and

driven by civil society itself, rather than imposed, there does seem to be some tentative examples of service delivery improvement and scope for their engagement.

Conclusions

The findings offer relevant and useful insights for understanding how this tool acts as an accountability mechanism at a local level within Khayelitsha sub-district. Such findings may have implications for further adaptations to the tool, potential scale-up by Treatment Action Campaign and for other low and middle income contexts.

Acronyms

ARV	Antiretroviral
CoCT	City of Cape Town Health Services
CHCs	Community Health Centers
CSO	Civil Society Organization
DHIS	District Health Information System
HIV	Human Immune Deficiency Virus
HPSR	Health Policy and Systems Research
HSS	Health Systems Strengthening
LMIC	Low and Middle Income Country
MSF	Medecins Sans Frontieres
MOU	Memorandum of Understanding
M & E	Monitoring and Evaluation
NHI	National Health Insurance
PHC	Primary Health Care
PTLA	Patient Treatment Literacy Advocate
TAC	Treatment Action Campaign
TB	Tuberculosis
WHO	World Health Organization
WCG	Western Cape Government

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Part A: Protocol

What is the functioning and potential influence of civil society within PHC facilities in Khayelitsha, South Africa?

1. Background

South African Context

Civil society has been defined as a group of organizations and institutions that share a common interest that is neither driven exclusively by state or market mandate (1). The advantage of civil society is its ability to embrace the general public at large, representing the social domain that is not part of the State or the market. It has been well documented that civil society has proven indispensable in challenging donors and developing country governments to increase and sustain health investments, and ensuring that those resources have the maximum impact (2). Historically in South Africa, civil society has played a key role within the health system, including advocating for equitable and quality health care services for the population (3). The Social Justice Coalition is a Western Cape community-based organization, for example, which is committed to addressing a broad range of issues that affect poor communities, including housing, education, substance abuse, crime and security (4). Among other notable projects, the Social Justice Coalition has played an important role in mobilizing social movement responses to xenophobic attacks that occurred within South Africa in 2008 and access to basic sanitation within informal settlements outside of Cape Town in 2011 (4).

Civil Society Organizations (CSOs) are understood to be not for state, not for profit, voluntary organizations (1). These organizations often have local knowledge which can contribute to improved health and other programming, by identifying the most acute and emerging needs of vulnerable

populations. CSOs worldwide are currently providing vital services that address target diseases such as HIV and TB, and also identified is their potential for broader roles in health systems strengthening. A notable example is the People's Health Movement, a coalition of grassroots organizations utilizing an empowerment approach as an underlying value to their advocacy activities. Their charter encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organizations and corporations (5). The charter then goes on to list about 60 recommendations, ranging from scope from advocacy of universal, comprehensive primary health care and the central participation of people's organisation in health programmes, to support for campaigns for peace and disarmament (5). However, lacking in the review of the literature is a model of *how* these CSOs can be successfully used to strengthen the health system.

Health Systems Strengthening (HSS) is a particularly relevant topic in the current South African context, as the country moves towards National Health Insurance (NHI), a system of universal health coverage. Maartens & Goemare (6) argue that in order to achieve universal health coverage, a shift in focus of health service delivery from the tertiary hospital level to the community level is needed. Therefore the data gathered in this study has the potential to contribute to informing how best civil society can engage in order to strengthening primary health services in particular. Bemelmans et al. (7) describe a breakdown of service delivery at a medicines depot in the Eastern Cape, South Africa during 2012. Collaboratively, Medecins Sans Frontieres (MSF) intervened to provide logistic support, and CSOs, including Treatment Action Campaign (TAC), identified facilities with critical medicine stock shortages and mounted a campaign to encourage patients to return to health care facilities to collect medication (7). This crisis is reflective of a breakdown in multiple areas of the district health system in South Africa, and further suggests the need for health systems strengthening and the potential for civil society to be involved.

TAC's HIV 'Treatment Literacy' programme has been an important contribution to empower and educate HIV-vulnerable about the science of HIV, health, and the benefits of treatment (3). Those receiving Treatment Literacy education often become TAC members themselves, swelling the ranks of those available for public protest and movement building. Since 2009, TAC volunteers whom have been trained in these areas are called 'Treatment Literacy Practitioners' (now known as PTLAs in the present context). Although they are seen as 'lay-persons' within the clinic setting, PTLAs are assigned to clinics, hospitals, and community organizations where they conduct further training and agitation for the right to treatment (3). Since their introduction, the role of the TLP's has been evolving, with the recent addition of 'Advocate' to their job description.

Focus of the research

The research centers on a partnership between MSF and TAC and using an action research approach, will focus on evaluating the implementation of a HSS pilot project jointly implemented by both organizations within Khayelitsha, South Africa. At present MSF funds 1/3 of TAC Khayelitsha's budget, as well as the entire PTLA programme –which is outlined in a current Memorandum of Understanding (MOU) between both parties and based on a historic partnership. The current MOU between TAC and MSF outlines the roles of the PTLAs, which includes an education and advocacy component, but also discusses how PTLA's should be monitoring 'Hygiene, service delivery and policy implementation at health facilities' (8). Both organizations are held accountable by the MOU, with funding releases by MSF contingent on adequate performance. The MOU outlines that PTLAs are to perform regular checks on how well service delivery is being implemented within facilities, and whether service users are able to fully realize their health services rights as outlined in the Patient Charter.

The City of Cape Town (CoCT) and Western Cape Government (WCG) are responsible for providing health services within Khayelitsha sub-district. Both organizations recognize the need for HSS and have

placed patient-centered and population-centered planning as well as health systems planning priorities among the principles for the District Health Plan 2014/2015 (9).

The Intervention

TAC and MSF recently implemented a health systems monitoring component to the role of the PTLAs in PHC facilities, and this tool forms the intervention in this particular study. The tool was implemented in June, 2014, and currently 9 PTLAs are utilizing the HSS monitoring tool within 9 PHC facilities in Khayelitsha. In addition to the regular reporting of their education and advocacy activities, PTLAs are also now monitoring systems level indicators including; human resources, provision of services, clinic environment, and community mobilization. Daily monitoring of indicators are performed by the PTLAs, and collected daily on a paper-based tool. PTLAs typically spend from 08h00-14h00 in their respective PHC facilities, and then two hours a day in their TAC branches where they work closely with TAC community mobilizers. PTLAs obtain data to complete the form from facility staff, as well as from service users who will be interviewed on whether they have had their service needs and expectations met.

Provider Report Cards

The focus of this study is the HSS tool developed by MSF/TAC, which is similar to a provider report card. 'Provider', or 'citizen' report cards as they are often referred to, compare providers within a specific geographic region on a routine basis according to certain standards of quality performance. These findings can be made public, and providers named and performance data presented to the public, and offers potential to improve choice and ability to dialogue (10). This accountability mechanism has been used far more frequently in higher income settings, with examples and studies mostly generated from a United States and Canada, and in hospital settings (10). However, this type of mechanism is being increasingly used in an LMIC context in PHC settings. For example, the Yellow Star Program, implemented in Uganda, evaluated health facilities on a quarterly basis using 35 indicators, and involved collaboration with the Ministry of Health and other donor organizations (10). Mcnamara (10) also

explains that most report cards in LMICs have been developed or supported by civil society. The appeal of report cards is their potential to promote accountability for quality, and the overarching theory is that report cards might impact quality by influencing provider behaviour, consumer behaviour, or both. However, the potential for report cards to improve quality depends on a number of contextual factors that affect the design, implementation, and use of report cards (10).

Research approach

An action research approach will be used in this study. This follows the action research approach whereby participation is fundamental: it is an approach which demands that participants perceive the need to change and are willing to play an active part in the research and the change process (11). It is expected that additional refinements of the tool will be needed during the implementation process. TAC and MSF have committed to making this a participatory process. As the actors implementing the tool, they will be consulted in order to gain their valuable feedback and create ownership over the tool. Other stakeholders including TAC members, city health and provincial partners will also be consulted. The principal researcher will play an active role in supporting and observing the implementation process. The strength of action research is its ability to influence practice positively while simultaneously gathering data to share with a wider audience (11). In this study, PTLAS will be posting results from the HSS tool in clinics, but will work with local clinic committees, which include civil society representation, and ultimately, protest action after community leader engagement. The results will be fed back to clinics, in addition to TAC and partners such as MSF, CoCT and WCG. This study looks to begin understanding the diverse elements related to the implementation of the MSF/TAC HSS tool, the policy process itself and how community accountability and governance interact within the health system.

Civil society and the health system: International experience

A health system includes ‘all actors, organizations, institutions and resources whose primary purpose is to improve health’ (12: 30). Similarly, civil society can be thought of as organized groups of people who

are independent of government, but who are interested in the welfare of society or specific populations (1). Coutinho et al. (13) explored the role of PEPFAR and other major sources of HIV funding in the global response to the HIV and conclude that the pace and intensity of the response could not have happened without the involvement of civil society. Further, during the process of scale-up, CSO's contributed significantly to overall HSS. With a health systems lens, it is important a step back from a fixation on individual components, and keep the entire system in mind when designing and evaluating systems strengthening interventions (14).

In De Cock et al's (15) analysis of HIV program scale-up, HSS occurred through technical approaches, such as improving laboratory, pharmaceutical and data management systems. Collaboration between governments, public health authorities, CSOs and others played a key role in ensuring health systems strengthening (15). Hafner and Shifman (16) state that HSS involves managing complex relationships and elements inherent in the system, which was reflected in De Cock et al's (15) findings. HSS interventions must therefore explore the interconnectedness between the different building blocks that make up the system (17). The solutions depend on context and the ability to reflect the interconnectedness of the health system.

2. Frameworks relevant to the research process

Policy Implementation

The HSS monitoring tool can also be viewed in terms of policy implementation. Policy can be seen as a contested process, with many interacting factors, actors, situations and practices that are constantly changing. Implementing new methods, guidelines or tools (policy) into practice, however, is a slow and unpredictable process, and the factors that play a role in the change process are not yet fully understood (18). Gilson & Raphaely (19) discuss that policy and the policy change is always a contested process, which is an important piece to consider in the implementation of this HSS tool. This research will draw specifically from Walt & Gilson's (20) health policy analysis triangle, a commonly used

overarching framework for policy analysis; this model is used to understand better the process of health policy reform and to plan for more effective implementation. Since implementation is an important piece of the policy process, and specific to this research, the framework will be used to understand better the process of policy implementation. The Walt & Gilson policy analysis triangle has been applied in various LMIC contexts (19), and will serve as a relevant analytical framework.

The framework considers not only the content of the policy, but the actors involved; the processes contingent on developing and implementing policy change; and the context it was developed and implemented within (20). Within the triangle are policy actors-individuals, groups, who identify problems or issues and are at the heart of policy and the policy implementation process (20). They are important to consider in the implementation process because they can exert their power in various ways, including; blocking the implementation of proposals and developing the strategies through which policies are developed and implemented (20). The triangle also represents an interconnectedness of each part within the policy process; as policy content influences actor's positions on policy and feasibility of implementation and actors are also influenced by the context within which they live and work (20). Context plays an important role and is affected by many factors such as instability or ideology, history, culture, and process of policy-making (20). Such analytic techniques offer a better understanding and more complete explanation of the policy environment and the factors influencing the effectiveness of policy implementation (21), which is the thrust of this study.

Health Governance and Accountability

Accountability plays an integral role in the governance of a health system, providing formal mechanisms by which patients and the broader population can hold key actors responsible for achieving the objective of access to quality services, satisfaction and fair financing (22). Civil society has a role to play in generally holding the government to account, and therefore the PTLAs are an important piece in this particular study, and also in seeking to improve the performance of PHC facilities within Khayelitsha. The

HSS monitoring tool utilized by PTLAs within their respective clinics can be seen as an accountability mechanism, in this respect. Cleary et al. (23) identify two types of accountability mechanisms which seek to regulate answerability between the health system and/or citizens and between different levels of the health system. The framework below (Figure 1) describes how both internal and external accountability mechanisms interact with the actors of the health system (24).

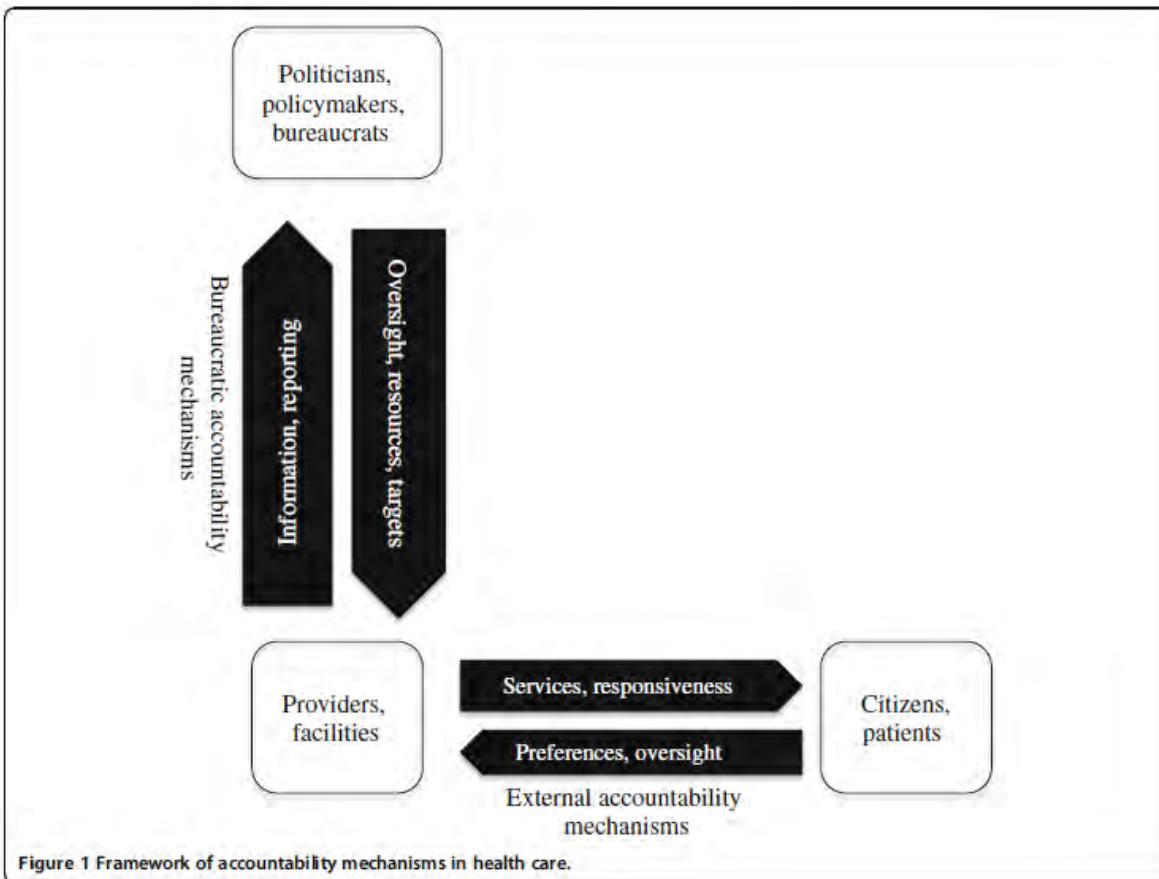


Figure 1: Framework of accountability mechanisms in health care (24)

The HSS tool recently implemented by TAC/MSF, and utilized by the PTLAs, is an external accountability mechanism. External (community) accountability mechanisms are used by non-state actors, including civil society, to hold public sector actors to account, and internal (bureaucratic) mechanisms that are comprised of the institutional oversights, checks and balances internal to the public sector (23).

Identified external accountability mechanisms include: involvement or participation of citizens in clinic

and district health committees, the use of patient complaints procedures, provider report cards, and patients' rights' charters (25). Most of the published literature typically focuses on effectiveness of clinic committees and the factors that influence their performance (25). In addition, Cleary et al. (23) found overall that governance and accountability were neglected areas within HPSR and therefore this research has potential to contribute to this gap.

Provider report cards as external accountability mechanisms

The HSS tool is based on a provider report card, and can be seen as an external accountability mechanism. As previously discussed, Mcnamara (10) identified key contextual factors that affect design, implementation, and use of report cards. Cleary et al. (23) also identified factors that influence the functioning of accountability mechanisms, including; values, attitudes, and resources (Figure 2).

Although Cleary et al.'s (23) review of the literature was focused on multiple mechanisms, report cards were included as a mechanism of analysis, and therefore their findings appear to be highly applicable to this study.

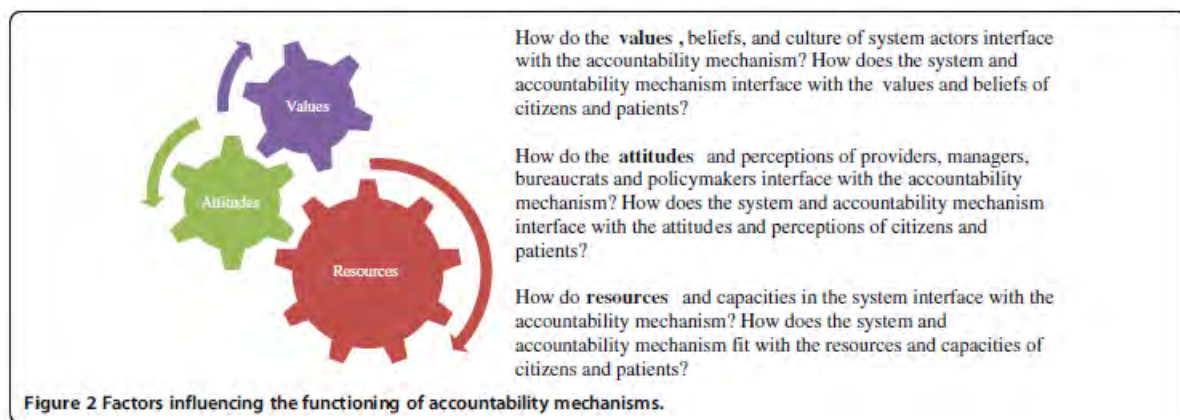


Figure 2: Factors influencing the functioning of accountability mechanisms (23)

The factors influencing functioning of external accountability mechanisms are: resources (time, space and capacity), attitudes and perceptions of actors, and the values, beliefs and culture of the system.

Within the framework, resources and capacities are the largest of the wheel, representing the power

yielded by this factor in the functioning of accountability mechanisms. Lack of resources allocated to external accountability initiatives, as well as concerns about whether citizens have the capacity to hold providers to account, can be barriers affecting this mechanism. For example, in the Yellow Star program implemented in Uganda, despite the early successes of the program and its potential to improve the quality of services and create a more efficient and effective supervision of health facilities, the government had difficulty sustaining it when donor funding ended in 2005 (26). The framework also identifies that accountability mechanisms require trusting interpersonal relationships between providers and citizen representatives, pointing to the importance of attitudes and perceptions of the actors. Underpinning external accountability mechanisms are values, beliefs and culture of the health system and local communities (24). The value in using this framework for this particular study is its direct application to understanding the practices that might strengthen accountability in ways that improve health system responsiveness, and the identification of specific factors to encourage innovation and patient-centered care (24).

3. Methodology

In the following section, an overview of study methodologies will be discussed.

Objectives

Primary Objective: To assess the functioning and potential influence of a HSS monitoring tool as an external accountability mechanism implemented within PHC facilities in Khayelitsha.

Secondary Objectives:

- 1) To identify the factors (resources, attitudes, and culture) potentially involved in influencing the functioning of the external accountability mechanism.
- 2) To identify the key actors involved and analyze how they exerted their power to shape the design and implementation of the HSS tool.

- 3) To evaluate the successes and failures of the implementation of this tool and convey initial 'lessons learned'.

Study setting

Khayelitsha

Located 56 km from the centre of Cape Town, Khayelitsha is a sub-district with an estimated population of 500 000. This large urban township is demonstrative of the many inequities facing the health system in South Africa (27). Infectious disease burden remains high as reflected by antenatal HIV seroprevalence increasing from 19.3% in 2000 to 37% in 2011 and is the highest in the Western Cape (27), (28). Marked socio economic inequities persist, as only forty-five per cent of the population live in formal housing, with a 38% unemployment rate, and of those working, 74% of households make an income of R3,200 or less (27). Due to high disease burden and other related socio-economic factors Khayelitsha is a health system under pressure. Care for the majority of the population is predominantly delivered through public primary health care clinics run by provincial or city partners. However, despite these disadvantages and the lack of resources, Khayelitsha plays an important role as innovator in South Africa.

MSF and TAC within Khayelitsha

Historically, Khayelitsha has been a site of partnerships between MSF, TAC, the City of Cape Town, and the Western Cape Province Department of Health (PGWC). MSF has been working within Khayelitsha since 1999 to provide ARV medications, and were one of the first to implement the provision of ARVs on the continent in 2001 (3). The battle to obtain access to quality generic anti-retrovirals (ARVs) was waged jointly and Maartens & Goemaere (6) argue that civil society played a major role, notably TAC, in the success of the programme. It became a symbol internationally in the fight for access to affordable ARVs in resource-constrained settings (2).

There is a high level of citizen engagement within Khayelitsha and communities are increasingly protesting around service delivery. Because of their successful advocacy history, TAC has strong community links in Khayelitsha, and other areas where they work within South Africa. TAC's primary target group is people living with (or at risk of) HIV/TB Co-infection, with the majority of this target group being urban-based, living in lower-income areas and dependent on the public health system. Successful community based pilot projects including adherence clubs and decentralized DR-TB have recently been implemented through collaborations with TAC and MSF, and PMTCT in Khayelitsha (28). As the sub-district continues to evolve in line with advances in global best practice of ART care, it remains at the forefront of innovation and has a history of collaborative partnerships, and was therefore an ideal site to implement this particular project.

There are eleven PHC clinics within Khayelitsha: three are large CHCs run by the Western Cape Government (WCG), two others are youth clinics, and all except the CHCs are run by the CoCT. Currently PTLAs are working within their respective facilities Monday through Friday, and each PTLA is assigned to one facility for the sake of continuity and to build relationships with health care workers and patients in that facility. In their day to day role, the PTLAs are typically found in the waiting areas for HIV and TB sections of the clinic. They are delivering education to the larger group of patients in waiting rooms, as well as answering specific questions from patients one-on-one. Because the PTLAs are an ongoing presence, they are in a position to develop trust with patients and can help to bridge the gap between patient and health care worker. With this external observer role, they are also able to identify bottlenecks in the daily flow of the clinic, as well identify advocacy issues to be brought forward. The supervisor for the PTLAs is responsible for visiting the PTLAs weekly on-site and also meeting with each of the facility managers to discuss concerns brought forward by the PTLAs.

Research Design

Action Research

Koshy et al. (29) argues that action research has; a participatory in nature, a democratic foundation, and contributes to knowledge and practice. Within the context of this particular study, the ‘action’ is the development and implementation of the HSS monitoring tool, and the primary researcher is supporting this intervention within the system. A foundational concept of action research is its emphasis on participation. Meyer (11) argues that action research is focused on doing research with and for participants, rather than on them. In following the action research approach, PTLAs will be asked for feedback weekly, in order to determine how the indicators have fared in practice. These weekly ‘reporting sessions’ are scheduled for every Friday, as this is typically when all the PTLAs meet together at the TAC office in Khayelitsha to check in with the PTLA supervisor and submit the completed tool. Feedback from the PTLAs will be used in order to inform further refinement of the tool. Action research’s strength lies in its focus on generating solutions to practical problems and its ability to empower practitioners (in this case, PTLAs)—getting them to engage with research and subsequent “development” or implementation activities.

Meyer (11) describes the role of the researcher in action research is to assist with identifying problems, seeking and implementing practical solutions, and systematically monitoring and reflecting on the process and outcomes of change. The weekly reporting sessions offer an opportunity for the principal researcher to engage with the PTLAs, the actors who are implementing the tool. In addition, the implementation process will be followed closely by the PTLA supervisor and principal researcher. Bi-monthly site visits will be conducted by the principal researcher and PTLA supervisor in order to gain knowledge of context and the health systems issues facing each primary health facility where the tool is implemented. The purpose of site visits is to also provide support to PTLAs, interact with the various

facility managers and nurses in charge at these sites, and gain additional feedback on the tool and process of implementation.

Justification for action research approach

Action research will be the approach taken in development and implementation of the HSS tool, as it allowed for engagement with the actors at the center of the health system. Loewenson (28) identifies the methodology as appropriate for health policy and systems research, because it can contribute to the re-orientation of health services towards a more people centered focus by strengthening the social accountability of the health systems. This methodology is complimentary to community engagement interventions, as it shares a similar participatory worldview. Action research is unique, in that it transforms those participating from being the object of research to active researchers and agents of change (28). Therefore this study reflects the same emancipatory view. Through the involvement of the PTLAs in the creation and implementation of the HSS tool, Meyer (8) argues that by drawing on the participant's situation and experience and can therefore generate findings that are meaningful to them. Loewenson (30) contends that in action research, the researcher is thus part of the community and a facilitator of empowering processes. This approach is also relevant to the study particularly because of the active role of the primary researcher in supporting and observing the implementation process.

Mixed Methods

Action research has been used in a variety of settings and disciplines and often employs a range of methods (11), therefore both quantitative and qualitative methods will be used in this study to provide a richer picture of the HSS policy implementation process. A mixed methods approach will be used with the purpose of 'expansion'; in this approach Johnson (31) argues that using multiple methods allows the researcher the opportunity to expand the breadth and range of inquiry by using different methods for different inquiry components. This study looks to begin understanding the diverse elements within the

implementation of the MSF/TAC HSS tool, the policy implementation process and how community accountability and governance interact within the health system.

Quantitative Component

The quantitative component of this study is based on the HSS tool completed by the PTLAs (See Appendix E & F). The indicators are similar to quality indicators used in both the Ugandan and Bangalore studies- where both report cards included process, structural and outcome standards (10),(32). The indicators chosen reflect these standards and include; human resources, provision of services, clinic environment, and community mobilization. They were chosen to be similar to what is set by the Office of Health Standards Compliance, a separate entity established by the National Department of Health. Using a three column table the indicators were scored by MSF and TAC leadership by 1) how easy they are to collect; 2) how possible they might be to affect; 3) how often they might need to be collected. An overarching goal influencing the selection of indicators was to demonstrate ‘proof of concept’ by choosing indicators that would be easiest to affect change. The aggregated score was taken and the most appropriate indicators for the task were chosen.

Mcnamara (10) suggests that provider report cards should be tailored specifically to help address a country’s priority concerns. Therefore, the primary researcher and MSF leadership selected the initial indicators in consultation with TAC members, specifically to reflect current challenges facing many of the PHC facilities as seen through site visits, and as brought forth in a recent district health community consultation forum. Within the Khayelitsha sub-district, the tool is being implemented in both the WCG and the CoCT facilities. All clinics offer the same basic primary health services, (with the larger CHC’s offering more specialized services such as maternity services), which will allow for easier comparison. However, each organization has a different organizational structure, which has historically provided challenges in monitoring clinics within the sub-districts. This M & E tool was designed to reflect both organizations, therefore an additional bonus is the ability to provide a standardized tool to measure

outputs such as absenteeism and staffing levels that are otherwise difficult to monitor across facilities (9).

The ability to utilize the results from these performance indicators strengthens the ability to apply pressure for improvement within the health system. A structured plan for activism/action will be organized by TAC to improve the performance indicators and reward those who meet targets via pressure (an incentive). TAC often uses pickets, marches, public meetings and hearings, door to doors, pamphleteering, dissemination of materials, radio slots, add up articles, media campaigns, and sit-ins as methods for action. In addition, indicators will be posted on walls, discussed with community leaders regularly, and presented to the clinic boards. The Cape Metro Health District is in the process of implementing community health boards, and the PTLAs are expected to assist with this implementation. The community boards are actors to involve in this intervention, as they complement the role of advocating for improved service delivery.

Qualitative Component

In action research, a focus on the process, as well as the outcomes of change, helps to explain the frequent use of qualitative methods by action researchers (11). Qualitative health research can help understand health systems complexities: the behaviours of actors, and the perceptions and culture of the people related to health systems (18). Moreover, qualitative research identifies facilitators and barriers to the implementation of programmes, and its results add to the comprehension of social, political and economic factors associated with contemporary and emerging health problems (33). This study aims to take in account this 'systems' thinking, in order to assess the functioning and potential influence of the HSS monitoring tool providing accountability within the health system.

Policy is not simply about description or prescription and nor does it develop in a social vacuum; it is the outcome of complex social, political and economic interactions (20). This HSS policy implementation is situated within a context which provides a rich environment to deepen understanding. Gilson &

Raphaely (19) identify that politics, process and power must be integrated into the study of health policies and the practice of health system development. Therefore, a local stakeholder analysis will be undertaken to take account of actors' interests and beliefs throughout the implementation process. A stakeholder analysis is an approach for generating knowledge about actors, individuals or organizations. It is a tool used to understand actor behaviour, intentions, inter-relations and interests; and for assessing the influences and resources they bring to bear on implementation processes (34). Therefore, this study will also involve the use of qualitative methods, such as semi-structured interviews to determine actor influence. Key policy actors from TAC, MSF, CoCT and DOH will be interviewed for the purpose of providing depth, richness, and diversity in perspectives related to their views on the implementation of the HSS tool.

Data Collection

Quantitative component

Recruited clinics will be PHC facilities within Khayelitsha that are staffed with a PTLA. Mcnamara (10), describes the process of public report card reporting (HSS monitoring tool) to work best with a mandatory participation requirement, otherwise low scoring providers can opt out. PTLAs are currently working in nine facilities out of eleven total facilities within Khayelitsha, and therefore all nine will be included. The two facilities that do not have a PTLA will be excluded. These facilities do not have PTLAs assigned due to a shortage of PTLAs, and are also the two smallest clinics within Khayelitsha. It is important to consider that PTLAs could quit and move to other jobs during this study and therefore data may not be collected on all 9 clinics throughout the planned four months of initial data collection.

Education sessions were held to train the PTLAS on the adapted form, the importance of M & E, and how to collect good quality data. TAC staff took the lead on these training sessions, but the principal investigator was also present to observe the process. One M & E form is to be filled out daily (See

Appendix E) and a separate form with different indicators will be completed every week (See Appendix F).

Forms are completed at alternating times of the day, in order to reflect a larger picture of service delivery. For data verification purposes, spot checks by the PTLA supervisor of the PTLAs completing the tool in their respective facilities will be done in order to verify accuracy. The forms are collected from the PTLAs every Friday and then entered onto a spreadsheet by a TAC intern. Data will be compiled by the TAC PTLA supervisor and the primary researcher, supervised by J Ashmore. For TAC the use of this form is indefinitely, however for the purpose of time for this specific project, data collection of the HSS monitoring tool will take place during a six month period, with results communicated monthly to key stakeholders.

The data is collected by PTLAs through observation, inventory records and interviews with patients at the clinics. Some of the questions require the PTLAs to inquire from health care workers, facility managers and patients within their health facility, in order to fill out all the necessary fields. McNamara (10) reported on a review of a small convenience sample of four facility surveys, and although the sample size was small, findings suggested facility surveys were particularly adept at capturing data on technical structure and interpersonal structure. Improvements in performance of facilities are currently being tracked by TAC/MSF for the HSS pilot project. For the purposes of this research, the analysis of results will be over a six month period, in order to evaluate the implementation process. Facilities will be tracked according to their performance, by a simple ranking of facilities based on aggregated scores. Utilizing a ranking method will allow for the identification of strongest and weakest facilities. It is also important to note that for this study, only a preliminary evaluation of indicators will be undertaken. Data will be undergo regular cleaning and simple analysis in Microsoft Excel.

Results will be posted outside of clinics, and the PTLAs help to motivate clinics to work towards meeting goals/targets set out by the facility managers. McNamara (10) refers to this style of reporting as 'public

reporting’ as this facilitates the citizenry use of ‘voice’ - public dialogue with and a challenge to leadership. A belief is that the publication of performance ratings triggers quality improvement in part because providers want to be viewed favourably by their peers. If successful, this type of reporting empowers civil society to explain why one provider has achieved better performance than the other (ibid), and therefore within the context of Khayelitsha sub-district, public reporting could stimulate the same dialogue.

Qualitative component

Recruitment for qualitative interviews will be done purposefully, in that targeted individuals will be key policy actors in the implementation process and have insight to offer in terms of the functioning and potential influence of the HSS tool as an external accountability mechanism. Sampling for this study used purposeful sampling techniques, where qualitative research seeks information-rich cases that can provide in-depth information about the subject of interest (35). Purposive sampling also allows for the selection of research participants according to pre-determined criteria while facilitating responsiveness to the research process (35). An action research approach will also allow the opportunity for the researcher to meet and build contacts with key actors in the field, and therefore snowball sampling will also be a technique used.

Policy actors may be individuals, organizations, networks, but it is also recognized that policy actors are not only those that formulate policy; but also those who make decisions through their practices; and those with concern for particular policy issues or likely to be affected by policy developments (19).

Gilson & Raphaely (19) discuss how actors’ attitudes, strategies and knowledge are socially constructed and influence both their behaviour and policy implementation. Flexibility in the field will allow for identification of these key informants as the research proceeds, however, likely candidates include PTLAs, facility managers, and representatives from TAC, MSF, CoCT and WGC within the Khayelitsha sub-

district. It is estimated that between 15-20 interviews will be conducted. Key informants will be approached using email (see Appendix C) and follow up phone calls to book a time for the interview. Semi-structured Interviews were selected as a method of data collection. Interviews are planned for the month of December, since at this point the tool will have been in place for six months, allowing for the opportunity to discuss the policy implementation process. Interviews will be conducted where it is most convenient and comfortable for the respondent. The primary researcher will be conducting all of the interviews, and will wear professional clothing as well as a UCT ID badge that identifies the researcher. Following the action research approach, the researcher will have been in the field and developing relationships, which may allow respondents to feel more comfortable in expressing their views during the interview process. Respondents will also be assured that their names and identifying characteristics will not be identified, for example a 'facility manager with primary health facility X' would be reported. A semi-structured interview guide (see Appendix B) will be used to explore the past experience of and current stakeholder opinions of the implementation of the HSS monitoring tool. Questions for the interviews have been adapted from Schmeer's (36) stakeholder analysis toolkit. Exploratory questions will relate to eight themes:

- 1) The nature, purpose, and expectations of the tool (policy) as perceived by the stakeholder;
- 2) Stakeholder's experiences with implementation of the tool;
- 3) Recommended changes to be made to the tool;
- 4) Position, interest, alliances and resources of the stakeholder;
- 5) Other potential 'opposers' or 'supporters' of the tool;
- 7) Thoughts about scale-up;
- 8) Any other issues to be aware of

It is expected that each interview will be 30-45 mins in length, being mindful that respondents are likely to be very busy people. Consent (see Appendix A) will be obtained prior to beginning the interview.

Each interview will be audio-taped with participants' consent. If a participant refuses to be audio-taped, notes will be taken by the interviewer. Data collection for the qualitative interviews is planned over two months to ensure response from the selected individuals. No further interviews will be taken once saturation point is reached and no new themes are emerging from the interviews. All interviews will be transcribed by the researcher, and organized using Microsoft One Note, which will be described in more detail in the validity section below.

Throughout the research process the principal investigator will keep field notes of observations related to context, specific activities/behaviours, and physical features of environment in the form of a researcher diary. Meyer (11) explains that in action research the onus is on the researcher to make his or her own values and beliefs explicit in the account of the research so that any biases are evident. This can be facilitated by writing self-reflective field notes during the research. Therefore this diary will allow for reflexivity, describe context and systematically monitor and reflect on the process and outcomes of implementation.

Data Analysis

Quantitative component

In order to address the research question, the quantitative data analysis will be supplementary to the qualitative exploration of the HSS tool as an accountability mechanism. However, the HSS tool will provide some data that can be analyzed in order to look for improvement in the indicators within the PHC facilities in Khayelitsha and the researcher will support the analysis of this quantitative data. Since PTLAs will be collecting the data, TAC will allow the primary researcher use of the data in order to complete the needed analysis (See Appendix D). A data 'cleaning' process will be employed by the data entry assistants at TAC/MSF - and supported by the PTLA supervisor and primary researcher. Data will need to be double checked for accuracy, and will be inputted via a customized Excel spreadsheet form which can be imported into STATA. The statistical analyses that will need to be performed are relatively

simple, and can be achieved with STATA 10 software. This is because the quantitative component of research is supplementary to the qualitative, or is at least secondary in importance in terms of addressing the research questions.

STATA will be used to look for significant increases across indicators ($p < 0.05$). It could be that some indicators may improve significantly across the board, or certain facilities may improve significantly across the board. Of particular importance to explore is what remedial actions were taken by the PTLAs over the 4 month period and what impacts they had on indicators. This can be assessed by using a graphic timeline analysis, a visual representation of the sequence and durations of recorded events.

Qualitative component

Since this research project is also about exploring the process of the implementation, of interest to unpack would be the complexity of policy environment and interaction of actors within it. The ultimate goal is to better understand what leads to a success in using an external accountability mechanism to improve health system performance. The transcribed data from the semi-structured interviews will be organized using Microsoft and a qualitative thematic analysis will be performed (37). The data will also be triangulated with field notes and participant observation.

Since the use of this tool is still ongoing, the process of implementation will be divided contextually and analytically into 3 temporal sections: before, during, and after implementation. The evaluation of the implementation will not be the analysis of the policy, but rather an analysis to inform policy and potential scale-up of this initiative. In order to analyze the specific factors involved in influencing the functioning of the HSS tool as an external accountability mechanism, the Cleary et al., (23) framework will be used and themes identified according to values, actors and resources.

The stakeholder analysis is suited to understanding power and interest of actors during the implementation process. Therefore analysis would include; stakeholder opinions, political acceptability, existing political and systems constraints, enablers and constrainers for implementation and scale up.

Policy actors will be classified on a spectrum of stakeholder positions and analysis will focus on comparing information and developing conclusions about the stakeholder's relative importance, knowledge, interests, positions and possible allies regarding the policy implementation (36). In order to analyze the overarching policy implementation process, coding will be guided by the Walt & Gilson (20) policy analysis triangle; and data categorized into actors, context, process and content. The purpose of multiple policy analysis and implementation theory in order to direct and guide analysis, deepen understanding, enable explanation and support and support generalization (19). Molyneux et al. (25) advises consideration the inter-related components of the triangle when drawing on the Walt & Gilson policy analysis framework. Therefore analysis of the HSS tool will be conducted as stated below (25).

- Content:
 - What is the design of accountability mechanism and how is it supposed to work?
 - Which aspects of service delivery are expected to be impacted upon and how?
 - What is the depth of community involvement planned at each stage?
- Process:
 - How is the accountability mechanism actually working?
 - How is the accountability mechanism incorporated in practice into the health system hierarchy?
- Context:
 - What are the wider contextual issues - at the health system, national, international and community levels -that might influence the above areas?

Results will feed into looking at how successful this tool was and what parts of the process made it successful or not. Analysis would be concluded with a set of initial lessons, which could be of interest for program scale-up and for individuals and organizations working with or within civil society to assist with HSS. Action research lends itself well to the discovery of solutions, its success should not be judged

solely in terms of the size of change achieved or the immediate implementation of solutions (38). Instead, success can often be viewed in relation to what has been learnt from the experience of undertaking the work (38). Some positive changes may be achieved in the course of this study, but the study may also shed light on continuing areas of weakness in the health systems and issues that needed to be improved in future developments.

Validity issues

In order to build a rigorous study, a number of strategies will be used in order to maximize validity of the qualitative data. Lincoln and Guba (39) present a useful framework for evaluating trustworthiness and reliability of qualitative inquiry. This divides into four criteria of assessment: credibility, transferability, dependability, and confirmability.

Firstly, 'credibility' refers to confidence in the 'truth' of findings. In this study, theory triangulation will be used, and is which is defined as use of relevant theoretical/conceptual material to increase validity (8). The factors influencing accountability mechanisms and the policy analysis triangle framework are examples of theory that will be triangulated in order to gain deeper understanding of research findings and the opportunity to cross check results. The action research approach to this study will allow the researcher more opportunity to engage in the research process, allowing for prolonged engagement with the research, and thereby increasing credibility. For example, the researcher will have interacted many times with the PTLAs before being interviewed. This enables the 'snapshot' of once-off interviews to become more of a process of uncovering how people really feel about a variety of issues, as they reflect more on what they have said, why they have said it, and both interviewer and respondent develop a relationship which clarifies their own position in the research process (38). However, it is noted that a drawback for the primary researcher will be the need to spend more time at the point of interview in order to convince the respondent of confidentiality.

Transferability', meanwhile, can be thought of as generalizability. A technique is to use 'thick description', this can be done during the interview process and asking respondents for as much detail as possible. Recording equipment will be used with permission, and otherwise notes will be taken. The detail noted can be included wherever practical in writing up and coding so as not to lose the context of what was said. The fieldwork diary, to keep a chronological and progress record of the research, as well as observational field notes of the visited sites, will be used to help enrich understanding of the functioning of the project's environment (18). Meyer (38) argues that in action research, experience of innovation should be accessible to both public and professional judgement. In order that the reader can judge the relevance of action research findings to their own situation and therefore increase transferability, the study needs to be reported in rich contextual detail, and written in an accessible language.

'Dependability' relates to minimizing idiosyncrasies in the study, in other words testing how replicable it is. Auditing can be used for this purpose, and the process of 'self-auditing' or 'immersion' in the data may need to happen a number of times before writing up (40). Secondly, the research supervisors can help through being a 'sounding board' for ideas, and by checking coding process to enhance its validity. Finally, 'confirmability' refers to the need for researcher bias to be limited. Caution is needed for reports to be detailed, rigorously accurate and impartial, in order that the experience of innovation is accessible to both public and professional judgement (39). For this purpose the research diary will be an important tool to keep every day. As well as providing a place for notes on interviews themselves, for example how respondents and the interviewer behaved, it will allow an opportunity to explore more general thoughts on bias. This includes sampling bias (i.e. how respondents are chosen) and biases connected to researcher predispositions. The aim will be to limit bias over time, and, just as importantly, to recognize where this did not happen or was not possible. It will also be important to reflect on the process of coding in this way, as the codes one constructs are strongly interpretable (39).

Coding processes are also important to establish validity (40). This will involve identifying forms, and within those forms different factors involved in affecting the functioning and potential influence of accountability mechanisms. Other codes may become relevant, and will be created on an ad-hoc basis. For this purpose Microsoft OneNote will be used, as it allows up to five levels of sub categorization within each file (notebooks, section groups - each with separate sections, pages, and sub-pages); customized conceptual tagging of important paragraphs; easy searchability including searching of specific tags and within specific locations; quick hyper-linking between ideas; and insertion of files such as transcripts. OneNote was also used for the literature review, and it is therefore already familiar to the researcher. It has the added bonus of allowing a diary, Excel data, reports and so forth to be kept in the same place, linking between each with hyperlinks.

4. Research Planning

The time frame is presented below.

Activity	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Intros with potential key informants (facility managers, PTLAs, TAC/MSF, etc..)	X							
Write: 'Part A-Protocol'	X							
Ethics (HREC, WGC, CoCT)		X						
Finish writing: 'Part B: Literature Review'	X	X						
Data Collection	X	X	X	X	X	X		

• HSS tool								
Data collection • Semi-structured interviews					X	X		
Data Analysis			X	X	X	X	X	
Write: 'Part C-Journal Ready Article'						X	X	X
Edits					X	X	X	X
Submission								X
TAC/MSF Presentations								X
Publication								X

Budget:

Part of Research	Item	Cost	Comment
HSS Tool	Printing for tool	-----	Funded by MSF/TAC
HSS Tool	Data capturer	-----	Funded by MSF/TAC
Policy actor Interviews	Digital Sony dictaphone	R 2, 015	
Policy actor Interviews	Notepads, paper and stationery	R 1000	
	Total :	R 3, 1015	

5. Ethical Considerations

The research team has a commitment towards establishing horizontal relationships with shared authority and ownership of the data, in addition to engaging participants and researchers. The supervisors for this project include J. Ashmore, current MSF Deputy Head of Mission for South Africa and Lesotho, and L Gilson, Professor at UCT with extensive experience as an HPSR researcher. The principal investigator is a Canadian with a nursing background with experience working within public PHCs in South Africa and Zambia. Research approval from the Provincial government will be applied for concurrently and is pending HREC approval.

The Human Research Ethics Committee (HREC) at the University of Cape Town (UCT) deems studies as minimal risk when the probability and magnitude of harm or discomfort anticipated in this project are not greater than the harms or discomfort ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests (41). With reference to the aforementioned statement by the HREC, there is minimal risk to the participants in this research project. The research will adhere to the principles found in UCT's Statement of Values (41), the MRC (SA) guidelines on Good Clinical Practice, the 2008 Helsinki Declaration, and UCT's Code for Research Involving Human Subjects. (<http://web.uct.ac.za/depts/educate/download/uctcodeforresearchinvolvinghumansubjects.pdf>). There are some ethical issues to consider in the study that arise from these documents which will now be discussed.

Since this study is using an action research approach, this form of inquiry must also be considered from an ethical standpoint. The primary researcher has been working alongside the development team at TAC and MSF during the creation and implementation of the HSS monitoring tool. This has been through observation, but also actively assisting with some of the development and implementation processes. The advantage is that it has already allowed the primary researcher a sense of how the intervention has developed, and this understanding has potential to expand during the study period. It has also offered

the opportunity to begin building trust with the team involved, which could improve access to respondents and the potential of them feeling more comfortable opening up. However, it is important to consider that the action researcher needs to be aware of participant's values, beliefs and power relations and sensitively work between differing agendas (11). Since this is a research action approach, an ethical code of practice must be considered and negotiated between action researcher and the participants. For example, Meyer (11) explains that change can be threatening, and participants who begin by collaborating, may later change their desire to do so. Therefore, the action researcher, must be mindful of the constantly changing dynamics throughout the research process.

Possible benefit to participants

This new M & E form was adapted by MSF and TAC colleagues working within Khayelitsha in consultation with others TAC at the TAC Western Cape branch. The supervisor of the PTLAs and TAC's Director in Khayelitsha, are both committed to this project (See Appendix D). Facility managers and staff within the PHC facilities in Khayelitsha are already aware of the PTLAs working in their respective clinics. TAC has a renewed focus to improve access to and uptake of prevention and treatment services and this project increases effectiveness of their activities. Added value of this research project is the potential to replicate this HSS pilot project at TAC sites across South Africa. PTLA programming has been cut recently at other TAC sites across the country; therefore this research could help to build stronger case for keeping the PTLA positions at PHC facilities. There is a long-standing partnership between TAC and MSF, and this project may further strengthen that relationship.

Possible risks to participants

There are no invasive procedures to be performed in this study. Consent will not be sought from health care workers or patients within the designated clinic because the PTLAs have already been working within these facilities, and have established relationships with their community. There is a chance that the PTLAs will be negatively seen as 'watchdogs' within their facilities, however, the HSS tool is a

continuation of current practices and not something new that this particular study is introducing. The PTLA supervisor, TAC and MSF do have a working relationship with these facilities and both WCG and CoCT have allowed the PTLAs to work as TAC members monitoring their clinics. PTLAs are employed through TAC, and therefore their performance in utilising this tool is part of their job description. Increased TAC strengthening could threaten PHC facilities and they could limit or deny access to data and/or facilities. Because this is a pilot project that is only specific to the Khayelitsha branch of TAC, other TAC branches could see this as favouritism and there could be a risk of alienating other branches. The principal investigator will be mindful of these concerns and bring awareness of any issues to both TAC, MSF, and supervisors should it be communicated or seen that this project is presenting issues related to clinic access or TAC branch alienation. Clear communication practices will be key.

In regards to the qualitative interviews, researching within Khayelitsha sub-district means taking up time of those key stakeholders that would be otherwise dedicated to work. This will be kept to a minimum by being as prepared as possible for interviews, and only interviewing policy actors whose responses will be useful. Using key stakeholders' time at all is justified because the research will help in formulating future policy that involves civil society in the health system. There should be no other possible harm done through the research proposed.

Possible benefits to the community:

The results from this study will provide help to provide a clearer picture of the human resource and health service delivery issues that are facing the PHC clinics within Khayelitsha. The community would benefit from increased service delivery and improvement in quality of care, as ideally this could begin to create health care facilities that listen to the needs of the community and tailor their services specific to their needs. This study could also help to inform future health policy that allows for civil society to play an ever increasing role in HSS.

Informed consent process

During the semi structured interview of policy actors, consent will be explained by the primary researcher following a script (See Appendix A). The interviews are aimed at key actors involved in the implementation of the tool. Since these actors are typically professionals working within the health system, the likelihood is that most will speak English and therefore interviews will be conducted in English. Should a participant wish to do the interview in Xhosa or Afrikaans then a translator will be provided, if required. Signed consent will be obtained prior to beginning the interview. The interview will only go ahead as long as the participant is fully informed. It will be stressed that participants can ask questions or leave the interview at any time. Consent may need to be reviewed if, for some reason, a participant would need to leave during the interview and then the interview would be completed on a different day. Consent would then be obtained again, in the same process as it was collected before, as detailed above. Participants may fear being taped, and if the participant refuses to be taped then they will have the option for the interviewer to record notes instead.

Privacy and confidentiality

The results from the HSS monitoring will not be kept confidential, as the purpose of the quantitative portion of the study is to highlight areas of the health system that need improvement. This follows the same practice the PTLAs have been doing historically in their respective clinics within Khayelitsha. The purpose of calling attention to the outcomes of these indicators is to provide incentive for facilities to improve or positively recognize a facility for performing well.

Transcription data from the semi-structured interviews will be transcribed by the primary researcher only, to preserve anonymity and confidentiality of the participant. All participants will be coded with a number, and their names will not be used during the research study. This will allow for protection of their identity and personal information during and after the research study. All files will be transferred

to a computer and then downloaded to an external drive. All computer files will be password protected and encrypted, and stored on a password protected computer. The computer will be kept in a secure locked location when not being used, and the researchers will be the only people with access to this computer. All researcher notes will also be kept in a locked filing cabinet. Only the principal investigator will have the computer that contains all collected data, and will be the only ones with the password to gain access to this data. All interview participants will be coded with a number, and their names will not be used during the research study. This will allow for protection of their identity and personal information during and after the research study. Data will be kept for five years within the Department of Public Health at UCT. After five years, audio tapes will be demagnetized and all remaining paper copies with data will be shredded.

Reimbursement for participation

There is no reimbursement offered for participating in this study.

What happens at the end of this study?

Plans for dissemination include presentations made to MSF's senior management and TAC's National Council as well as representatives of study findings. A report will be produced and be made available at each PHC facility within Khayelitsha. A more formal report will also be prepared and distributed to MSF, TAC, CoCT and DOH. Further efforts will be made to distribute this report to Provincial and National health divisions in the South African government, in order to communicate findings to senior health officials and policy makers such as at the South African National AIDS Council (SANAC). Abstracts will also be submitted for conferences such as the International AIDS Society (IAS) in order to disseminate findings in an international setting. A publication will also be pursued.

TAC is a CSO with a mandate that was historically focused on advocating for the right to treatment, they are now looking towards a new direction aimed by adding a HSS component to their advocacy work. The

project could inform and support other TAC sites to implement a similar project, and also stimulate further research in other districts/provinces within South Africa and other LMICs.

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Part B: Structured Literature Review

Title: International and South African experience of community accountability for health systems strengthening

1. Introduction

This literature review provides background to the article that follows. The research centers on the Civil Society Organization (CSO), Treatment Action Campaign (TAC,) and a recently added Health Systems Strengthening (HSS) component to their role within Primary Health Facilities (PHC) facilities in Khayelitsha, South Africa. The aim of this study is to evaluate the implementation of the HSS intervention by: 1) assessing the functioning and potential impact of the new HSS monitoring tool as an external accountability mechanism, and 2) gathering feedback from actors related to implementation. In addition, the purpose is to also look at the broader policy implementation context within which this HSS tool is situated.

In this literature review, the topic of community accountability will be explored using the lens of participatory governance for health systems strengthening. In order to build context, the South African experience of community accountability will first be discussed. Accountability mechanisms are governance tools that will be considered, specifically external accountability mechanisms, as they reflect a community orientation relevant to this study. The HSS tool implemented by TAC is most similar to provider report cards, and therefore this type of accountability mechanism is discussed in greater detail. Civil society is emphasized in this literature review, as actors implementing the intervention in the study, but also because they are linked to the understanding community accountability mechanisms. Expanded in the review of the literature is the potential role that civil society can play in the implementation of provider report cards. Also considered are the complexities of development and implementation of provider report cards, in order to promote accountability.

2. Methodological approach

Initially, a scoping literature search was conducted using PubMed and Google Scholar for relevant articles. In total, 174 documents (journal articles, reports and meeting minutes and conference papers) were reviewed. Webster & Watson (1) identify that a high-quality review is complete and focuses on concepts. Therefore, various combinations of search terms were used, and the documents can be clustered into three groups.

- Systems oriented terminology (to frame the health systems lens): health systems, health systems strengthening, people-centered health system, health policy, health policy implementation, and policy analysis.
- Civil society (as actors implementing the tool): civil society, civil society organization, and TAC.
- Participatory health governance (related to tool): community participation, community engagement, community accountability, accountability, external accountability mechanism

To accumulate a relatively complete census of relevant literature, a ‘backward’ and ‘forward’ approach as recommended by Webster & Watson (1) was performed, reviewing citations listed by leading journals (*such as Health Policy and Planning*). This approach yielded many articles, so the search was further refined to articles from only South African and Low and Middle Income (LMIC) settings. This was also to provide literature that was more appropriate to the study setting. Additional search terms included:

South Africa, LMIC, public health, district health, sub-district, primary health care, and local level.

Subsequently, a more in depth search was performed on community accountability mechanisms, to gain a deeper understanding of the various mechanisms used in LMIC settings. When the search was limited to provider report cards, only four studies were found to be specifically related to this type of community accountability mechanism (2)-(5). Therefore the search was opened to include studies that included other community accountability mechanisms (clinic committees, patient rights’ charters, and

patient complaint procedures) and accountability mechanism reviews. The lack of studies on provider report cards in LMIC settings signifies that there is a lack of attention given to this area of provider accountability mechanisms, and therefore further academic research is warranted in this area. Broader Google and Google Scholar searches were then conducted to identify additional grey literature, including CSO related websites, such as for TAC. Reports, meeting minutes, and conference presentations from TAC added to the grey literature found. The information resulting from the grey literature was helpful to follow events related to contextual issues to further inform the implementation process, such as service delivery protests organized by TAC.

3. Summary and Interpretation of Literature

Health system strengthening

Systems thinking is a way of thinking that appreciates the dynamic and constantly changing nature of complex systems (5), and is an approach that will be used in this literature review. It is relevant because Health Systems Strengthening (HSS) refers to a range of activities and initiatives designed to improve the underlying health system or manage interactions between components of the system in ways that help ensure more equitable and sustainable health services and health outcomes (6).

Community participation

The Alma Ata Declaration of 1978 highlighted the importance of community participation; the Declaration itself stating that essential health care must be made ‘accessible to individuals and families in the community through their full participation’ (6:2). Marston et al. (7) view community participation as a way to distribute power more evenly between the health system actors, while also developing individuals’ and groups’ own abilities to participate in the process of change. The notion of community participation acknowledges these social processes and is a way to empower actors.

Rifkin (8) views community participation as a process itself, one that facilitates an intervention rather than a reductionist view of only investigating the link between participation and outcomes. In a review of World Bank supported health sector reforms in Asia, Murthy & Klugman (9) recommended that community participation and service accountability required more investment of resources, after discovering community participation was often limited to non- participatory processes of programme management and service delivery. They argued for increasing quotas for participation of marginalized groups, enhancing the power of civil society representatives and investment in capacity building (ibid). Therefore this 'community development' approach, sees participation as a longer-term process, where communities 'are actively involved in deciding on and implementing strategies to alter the socio-political, economic, and psychological conditions that shape their health' (7:2). The idea of community participation as an empowerment process is a notion recognized during the HSS tool development and implementation in the subsequent article.

Participatory health governance

Governance/ Leadership is one of the six key building blocks within the health system, and recognized as important component to strengthen health system performance (10). In order to achieve health system strengthening through increased governance, active engagement with all actors is required.

Mechanisms of participatory governance range from local health committees to the national level, where people come together to inform decision making and to hold health systems accountable (11).

The focus of this proposal is directed at community level governance. Sheikh et al. (12) argue for the establishment of people centred governance processes, as it leads to confronting existing power balances within health systems including the (often disproportionate) power held by clinicians, more wealthy groups and commercial interests. By understanding how the diverse elements within the system interact, innovative models/ways can be applied to address these power imbalances. The

promotion of community accountability in order to protect the public interest in health, is an important concept within participatory health governance which will be explored in the following section.

Accountability

Accountability is described using many definitions in the literature. In the range of possible definitions of accountability, answerability is the fundamental theme. In particular, answerability within the health system, 'between sets of actors in relation to specific activities or interventions (11: 542). In the definition of accountability, Schedler (13) argues that although answerability speaks to the dialogue between sets of actors, enforceability plays an equally important role. The concept of enforceability essentially involves rewarding for positive behaviour and punishing for negative behaviour and the capacity of actors to impose sanctions on power holders who have violated their public duties (13). Therefore accountability is recognized as a multifaceted concept, with dual concepts of enforceability and answerability playing equally important roles.

Community Accountability

'Public accountability' concerns a spectrum of approaches, mechanisms and practices concerned with public services to ensure a desired level and type of performance (4). 'Community accountability' is one approach to strengthening public accountability, and most appropriate to this study, as it involves directly involving users or the general public in health delivery (11). Molyneux et al. (11) argues that community accountability moves beyond community participation, requiring the health system to be responsive to the ideas or concerns raised by or with community members. With an increased emphasis on community accountability, the appropriateness of health service delivery for users, quality of care and ultimately patient satisfaction and utilization can be enhanced (10).

The role of civil society in community accountability

Civil Society has a role to play in strengthening community accountability. Mcnamara (14) describes a lack of accountability within the health system, particularly in under-funded systems and LMIC settings,

where the need to ensure coverage and access takes priority and the discussion of the monitoring and improving of quality of care is often overlooked. Maartens & Goemaere (15) relate the ongoing issue of drug stock-outs in the South African public health services as a sign of a general lack of accountability within the system; further supporting the need for independent civil society groups to monitor service delivery and where necessary, exert pressure on the health services to deliver their mandate. Ahmad (2) argues some of the best models to implement concepts of community accountability have been at local level; where a key feature has been increased reliance on CSOs, signalling the value of reaching down to local levels of innovation.

Although the value of CSO involvement in community accountability has been demonstrated, it is equally important to consider the negative potential or risk of civil society in attempting to hold the state and/or health providers accountable. The political roles or polemic approaches used by civil society may generate tension with governments and often CSOs have varying levels of accountability to the communities they speak for, thus weakening the position of CSOs in multiple platforms. Some CSOs may be a hidden channel for corporate interests and potential conflicts of interest that are contrary to public good. In addition, the cross cutting and multiple role CSOs play in the health system can lead to a great diversity in views and numbers, which can be difficult to manage (16). It is also important to consider the risk for CSOs when involved in accountability processes related to health. The dependence on the state for access or resources may compromise the accountability or autonomy of CSOs, and make CSOs reluctant to criticize health care providers. Government links may also distort CSO voices and lead to representation by a few, such as CSOs with more affluent interests (16). The possible risk of tensions between CSOs and health care providers/state are important to note, however, the benefits of collaboration have also been argued.

South African experience

Historically in South Africa, CS has played a key role within the health system, including advocating for equitable and quality health care services. The well-documented 'era of denialism' under President President Thabo Mbeki and his Health Minister Dr Manto Tshabalala-Msimang, revealed complexities of the South African government's response to HIV (15), (17). This lack of response to the rising AIDS epidemic catalyzed the formation of the Treatment Action Campaign in 1998. TAC recognized HIV was a symptom of a deeper social and political crisis, and aimed to demonstrate successful campaigns for better health and socio-economic rights (18). The battle to obtain access to quality generic anti-retrovirals (ARVs) was waged jointly with the TAC and other civil society actors and became a symbol internationally in the fight for access to affordable ARVs in resource-constrained settings (20). Coutinho et al. (21) describe CSOs as part of the fabric of a country's health system, as they can not only serve as indigenous resources for capacity building, but also play a critical role in helping to ensure continuity of care from health facilities to the community. Civil society has been a consistent advocate in the right to health in the South African HIV movement. CSOs, such as TAC, have maintained oversight of the health systems (22).

Cullinan (23) describe a project called Our Health, which utilized civil society and the media to report health conditions at a district citizen level. This project is a recent example of the potential for civil society to monitor government service delivery within a South African setting. In response to a need for increasing access to and participation in health care by adolescents, the Reducing Child and Mortality (24) programme, implemented community based monitoring of health services. This initiative brought together teams of community members to monitor quality indicators at clinics or community health centres. In addition, feedback was provided to staff and the community, for the purpose of collaboration to jointly find solutions to identified challenges. Both interventions are successful examples of

community accountability interventions specific to a South African setting, and support the implementation of future initiatives.

Accountability Mechanisms

Cleary et al. (25:2) identify accountability mechanisms as ‘governance tools which seek to regulate answerability between the health system and/or citizens and between different levels of the health system’. These mechanisms introduced to strengthen community accountability can be distinguished by a horizontal or vertical orientation within the health system. Two types of accountability mechanisms identified by in the literature include; external (vertical) accountability mechanisms which are ‘used by non-state actors to hold public sector power holders to account’ and internal-bureaucratic (horizontal) mechanisms that are ‘comprised of the institutional oversights, checks and balances internal to the public sector’ (25: 2). The articles found in the next section will focus on the factors and functioning of external accountability mechanisms, as they are more appropriate to the community focus taken.

Ahmad (2) found that a greater focus on external accountability such as transparency mechanisms, monitoring tools, and participatory voice interventions can lead to improved governance. External accountability processes are relevant to this research as this particular type of mechanism has a direct link to citizen responsiveness; requiring providers to be responsive to citizen input, including through taking action to alter services in response to ideas or concerns raised by citizens (25). External accountability mechanisms identified in the literature include a range of interventions to increase citizen voice including; the use of patient complaints procedures, clinic committees, provider report cards and patients’ rights charters (9), (25). These interventions will be discussed below.

Clinic committees

Often found to be the focus of empirical articles related to community accountability mechanisms, the clinic committee is a structure implemented within a health facility as a strategy to strengthen the health system through accountability (11), (26). Individuals involved in this type of accountability

mechanism are health worker representatives, members of the community and appointed key figures.

Clinic committees play a key role in promoting active participation in decision making and increasing and consultation with communities relating to health facilities (11).

However, the implementation of clinic committees can prove challenging. In South Africa, the health system is constrained by factors such as; inadequate human resource capacity and planning, poor stewardship, leadership, and management (26). A lack of stewardship is particularly relevant for civil society to consider, as this has often resulted in a failure to ensure that community involvement is in place. In the case in South Africa, clinic committees and hospital boards are often under-resourced and dysfunctional with insufficient local political accountability; communities have been challenged in their ability to change the quality of health care (26). Molyneux et al. (11) found multiple factors impacting the functioning of clinic committees such as; how committee and group members were selected and their motivation for involvement; the relationship between groups or committees, health workers and health managers; and the provision of adequate resources and support by local and national governments.

Patients' rights charters

This type of external accountability mechanism involves providing information on standards of care that patients can expect to receive and demand as a basic human right (27). The need for a strong civil society presence in South Africa is driven by the constitution which 'binds the state to work towards the progressive realisation of the right to health' (18: 824). The concept of a Patients' rights charter utilizes the constitution as its cornerstone and attempts to empower the patient to demand health as a human right. In South Africa, London et al. (28) found that patients' rights charters were often found in facilities, and various actors were positive about the charter and its ability to motivate staff. However, implementation also presented concerns, and the charter was often seen as a threat by health care

workers. These negative sentiments and dynamics increased stress and strain on relations between actors rather than improving them.

Provider Report Cards

A provider report card is another external accountability mechanism, and evaluates different service providers from a user perspective, on a routine basis, according to certain standards of quality performance (2), (14). The HSS monitoring tool implemented in this particular study is most similar to the 'provider report card' or 'citizen report card', and therefore will be explored in more detail within this literature review. The appeal of provider report cards (and potentially the HSS monitoring tool) rests in their ability to promote accountability thereby making service providers more accountable to the citizens, by influencing provider behaviour, service user behaviour or both (ibid). Paul (4) viewed the provider report card as an important tool to stimulate change, first, by compensating for weak government self-monitoring by providing information to providers in order to orient the system towards citizen preferences. Secondly, by introducing pressure to improve performance; including poorly performing providers and competitive pressures between providers.

Provider report cards can also act as internal accountability mechanisms, as demonstrated in Afghanistan, where The Ministry of Public Health implemented a balanced scorecard to regularly monitor the progress of its strategy to deliver a basic package of health services (29). The tool was found to be useful in its ability to summarize the multidimensional nature of health service performance and enables an objectives based approach to management of health services in the Afghan context (30). The experience in Afghanistan highlights the potential for provider report cards to play a dual role, as both internal and external accountability mechanisms. However, since the focus of this study incorporates civil society as 'non state actors' implementing the HSS tool, discussions in the literature review will center on provider report cards acting as external accountability mechanisms.

International experience

Provider report cards have been applied in a variety of settings around the world. In a review of provider report cards, Mcnamara (14) found examples from LMIC settings were primarily implemented in primary health facilities and often developed and supported by CSOs. The information gleaned from report cards offers civil society a foundation to pressure for improved services and obliges government to open themselves up to the voice of the community (4). Kingdom and Jagannathan (31) found this type of 'public reporting' to have the ability to empower civil society and bring further attention to the question of why one provider has achieved considerably better performance than another. By stimulating the organization and mobilization of society, report cards can play an important role in complementing other initiatives which have strong human rights content.

The use of provider report cards is rising (3). One of the earliest and most notable projects within an LMIC setting was the Bangalore score card -initiated in 1994 in Bangalore, India. The report card was repeated on three separate occasions; while overall satisfaction levels had ranged between 5% and 25% in 1994, and between 16% and 67% in 1999, by 2003 they had skyrocketed to between 64% and 96% (4). Although not all can be linked directly to the implementation of the report card, Ackerman (3) attributed some improvement of the satisfaction scores noted between the three report cards to this intervention. This tool was also successful in increasing public awareness and generating a new confidence among citizens that collective action was feasible (32). In Bangalore, CSOs played an important role, and facilitated increased demand for better performance (2),(32). Although the score card was not initially created to exclusively to target health sector performance, it has since been applied successfully to health care in Bangalore (2),(14). Report cards have also been replicated in the Philippines and results showed a lack of alignment between citizen and government priorities in health service delivery, which prompted the state to increase citizen consultation. In addition, the implementation experience demonstrated the tool's ability to empower citizens to provide feedback on public services, even in

those that had not belonged to a formalized CSO (2). Within the Sub-Saharan African context, Bjorkman and Svensson (33) implemented a randomized field experiment on community based monitoring of public health providers in Uganda, including the use of report cards. They noted a year after the intervention was in place, treatment communities were more involved in monitoring the provider, and health workers appeared to exert higher effort to serve the community, in addition to large increases in utilization and improved health outcomes. The Yellow Star Program, also implemented in Uganda, evaluated health facilities on a quarterly basis using 35 indicators, and involved collaboration with the Ministry of Health and other donor organizations (14). Public disclosure was an additional element to this programme, as ratings were made available to the general community, and clinics given a 'star' for demonstrating positive performance in two consecutive quarters. The star was posted prominently outside each recognized facility for the community to see, and preliminary data demonstrated the average score climbed from 47% for the first quarter to 65% for the second, suggesting success of this report card intervention (5).

Local experience

In the South African context, Making All Voices Count is a development programme that funds multiple community accountability projects. One in particular was the Community Monitoring and Advocacy project initiated in 2010 by the Black Sash, a local CSO. The project involved clinic monitors utilizing a questionnaire to interview patients and providers at service delivery sites. The data was collected and compiled by the Black Sash, presented to stakeholders for input, and disseminated to community organizations for use in motivating active citizenship and government accountability at service delivery sites (34). In an independent evaluation report, the Community Agency for Social Enquiry found outcomes of the project included; improved awareness of rights and active citizenship, improvement in service delivery and strengthened stakeholder relationships (35). The results are indicative of the potential for the promotion of active citizen engagement in accountability processes within South Africa.

Limitations

In Ackerman's (3) review of human rights and social accountability approaches, provider report cards were found to be highly effective at improving government accountability and performance. However, also noted was their inability to put patients directly in charge of their own development, as often they are designed by NGOs or applied by market research firms. They also do not automatically give any new government information to citizens in how public services are run (3).

Key considerations for implementation

It is important to consider the challenges that have been associated with provider report cards when designing, implementing and utilizing this specific tool. Interventions, such as provider report cards, that seek to influence change are generally complex and dynamic; often evolving in response to local circumstances, actor engagement and other events beyond the control of the implementers, which can adversely affect the impact of the intervention (36). It is noted how the wider social, political and cultural environment affects community and health system issues, and therefore context has an important influence that must be accounted for (11). Another piece to consider is the interaction of provider report cards with internal-bureaucratic accountability mechanisms. Cleary et al. (25) found that bureaucratic accountability mechanisms have a tendency to crowd out external accountability mechanisms, and therefore recommend particular care to ensure that bureaucratic mechanisms are complementary to health system goals of responsiveness.

Factors influencing functioning

In their review, Cleary et al. (25) identified three sets of factors influencing the functioning of accountability mechanisms: resources (time, space and capacity), attitudes and perceptions of actors, and the values, beliefs and culture of the system. There is overlap between the three elements; as 'values of the system are reflected in resource flows; resources and capacity impact on attitudes and perceptions; and attitudes and perceptions impact on the use of capacity and contribute to enforcing or

changing values' (25:8). These factors will now be explored in relation to provider report cards.

Values, beliefs and culture of the system

Related to provider report cards, a bottom up approach must be considered from the beginning of the process. Paul (4) identifies participation as a key underlying value; “though a report card on public services can be conducted as a technical exercise, the dissemination and advocacy work to follow will benefit a great deal if concerned civil society institutions are involved in the process from the start” (4:22). A health system oriented towards valuing community input is important, as Molyneux et al. (11) found conflicting views on when and how to involve communities often lead to a limited depth of accountability. Also highlighted was the importance of alignment in participatory values between the health system and local communities. Cleary et al. (25) argue that bureaucratic health systems must be willing to relinquish power to citizen groups. An active civil society that is willing and able to use the information provided in the report card to pressure the government for reform is key, however, most important are public officials who are willing and able to use the information to implement changes in service provision (3). Ahmad (2) reflects this same notion and argues one of the greatest risk to provider report cards is the absence of an enabling environment—policy, legal and regulatory frameworks, an accommodating political environment, and accessible government.

Attitudes and perceptions

Building trustful relationships in these contexts is an important consideration for the implementation of provider report cards. Cleary et al. (25) found in some instances where relationships were poor, community members reported feeling concerned about raising complaints in regards to facilities or providers. In addition, a mis-alignment in expectations of the local community may exacerbate disharmony in citizen-provider relations particularly where government capacity of delivery is weak (2). In some instances, providers may want to implement changes in response to feedback from report cards, however, may have low operational autonomy or be as restricted by government rules, which can

limit providers' ability to respond to shortcomings (2). Cleary et al. (25) found resistance to citizen involvement was often related to the perception that community members were seen as 'watchdogs', and exercising control and power without offering support. Related to this concern, is that providers will focus exclusively on indicators that are being measured and ignore other aspects of service delivery (27). In the Uganda DISH programme, Mcnamara (14) reflected that providers had a tendency to focus on the measures rather than other aspects of care during implementation. In order to address such issues, Bjorkman and Svensson (33) found that it is important to agree and coordinate expectations of what is reasonable to demand from the provider, given the limitations in each context where report cards are implemented.

Resources and capacities

The information system capacity plays an important role in the success of provider report cards. A lack of timely and routine data collection and information systems and CSO capacity to monitor indicators on the provider report card prove to be a challenge (37). In addition, efforts to develop and maintain the information systems can be costly, particularly in under-resourced settings (14). The functional capacity of the CSO implementing the provider report card is also a consideration. Ahmad (2) noted that internal governance and accountability weaknesses of CSOs may lead to the undermining of civic engagement. Also observing that better organized CSOs had the ability to take advantage of provider report cards in comparison to other grassroots groups. In addition, technical expertise is required in the design, implementation and analysis of the report card, and this capacity may not be present within a CSO. Such information and resource asymmetries between health staff and community representatives can also lead to concerns about whether citizen groups have the capacity to hold providers to account (25). In addressing resource and capacity concerns, clarity in rights, roles and responsibilities of all actors involved allows for an increased ability to engage with health providers and potential success in implementation of provider report cards (11).

4. Identification of gaps or needs for further research

Drawing on elements of community participation and governance, this study will examine the ‘bottom up’ development and implementation of a HSS tool and the subsequent policy implications. Community participation in health has been a priority within an LMIC setting for many years, however, this interest has not been matched by empirical evidence (26). Rifkin (8) found when examining community participation processes, most studies had a tendency to focus on the simplistic ‘what works’, instead of understanding ‘how’ participatory processes can develop community ownership to potentially improve health outcomes. CSOs are currently providing vital services that address target diseases such as HIV, and also identified is their potential for broader applications to the health system (19). However, lacking in the literature is a model of how these CSOs can be successfully used to strengthen the health system. In Marston et al.’s (7) review of community participation interventions, they found few high-quality, quantitative studies, but also a lack information about why participation interventions did and/or did not succeed. The authors suggested a need for qualitative investigation to fill this information gap (7). Rifkin (8) confirmed the lack of qualitative data, and highlighted particularly its importance, since qualitative inquiry defines more clearly the importance of context and situation. These views summarize a need for mixed methods research in order to meet the need for good quality quantitative data using observable measures, in addition to qualitative research to build findings that are sensitive to context. Molyneux et al. (11:552) state ‘considering the undeniable importance of qualitative research in this field, but also the potential contribution of quantitative data, we propose mixed methodology experimental studies wherever possible.

Cleary et al. (25) and Molyneux et al. (11) found a lack of empirical evidence on participatory governance and accountability mechanisms. Although there has been progress in identifying mechanisms and factors relating to external accountability, the interactions between the two forms was relatively neglected. Specifically related to external accountability mechanisms, Molyneux et al. (11) found the

most popular mechanism reported on was committees (health centre and clinic, village health committees and ward committees) followed by groups, most popular women's groups. Similarly, McCoy et al (26) observed the most commonly promoted mechanism for community participation as the health facility committee. This points to limited information of other external accountability mechanisms such as provider report cards. Of the studies found related to provider report cards, most research was from a Western perspective, with examples and studies mostly generated from a United States and Canada, and in hospital settings (14). However, provider report cards are relevant to an LMIC setting due to the emphasis on community participation within the health system (14). Within a Sub Saharan African setting, only three studies were specific to provider report cards, and none were from a South African setting. Considering the importance of context in implementation of provider report cards, more studies from a South African perspective are warranted.

5. Study's contribution to the literature

Coovadia et al. (18: 832) state 'without concerted efforts to change national thinking on accountability, South Africa will become a country that is not just a product of its past, but one that is continually unable to either address the health problems of the present or to prepare for the future'. This study attempts to contribute to the literature on 'how' civil society can strengthen the local health system through increased accountability. Community accountability is highly applicable to this study as it directly speaks to the involvement of civil society in promoting accountability. This is justified by a growing appreciation for more participatory and people-centered forms of development.

Among the various mechanisms for promoting accountability, external accountability mechanisms are the focus of this particular piece of research. In exploring options to enhance accountability within the health system, provider report cards are a tool worthy of consideration. This study will provide evidence of a provider report card implemented in a South African setting, including building knowledge related to the factors and potential influence of civil society as implementing actors. Context plays an important

role, and therefore application of a provider report card intervention applied in a South African setting can contribute to informing development at a local level. Civil society is particularly suited to provider report cards, as it can provide the social power and influence of ordinary people (16). This research will feed directly into further development and refinement of the HSS monitoring tool and potentially offer greater understanding of practices, such as increased civil society monitoring, implemented to strengthen accountability within the health system.

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PART C: Article Manuscript

Journal targeted: BMC Health and Human Rights

Title of article:

Civil Society's role in health system monitoring and strengthening: Evidence from Khayelitsha, South Africa

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Background: Civil Society Organizations, including Treatment Action Campaign (TAC), have played a vital role in mobilizing people to campaign for the right to health and HIV treatment and access. Primary health care facilities in Khayelitsha, South Africa continue to face challenges to deliver care to individuals living within the sub-district. The high prevalence of diseases such as HIV and TB places constraints on an already overburdened public health system. This study centers on a partnership between Medecins Sans Frontieres and TAC, and specifically focuses on evaluating the implementation of a health systems' strengthening pilot project jointly implemented in Khayelitsha. Specifically, this study considers the pilot project implementation process, as well as the functioning and potential impact of a monitoring tool introduced as an external accountability mechanism at the facility level within Khayelitsha.

Methods: Using an action research approach, the researcher engaged with implementing actors in the development and implementation of the monitoring tool. As part of this engagement, seventeen semi-structured qualitative interviews were conducted exploring: the understandings of various stakeholders about the tool, their interests or concerns, potential positions, power and influence on its implementation. The challenges during its implementation and how these were overcome were also explored.

Results: The actors implementing the tool appreciated being active participants in the process of design and implementation. Key actors at the local department of health management level expressed the desire to have been consulted more directly, over tool design and implementation processes. Variation in the use and the interpretation of the tool's purpose was seen across all stakeholders. Those actors directly involved in daily use of the tool, expressed an increased awareness and broadened engagement with patients, providers and facility managers, at the local level. Values, attitudes and resources were important factors that influenced the functioning of this tool.

Conclusions: This research can feed directly into further development and refinement of such HSS monitoring tools and potentially offer greater understanding of practices, such as increased civil society monitoring within PHC facilities, implemented to strengthen accountability within the health system.

Introduction

Civil society has historically played an important role in South African human rights movement. Civil Society Organizations (CSOs) channel the social power and influence of ordinary people to pursue collective interests and engage in activities of public importance (1). The Treatment Action Campaign (TAC) is a South African CSO that helped overcome legal and political barriers to HIV treatment by mobilizing patient voices for HIV treatment access. They have continued to play an important watchdog role in the area of South African HIV, TB, and health policy since HIV treatment was rolled out in 2004 and since the Mbeki administration, which stalled HIV treatment progress, was ousted in 2008 (2),(3). While the literature notes the importance of civil society contributing to a range of health system functions such as health service provision, policy setting, and monitoring of quality and responsiveness (1), there are few examples of *how* civil society can be used to strengthen the health system. In order to address health system inequalities, Gilson (4) also identifies the involvement of CSOs 'in decisions and actions that identify, address and allocate resources to health needs' (p.5). This research project helps to evaluate the role of civil society, presenting evidence drawn from an action research project which focuses on implementing a health system monitoring tool in Khayelitsha, South Africa.

Systems thinking is a way of thinking that appreciates the dynamic and constantly changing nature of complex systems (5), and is an approach that will be used in this paper. It is relevant to this study because Health Systems Strengthening (HSS) refers to a range of activities and initiatives designed to improve the underlying health system or manage interactions between components of the system in ways that help ensure more equitable and sustainable health services and health outcomes (6).

HSS is a particularly relevant topic in the current South African context, as the country moves towards National Health Insurance (NHI), a system of universal health coverage. Strengthening public primary health services is an important goal in preparation for NHI. Maartens & Goemare (7) argue the achievement of universal health coverage will depend on shifting the central focus of health service

delivery from the tertiary hospital level to the local level, lending more support to HSS initiatives at the district level. The analysis in this study has the potential to contribute to informing how best civil society can engage at the local level in order to strengthen Primary Health Care (PHC) services.

The evaluation of this particular HSS activity, implemented by TAC, was conducted in Khayelitsha, a large urban township outside Cape Town. TAC has been instrumental in transforming the approach to HIV in local primary health clinics, in addition to advocacy around issues such as crime and violence against women (8). Medecins Sans Frontieres (MSF) has been an important partner for TAC since it began working in Khayelitsha in 1999, providing ARVs through public clinics since 2001. Bemelmans et al (2), Heywood (8), and Levy et al. (9) reflect that 'MSF made an additional impact through its coordination and cooperation with TAC'. Many programmes implemented in Khayelitsha have been developed in close collaboration with the Western Cape Government (WCG) and the City of Cape Town (CoCT).

Khayelitsha continues to be a site for innovative pilot projects including PMTCT and community supported models of ART delivery and management (10), implemented through collaboration between partners including TAC and MSF.

This article centers on the partnership between MSF and TAC, focusing on evaluating, through an action research approach, the implementation of a HSS pilot project jointly implemented by both organizations within Khayelitsha. The project involved TAC implementing a HSS monitoring tool within PHC facilities in Khayelitsha sub-district. The initial tool was developed by the primary researcher, in consultation with TAC and MSF partners, for use by Patient Treatment Literacy Advocates (PTLAs, who work for TAC in all local clinics to liaise with patients) in monitoring and strengthening clinic performance. In addition to the regular reporting of education and advocacy activities, TAC monitored systems' level indicators including staff absenteeism, (un)availability of services, cleanliness of clinic environment, and community mobilization actions.

This paper focuses on lessons learned from the implementation of the HSS monitoring intervention, applying an action research approach in evaluation. These lessons can not only be used to strengthen advocacy work elsewhere, but also to identify and improve broader health systems challenges facing the clinics. Analysis of the policy environment and implications for policy implementation of this pilot project could also inform possible scale-up to other sites and could help to direct TAC and MSF's agenda moving forward. In addition, this is a fairly novel and unique opportunity to consider the potential role of civil society in the burgeoning field of HSS, and to briefly evaluate potential strengths and weaknesses of the particular approach undertaken.

The paper now introduces several conceptual frameworks that were helpful for interpretation of data from the qualitative, action research methodological approach. The findings section is organized first into an evaluation of the actors, processes and context that helped and hindered the implementation of the HSS monitoring tool, before outcomes of the tool itself are discussed.

Conceptual frameworks

The development and implementation of the HSS monitoring tool can be understood as a policy process. The Walt & Gilson policy analysis triangle has been applied in various LMIC contexts (11), and will serve as a relevant analytical framework for examining the specific policy environment surrounding this process. The framework considers not only the content of the policy, but the actors involved; the processes contingent on developing and implementing policy change; and the context it was developed and implemented within (12). In understanding the influence of actors over the tool's development and implementation, a local stakeholder analysis was conducted. Stakeholder analyses map out the power of different stakeholders involved in or potentially influenced by a policy decision, and assesses the extent to which they may be supportive or opposed to the decision (14). In practice, this involved considering key stakeholders' relative importance, knowledge, interests, positions and possible allies regarding the tool (13).

The newly implemented HSS monitoring tool is similar to a ‘provider report card’, a type of external accountability mechanism where citizens express their preferences about services, and are involved in monitoring and supervising facilities and providers (15),(16). The HSS monitoring tool is also similar to quality indicators used in ‘provider report cards’ in other LMIC contexts such as Uganda and India (17), (18). A final lens applied in analysing implementation experience around the HSS tool is, therefore, the set of factors identified by Cleary et al. (15), through review of relevance experience, influencing the functioning of any accountability mechanism, namely; values, attitudes, and resources (see Figure 1). These factors will be relevant in assessing the actual functioning and potential influence of the HSS monitoring tool.

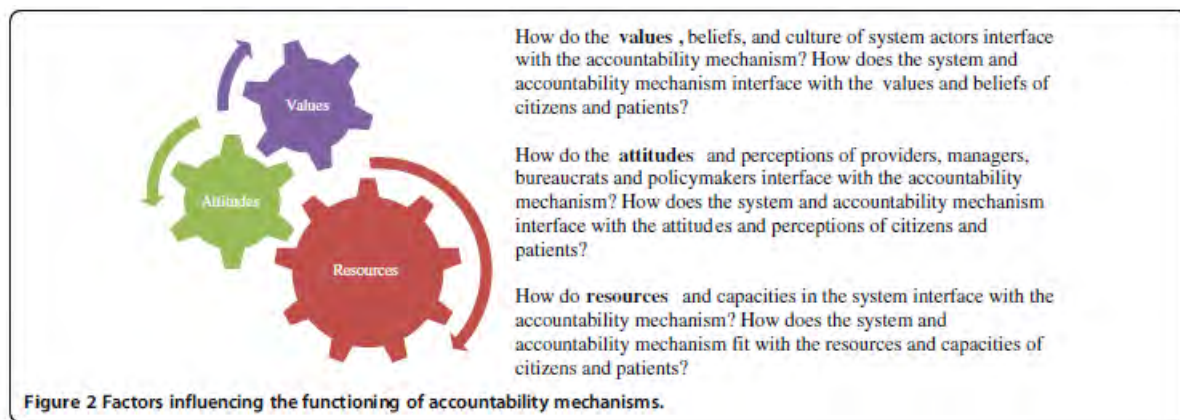


Figure 1: Factors influencing the functioning of accountability mechanisms (15)

Methods

Study setting

This project was conducted in Khayelitsha sub-district, within the Cape Metro Health District, where the majority of the population is uninsured and mostly dependent on public sector services (19).

Khayelitsha, an urban township, is demonstrative of the many inequities facing the health system in South Africa. Infectious disease burden remains high as reflected by antenatal HIV prevalence increasing from 19.3% in 2000 to 37% in 2011 and is the highest in the Western Cape (20), placing strain on an

already overburdened public health system. PHC facilities in Khayelitsha continue to face challenges to deliver care to the almost 400,000 individuals living within the sub-district (20). This research aligns with WCG and CoCT priorities to increase community participation in healthcare and place emphasis on health systems planning (19).

Study design

This study used an action research approach, which focuses on working with people to identify problems in practice, implement solutions and to monitor the process and outcomes of change (21). It reflects a participatory worldview and cyclical research process. Within the context of this particular study the ‘action’ is the development and implementation of the HSS monitoring tool. The principal researcher supported this intervention within the system as not only an observer, but also by assisting with its creation and implementation. The implementing actors, PTLAs, were specifically engaged from the beginning to gain feedback and create ownership over the tool. Loewenson, (22) argues the strength of action research lies in its ability to empower, by getting participants to engage with research and the subsequent development of implementation activities. Other stakeholders including TAC, MSF and the DOH were also engaged.

Action research often employs a range of methods (21), therefore both quantitative and qualitative methods were used in this study. Seventeen qualitative interviews were conducted in total: 11 respondents from TAC, including all nine PTLAs and one manager and PTLA supervisor; as well as 5 local managers from the sub-district, including three facility managers and two from the senior leadership team, and one senior manager from MSF. All respondents were involved in some aspect of creation and/or implementation of the tool. All TAC and MSF management interviewed were directly in the development of the tool. DOH managers were involved more in the implementation phase, and not all managers whom interacted with the tool at the clinic level were interviewed. Participant observation as well as researcher diary with field notes were taken during clinic visits and interactions, and formed a

component to the qualitative data analyzed. Researcher insights drawn from engagement processes were complimentary to the qualitative data collected. Quantitative data allowed for the ability to track potential improvements in clinic performance in terms of operational research, however, the qualitative component will be reported on in order to address the research aims of this particular paper.

Tool development

Stakeholder engagement

Initially, the principal researcher was introduced to key actors within TAC and MSF in order to gain entry to the setting. This was important to develop trusting relationships with key actors. Initial site visits were conducted to gain knowledge of the context and the health systems issues facing each PHC facility. The principal researcher was also introduced to various facility managers and senior nurses, conducting initial interviews to inform tool development. A researcher diary was used to take field notes in regards to these interactions, and also to allow the primary researcher to reflect on her role in the research project. As Khayelitsha is a predominantly Xhosa speaking area, narrative reflections also included the perception of the researcher as a white foreign nurse involved in the study. This same process continued over the next two months, with regular site visits made weekly to provide support, as well as the opportunity to discuss the tool and process of implementation. Field notes were taken vigilantly throughout.

Method for developing the tool

Tool development was a participatory process, with input from TAC and MSF partners. The initial tool was adapted from a previous M&E tool which had been in use by TAC nation-wide. Also used to inform the new HSS tool was District Health Information System (DHIS) routine data – indicators were based on similar government categories in the DHIS. The first version of the tool was introduced to the PTLAs, prior to initial implementation, to ensure that all PTLAs were able to offer initial feedback and begin building a sense of participation and ownership over the research process. At this introductory session,

PTLAs were explained that weekly feedback sessions were an opportunity to discuss the tool, and edits would be made according to their feedback throughout the implementation period. The purpose was also to build a tool containing a short list of health systems indicators that were reflective of issues currently seen by TAC, and therefore locally relevant.

The indicators were to be kept to minimum for purposes of proof of concept, and were initially planned to be 1) easily measurable; 2) relevant to TAC and their advocacy priorities; 3) possible to improve upon through advocacy efforts. Subsequent meetings were held with representatives from TAC National coordination office. All feedback from TAC Khayelitsha and National office was incorporated into the tool.

Initial pilot

The tool was initially piloted in July 2014. The primary researcher and TAC members met weekly for feedback sessions. These 'reporting sessions' were scheduled every Friday at the TAC office, in order to debrief on weekly activities and gather feedback for further refinement of the tool. The primary researcher and PTLA supervisor co-led the reporting sessions. The tool was adapted based on feedback directly from the PTLAs and PTLA supervisor and the final version of the tool was implemented in November, 2014. Sessions were held in an environment where participants felt comfortable. This also followed the action research approach, where participation is fundamental and demands that participants be seen as equals, perceive the need to change, and are willing to play an active part in the research and change process (21).

The initial tool was introduced to all facility managers in the sub-district by the PTLA supervisor at a monthly DOH meeting. The facility managers were asked to then review the tool with the staff from their respective facilities. The PTLA supervisor and primary researcher answered questions or clarified changes made to the tool, on site visits throughout the implementation process.

Data collection and analysis methods

The HSS monitoring tool was implemented within 9 of the 11 primary health clinics in Khayelitsha.

Within the sub-district, 3 large Community Health Centres (CHCs) are run by the WCG, two are youth clinics, and six clinics which are managed by the CoCT. Quantitative data were collected via the tool by TAC with assistance from MSF, and all data were entered by the primary researcher and reviewed by JA (supervisor to the primary researcher). The tool was adapted frequently throughout the implementation process. The quantitative data collection ran for six months from July to December, 2014.

In terms of qualitative data collection, semi-structured, conversational interviews were conducted with a total of 17 respondents from TAC, MSF and the DOH over 2 months, from November to December, 2014. Respondents were selected purposefully as they were stakeholders most involved in the development and implementation of the tool. Interviews took approximately 30-60 minutes to complete and were conducted in English at the respondent's place of employment. Conversational interviews allowed inquiry into experiences and understandings of various stakeholders, their interests or concerns, potential positions, power and influences on the implementation of the HSS monitoring tool, as well as the challenges during its implementation and how these were overcome. The specific questions considered in the interviews related to themes such as 1) the nature, purpose and expectations of the tool; 2) experiences with implementation; 3) potential opponents or supporters of the tool.

Unfortunately, it was only possible to interview a limited number of facility manager and senior DOH leaders given difficulties in accessing respondents. In addition, direct providers of care (such as nurses) and patients were excluded given the study's primary focus on the tool's development and initial use, as well as due to limitations on scale of the study and time constraints.

The action research approach gave the researcher more opportunity for prolonged engagement in the research process, thereby increasing credibility and rapport with the PTLAs. For example, the researcher interacted many times with the PTLAs during the implementation process and before qualitative interviews were actually conducted. The prolonged engagement between the researcher and PTLAs potentially enabled the 'snapshot' of once-off interviews to become more of a process of uncovering how those respondents in particular really felt about a variety of issues, as they may have reflected more on what they said and why they said it. This longer time in the field allowed for more pluralistic perspectives from respondents and a better understanding of the context of respondents views. The multiple interactions also provided the opportunity for the primary researcher to critically reflect on particular lenses brought to the study and paradigm assumptions of the researcher, in order to clarify her own position in the research process.

During the interview process, respondents were asked for as much detail as possible. Detailed notes were written immediately after all interviews, so as not to lose the context of what was said. The fieldwork diary allowed a chronological and progress record of the research to be kept, as well as observational field notes of the visited sites. This also helped to enrich understanding of the functioning of the project's environment (15).

All transcripts were recorded, transcribed verbatim, coded, and thematically analyzed. Participant observation as well as researcher diary with field notes were taken during clinic visits and interactions, and formed a component to the qualitative data analyzed. The process of 'self-auditing' or 'immersion' in the data occurred a number of times during the analysis process. Peer debriefing was another technique used, as the primary researcher's co-supervisors (LG and JA) were often a sounding board for ideas, and checked coding process to enhance its validity. Data was analyzed to look for themes related to the study question. An inductive thematic analysis was performed first, and then all data was recoded deductively according to conceptual ideas and frameworks previously mentioned.

Ethics

Ethical clearance for the study was obtained from the University of Cape Town Health Sciences Ethics Committee in July, 2014. Research approval from CoCT was also granted. Written informed consent was obtained from all participants.

Findings

The actual project duration was too short to demonstrate outcomes in the quantitative data, and the tool needed multiple edits during the process of implementation. However, successes of this tool included increased empowerment of the PTLAs, the implementing actors. Some PTLAs discussed how utilizing the tool created a space for self-expression, as prior to implementation they had no formal means to communicate clinic advocacy challenges. Others found the tool clarified their role as advocates in the clinics.

It helped me. If I think about me and how this changed me. Before when I came in I was just given papers to fill in. But for me doing this as a team, building this [tool] and all of the chopping and changing and all of that has been very helpful for me. Because even if I go to work somewhere else I understand the importance of monitoring and evaluation. If people don't understand why they are filling out a certain paper or a certain thing and they don't feel interested in it. (PTLA, TAC, Interview 5)

PTLAs reported increased interaction with patient. Additionally, increased communication was noted between some PTLAs and providers (and facility managers) within their PHC. Some identified key staff in their clinics they aligned with in order to complete the tool and bring forth their concerns to ensure that they were resolved. Specifically, PTLAs often mentioned aligning with them (and facility managers) in order to make the tool function better in the facility.

Process of implementation

The findings below are framed by Walt & Gilson's (12) health policy analysis triangle which includes; context, process, content and actors. A stakeholder analysis specifically allowed assessment of actor's position and power in relation to the tool and its development.

The Context

As per the Walt-Gilson policy triangle, context was important to consider during the process of implementation. Salary was a contextual factor noted to impact implementation. PTLAs were initially thorough in filling out the tool. However, one month into initial implementation, completion rates dropped. This culminated when all of the staff at the TAC Khayelitsha office threatened to resign over salary issues. PTLAs felt their salaries were not high enough and attained a pay increase, along with another TAC cadre. Completeness of the tool was noted to improve with salary increase.

At mid-point during implementation, it was made public that the TAC was facing severe budget cuts as an organization. One third of their budget was cut entirely and TAC had failed to raise funds for 70% of their 2015 budget. Although the organization secured several million rands as of January 2015 for their activities, the threat of TAC closure and/programme cuts continues to loom. These political and systems constraints did play a role in the development and implementation process, as some respondents expressed feeling pressure to demonstrate results from their advocacy activities.

Khayelitsha has historically been a site for collaborative, innovative pilot projects including PMTCT and community supported models of ART delivery and management (10), through collaborations between partners including TAC, MSF and the local government. A large part of the success of these projects is due to successful partnerships and therefore, Khayelitsha, was an ideal site to implement this particular study. These historical partnerships enabled the implementation process, as they provided an environment conducive to implement pilot projects. Additionally, there is a high level of citizen

engagement within Khayelitsha and communities are often protesting around service delivery. Because of their successful advocacy history, TAC has strong community links in Khayelitsha, and other areas where they work within South Africa. TAC organized two service delivery protests four months after implementation of the tool.

The Process

Chronology of tool development

From initial piloting of the tool to having the final version in place was five months, ending in November, 2014. The primary researcher and MSF leadership selected the initial indicators in consultation with TAC members, specifically to reflect current challenges facing many of the PHC facilities as seen through site visits. Subsequently multiple edits were undertaken with staggered inputs from a variety of stakeholders, the tool was edited a total of eight times before arriving at the finalized version. The primary researcher was responsible for making the edits to the tool, and then bringing the new version to TAC and MSF leadership for approval. Other stakeholders from the DOH were subsequently consulted once the tool had been piloted. The primary researcher and PTLA supervisor were the facilitators in gathering feedback from other DOH stakeholders, informal feedback sessions most often occurred face to face with managers and nurses-in-charge during clinic visits. PTLAs also brought forward feedback from DOH stakeholders and frontline workers (such as nurses) during weekly reporting sessions. Those interviewed in TAC felt particularly well consulted in the tool design process, and valued the opportunity to have their own inputs heard and then reflected in the tool itself. TAC noted the tool became simpler to use.

When I think of the process in how we developed this tool, I can make the example of HIV or a drug. For example, ARV or TB medication, these drugs must be tested first before they come onto the market.

When you go to the clinic you get tested and hear that you are HIV positive. HIV goes in stages from stage 1 to stage 4, it is a process, and finally they say you have full blown AIDS. So everything must go

through a process, everything must go through stages. So this process of developing the tool has been much the same. (PTLA Interview 8)

At first yoh it was boring and I couldn't understand. We made lots of edits, but I didn't get it at first that the changes we were making were the changes we had asked for. We were adding and changing and then all of a sudden I really started to understand what it is we are doing and our aims. The one before was complex - but this one is simple, and I like it. (PTLA, TAC, Interview 9)

The Content

The tool was edited a total of eight times from the time of initial pilot to final version of the tool being implemented. The initial version of the tool contained human resources, provision of services, clinic environment, and community mobilization indicators. Once the tool was implemented, the conversation in weekly 'reporting sessions' between the PTLAs, PTLA supervisor and primary researcher, began to shift from discussions regarding administration issues to the advocacy issues within PTLAs' respective clinics. This led to discussions with the PTLAs and TAC/MSF leadership about the need for additions or removal of certain indicators on the tool.

For example, the issue of 'Missing Folders' became highlighted as an issue across PHC facilities in Khayelitsha. PTLAs noted that patients came to them frequently in clinics because their folders had been lost causing a delay in accessing services or patients not being seen altogether. PTLAs also stated that they had seen poor patient-provider interactions, or had patients come and speak to them about issues with staff attitude. . This dialogue initiated by the PTLAS at weekly reporting sessions led to the request that these indicators be added to the tool. As indicated in the qualitative interviews, preferred indicators of the PTLAs were the 'Advocacy Action Plan' and 'Workplace Conditions' and 'Stock-outs' and 'Patient Interviews'. They were preferred because the PTLAs saw these indicators as most relevant to their viewed concerns in the clinic.

Major edits to the tool were done three months after initial tool implementation, after various concerns arose from stakeholders involved in the implementation process. DOH managers felt the tool was too lengthy and were concerned about some of the indicators. For example, the human resources indicator was deemed inappropriate for TAC to be collecting as the DOH judged it was at their discretion to decide how their staff was distributed. PTLAs often felt uncomfortable collecting this information, as they felt some resistance from front line staff and managers. Some within TAC leadership were concerned that the tool was too long and PTLAs were bogged down by paperwork. Some at MSF felt that TAC did not have enough ownership of the tool and that it wasn't aligned with the MOU between both organizations.

Subsequently, the tool was edited and new emphasis placed on measuring 'reach' of services. Major changes included the addition of five daily patient interviews for PTLAs to complete. In the interviews patients were asked 'What services were accessed' that day, allowing for the collection of quantitative data related to 'reach' of services. Being mindful of the administrative concerns related to the implementation of a lengthy paper-based tool, the indicators on the tool were significantly reduced in order to streamline use. For example, the 'Correctional Steps Taken' indicator was changed to a short and structured advocacy action plan for PTLAs to identify the top three weekly advocacy issues in each clinic. Feedback from PTLAs was ultimately positive, most stating the tool was easier to use and took less time to complete on a day to day basis.

Initial Indicator	Final revised indicator /	Reasons for revision?	Total revisions	Main proponent of	Main blocker of
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	removed			indicator	indicator
Education (session, number, topic)	Education (session, number, topic)	Too lengthy Not informing HSS	3	TAC	MSF
Human Resources (who is missing, title)	Staffing issues (yes/no)	Too subjective	4	PTLAS, TAC, MSF, Researcher	CoCT
Drug stock-outs (yes/no)	Drug stock-outs (yes/no, what drug)	To monitor what drugs missing	1	TAC, MSF	CoCT
Condom availability (yes/no)	Male and Female condom availability (yes/no)	More appropriate	1	MSF, TAC, CoCT	
Missing folders (yes/no)	Missing and duplicate folders (yes/no)	Duplicate folders also an issue	2	PTLAS, TAC	MSF
Service availability (yes/no)	Patient interview (service accessed)	Too subjective	3	MSF, PTLAs	CoCT
Complaints (open ended)	Patient interview (complaint)	To encourage patient interaction	3	MSF, PTLAs, Researcher	CoCT
Patients turned away from service (yes/no)	Patient interview (turned away from service)	To better inform advocacy action plan	3	TAC, MSF	CoCT
Staff attitude (yes/no)	Staff attitude (open ended)	Not specific	3	MSF, PTLAs, Researcher	CoCT
Facility environment (yes/no)	Facility environment (yes/no, describe)	Different issues at different clinics	4	MSF, TAC	CoCT
Correctional steps taken (open ended)	Advocacy action plan	Too open ended	4	TAC, PTLAs, Researcher	
Queue length (number)	REMOVED	Difficult to measure	2	MSF, Researcher	PTLAS, TAC, CoCT
Essential equipment (yes/no)	REMOVED	Not a priority concern	2	MSF, Researcher	TAC, CoCT
Clinic Committees	REMOVED	Committees not meeting	2	TAC, CoCT	
Baseline staff (count)	REMOVED	Sensitive	1	MSF, TAC, Researcher	CoCT

Figure 2: Changes made to HSS tool

The Actors

As noted in indicator selection, power was exerted by various stakeholders in order to see that certain indicators were added/removed. These actors influenced development of the tool, and the final version of the tool is indicative of how actors' wielded their power to influence the tool content. Walt & Gilson (12) identify policy actors at the heart of the policy process; they are important to consider in implementation because they can exert their power to influence the policy process. The Policy actor map (Figure 3) represents a focus on the actors in the Walt & Gilson policy triangle, specific to the process of development and implementation of the tool.

To give an indication of the actor influence related to implementation of the tool, a mapping of the overall estimated power of each, in relation to their positions and power, is presented in the force-field analysis (Figure 3). The stakeholder analysis reveals in more detail the power relations influencing implementation. It was conducted six months after tool implementation, when multiple service delivery protests had recently been undertaken by TAC Khayelitsha. The protests presented an opportune time to explore stakeholder opinions about the tool, in particular to note how they exerted their power during this time of service delivery protests. The stakeholder analysis in the following section will discuss how power relations influenced implementation and shaped outcomes of the tool.

	Proponents			Opponents		Not mobilised
	high support <<		Neutral	>>	>> high opposition	
POWER	Enthusiastic Compliant	Helpful	Hesitant/ Indifferent	Uncooperative Hostile	Opposed	
Very High v v						
		MSF TAC National	International Donors	Department of Health senior leadership		
Medium		PTLA Supervisor TAC Khayelitsha	Facility Managers PHC providers	Facility Mangers PHC providers		
	PTLAs					
v v Very Low	Patients					

Figure 3: Policy actor map

Description of potential influence and power of stakeholders

Proponents

From the force field analysis (Refer to Policy actor map, Figure 3), one of the main proponents of this tool were the PTLAs -the actors implementing the tool. PTLAs saw themselves as educators and advocates in the clinics. Most agreed that the tool enabled them to collect and organize their advocacy issues related to service delivery issues within their clinics. Their view as advocates who collect data to

inform their advocacy activities, was a new concept that required a shift in thinking of their daily work and role in the clinic.

It (the tool) will help us. Especially for those who didn't recognize their advocacy issues in their clinic before. Before we used to talk about these minor issues like missing folders or the issue of nurses because we always thought it was a minor issue. But the patients were always complaining in reception and nothing changed. But now we know that we should write it down. Because if you don't write it down nothing will change. (PTLA, TAC, Interview 2)

PTLAs are 'lay workers', and parallels can be drawn in this regard with local-level health care providers including lay counsellors and Community Health Workers. In particular, through the use of the tool, PTLAs began interacting more frequently with the patient population. Local-level health workers generally possess professional knowledge and interact directly with patients and are therefore at the centre of the successful implementation of a policy.

It is noted that these actors have lower power, specifically related to other health care providers working in the PHC facilities, and PTLAs often struggled to demonstrate legitimacy of their role within their clinics. However, they are seen as legitimized from a patient perspective, due to their initiative in developing trusting relationships. Participants discussed they were able to initiate conversation with patients who might have been silent otherwise and not come forward with concerns. The same increased patient interaction was also observed within the community. As PTLAs were also expected to attend TAC branch meetings, their reach was extended beyond the clinic and into the surrounding communities.

Because sometimes patients have something inside of him or her and they don't feel comfortable to say it. But by you coming to him or her to ask at least she will open up to you. Even though they were going to leave the clinic and not say anything.... So this tool is very helpful for them and more specifically for us to know what is happening around the clinic. (PTLA, TAC, Interview 7)

PTLAs are placed higher in power than patients on the force field analysis, which is reflective of their closer link and daily interaction to those of more power within the health system such as facility managers. The identification of advocacy issues did present them with some power, in the ability to present their findings to health care providers/facility managers to see that change did occur. Additionally, all PTLAs felt as though the data gathered using the tool was helpful to justify service delivery protests. The avenue to exert their power at a community level, and beyond the PHC facility, was through protest action. The PTLA at this facility discusses the lead up to the service delivery protest at this facility:

But now it has been a year since I've been working at PHC X. I noticed there is challenges when we open a branch in [community x]. When we speak with members of the branch they complain about the clinic. We as branch members go to the clinic to do interviews to hear the side of the patient. Then after the interviews we come and collect all the information that we get from the patient and see there are a lot of problems. After that we call a meeting with the facility manager and we raise our concerns with the clinic. Then even after we raise our concerns nothing changed in the clinic so then we decided to do the march. Because I think the form helped us to write down all the problems and we do interviews and branch members come with their problems from the clinic. I think that is why we combine all the information. Then we marched and many people came! (PTLA, TAC, Interview 2)

The PTLA supervisor also carried power in representing the PTLAs at various stakeholder meetings and in clinics. All PTLAs and the PTLA Supervisor recognized their individual ability to influence outcomes in terms of protests was increased when they were combined with the collective power of TAC. TAC, due to its strong history of activism in South Africa and Khayelitsha, has proven that it has the ability to influence public opinion. TAC members interviewed spoke of seeing results from the protests. As such TAC Khayelitsha is placed as higher in power than the PTLAs. TAC has a strong link to the community within Khayelitsha and can command large numbers during a protest.

Some tensions were found between TAC Khayelitsha and the National Office, however, in terms of tool development, the TAC national office wanted to see emphasis on the advocacy indicators, due to the pressure from donors to report outputs from TAC's advocacy work. Some expressed feeling ongoing pressure to demonstrate data from TAC Khayelitsha, in addition to demonstrating TAC's reach up through to the provincial and national level. At the height of the funding crisis, it was often expressed that data was needed in order 'to save the organization'. There was also a general recognition by respondents that TAC would have more power with quality data and accurate reporting of results to inform TAC activities, in other words, movement towards more evidence based advocacy.

It is difficult for TAC to take credit because it has not been systematically recording its activities, and so that is where the tool comes in, and if they had been using the system properly they would have been able to demonstrate the good that we do in this country. (Manager, TAC, Interview 14)

This [tool] is the one that is good. I wouldn't change it. Because at the end of the day we need to have data that speaks speak to the challenges. The tool will help us in terms of collecting that data. When we do our strategic planning, we talk about the data from the clinic and it is easy for you when you are doing your report. You just go to that data and account for it. I feel like we needed this time in order to get a good tool. The previous one was only getting at the numbers. But this one doesn't speak to the numbers only, it speaks to everything that goes on in the clinic, which is good. (PTLA, TAC, Interview 8)

The TAC funding crisis played a role in placing pressure on the organization to demonstrate results, but it also highlighted allies within the health system that were important to the success of the tool. MSF and Section 27 (another NGO) were actively involved with TAC at a national level, in attempting to find sustainable funding solutions and fundraising efforts were implemented to raise the funds needed. This highlights a key alliance that TAC has already, and potential for exploring other alliances with NGOs of similar backgrounds and goals. This could also strengthen the power level of TAC National, which is currently judged to be medium. Other potential stakeholders that could be proponents with significant

resources and power, as mentioned by others interviewed, include international donors who fund HSS projects and civil society.

MSF was an important partner to ally with as the organization provided financial resources and international experience and expertise to support policy implementation. They can therefore rally behind TAC through advocacy and research or use their connections to attract international funds to support the implementation of the policy. In Khayelitsha, this credibility has played an important role in maintaining close relationships with the DOH. Not only were individual relationships between staff and PTLAs key to successful implementation, organizational relationships between TAC, MSF and DOH also made a difference.

No I don't have any problem. Clinic X is an important clinic that understands TAC and we have MSF in the clinic. That is why I have an advantage of doing all of this paper work [referring to the tool]. Because we have Clinic X, we have MSF, we have [nurse in charge]. Even if we have something I don't like I go to the facility manager and they go and talk to someone and immediately we solve it. So if at Clinic x there is no a doctor and me I don't like this man, and I talk to someone. Then I go to someone else and say I don't like this and we solve the problem....because we have MSF and a facility manager that is acceptable to everything. I even just had two meetings with facility managers, so at Clinic X we are fine. (PTLA, TAC, Interview 1)

Neutral

Within the department of health, facility managers were a potential key source of support to garner in terms of success of implementation. However, some were not supportive and exerted their power in order to oppose the tool. This is reflected on the force field analysis, as facility managers are also placed in the opponent category. The most contested indicator by other health care workers and management was the monitoring of 'human resources' and the absence of staff in clinics. This was blocked by some facility managers saying they must ask their superior to complete this indicator and others saying they

didn't have access to this information. In addition, some at the department of health were concerned that this was not the sort of indicator that should be monitored by the PTLAs and it was the judgement of the facility manager as to what staff decisions they made.

PHC providers were not interviewed for this research, but many respondents spoke about observations on provider interactions with the tool. Some mentioned providers within their facility specifically coming to them to discuss issues they felt as though they could not bring to management. This therefore places them at a lower level of power than other DOH management, but this tool provided an avenue to raise concerns and therefore PHC providers and facility managers who were supportive of the tool, were allies.

At the staff meeting the facility manager introduced the tool, and that allowed me to go in whatever areas I needed to complete the tool. And at the end of the day they also say: 'This tool will help us to understand our problems in the clinic and how we work. And TAC is an advocacy organization that can help us to identify these gaps and help us to act. Because we are government workers and sometimes we are not allowed to have marches, so they can march on our behalf.' So we are the voice of the voiceless. We are the voice often of the [clinic] employees. But TAC is not the government and they are doing their best to help raise the concerns of the staff who cannot march against their employer. (PTLA, TAC, Interview 8)

Opponents

Local management at the sub-district office were interviewed shortly thereafter, and some demonstrated oppositional support towards the tool, specifically in response to service delivery protests instigated by TAC. They also found the tool, at times, to be confrontational.

This tool is currently being used in almost a sort of punitive stance. Almost in a 'we will show you to the world, how bad you are'. And that was the purpose. What should be happening is whatever the [PTLA] has seen on a daily basis, he or she should go to the facility manager and say do you know that there are

no condoms? Then the facility manager can tell them to go to the store room and take these boxes. So it should be supportive and at the moment it is more for hype. More to agitate than to support. (Senior manager, DOH, Interview 17)

Senior managers within the DOH recognized that TAC had their own source of power in terms of community support and advocacy, however, their level of power was higher as they controlled the resources and investment for health services within Khayelitsha. Although facility managers were very much the gatekeepers of the tool's success within PHC facilities, more senior management held the power over resources and the reality of change resulting from TAC's advocacy demands. DOH senior management expressed frustration in a lack of recognition of the investment and commitment within Khayelitsha sub-district.

Outcomes of the tool

As noted in the above section actor power relations influenced and shaped development and implementation of the tool. The tool itself can be seen as an external (community) accountability mechanism, a governance tool seeking to regulate answerability between the local health system and the community in Khayelitsha. As community accountability mechanisms are used by non-state actors to hold public sector power-holders to account (15), power relations are important to consider in implementation processes.

Cleary et al. (15) identified resources, attitudes, and culture, as factors influencing the functioning of external accountability mechanisms and relationships within the district health system. The following section will now consider these factors as applicable to the implementation of the monitoring tool. These factors can help to understand the outcomes observed during the implementation process in Khayelitsha.

Resources

Capacity of civil society

Cleary et al (15) identify concerns about whether accountability mechanisms involving citizens in the monitoring of providers have the resources and capacities to hold providers to account. This same issue was also highlighted during our research. In terms of technical capacities, barriers to implementation, included TAC's limited knowledge of gathering and utilizing data and computer skills for data entry. TAC members' often had limited comprehension levels, affecting their ability to express specific advocacy concerns.

'What I realized about the field workers or the PTLAs in this instance is that they often struggle to express themselves, particularly in English, about what the challenges are. And sometimes it makes it difficult to express a complex issue'. (Manager, TAC, Interview 14)

It was difficult to gather quality data as PTLAs were not used to M&E processes and did not have prior training in this area. Initially, many had limited understanding of what they were collecting and why. If PTLAs felt more comfortable with the tool, they had a more positive view of the tool itself and understanding of how to apply the information collected, for example in the form of protest/march. The first service delivery protests occurred four months after the implementation of the tool. Although it was not the 'worst performing' clinic when compared across multiple indicators, the tool had documented quantitatively; issues around long queues, missing folders, stock outs of medication for family planning and shortage of staff. These findings suggest the tool did potentially contribute to informing and justifying the service delivery protests, from TAC's perspective. These protests also speak to the capacity for TAC to mobilize the community, as over 500 Khayelitsha community members were present at this protest. The facility manager discussed being in solidarity with the march, and associated positive outcomes within the PHC facility afterwards:

It is just that TAC got frustrated with the lack of action and so the result was a march. The march was quite peaceful and it helped us a lot. Because even the other departments and the district manager had tried to motivate and get other resources, but those resources took time to come. But now we can see the speed and things are improving. (Facility Manager, DOH, Interview 12)

Attitudes

Increasing awareness

A shift in attitudes of various stakeholders was also observed, such as increasing awareness of the local health system. During implementation, PTLAs began to shift their activities from only delivering education and advocacy to monitoring service delivery issues facing their respective clinics. Before the tool was implemented PTLAs were most often found in the ARV and TB services side of the clinic, reflective of its origins as an HIV advocacy organization. However, through the use of the tool, many PTLAs mentioned they began actively monitoring other areas of the clinic such as chronic disease. They perceived an increasing awareness of not only programmatic services such as HIV and TB, but the overall system and other services available in their clinic.

Yes. I am looking at my clinic from many different ways now. To be honest..I didn't check before, last time I was only looking at the ARV site. Now I go to family planning to check that everything is ok. I go to the staff and introduce myself. Because some of the staff at the clinic said: 'we saw you, sometimes you wear your shirt that says 'HIV positive' and so we thought you were from TAC.' But now they talk to me, and I feel like I can ask anything... now when I have time I go to the other areas of the clinic and I am aware of other things happening in my clinic. So this tool challenged me to do my job properly. (PTLA, TAC, Interview 4)

In addition, they discussed how the tool increased their reach in the facilities. Facility managers recognized their limitation in interacting with patients due to their managerial commitments and time

constraints. They also spoke about patient's comfort level in raising concerns, whereas they may have been more comfortable in speaking with a PTLA, rather than a facility manager.

Like for me I might be sitting here and busy with my work. For me condoms is not a priority -but yet it is a major thing and they should be there because of the high incidence of infectious disease. Like maybe masks aren't there, but I am not aware, and [the PTLAs] will come to me. Like [the PTLA] will come to me and say: 'Mums, are you aware of this and that'. So she makes me aware of other issues that I am not aware of. So I say: 'Thank-you for bringing that to my attention, we will work on that together.' I like their presence, because they really make me aware of issues. (Facility Manager, DOH, Interview 12)

The clients go to them and for me I think it is a more honest interview. Rather than me calling a client in and saying: 'How was your service today?' Even if he/she had an issue with staff attitude they might not say that to me. With the peer educator it is easier for them to say whatever. (Facility Manager, DOH, Interview 15)

Watchdog role

Cleary et al. (15) discussed resistance to citizen involvement in health facility monitoring was often related to perceptions that community members were behaving like 'watchdogs' – 'exercising control and power without offering support' (p.5) The same finding was also reflected in this study.

PTLAs did express how the tool made them take on more of a watchdog role by documenting issues and reporting them to the facility manager, health care providers, department of health and TAC. Some expressed feeling comfortable with being seen as a watchdog, recognizing their actions were contributing to improved service delivery and quality of care for patients. When speaking about being seen as a watchdog in the clinic, one PTLA commented:

No not at all. I like it [being called a watchdog]. Because when I am in the clinic I see everything in the clinic. Because sometimes they don't treat our clients well. That's why I like it. Because I can go to the

nurse and say this is not right. This client deserves better. And the clients they tell us 'Thank you very much, because you helped me' (PTLA, TAC, Interview 6)

Others did not like the term watchdog and the negative connotation and stigma they found to be associated with the term. Some felt uncomfortable with the label of 'watchdog' but recognized their role in monitoring and reporting clinic concerns in order to create an accountable clinic within their community.

Yo it is hard being a watch dog. It is not easy. Because even if you are doing your education and stuff, you are being attacked/charged man. Everyone will say: 'this oh this one, hei this one, watch her'. But at the end of the day you do your job. But they say: 'hei that one, don't talk next to him or her because they will record and talk to TAC.'...But ya, you are making a difference. Because look, at the end, that is what you must do. (PTLA, TAC, Interview 1)

Of those facility managers interviewed, all appeared to have a higher level understanding of the term 'watchdog'; recognizing that it was often up to the individual to choose how reported information was utilized. Most commented it was dependent on providers being open to this form of input from the public, if they were not, the resistance was likely and the PTLAs seen as 'watchdogs'. Additionally, just as PTLAs recognized the need for a positive approach for the tool to be well received in clinics, so did the facility managers.

Culture

Hierarchy

A culture of hierarchy is often found in the South African health system. Within this study, hierarchy was reflected in the PHC facilities as discussed by respondents. PTLAs had to negotiate these issues of power dynamics when utilizing the tool –as often it would challenge this hierarchy. Respondents from the DOH found reporting of the results from this tool often circumvented the formalized reporting structures

inherent within the system. Therefore many suggested formalized reporting sessions in the future, in order to avoid conflict. In addition, emphasis was placed on the first line of reporting to the in-charge or facility manager, rather than directly to TAC.

So those things only work if they talk to the facility manager, if they don't and only report to the TAC, it helps nobody and just fuels conflict. (Senior manager, DOH, Interview 16)

It would be nice if they pick up something that day then they come and say to me: 'Ok this is the problem'. Even if you aren't going to act on it that day, it makes you aware rather than waiting for a month for a report. (Facility Manager, DOH, Interview 13)

One facility manager reflected on hierarchy, and highlighted the potential for mis-match between the participatory values and beliefs of the health system and local communities, relative to the tool. She recognized the value of 'outside monitoring' as a theme inherent within the South African health system, and a reality of the day to day work in PHC facilities; suggesting that the local community in Khayelitsha has a culture of voluntary participation in local activities such as health care. She suggests there is potential for management and the health system to adapt to civil society acting as formalized community accountability mechanisms.

Especially in South Africa there is a culture of hierarchy. I'm a manager, I don't report to you [PTLA]. So why would a facility manager or a clinic want to account to a TAC member. It is a good relationship if they can see the purpose of it. But if they think it is because of the HIV positive t-shirt, and you are scared they will come and do a toyi toyi [protest]. That's why you are accountable to them? Then it's a power play that they are trying to prove. But if there was desire from the DOH to account to civil society as a whole to say this is what we are doing and we are engaging with so many people that are in our facilities and every challenge that they have shown us this is the change that we have made. They also need to celebrate their achievements. They can account to civil society but as we know it is not always possible or done (Manager, TAC, Interview 14).

Discussion

This study appears to demonstrate the potential for innovative tools, utilized by civil society, to monitor and strengthen the health system. One of the earliest and most notable provider report card projects within an LMIC setting was the Bangalore score card -initiated in 1994 in Bangalore, India. This tool was successful in increasing public awareness and generating a new confidence among citizens that collective action was feasible (17). In this study, PTLAs were particularly engaged, and results confirm implementation of this type of governance tool can be an empowering process for members of civil society.

This study affirmed value in a ‘bottom up’ approach to implementing potential HSS interventions. Paul (23) identifies participation as a key underlying value in provider report card development; “though a report card on public services can be conducted as a technical exercise, the dissemination and advocacy work to follow will benefit a great deal if concerned civil society institutions are involved in the process from the start” (23:22). However, the bottom up approach to tool design and implementation did present a challenge from the perspective of the DOH. These actors expressed concern that the approach was not participatory enough, as it did not directly involve them in the creation of the tool. This study demonstrates the challenge to foster capacity and maintain accountability with diverse actor opinions. Findings show that implementation of the monitoring tool was a complex and dynamic process. This study thus compliments other LMIC studies that provide evidence on this point. Maluka et al. (24) found accountability interventions often evolve in response to local circumstances, actor engagement and other events beyond the control of the implementers. In this study, contextual factors such as salary issues, were found to constrain the implementation process. However, the environment was conducive to the implementation of a monitoring tool, as Khayelitsha is often a site for innovative and collaborative pilot projects. In a review of community accountability mechanisms, Molyneux et al. (16)

note how the wider social, political and cultural environment affects community and health system issues. Therefore findings from this study confirm the important influence of context.

Limitations

This study did have some limitations. The action research approach meant the primary researcher was mindful in keeping a balance of; gaining access, forming relationships, being active in the creation and implementation of the tool, but also trying to remain as the external 'researcher' within this project. As all site visits were done with the PTLA supervisor, it is possible that health care workers, facility managers and in-charges could have assumed the primary researcher to be aligned with TAC. This may have influenced interactions at the clinic level and subsequent qualitative interviews with DOH respondents. The primary researcher was also a white foreigner with a nursing background. Recognizing the potential for inherent power and hierarchy issues that can be present when seen as a 'white foreigner' or 'nurse' in South Africa, the researcher was mindful to reflect upon these issues in the reflexive diary, field notes and also in discussions with JA and LG. In addition, most of the TAC members spoke Xhosa in their day to day exchanges with each other. The primary researcher only spoke English, and therefore language could have been a possible barrier to not understanding all exchanges between participants.

In qualitative interviews conducted, there is a risk that respondents might have expressed what they believed the researcher wanted to hear, rather than their true experience with the intervention (social desirability). Due to limited time and scale of the research project, interviews were conducted with a small number of facility managers, and management from the CHCs were not interviewed. In addition, direct health care providers such as nurses in charge, nurses, and clerks were not interviewed, although they may have encountered and/or interacted with the HSS tool at their designated PHC facilities. PTLAs working in those clinics spoke of less resistance with utilizing the tool and therefore larger provincial facilities may have been more comfortable with the tool and the process of implementation. PTLAs are

not present in all of the clinics within Khayelitsha, but are still part of the community. These facilities have also not been reported on, yet they may still face similar advocacy issues.

Conclusions

Tool <i>development</i>: What worked well <ul style="list-style-type: none"> • 'Bottom up' approach to tool development • Regular feedback sessions • Adapting tool to increase patient interaction
Tool <i>development</i>: Challenges <ul style="list-style-type: none"> • Ensuring quality data collection and entry • Paper based system of reporting laborious • Not all stakeholders on board with the tool
Elements <i>facilitating implementation</i> <ul style="list-style-type: none"> • Local champion (PTLA supervisor) who had longstanding relationships with all stakeholders involved • DOH priority towards HSS and patient centered health system • Close relationships between MSF, TAC and the local government
Elements <i>constraining implementation</i> <ul style="list-style-type: none"> • Poor stakeholder awareness (DOH level) • Pressure on TAC to produce results in view of funding crisis • No formalized reporting mechanism to report results of tool to relevant stakeholders

Figure 4: Summary assessment of the HSS tool

The findings from this study suggest that civil society plays an important role for patient advocacy within the health system, in order to re-orient health services towards patient centred health systems. In the context of achieving universal health coverage in South Africa, this intervention presents an innovative opportunity to empower communities and patients, for improved primary health services. However, advocacy demands should be actionable items that can be carried out by citizens and/or communicated to providers, in order to foster positive relationship between all stakeholders.

Additional challenges to implementation of the tool included lack of technical capacity to carry out data collection and analysis of tool findings, as implementing actors were not accustomed to M&E processes. Findings in this study have highlighted the need for CSO monitoring tools to be not only methodologically sound but, more importantly, accepted by the activists. Additionally, monitoring tools

must be authorized and seen as relevant by service providers, government and donors. It can be a challenge to achieve balance in order to please all stakeholders.

This study's exploration of the development and implementation process of a monitoring tool extends the available evidence on the role of civil society in HSS. The results are useful for understanding how this tool interacts within the local level health system, where constructive community engagement occurs. Recognizing that good governance allows for citizen involvement, policy recommendations center around the need for innovative methods to bring in the voice of civil society for HSS. Such findings may have implications for further adaptations to the tool, potential scale-up by TAC and/or MSF, and for other LMIC contexts. Continued work is warranted with civil society and policy makers to institutionalize community participation in monitoring and partnering with health services at the district and sub-district level.

List of abbreviations used

ARV	Antiretroviral
CoCT	City of Cape Town Health Services
CHCs	Community Health Centers
CSO	Civil Society Organization
DHIS	District Health Information System
HIV	Human Immune Deficiency Virus
HSS	Health Systems Strengthening
LMIC	Low and Middle Income Country
MSF	Medecins Sans Frontieres
MOU	Memorandum of Understanding
M & E	Monitoring and Evaluation
NHI	National Health Insurance
PHC	Primary Health Care
PTLA	Patient Treatment Literacy Advocate
TAC	Treatment Action Campaign
TB	Tuberculosis
WHO	World Health Organization
WCG	Western Cape Government

Competing interests

None declared

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Appendix A: Information Sheet + Consent Form for Semi-structured Interview



UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA - UNIVERSITEIT VAN KAAPSTAD

**What is the functioning and potential influence of civil society within PHC facilities in
Khayelitsha, South Africa?**

I. Who is conducting the study?

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Background:

The information provided here can be explained to you verbally and if needed, in Xhosa or Akfrikaans. I would like to know more from your perspective how civil society organizations like TAC can help to strengthen the health system. I am also interested the process of implementing a specific tool and your views on that process. This information also serves as an agreement between you and me as we share this learning process. I encourage you to ask me questions if you do not understand the information being explained to you either by me or the translator. I have been given permission by the University of Cape Town to do this study. After understanding the information explained to you, it is up to you to decide whether you would like to talk to me.

II. What is the purpose of this study?

The study is part of my Masters of Public Health at the University of Cape Town. The research project focuses on a tool created by Treatment Action Campaign (TAC) and Medecins Sans Frontieres (MSF). This tool is utilized daily by Patient Treatment Literacy Advocates (PTLAs) in health clinics within Khayelitsha. This tool has been recently changed to add a section to monitor the quality of health care in those clinics. The purpose of this study is to see whether this change is helpful and to look at the policy process surrounding it.

III. Why are we doing this study and why should you take part in this study?

TAC is an example of what is called civil society organization. This study will be looking more closely at how civil society can help to make health services better for the community. Your opinions are very important in helping us to understand how civil society can do that. The research is also going to be used for my master's degree, and I hope it will also help to create better policies in the future. I aim to get the research published.

IV. What would I have to do?

I would like to have an interview with you that will take about 30-45 minutes of your time, at a place that is convenient for you. The interview will be casual and like a conversation. During this conversation, I will ask you some questions. The questions will be about this tool, and I would also like to know your opinions and ideas about how civil society can help to improve health care. With your permission, I would like to record the conversation about your agreement to take part, as well as the general conversation. The recorded information will later be typed up and I will be the only one to do that.

V. Study results

A report of the study results will be completed and shared with people in MSF and TAC, as well as those who deliver health services in Khayelitsha. The information collected will be helpful in creating better services for the community. The study results will also be published in academic journals and presentations.

VI. Is there any way being in this study could be bad for you?

This study will not pose any harm to you personally. If you do not want to answer particular questions, we will move on to the next question. Before agreeing to talk with me, you are encouraged to ask questions and discuss with me any of your doubts or fears. The risks will be minimal. We may discuss sensitive issues, but confidence will be respected and all efforts will be maintained to keep your responses anonymous and unidentifiable. I will not write your name or contact details on interview sheets. Also remember if you do not want to answer a question, you do not have to.

VII. What are the benefits of participating in this study?

Your participation will not benefit you directly, but will benefit the health sector of this country by providing evidence on future policy related to how civil society organizations like TAC, can help to strengthen the health system. There will be no other risks to you from taking part in these interviews, and you will be helping important people to better understand how this can be done better.

VIII. How will your identity be protected and your privacy maintained?

The interview will be totally confidential, so you should know you can tell me anything you feel comfortable with. I also promise that I will not judge anything you say, and you cannot get into trouble for saying it. Code numbers will be used for the interview. A list of people I interview along with the code number and consent forms will be stored separately from the data. All materials related to this discussion (tapes, digital recordings, hard copies of transcripts, electronic files on disk), will be stored in my office in a locked cabinet or on a password protected computer. These data will be stored for the standard time period (5 years) after which the records will be destroyed.

I do want to use the information you give me in my Master's degree and publications. If I do, I will not use any part of your real name and I won't say where you work -your identity will be kept secret and confidential. I will most likely not even have to refer to you, but if I do, I will call you 'Facility manager from Clinic Y' or 'TAC Member' as examples. If I do that I will also then check with you later that I have written what you said and meant accurately. I want you to be a part of this process.

IX. Will you be paid for your time/ taking part in this research study?

You will not be paid for the time you take to be in this study.

X. Who can you contact if you have questions about the study?

If you have any questions or concerns about what we are asking you, please contact myself or one of my supervisors. The names and telephone numbers are listed at the top of the first page of this form.

XI. Who can you contact if you have complaints or concerns about the study?

If you have any complaints about your treatment or rights as a research subject, you may contact the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee, Room E54-24 Groote Schuur Hospital Old Main Building, Observatory, 7925, Telephone +27 (0) 21 406 6626, facsimile +27 021 406 6411, email: shuretta.thomas@uct.ac.za The research Ethics Board comprise of staff of the University of Cape Town who see to it that all humans participating in research do so devoid of harm or coercion. They ensure that participants' rights are protected. These group of people have reviewed and

approved of this study and will be more than happy to respond to your questions if you have any doubts.

XII. Participant consent

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on access to healthcare services. *You may refuse to answer any question you do not wish to respond to. You may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed.*

Consent:

I understand the information Jessica Barker has explained to me concerning this study and I agree to take part. I understand that I am volunteering to talk, but I can decide at any time to stop the conversation. If I do not want to continue and there will be no problem. I may refuse to answer any specific questions or I may stop the interview at any time if I feel uncomfortable continuing. I understand that some of my exact words may be used in the final print form which the general public may have access to later, but my name will not be used. I have been assured that I can ask questions, and that all questions I have will be answered to my satisfaction. I understand that I will give approximately 45-60 minutes of my time for our conversation.

I have either read or had the consent read to me and have had all of my questions answered. The study has been explained to me and I understand that completing the interview indicates my consent.

I agree to let you: take notes during the interview / Record the interview [circle as appropriate]

Signature and name of participant:

Signature: _____ Name: _____

Signatures and name of person who sought consent (principal researcher):

Signature: _____ Name: _____

Date: _____

Appendix B: Interview Guide for Semi-structured interviews



UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA - UNIVERSITEIT VAN KAAPSTAD

Date: __/__/____ ID #: ____

INTRODUCTION:

As a key person in the health sector, it is important to obtain your opinion and that of your organization. I would like to ask you a few specific questions about your opinion regarding a 'Health Systems Strengthening' monitoring tool that has been recently implemented within PHC facilities in Khayelitsha.

YOUR OPINION:

1. Have you heard of this HSS monitoring tool?
2. If so, how did you hear of it?
3. What do you think this tool is for?

This was a pilot project implemented by the Treatment Action Campaign (TAC) and Medecins Sans Frontieres (MSF) in July of this year. The HSS monitoring tool is an adaptation made to a form previously used by Patient Treatment Literacy Advocates (PTLAs). The new indicators added cover human resources, provision of services, clinic environment, and community mobilization standards. In addition to their advocacy and education roles, PTLAs are now filling out these forms within their designated facilities in Khayelitsha (Show copy of 'Daily Checklist for PTLAs' and 'Weekly Checklist for PTLAs')

Let's talk next about the indicators found on the HSS monitoring tool. (prompt for feedback on new indicators: human resources-absenteeism; provision of services-length of queues, patients turned away from services, missing folders, drug stock-outs, staff attitude; clinic environment; community mobilization-clinic committees)

4. Which of the indicators on the tool do you support? Why?

5. Which of the indicators on the tool do you oppose? Why?

Now let's talk more generally about the HSS monitoring tool.

6. What factors enabled or hindered the implementation of this tool? *(prompt for contextual, individual and organizational barriers/enablers)*

7. What is the potential to you and your organization of using this tool? *(prompt for advantages/disadvantages)*

8. Which of these categories best describes your opinion of the tool *(Read answer options and circle answer given.)*

a) I strongly support it

b) I somewhat support it

c) I do not support nor oppose it

d) I somewhat oppose it

e) I strongly oppose it

If stakeholder answers a, b, or c, continue below. If stakeholder answers d or e, pass to question #11.

For those who answer "a," "b," or "c" to question #8:

9.

- a) In what manner would you demonstrate this support?
- b) Would you have many, some, or no resources to dedicate to supporting this policy?
- c) Would this support be public?
- d) Would you ally with any other persons or organizations in these actions?
- e) What conditions would have to exist for you to express this support?
- f) Would you take the initiative in supporting this tool, or would you wait for others to do so?
- g) How quickly would you be able to mobilize your support?

10. Under what conditions would you choose NOT to support the tool?

For those who answered “d” or “e” to question #8:

11.

- a) In what manner would you demonstrate this opposition?
- b) Would you have many, some, or no resources to dedicate to opposing this policy?
- c) Would this opposition be public?
- d) Would you ally with any other persons or organizations in these actions?
- e) What conditions would have to exist for you to express this opposition?
- f) Would you take the initiative in opposing the tool, or would you wait for others to do so?
- g) How quickly would you be able to mobilize your opposition?

12. Under what conditions would you come to support this tool?

I would now like to ask you a few specific questions about your opinion regarding others’ opinions of the HSS monitoring tool.

OTHER SUPPORTERS:

13. What other organizations, departments within an organization, or persons do you think would support this tool? *(Prompt for DOH and non-DOH stakeholders)*
14. What do you think these supporters would gain from the implementation of this tool?
15. Which of these supporters would take the initiative to actively support the implementation of this tool?
16. Which of these supporters would work together to demonstrate their support for this tool?
17. Under what conditions do you think these actors would come to oppose this tool?

OTHER OPPOSORS:

18. What other organizations, departments within an organization, or persons do you think would oppose this tool? *(Prompt for DOH and non-DOH stakeholders)*
19. What do you think these opponents would gain from preventing the implementation of this tool?
20. Which of these opponents would take the initiative to actively oppose the implementation of this tool?
21. Which of these actors would work together to demonstrate their opposition of this tool?
22. Under what conditions do you think these actors would come to support this tool?

Let's talk now about the potential for expanding (or scaling up) this pilot project.

SCALE-UP POTENTIAL:

23. Do you see this tool working in other districts in the Western Cape and/or South Africa? *(Prompt for why or why not)*

OTHER:

24. Anything else you would like to comment on that we haven't covered?

We are now finished. Thank you for your time!

Appendix C: E-mail script for Actor Recruitment



UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

Dear, _____

My name is Jessica Barker, and I am a Masters of Public Health Student (Health Systems Track) at the University of Cape Town. As part of my thesis I am completing a research project with Medecins Sans Frontieres (MSF) and Treatment Action Campaign (TAC). The study focuses on a health systems strengthening (HSS) project recently initiated by MSF and TAC. HSS has the potential to improve the efficiency and quality of health services within Khayelitsha, and a system that is responsive to the needs of the community.

The research project centers on TAC and MSF's newly adapted Monitoring and Evaluation (M & E) tool being utilized in primary healthcare facilities within Khayelitsha sub-district. Patient Treatment Literacy Advocates (PTLAs) complete these forms on a daily/monthly basis in their designated facilities. The aim of this research project is to look at the implementation of this tool, how it can affect accountability within the health system, and also to analyze the policy process surrounding the implementation of the initiative.

I would like to interview you about the implementation of this tool, in order to gather perspectives from key stakeholders. This interview would be conducted in the location of your choice and would take approximately 30-45 minutes of your time. Please let me know if you would be available for an interview, they would be conducted anytime between 22nd September and 17th October, 2014. This is an opportunity to assess the potential role of civil society in the growing field of HSS and your feedback is valuable.

Thank you,

Jessica Barker

Appendix D: TAC-Letter of Support



Mandla Majola
Western Cape Coordinator
Treatment Action Campaign
Town One Properties, Sulani Drive
Site B, Khayelitsha

To Whom It May Concern,

17 July, 2014

I am writing on behalf of the Treatment Action Campaign (TAC), to offer support towards a research project conducted by Masters of Public Health student, Jessica Barker, at the University of Cape Town. This study would focus on a health systems strengthening (HSS) project TAC is undertaking, in partnership with Medecins Sans Frontieres (MSF). The aim of the research project is to assess whether the HSS intervention was effective and also to analyze the policy process surrounding the implementation of the initiative.

TAC and MSF have a long standing history, solidified in a Memorandum of Understanding (MOU), aimed at increasing the effectiveness of their activities. The document reflects TAC's renewed focus on local activism with the aim of improving access to and the uptake of prevention and treatment services. This forms a pilot initiative that uses strategic service delivery to ensure TAC is able to continuously monitor the provision and quality of prevention and treatment services within Khayelitsha.

The research project focuses on TAC and MSF's newly adapted Monitoring and Evaluation (M & E) tool being utilized in primary healthcare facilities within Khayelitsha. It will be completed on a daily/monthly basis in identified facilities by TAC's Patient Treatment Literacy Advocates (PTLAs). I give clearance for MPH candidate, Jessica Barker, to utilize the data collected by the PTLAs. I understand that she will be analyzing this data retrospectively in order to complete her thesis project. If we are able, we will offer a TAC intern to assist with data capturing. I also support interviews of TAC members in order to analyze the policy process. We would also collaborate to ensure dissemination of these research findings.

Ultimately this research project is valuable for TAC, as it helps to inform our HSS agenda as we move forward as an organization. It is also a unique opportunity to assess the potential role of civil society in the growing field of HSS.

Sincerely,

A handwritten signature in black ink, appearing to read 'MCM', enclosed within a hand-drawn oval.

Mandla Majola

Appendix E: HSS Monitoring Tool (Initial Version)



DAILY FACILITY CHECKLIST FOR PTLAs

Please fill this form out in the morning on one day and the afternoon the next day, every day

BACKGROUND SECTION

Name:

Date: Day of the week: Time of day:

Province: Type of Facility:

Facility name:

Q1. Education

1.1 Session details:

Type of Session	# of Sessions	Main Topic	# of Males	# of Females
One on one				
Group session				
Presentation at other facility/branch Where: <input type="text"/>				
Other				

1.2 The end-results of the session: (Who wants to access the service as a result of this session?)

Ensure that this information provided below is submitted with a corresponding Service Accessed Register		
Name of service	Number of males	Number of females

1.3 What other health services did people require as a result of you giving PTL SESSIONS?

Ensure that this information provided below is submitted with a corresponding Service Accessed Register		
Name of service	Number of males	Number of females

Q2. Human Resources

2.1 Who is missing from the clinic today?

THEIR ROLE/TITLE	NUMBER	JUSTIFICATION



Q3. Performance in the provision of services

3.2 Length of queues (tick all that apply):

SERVICE	NUMBER OF PATIENTS IN QUEUE								
	0-20	21-40	41-60	61-80	81-100	101-120	121-140	141-160	160+
Reception									
Pharmacy									
ARI Service									
TB Service									
TOP									
STIs									
HCT									
HPV									
Other:									

3.3 Any patients turned away today from the services listed above?

LOCATION	NUMBER	JUSTIFICATION

3.4 How many patients with missing folders today?

0-10	11-20	21-30	31-40	41-50	51-60	61-70

3.5 Condoms available in all the rooms today?

☐ Yes ☐ No

3.6 Any patient complaints about the clinic today? What was the advisory issue resolved today?

Advisory Target	
Advisory Demand	
Activity	
Actual end-results	
Lesson Learnt	

This section should be verified by a person in a leadership role such as a member of the DEC, PCC or Clinic Supervisor

Signature Verification

This section is used to ensure the issues identified are addressed as a means to facilitate resolution of this data on the day it is collected.

Name and surname: _____ Signature: _____

Position: _____ Date: _____



WEEKLY FACILITY CHECKLIST FOR PTLAs

Please fill this form out every Thursday and bring to TAC office on Friday

BACKGROUND SECTION

Name:

Date: Day of the week: Time of day:

Province: Type of Facility:

Facility name:

Q1. Human Resources

1.1 List the number of each employed by the facility at the present time (1/2 if part time):

HUMAN RESOURCES COUNT	NUMBER	HUMAN RESOURCES COUNT	NUMBER
Medical manager		Allied Health Professionals	
Human Resource Manager		Pharmacist	
Doctors - Medical Specialists		Pharmacy assistants (Post Basic)	
Doctors - Registrars		Pharmacy assistants (Basic)	
Doctors - External Visiting Medical Specialists		Pharmacy interns	
Doctors - External Visiting Medical Practitioners		Pharmacy manager	
Doctors - Medical Practitioner Interns		Lay Counsellors	
Doctors - Medical Practitioners		Medical equipment maintainer	
Nursing management		Medical and Science Technicians / Technologists	
Nursing Staff - Professional Nurse		Other Infrastructure and Construction related Technicians	
Nursing Staff - Clinical Nurse Practitioners		Clinical engineering technician	
Nursing Staff - Enrolled Nurse		Administrative staff	
Nursing Staff - Enrolled Nurse Assistant		Community Health Workers (CHW)	
Nursing Staff - Advanced Midwives		Cleaner	
Nursing Staff - Specialized Nurses (Excluding Advanced Midwives)		Security guard	

Appendix F: HSS Monitoring Tool (Final Version)



DAILY FACILITY CHECKLIST FOR PTLAs

Background Section

Name:

Date: Day of the week:

Province: Type of facility:

Facility name:

Q1. Education

Session details:

Type of Session	# of Sessions	Main Topic	# of Males	# of Females
One on one				
Group session				
Presentation at other facility/forums				
Where: <input type="text"/>				
Other: <input type="text"/>				

Services Accessed (as a result of sessions)		
Name of service	# of Males	# of Females
<input type="text"/>		

Q2. Any major staffing issues at the clinic today (e.g. nurse missing so closed STI clinic)?

☐ Yes ☐ No If yes, who was missing?:

Q3. Stock-outs of any medication today?

☐ Yes ☐ No If yes, what meds?:

Q4. How many patients with missing and/or duplicate folders today?

Number of missing folders: Number of duplicate folders:

Page

(WC / -- / -- / PTL / -----) (PROV / YY / MM / PTL / 0000)



Q. 5 Patient Interviews

Note that 5 patients must be interviewed every day as they exit the clinic and ask the following questions and fill in the details after the example.

No.	Services accessed (e.g. ICT, Family Planning, TA...)	File accessed?	Turned away? (where?)	Time arrived	Time left	Other issues, including treatment by staff? (specify below)
Example	Family planning, ICT	Missing	HCT	08:30	10:00	Confidentiality – open doors
1						
2						
3						
4						
5						



WEEKLY FACILITY CHECKLIST FOR PTLAs

Please fill this form out every Thursday and bring to TAC office on Friday

BACKGROUND SECTION

Name:

Date: Day of the week:

Province: Type of facility:

Facility name:

Q1. Services

1.1 Any services that weren't provided this week?

LOCATION	Why?
Example: family planning	Medication out of stock, not enough staff to provide the service

1.2 Condoms available in all the rooms this week?

Male ☐ Yes ☐ No

Female ☐ Yes ☐ No

1.3 Any issues with staff attitude this week?

☐ Yes ☐ No

If yes, please explain:



Q2. Workplace conditions

Tick which answer applies:

FACILITY ENVIRONMENT	YES	NO	ISSUE
Patients standing due to lack of seats			
Lack of space/confidentiality			
Leaks or holes in roof			
Safety concerns			
Windows not open			
Dirty male and female toilets			
Dirty surfaces around the facility			
Overflowing dustbins			

Q3. Advocacy Action Plan

3.1 What are the top three advocacy issues in your clinic this week?

1.
2.
3.

3.2 Any steps taken to mobilize the facility manager/community and address issues above?



Q. 5 Patient Interviews

Note that 5 patients must be interviewed every day as they exit the clinic and ask the following questions and fill in the details after the example.

No.	Services accessed (e.g. HCT, Family Planning, TB...)	File accessed?	Turned away? (whom?)	Time arrived	Time left	Other Issues, including treatment by staff? (specify below)
<i>Example</i>	Family planning, HCT	Missing	HCT	09:30	10:00	Confidentiality – open doors
1						
2						
3						
4						
5						

Appendix G: Ethics approval



CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

CITY HEALTH

Dr Hélène Visser
Manager: Specialised Health

T: 021 400 3981 F: 021 421 4894 M: 083 298 8718
E: Helene.Visser@capetown.gov.za

2014-09-10

Re: Research Request: What is the functioning and potential influence of civil society within PHC facilities in Khayelitsha, South Africa? (ID NO: 10437)

Dear Dr Barker,

Your research has been approved in the Khayelitsha Sub District.

Khayelitsha Sub District:

Contact People

Dr V de Azevedo (Sub District Manager)
Tel: (021) 360-1258/ 083 629 3344
Mrs S Patel Abrahams (Head: PHC & Programmes)
Tel: (021) 360-1153/ 084 405 6065
6361

Please note the following:

1. Please liaise with Dr de Azevedo about the facility check list with a view to making this shorter and simpler.
2. All individual patient information obtained must be kept confidential.
3. Access to the clinics and its patients must be arranged with the relevant Managers such that normal activities are not disrupted.
4. A copy of the final report must be sent to the City Health Head Office, P O Box 2815 Cape Town 8001, within 6 months of its completion and feedback must also be given to the clinics involved.
5. Your project has been given an ID Number (10437). Please use this in any future correspondence with us.
6. No monetary incentives to be paid to research subjects on the City Health premises.

Thank you for your co-operation and please contact me if you require any further information or assistance.

Yours sincerely

DR G H VISSER
MANAGER: SPECIALISED HEALTH

cc. Dr de Azevedo & Mrs Patel Abrahams
Dr Jennings
Ms Caldwell

CIVIC CENTRE IZIKO LOLUNGU BURGERSENTRUM
HERTZOG BOULEVARD CAPE TOWN 8001 P O BOX 2815 CAPE TOWN 8000
www.capetown.gov.za

Making progress possible. Together.



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



Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 5412 • Facsimile [021] 406 5411
Email: Sunayah.arietien@uct.ac.za
Website: www.health.uct.ac.za/hrs/research/humanethics/Forms

18 August 2014

HREC/REF: 566/2014

Prof L Gilson
School of Public Health & Family Medicine
Falmouth Annex
FHS

Dear Prof L Gilson:

Project Title: WHAT IS THE FUNCTIONING AND POTENTIAL INFLUENCE OF CIVIL SOCIETY WITHIN PHC FACILITIES IN KHAYELITSHA, SOUTH AFRICA? (Master's candidate-J Barker)

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

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

Approval is granted for one year until the 30 August 2015.

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.

We acknowledge that the following student-J Barker is also involved in this project.

Please note that the on going ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC REF in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKHAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001537.

Institutional Review Board (IRB) number: IRB00001938

Hrec/ref:566/2014

Appendix H: Journal requirements

Title page

The title page should:

- provide the title of the article
- list the full names, institutional addresses and email addresses for all authors
- indicate the corresponding author

Please note:

- the title should include the study design, for example "A versus B in the treatment of C: a randomized controlled trial X is a risk factor for Y: a case control study"
- abbreviations within the title should be avoided

Abstract

The Abstract of the manuscript should not exceed 350 words and must be structured into separate sections: **Background**, the context and purpose of the study; **Methods**, how the study was performed and statistical tests used; **Results**, the main findings; **Conclusions**, brief summary and potential implications. Please minimize the use of abbreviations and do not cite references in the abstract. **Trial registration**, if your research article reports the results of a controlled health care intervention, please list your trial registry, along with the unique identifying number (e.g. **Trial registration**: Current Controlled Trials ISRCTN73824458). Please note that there should be no space between the letters and numbers of your trial registration number. We recommend manuscripts that report randomized controlled trials follow the [CONSORT extension for abstracts](#).

Keywords

Three to ten keywords representing the main content of the article.

Background

The Background section should be written in a way that is accessible to researchers without specialist knowledge in that area and must clearly state - and, if helpful, illustrate - the background to the research and its aims. Reports of clinical research should, where appropriate, include a summary of a search of the literature to indicate why this study was necessary and what it aimed to contribute to the field. The section should end with a brief statement of what is being reported in the article.

Methods

The methods section should include the design of the study, the setting, the type of participants or materials involved, a clear description of all interventions and comparisons, and the type of analysis used, including a power calculation if appropriate. Generic drug names should generally be used. When proprietary brands are used in research, include the brand names in parentheses in the Methods section.

For studies involving human participants a statement detailing ethical approval and consent should be included in the methods section.

For further details of the journal's editorial policies and ethical guidelines see ['About this journal'](#).

For further details of the journal's data-release policy, see the policy section in ['About this journal'](#).

Results and discussion

The Results and discussion may be combined into a single section or presented separately. Results of statistical analysis should include, where appropriate, relative and absolute risks or risk reductions, and confidence intervals. The Results and discussion sections may also be broken into subsections with short, informative headings.

Conclusions

This should state clearly the main conclusions of the research and give a clear explanation of their importance and relevance. Summary illustrations may be included.

List of abbreviations

If abbreviations are used in the text they should be defined in the text at first use, and a list of abbreviations can be provided, which should precede the competing interests and authors' contributions.

Competing interests

A competing interest exists when your interpretation of data or presentation of information may be influenced by your personal or financial relationship with other people or organizations. Authors must disclose any financial competing interests; they should also reveal any non-financial competing interests that may cause them embarrassment were they to become public after the publication of the manuscript.

Authors are required to complete a declaration of competing interests. All competing interests that are declared will be listed at the end of published articles. Where an author gives no competing interests, the listing will read 'The author(s) declare that they have no competing interests'.

When completing your declaration, please consider the following questions:

Financial competing interests

- In the past three years have you received reimbursements, fees, funding, or salary from an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? Is such an organization financing this manuscript (including the article-processing charge)? If so, please specify.
- Do you hold any stocks or shares in an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? If so, please specify.
- Do you hold or are you currently applying for any patents relating to the content of the manuscript? Have you received reimbursements, fees, funding, or salary from an organization that holds or has applied for patents relating to the content of the manuscript? If so, please specify.

- Do you have any other financial competing interests? If so, please specify.

Non-financial competing interests

Are there any non-financial competing interests (political, personal, religious, ideological, academic, intellectual, commercial or any other) to declare in relation to this manuscript? If so, please specify.

If you are unsure as to whether you, or one your co-authors, has a competing interest please discuss it with the editorial office.

Authors' contributions

In order to give appropriate credit to each author of a paper, the individual contributions of authors to the manuscript should be specified in this section.

According to [ICMJE guidelines](#), An 'author' is generally considered to be someone who has made substantive intellectual contributions to a published study. To qualify as an author one should 1) have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; 2) have been involved in drafting the manuscript or revising it critically for important intellectual content; 3) have given final approval of the version to be published; and 4) agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. Acquisition of funding, collection of data, or general supervision of the research group, alone, does not justify authorship.

We suggest the following kind of format (please use initials to refer to each author's contribution): AB carried out the molecular genetic studies, participated in the sequence alignment and drafted the manuscript. JY carried out the immunoassays. MT participated in the sequence alignment. ES participated in the design of the study and performed the statistical analysis. FG conceived of the study, and participated in its design and coordination and helped to draft the manuscript. All authors read and approved the final manuscript.

All contributors who do not meet the criteria for authorship should be listed in an acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chair who provided only general support.

Authors' information

You may choose to use this section to include any relevant information about the author(s) that may aid the reader's interpretation of the article, and understand the standpoint of the author(s). This may include

details about the authors' qualifications, current positions they hold at institutions or societies, or any other relevant background information. Please refer to authors using their initials. Note this section should not be used to describe any competing interests.

Acknowledgements

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Healthwise Knowledgebase. US Pharmacopeia, Rockville. 1998. <http://www.healthwise.org>. Accessed 21 Sept 1998.

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Doe, J: Title of preprint. <http://www.uni-heidelberg.de/mydata.html> (1999). Accessed 25 Dec 1999.

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