EXPLORING MECHANISMS FOR RECEIVING AND RESPONDING TO CITIZEN FEEDBACK IN LMIC HEALTH SYSTEM: A MIXED METHODS EVIDENCE MAPPING OF THE WESTERN CAPE PROVINCE OF SOUTH AFRICA

TAMARYN SUTHERNS

STHTAM003

Submitted in partial fulfilment of the requirements for the degree

MASTER OF PUBLIC HEALTH

(Health Systems Specialization)

At

UNIVERSITY OF CAPE TOWN

March 2020

Supervised By:

A/Prof Jill Olivier

Plagiarism declaration

I, Tamaryn Sutherns, hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the university to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

Signature: Signed by candidate

Date: 28 March 2020

Abstract

Despite national governments striving for responsive health systems and the implementation of mechanisms and interventions to foster citizen feedback and participation in health, current evidence does not adequately address these mechanisms and interventions in low-income and middle-income countries (LMICs).

This mixed method descriptive and exploratory study 'maps' types of health system responsiveness mechanisms and their functionality in the South African health system, with a focus on the Western Cape Province, based on the available descriptive evidence.

Multiple forms of data are scrutinized and synthesized to provide a deeper, contextual understanding of ´formal´ mechanisms that are constituted or mandated into South African and Western Cape policies and guidelines.

This research shows that while national, provincial and district policies make strong provisions for health system responsiveness, including mechanisms to foster citizen feedback, in reality, implementation is not standardised and sometimes non-functional.

Many of these mechanisms also currently exist in isolation, failing to feed into an overarching strategy of health system responsiveness, where feedback mechanisms may complement one another and lead to quality improvement in the health system.

While there are cases for effective and well-functioning mechanisms for receiving and responding to citizen feedback, government on all levels is often hampered by resources and other constraints. These findings have implications for health researchers as well as national and provincial policymakers, seeking to enhance health system functioning.

Acknowledgements

To Associate Professor Jill Olivier, who supported me throughout the three year process, including offering me a wealth of patience and assistance while completing the MPH from across the world.

A thank you to my interesting and dynamic MPH colleagues, who helped this work to feel shared, while offering unique perspectives and experiences from a variety of backgrounds and countries.

And to my family, my husband and my friends, for spending the last three years offering kindness, validation and acknowledgement – all of the things needed to keep pushing forward. Thank you.

Acronyms and abbreviations

ANC	African National Congress
CAR	Capacity-Accountability-Responsiveness
CBO	Community-based organisation
CCSC	Complaint, Compliment and Suggestion Committee
CFRM	Community Feedback and Response Mechanism
CHSS	Community Health Systems Strengthening
CHW	Community Health Worker
CG	Community Group
CSS	Client Satisfaction Survey
CTC	Close-to-community
DA	Democratic Alliance
DCE	Discreet choice experiment
DFID	Department of International Development
DOH	Department of Health
LMIC	Low-income and middle-income countries
HFC	Health Facility Committee
HIC	High-income countries
HIV	Human Immunodeficiency Virus
IEC	Information, education, communication
ICT	Information, communication and technology
MDG	Millennium Development Goals
NGO	Non-governmental organisation
NPO	Non-profit organisation
NHA	National Health Act
NHC	National Health Council
NHRD	National Health Research Database
NHIS	National Health Insurance Scheme
OHO	Office of the Health Ombudsman
OHSC	Office of Health Standards Compliance
PHC	Primary health care
PI	Principal Investigator
PICO	Population, Intervention, Comparator, Outcome
PSI	Patient safety incidents
PSS	Patient Satisfaction Survey
SA	South Africa
SADOH	South African Department of Health
SOP	Standard Operating Practice
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
UNDP	United Nations Development Programme
WBPHCOT	Ward-based Primary Health Care Outreach Teams

WC	Western Cape
WCDOH	Western Cape Department of Health
WHO	World Health Organization
WHS	World Health Survey
WP	Western Cape Province (South Africa)

Glossary of key terms

Accountability mechanisms	"Governance tools that seek to regulate answerability between the health system and the community (external accountability) and/or between different levels of the health system (bureaucratic accountability)" (Cleary et al, 2013).
Formal feedback mechanisms	Measures that "support a broad range of activities that include information dissemination, monitoring, norm setting, peer pressure, mediation, contestation and institutionalized coproduction between various actors in both public and private sectors" (George, 2009).
Health policy	The decisions, plans and actions undertaken to achieve specific health goals (WHO, 2017).
People-centredness	"Ultimately directs attention to the need for spaces in which people´s voices have influence in shaping the health system that seeks to serve their interests, i.e. the public interest (Sheikh et al, 2014).
Responsiveness	"When institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals" (de Silva, 2000).

Contents

PROTOCOL

Introduction

Health system responsiveness is a concept that is prominent in health systems literature and a goal that is key to many national government health system strategies. The World Health Organization (WHO) considers a health system to be responsive "when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals" (de Silva, 2000). In more recent research, responsiveness is aligned with accountability and community participation in health systems (Mirzoev and Kane, 2017; Adam et al., 2012).

A responsive health system is considered significant because if it responds appropriately to citizen expectations, it can "anticipate and adapt to future health needs, and harness emerging opportunities to promote universal access to effective interventions" (Ebenso et al., 2017). Thus a responsive health system is considered necessary for legitimate services, relating to an individual´s experience based on factors such as their needs, rights and/or or values (Robone et al., 2011). Through a prominent WHO-developed measurement tool, responsiveness can be measured by eight factors: dignity, autonomy, prompt attention, choice of service provider, communication, confidentiality, quality of amenities and access to social support (Askari et al., 2016). A responsive health system that measures well in this framework is one that is considered as contributing to better health outcomes for citizens (Mirzoev and Kane, 2017).

This fits into the WHO Health Systems Framework (WHO, 2007), which details how the building blocks of service delivery, health workforce, information, medical products, vaccines and technologies, financing and leadership/governance play a role in access, coverage, quality and safety, leading to the outcomes of improved health, responsiveness, social and financial risk protection and improved efficiency.

For this reason, feedback from health service users is being requested more regularly by governments and researchers across the globe in order to gain information on health service experiences, with a systematic review showing that collecting this feedback has a positive impact on health services as it facilitates patient participation and accountability (Ebenso et al., 2017; Mirzoev and Kane, 2017).

Yet, despite national governments striving for responsive health systems and the implementation of mechanisms and interventions to foster accountability, citizen feedback and participation in health, it is argued that current evidence does not appear to adequately address these mechanisms and interventions in low-income and middle-income countries (LMICs) (Mirzoev and Kane, 2017). Furthermore, citizens in these countries do not have as much opportunity to participate and provide feedback in their health systems, with initial engagement in health systems responsiveness literature suggesting inequitable access to feedback mechanisms (Malhotra and Do, 2013; Adesanya et al., 2012). Researchers have argued that inequalities in health responsiveness need to be explored further:

> *"[The] presence of socio-economic disparities in health system responsiveness may be damaging not only from a human rights perspective but also in sustaining confidence in the system. Identifying the extent of such socio-economic disparity can be the first step in improving the quality of health services and patient satisfaction with services in a given health system"* (Malhotra and Do, 2013).

An initial literature search highlights another gap in the LMIC context: the redressing of grievances and the acting upon of patient feedback, "because patients who do not receive responses to their feedback (especially

complaints) are more likely to feel frustrated and disengaged with health services" (Mirzoev and Kane, 2017). Violence against health workers (Ahmed et al., 2018) suggests that feedback and the mechanisms that facilitate feedback may need to be understood and possibly strengthened.

Current global health systems literature features several further shortcomings including a lack of investigation into the interaction between people and their health system, limited recognition of the wider determinants of health system responsiveness and an overwhelming emphasis on health services, rather than the institutional arrangements, processes and relations within health systems, such as accountability (Mirzoev and Kane, 2017).

Furthermore, while there are several frameworks for measuring health system responsiveness, including the WHO´s responsiveness toolset, established in the World Health Report 2000, it is a complex field that lacks adequate research and evidence (Olivier et al., 2017). The frameworks and tools for measuring and determining health system responsiveness, themselves, are also argued to be inadequate (Mirzoev and Kane, 2017; Robone et al., 2011).

Adding to the complexity of this concept is the fact that the comparison of health system responsiveness across different countries and contexts appears to be problematic. The World Health Survey (WHS) is one data collection method that has been used by the WHO to measure health system responsiveness globally. In 2002, 71 countries implemented the WHS in different forms (WHO, 2018). However, as Robone et al (2011) points out, this is challenging because the data is self-reported data and is displayed in order of magnitude (on an ordinal scale) without any standard of measurement of differences, which means the WHS is likely to result in varying interpretations in different contexts (Robone et al., 2011).

These challenges appear to be compounded by the fact that health system responsiveness as a concept or theory is poorly developed. Research seems to focus on patient satisfaction and quality of care in health services, rather than adequately addressing the scope, range and rationale of health system responsiveness (de Silva, 2000) including effects over time.

It is the complexity of the health system, with its adaptiveness, feedback loops and sometimes unexpected outcomes (van Olmen, 2012) that needs to be mapped in order to begin to grapple with the interdependence and interaction between its elements.

Mechanisms for receiving and responding to citizen feedback

The *formal mechanisms* that are supposed to improve responsiveness (and accountability and community participation – which are related) have had slightly more attention than the feedback back into the system. However, in several LMICs, there are emerging signs of attention being paid to mechanisms, and the feedback they produce. For example, in 2017, a protocol was published for an 18-month project that aimed to evaluate the system of collecting and responding to user feedback in Bangladesh (Ebenso et al., 2017). A key point in this study was the two-way flow of interaction in responsive health systems. The researchers argued that this interaction is critical in two ways: "First, it gives service users the opportunity to provide feedback on issues such as their experiences of the care they received, perception of staff expertise, availability of supplies and so on. Second, the interaction provides the health system with the opportunity to collect, respond to and use user feedback" (Ebenso et al., 2017). They also point out that feedback should encompass both complaints and compliments.

In 2018, Feruglio and Nisbett examined "the challenges of institutionalizing community-level social accountability mechanisms for health and nutrition" in a qualitative study in Odisha, India. The study aimed to assess the effectiveness of social accountability mechanisms by mapping community-level mechanisms in three districts, and investigating how they are perceived to function by their members and frontline health workers (Feruglio and Nisbett, 2018). Social participation, in its many forms, has also been explored in LMICs, including in a study in Guatemala (Flores et al., 2009). The researchers argue that "participation can vary from a symbolic act, which does not involve decision making, to processes in which it constitutes the principal tool for redistributing power within a population" (Flores et al., 2009).

The health system responsiveness literature suggests that gaining a better understanding of health system responsiveness is important, particularly for LMICs, where economic and social development is occurring at a rapid pace. In 2008, the WHO published a World Health Report focused on primary health care, entitled *Now More Than Ever*. In it, they point out: "The legitimacy of health authorities increasingly depends on how well they assume responsibility to develop and reform the health sector according to what people value – in terms of health and what is expected of health systems in society" (WHO, 2008). In this vein, 'accountability' in health systems research is an area that has received considerably more attention than health systems responsiveness (although they are closely related, if not inseparable), and has been central to discussions and debates following the Millennium Development Goals (MDGs) (Lodenstein et al, 2013). Accountability is considered a key route to achieving equity and quality in health services (Lodenstein et al, 2013). The Department of International Development (DFID), for example, uses ´accountability´ and ´responsiveness´ in a framework to assess accountability, along with the concept of 'capability' (the so-called Capacity-Accountability-Responsiveness CAR framework). DFID argues that these three concepts interact and reinforce each other, creating a "virtuous cycle of good governance" (DFID and AusAID, 2010).

The literature suggests that interventions that address accountability, responsiveness and capability have been applied in countries across the globe, including in LMICs. These interventions commonly include the implementation of formal feedback mechanisms into the health system, intended to generate feedback about health services and the health system, encourage citizen participation and create an opportunity for the health system to respond to the relevant feedback.

The Bangladesh study highlights the fact that there are two approaches to collecting user experience through formal feedback mechanisms: collecting data by service providers, researchers or managers or when service users actively provide information (Ebenso et al., 2017). Mechanisms commonly highlighted in the literature include community engagement committees, provider report cards, complaints mechanisms such as suggestion boxes, exit surveys, call centres and incident reports, as well as patient rights charters (Cleary et al., 2013).

While these mechanisms are described in LMICs, there appears to be a lack of in-depth evidence on the detail of each mechanism and how they facilitate health system responsiveness beyond the provider perspective (de Silva, 2000), pointing to a need to explore, understand and map these mechanisms more thoroughly.

Box 1: Defining Formal Feedback Mechanisms

For the purposes of this study, we utilise the George (2009) definition of feedback mechanisms, as:

Measures that support a broad range of activities that include information dissemination, monitoring, norm setting, peer pressure, mediation, contestation and institutionalized coproduction between various actors in both public and private sectors. Source: George, 2009

Formal feedback mechanisms in South Africa

In South Africa, where the majority of citizens access public health care services, quality of care – including the interface between provider and patients, between health services and community – is regarded as imperative to transforming the country´s health sector (Mirzoev and Kane, 2017). Understanding the feedback mechanisms that contribute to health systems responsiveness is valuable in this context. As the WHO states:

> "*The ability to engage people as co-producers of care has become a core commitment, not simply as a means to promote active and healthy living and reduce the reliance on institutional and specialist care, but also as a way to pull health systems away from a supply-driven approach that has become disconnected from people's expectations*" (WHO, 2015).

Despite the need for this understanding, the literature on health system responsiveness in South Africa is extremely limited - despite this being a clear policy priority (Health Systems Trust, 2017; Olivier et al., 2017). The literature that does exist focuses on client satisfaction surveys conducted at point-of-care, and broader household and population surveys. It has been widely argued that these are not always the best way to measure quality of care (Health Systems Trust, 2018), and a corollary of that is that patient satisfaction surveys can limit understanding of health system responsiveness (Health Systems Trust, 2018).

The National Department of Health in South Africa (SADOH) has, since 2017, featured a *National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa*, which cites the national *Patient's Rights Charter*: "Everyone in South Africa has the right to complain about the healthcare they receive, to have such complaint investigated and to receive a full response on such investigation," (SADOH, 2017). The guidelines were developed to give citizens access to information on how to complain or give a compliment or suggestion, as well as what to expect once a complaint, compliment or suggestion has been given, while also guiding those in the health sector on the process for managing this citizen feedback. The guidelines stipulate, "It guides a process whereby valuable information is gathered from which the health system could learn and to which it can positively respond by bringing about the required change," (SADOH, 2017).

The national guidelines are detailed, providing definitions of complaints, compliments and suggestions while describing how the management of complaints, compliments and suggestions forms part of clinical governance. It also depicts a three-stage system for managing complaints and includes resources for health facilities such as a form to lodge a complaint or record a compliment or suggestion; specifications for suggestions boxes; posters to inform citizens about complaints, suggestions and compliment processes; a template for registers of complaints, compliments and suggestions; a summary form on the outcome of a complaint investigation; categories for complaints, compliments and suggestions as well as statistical data templates for complaints, compliments and suggestions.

While research, such as the Bangladesh study, appears to have been done in other LMICs in order to descriptively map feedback mechanisms, such as complaints and how they are responded to, an initial review shows little understanding of what feedback mechanisms exist in South Africa beyond suggested national guidelines, or how they interrelate in a complex adaptive health systems context. Annual reports, for example, refer to guidelines or list how many complaints were received in a year and how many were responded to, but data or a national or even provincial descriptive map on what mechanisms exist is not easily available.

Formal feedback mechanisms in the Western Cape Province of South Africa

Considering that there is a quasi-federal structure (Katuu, 2018) in South Africa, with each of the nine South African provinces featuring local governments, there is also a need to map these feedback mechanisms in order to determine if and how they function in the different provinces. Katuu (2018) argues: "A country's system is not simply the product of one, logical policy-making experience but rather the manifestations of many years of historical development. A healthcare system such as the one in South Africa reflects the country's cultural and political administration, as well as its financial and economic capabilities." Like others, the South African health system is made up of systems within systems, and feedback and response flows differently within each province. There is a need to assess feedback mechanisms within varied local provincial contexts, as an initial step to understanding health system responsiveness in South Africa more broadly. Focusing on one province, such as the Western Cape (WC), allows for a more focused initial exploration.

Provincial strategy documents for the Western Cape, include "responsiveness" and "client-centred quality of care" as values and goals (WCDOH, 2011). However there is little evidence of the province´s alignment with *National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa*. Patient satisfaction surveys and complaints and complements are identified as "important sources of feedback" (WCDOH, 2011), but an understanding of and the descriptive mapping of the mechanisms that foster this feedback is needed. While some are referred to, including patient and staff satisfaction surveys, complaint registers as well as clinic committees and health forums, confirming the existence of feedback mechanisms and describing the processes and functions of these mechanisms in the provincial and national context will assist a deeper exploration of health system responsiveness in South Africa.

This study aims to contribute to wider health systems literature on accountability, capability and responsiveness, by focusing on and descriptively mapping mechanisms that enable both citizens to provide feedback and health systems to respond to feedback in the South African health system.

Research aims and objectives

Aims:

1. To inform understanding of mechanisms that exist in South Africa's health system for receiving and responding to citizen feedback
2. To contribute to a broader study exploring health system responsiveness in South Africa

Objectives:

1. To review, via a desk-based study and secondary analysis, the current literature on health system responsiveness mechanisms in LMICs
2. To explore and descriptively map the evidence on formal feedback mechanisms that exist in the South African health system, focusing on the Western Cape Province
3. To trace the functioning of health responsiveness mechanisms in South Africa, identifying any policy reforms and innovations

4. To check findings from synthesised documentation with experts in the Western Cape health system[1]

Research purpose and level

The research study is low-risk, descriptive and exploratory in purpose (Robson, 2002), seeking to 'map' health system responsiveness mechanisms and (if possible) begin to assess their functionality in the South African health system, using the Western Cape Province as a 'case' example.

The focus will be on ´formal´ feedback mechanisms that are constituted or mandated into South African and Western Cape policies and guidelines, although the operationalisation of how the term 'mechanism' is used by government will be examined more closely.

The study utilises a macro-level of analysis, exploring and describing feedback mechanisms and their functioning across the South African and Western Cape Province of South Africa contexts.

Robson argues that a good research question is substantively relevant if it is a "worthwhile, non-trivial question, worthy of effort to be extended" (Robson, 2002). So far, a case has been made for the substantive relevance of the research from both a LMIC perspective and the South African context.

Research question

What formal mechanisms are in place in the Western Cape Province of South Africa for receiving and responding to citizen feedback, and what effect can these mechanisms be seen to have on provincial and national health system functioning?

Research sub-questions

The following sub-questions will be investigated throughout the study – but may alter slightly as the study develops and evolves.

1. What are the formal feedback mechanisms for receiving and responding to citizen feedback in South Africa?
2. How do formal feedback or health system responsiveness mechanisms differ from informal feedback mechanisms?
3. Who are the key actors responsible for formal health system responsiveness mechanisms in the Western Cape and is there an overarching strategy that considers all of these mechanisms in relation to national health system responsiveness?
4. In individual experiences with the feedback mechanisms in the Western Cape Province of South Africa, does the information flow of responsiveness, facilitated by the formal mechanisms, align with policies and guidelines?
5. To map what is known about the functionality of formal feedback mechanisms in the Western Cape Province, both provincially and within the national health system context?

Sub-study arrangement

[1] See explanation on limitations to achieve Objective 4 in Box 2 below

This post graduate student research study will form part of the descriptive mapping phase of a critical study (Appendix 6), which aims to better understand the processes of and environment within which service users' feedback is collected in South Africa and Kenya. In the longer term, this evidence will contribute to the implementation and assessment of a comprehensive intervention at larger scale, to improve responsiveness of the health system in South Africa and Kenya. The broader study is a mixed-methods study, running from 2018 to 2021 (University of Cape Town Ethical Clearance number HREC 885/2019).

After health system mapping of feedback mechanisms is conducted in both Kenya and South Africa, the second phase will include in-depth case studies in each country, and the third phase will consist of knowledge translation and cross-country comparison.

Project partners for the study include the Western Cape Government and the Department of Health (South Africa) as well as the county Departments of Health in the Kilifi and Mombasa Counties (Kenya).

This study will contribute to the first phase of the broader health systems responsiveness study, mapping the feedback mechanisms in the Western Cape, while exploring how they fit into the national health system.

The student project supervisor is also the PI of the larger multi-country study – and this sub-study will comply with all broader project ethical and data management strategies (see below).

Methodology

This is a low-risk, desk-based, flexible mixed-methods evidence mapping study which gathers, reviews, and integrates existing literature with secondary analysis of multiple forms of existing data to explore and describe what mechanisms are in place in the Western Cape Province of South Africa for receiving and responding to citizen feedback, and what effect these mechanisms can be seen to have on provincial and national health system functioning.

This mixed-methods evidence mapping approach will allow for a comprehensive exploration of the study´s research question, integrating merged quantitative data with merged qualitative data to describe these mechanisms, facilitating the consideration of South Africa´s complex, adaptive health system, where either qualitative or quantitative data on its own may be insufficient to fully explore these mechanisms (Creswell, 2013).

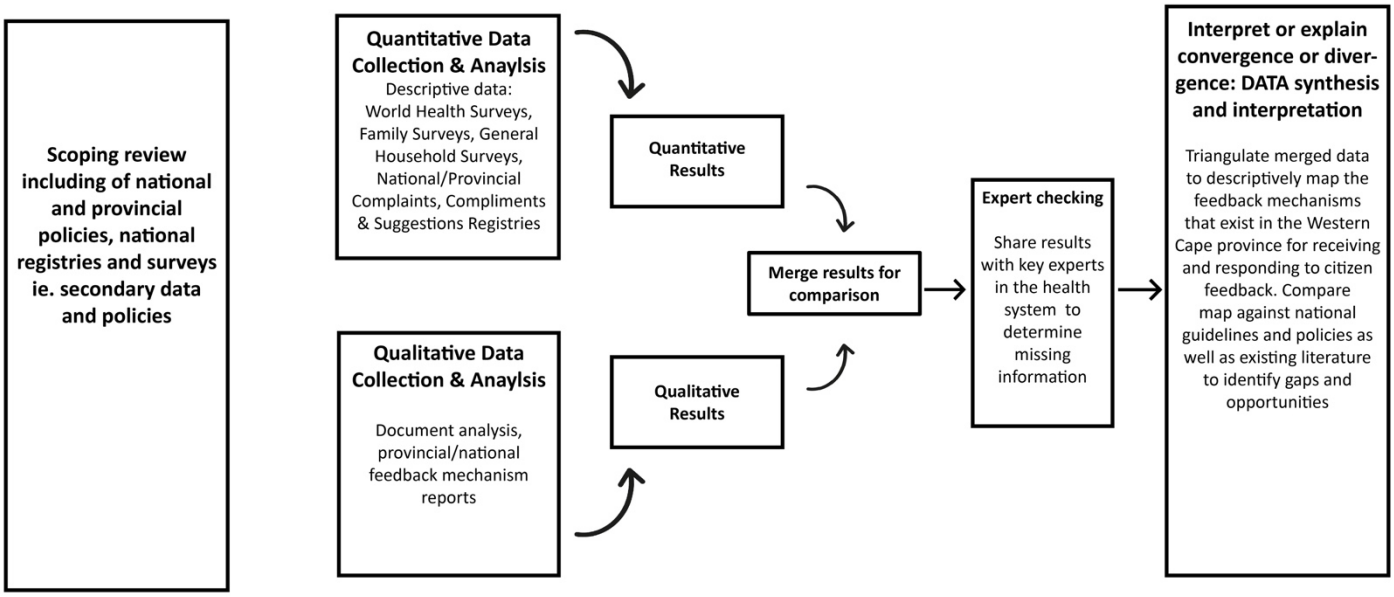
The study will employ some cross-sectional study qualities in that it aims to map the feedback mechanisms by considering and describing what exists at a particular point in time. However, by utilising a mixed-methods evidence mapping approach, differing and numerous perspectives can be taken into account. This will allow for triangulation, a technique that aims to "seek a more in-depth nuanced understanding of research findings and clarifying disparate results by placing them in dialogue with one another" (Mertens and Hesse-Biber, 2012).

In order to utilise both quantitative and qualitative data, integrating it appropriately, the existing data will be collected in parallel in a convergent parallel research design for mixed methods (Creswell, 2013) via a desk-based study. Once collected, the data will be integrated in order to create an overall description of feedback mechanisms for receiving and responding to citizen feedback in the Western Cape. Integration will be key to study design, differentiating it from research that simply utilised both quantitative and qualitative methods

(Brown et al., 2015). These methods will be mixed purposively during analysis, interpretation and discussion, resulting in meta-inferences (Brown et al., 2015).

Figure 1 provides an overview of the convergent parallel research design for this study, including data types, data collection and analysis methods, data synthesis and interpretation of results (adapted from Creswell, 2013).

Figure 1: Research design. Source: authors, adapted from Creswell, 2013.[2]



Much of the quantitative and qualitative data available for this research study will have been collected prior to this study, for many different purposes including government reporting, monitoring and evaluation and other research studies. Thus for the purposes of this study, secondary qualitative and quantitative data will be analysed as a "cost-efficient way to make full use of data that are already collected to address potentially important new research questions or to provide a more nuanced assessment of the primary results from the original study" (Cheng and Phillips, 2014).

This will be a research question-driven approach (Cheng and Phillips, 2014), with suitable data chosen to address this particular research study, which focuses on mechanisms for receiving and responding to citizen feedback in the Western Cape Province of South Africa. However, elements of a data-driven approach will be employed (Cheng and Phillips, 2014) in that any available data will be briefly reviewed for potential inclusion due to the fact that not many datasets are likely to address feedback mechanisms as a primary focus. Thus the available data may need to be mined for relevant quantitative and qualitative input to this research study. This type of analysis will take into account the strengths and weaknesses of each dataset, including any missing data.

The evidence mapping of synthesized qualitative and quantitative data will facilitate the review of all available policies, secondary data and information available on mechanisms for receiving and responding to citizen

[2] See explanation on limitations to expert checking part of the research design in Box 2 below

feedback in the Western Cape Province of South Africa, allowing for the identification of gaps or where further research is necessary (Miake-Lye et al., 2016).

Note that this approach (synthesis of multiple forms of data, taking context into account) might suggest that a case study strategy could be appropriate. However, given that the main aim of this research is descriptive, and the current need is to initially *map available evidence* (not, for example, compare the functioning of cases of responsiveness mechanisms), it was decided that a mixed-methods approach was most appropriate.

The evidence will be represented in tabular format, according to themes and identified feedback mechanisms, detailing how much evidence exists for each as well as key definitions and potential trends. This method has been chosen due to the diverse types of qualitative and quantitative data that is likely to be available as it can be utilised as a "key mechanisms for incorporating extensive, complex and specialised evidence into policy and practice, and in guiding future research" (O'Leary et al., 2017)

Therefore, this low-risk, desked-based mixed-methods evidence mapping study will address feedback mechanisms that exist for receiving and responding to citizen feedback in the Western Cape Province of South Africa via secondary analysis and by integrating multiple forms of existing literature. A convergent parallel mixed methods design will be used - a type of design in which qualitative and quantitative data are collected in parallel, analysed separately and then merged. In this study, existing surveys such as national family surveys as well as registries such as the national registry of health complaints will be used to test the theory of feedback mechanisms. The expert checking process will explore these feedback mechanisms in the context of a provincial and national health system, validating the findings that have been synthesized.[3]

Data collection and analysis will occur in the following phases:

- Phase 1: Scoping review including of national and provincial policies, national registries and surveys
- Phase 2: Descriptive mapping of health feedback mechanisms in broader, national health system context
- Phase 3: Evidence mapping of policy and formal feedback mechanisms available to citizens in the Western Cape including functions using quantitative data in national mapping phase and qualitative expert checking
- Phase 4: Sharing results with 3-5 national/provincial health system experts to check the synthesis and interpretation of the existing data and evaluate if any missing data (see Box 2 below)

Phase 1: Scoping review

A thorough scoping review of literature, focusing on formal feedback mechanisms in South Africa and the Western Cape Province in the context of health system responsiveness, will be undertaken over four months, allowing for a prompt overview of the key concepts that underpin the research area in the allocated study time frame (Arksey and O'Malley, 2005). A scoping review is defined as "A systematic approach to map evidence on a topic and identify main concepts, theories, sources, and knowledge gaps" (Tricco et al., 2018).

By opting for a scoping review rather than a systematic review, the synthesis of the existing information will be quicker and less resource-intensive as the process is slightly simpler (Tricco et al., 2015). A scoping review also lends itself to a mixed-methods study as it caters to a variety of study designs (Dijkers, 2015). The

[3] See explanation on limitations to expert checking part of the research design in Box 2 below

traditional steps in a rapid scoping review of the literature available will be followed: identifying the research question, identifying relevant studies, study selection, charting the data, collating, summarising and reporting the results (Arksey and O'Malley, 2005). By following these traditional steps, the literature review aims to be consistent and systematic despite not following a systematic review method.

The aim of the scoping review is to examine and conceptually map health system responsiveness mechanisms and gain an understanding of the available literature. The results of this search will be used to identify gaps in the literature as well as opportunities.

Multiple forms of information and data will be scoped retrospectively, contributing to an extensive literature review. While sources may be limited due to the rapid nature of this scoping review, transparent and reproducible search methods (Roth, 2018) will still be applied.

An initial review of the available literature suggests that a national registry does exist, detailing complaints, compliments and suggestions as well as processes utilised to respond to feedback. In the Western Cape, provincial policies and reports describe the types and amount of feedback received annually as well as how many of these cases were resolved, however the actual types of mechanisms that exist to foster this feedback as well as their functionality remain undescribed.

The scoping review will thus critically and rigorously appraise grey and peer-reviewed literature from electronic databases such as PubMed, EMBASE and CINHAL; national and provincial policies, guidelines and reports; South African and Western Cape Province print media reports as well as any existing quantitative data sets such as call centre data or patient exit surveys. Reference lists of similar articles will be reviewed and requests to access national and provincial databases will be made, including the *National Guidelines on Conducting Patient Experience of Care Survey* and its accompanying web-based database. Open access databases, including the Cape Area Panel Study will be utilised. Thus while some of this data is readily accessible, others will need to be requested.

The research question outlines some initial key terms used for the scoping review, including *citizen feedback mechanisms, feedback mechanisms, provincial health system functioning, national health system functioning, responsiveness mechanisms, citizen health feedback*. These terms will be applied to South African and Western Cape Province literature, resources and data. However, due to the generic nature of these terms, the PICO (Population, Intervention, Comparator, Outcome) framework will be utilised for review inclusion criteria:

Table 1: PICO framework for inclusion criteria. Source: Schardt, et al, 2007.

P	Stakeholders in LMIC health systems, notably in South Africa
I	Any mechanism that facilitates citizen feedback on the health system. Due to the variety of feedback mechanisms that do exist, they will also be searched for individually, including *patient / client satisfaction surveys, health surveys, suggestion boxes, health committees, satisfaction interviews, media reports, protests, scorecards*
C	Any or no comparator between health system responsiveness mechanisms will be eligible for inclusion
O	These include feedback being recorded or tracked as well as responded to or resolved

Due to the lack of literature on these feedback mechanisms as well as the exploratory, mixed-methods nature of this study, all study designs will be included in the scoping review. While South Africa has 11 official languages, the scoping review will focus on English literature and information sources where possible. While this has been identified as a cause for language bias (Morrison et al., 2012), all official documents including

national and provincial policies and guidelines are available in English, so this type of bias is expected to be mitigated. While the aim of the scoping review is to provide a foundation for the descriptive mapping of feedback mechanisms currently, context and history may create a deeper understanding. For this reason, literature published between 2009 and 2019 will be reviewed for the purposes of understanding the current landscape of feedback mechanisms in South Africa. For data available on family and health surveys, which include patient satisfaction data, the most recent will be used for each available, aiding the study with a cross-sectional look at the current data. In terms of theory and context, however, the scoping review of the literature will include research published in the last 20 years in order to take into account a wider breadth of evidence available.

The rapid scoping review will facilitate the capturing of data and research around general health system responsiveness mechanisms in South Africa and the Western Cape Province, as well as allow for deeper engagement with the descriptions and functions of the mechanisms themselves. The data can be collated and understood per feedback mechanism, outlined above in the intervention section of the PICO framework.

The data will be descriptive in nature and thus will be categorized and collated into an excel spreadsheet. The categories will include descriptions per feedback mechanism but will also include an exploration of the national guidelines around the feedback mechanisms, detailing what the feedback process should look like.

The data gathered in the rapid scoping review will be categorized according to type of citizen feedback mechanism, but other themes and trends may arise during analysis. The excel spreadsheet will allow for a clear break down of these themes and trends, while allowing for integration at a later stage.

Phase 2: Descriptive mapping of health feedback mechanisms in broader national context and policy

After the scoping review (identifying literature on feedback mechanisms in South Africa); further desk-based descriptive mapping will occur, of the evidence relating to the national context and policies that surround these mechanisms, their functions and the feedback process and information flow that occurs. After this, descriptive mapping of the Western Cape Province feedback mechanisms for receiving and responding to citizen feedback will be conducted – positioned within an understanding of the South African context.

While the *National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa* was published in April 2017 by the South African National Department of Health (SADOH), it focuses on the process and information flow of complaints, compliments and suggestions, rather than the mechanism that exist to facilitate complaints, compliments and suggestions (feedback). Thus, in this phase, the National Guidelines will be compared to policies identified in the scoping review, positioning them in the national policy context while identifying what mechanisms are utilised to support South African policy on the reception and response to citizen feedback in the national health system.

National health policies, strategies and reports will thus be utilised, while data that exists around patient satisfaction and complaint, compliment and suggestion registries will be accessed. While some of this data is open access, others – such as the registries – will need to be requested.

In the national context and policy mapping phase, there will be a focus on ‘formal’ feedback mechanisms which have been constituted or mandated in national/provincial policies and guidelines, however this is a definition that seems inadequately operationalised in health system responsiveness literature. There has been argument that ‘informal’ mechanisms can have great impact on health system – such as varied media-based mechanisms (Olivier et al. 2017). This is why utilising data from media reports, where the media is used as

another platform for citizen feedback and facilitates an information flow and response process, is important. While this study does not aim to make recommendations for what feedback mechanisms are considered formal and what feedback mechanisms are considered informal, it will aim to explore and describe examples of the media as a feedback mechanism as well as briefly consider mechanisms such as protests or violence against health workers or facilities, in the South African national health system context. As researchers exploring similar concepts in LMICs have argued,

> "*Accountability entails a cooperative process that like other regulatory processes includes ´a mixture of formal rule setting and explicitly contractual agreements, or formal regulation, and of informal understandings and established behaviour patterns, the latter based in norms, ethics and mutually understood principles*"(George, 2009).

Online media archives will be accessed for this information.

The data and information gathered will create an understanding of the policies and mechanisms that exist around the SADOH´s three-stage system to manage complaints, which include ´enabling complaints´, ´responding to complaints´ and ´accountability and learning´ (SADOH, 2017) as well as their similar processes for compliments and suggestions. Exploring the national context and mapping the policies will allow for further exploration of these processes in the Western Cape provincial context at a later stage. The data will also generate a broader understanding of feedback mechanisms beyond complaints, compliments and suggestions.

This phase, where data, evidence and information will be descriptively captured into the excel spreadsheet described in the rapid scoping review phase, will allow for a broad understanding and secondary analysis of the functions of feedback mechanisms in the South African health system, grappling not just with how they enable feedback but also how they enable responses to feedback as well as accountability and learning.

Phase 3: Descriptive mapping of Western Cape mechanisms

The existing quantitative and qualitative data obtained throughout the first two phases of the study, in parallel, need to be integrated and synthesized in order for mechanisms for receiving and responding to citizen feedback to descriptively mapped in the Western Cape Province of South Africa via secondary analysis. The collection of the data will result in an overall assortment of existing quantitative and qualitative data via secondary analysis, where the quantitative data will be analysed using quantitative methods while the qualitative data will be analysed using qualitative methods, as per a tradition mixed-methods study design (Onwuegbuzie and Combs, 2011).This will provide an overall, contextual snapshot of what mechanisms exist, what their functions are and what the feedback process is around them, in one particular province in South Africa.

The descriptive evidence mapping will include the naming and describing of the feedback mechanism, how it functions and how it links to citizen responsiveness. If possible, these mechanisms will also be described in relation to the national health system context. Table 2 depicts an example of what this may look like, based on initial scoping work.

Table 2: **Examples of types of formal mechanisms for receiving and responding to citizen feedback in health systems in the Western Cape.** Source: authors, adapted from Cleary et al., 2013.

Type of mechanism	Function example	Link to citizen responsiveness	Link to national health system context

Patient satisfaction surveys	Citizens rate quality of health services under specific domains e.g. Waiting times	Direct, provincial	Reported in provincial annual report and national health standards quality and annual reports
Complaint/suggestion boxes	Citizens provide anonymous or non-anonymous suggestions/complaints in health facilities	Direct, provincial	South African Department of Health (SADOH) extracts patient perspectives and sensitizing staff in national training programmes
Ombudsman	Citizens can submit online health service complaints or call a complaints call centre. Fax, email, post and walk-in are also possible. The Ombud investigates certain complaints.	Direct, national	Health Ombud reports nationally on complaints and investigations
Complaints hotline/ whatsapp line	Citizens can submit complaints via a hotline or whatsapp line	Direct, provincial	SADOH advises citizens to first direct complaints to the manager of the relevant health facility, before utilising provincial complaints lines. A phone number, fax number and postal address is also available for the SADOH and the Minister of Health.
Health Facility Committees (HFCs)	HFCs build a relationship with the community and creates a forum for hearing their concerns and needs, which is fed back to the health facility management	Direct, provincial	National Heath Act creates HFCs, but provincial legislation determines role.
Traditional media	Citizens report health service complaints/experiences to traditional media such as newspapers	Indirect, provincial or national	May trigger public scrutiny or further complaints or backlash
Social media	Citizens report health service complaints/experiences on social media to followers	Indirect, provincial or national	Social media post may go viral or address SADOH, triggering public or media scrutiny

Phase 4: Expert checking[4]

On completion of phases 1-3, preliminary mapping and descriptive results will be sent to 3-5 policymakers and members of the WCDOH or SADOH, seeking comment and addition. These are not formal interviews, and will instead provide a level of 'checking' of feedback mechanisms, their functionality and the process of response around them in order to verify the findings of the desk-based synthesized evidence. If some data has been difficult to access, we will also seek further data at this stage, and add it into the last round of synthesis and analysis. This expert checking process will be in the nature of 'expert interviews' defined as a "conversation with a set purpose and set tasks which are related to obtaining information relevant to the ongoing research" (Libakova and Sertakova, 2015). However, these are not primary data collection interviews requiring full consent processes, but instead are guided conversations aimed at gathering expert opinion through a verbal or electronic exchange between the researcher and expert based on a first draft of the mapping of feedback mechanisms already synthesized by the researcher.

By including micro-level expert perspectives and contextualization, the experiences of this complex flow of information around one or two of the health system responsiveness mechanisms can be explored. This may contribute to research that is more people-centred, recognising actors as "generators, sources and users of knowledge about the system" (Sheikh et al., 2014).

[4] See explanation on limitations to expert checking part of the research design in Box 2 below

The individuals will be selected for the expert checking process based on their experiences in the health system, allowing for a low-risk, efficient yet effective and "information-rich" process (Palinkas et al., 2015). Considering the expected competency of each expert, (Libakova and Sertakova, 2015, 2015) this will be useful. The selection may also be beneficial in terms of "the importance of availability and willingness to participate, and the ability to communicate experiences and opinions in an articulate, expressive and reflective manner" (Palinkas et al., 2015).

As part of a mixed methods study design, the integration of the quantitative and qualitative data will put the data into a more "comprehensive explanatory framework" (Mertens and Hesse-Biber, 2012) through triangulation. The expert checking will be a final stage in this, allowing for missing data, information or evidence to be identified and ensure that findings align with experts´ knowledge and experience.

Potential experts will initially be approached via email and invited to assist in the expert checking process. Those who do not respond will be reminded via email after seven days. If another three days passes with no response, they will be followed up with via telephone. Three attempts will be made to reach them. Email addresses will be obtained via online public portals and documents, such as the SADOH website and the WCDOH website. Stakeholders within the larger South African/Kenyan study may be approached to assist with access to potential experts.

Emails sent to the potential experts will detail the study, including its purpose, aims and objectives and any benefits or risks and include the initial mapping and findings draft for their input (Appendix 4).

While this is a low-risk, desk-based research study that will in no way be evaluating the health system, with expert checking only used as a way to check data that has been gathered and synthesized, experts will remain anonymous in the reporting of the study, with email identifiers being unavailable to anyone apart from the researchers themselves. No names will be recorded during initial contact or the later expert checking process, with codes used to designate participant status (i.e. Policymaker, Complaint Manager etc).

Once potential experts have confirmed that they are available and willing to check the mapping against their expert knowledge, telephone or email responses will be requested by a certain date, based on a set of questions that will be emailed through to them. These questions (Appendix 4), will guide them in checking evidence and findings gathered through desk-based information synthesis. The questions will be informed by the study´s main research question as well as the study´s sub-questions, focusing on the feedback mechanisms and how they function in the larger health system. The questions will be open ended in order to utilise the expert checking: "to obtain additional unknown or reliable information, authoritative opinions serious and professional assessments of the research topic" (Libakova and Sertakova, 2015).

Telephone or email responses will be recorded and saved in a confidential, electronic folder and the telephone responses will be transcribed verbatim. The information that emerges from the expert checking will be synthesized and any missing data or evidence will then be collected, allowing for a deeper final synthesis of all information available. No reimbursements will be provided to experts.

Box 2: Adaptations made to this study as a result of Coronavirus outbreak in early 2020

The global outbreak of COVID-19 had a direct impact on this small descriptive and exploratory study.

At the time that the completed and synthesized findings were sent to the three health system experts for checking in early 2020, South Africa was moving into a heightened stage of preparation ahead of COVID-19, and then ultimately national lock-down. Given that these experts were senior officials operating at the front-line of the local pandemic response, it became unreasonable to request/expect their timely participation in this study (even though they had earlier indicated a strong desire to do so). It also became clear that waiting for this participation was not viable, as the 'end-line' of local health system response was likely at least six months away, if not longer.

On the advice of the student supervisor, a decision was made to go ahead and submit the student thesis for external examination, without this step of expert checking, and missing a small handful of routine datasets that were being chased via these experts (mainly quantitative tracking of mechanism utilisation).

This decision was made based on a judgement that as descriptive and exploratory study, and having already pulled extensively on multiple forms of data (through triangulation), that the research had sufficient evidence and rigor to stand on its own without this additional checking step.

However, the researcher and supervisor regret this was a necessary decision – and have committed to continue to pursue the expert opinions, and to integrate any additional insights gathered – even if this comes after examination, and preferably before formal publication.

Data synthesis, analysis and integration

Due to the nature of the mixed-method study design, this study will involve the parallel research and collection of many different types of data, including qualitative and quantitative. Table 3 depicts an initial overview of what type of data is available, how available it is and when it will be used.

Table 3: Initial overview of available data. Source: authors.

Data type	Location	Availability	Use in study
Secondary literature: peer reviewed materials	PubMed, EMBASE, CINHAL, other academic platforms & portals	Available (have)	Phase 1, 2 and 3
Secondary literature: institutional reports	SADOH, WCDOH	Available (have)	Phase 1, 2 and 3
SA/WC policy documents	http://www.health.gov.za/ https://www.idealhealthfacility.org.za https://www.gov.za https://www.westerncape.gov.za	Available (have)	Phase 1, 2, 3 and 4
SA National Guidelines to Manage Complaints, Compliments, Suggestions in the Public Health Sector of South Africa (2017)	Accessible online as a PDF: https://tinyurl.com/s4s9v6k	Available (have)	Phase 1, 2, 3 and 4
Survey data	General Household Surveys (GHS), Cape Area Panel study including World Health Survey, Integrated Family Survey etc	Available (have)	Phase 1, 2, 3 and 4
National complaint, compliment, suggestion evaluation data, registries and reports from submitted feedback (written, hotline or other)[5]	SADOH	Not easily available	Phase 1, 2, 3 and 4
Provincial (Western Cape) complaint, compliment, suggestion evaluation data,	WCDOH	Not easily available	Phase 2, 3 and 4

[5] See explanation on limitations to obtain this data in Box 2

registries and reports from submitted feedback (written, hotline or other)[2]			
National forms to submit in a complaint/compliment/suggestion (English, Afrikaans, Isixhosa, Ndebele, Sepedi, Sesotho, Setswana, Siswati, Venda, Xitsonga)	https://www.idealhealthfacility.org.za/	Available (have)	Phase 1, 2, 3 and 4
Posters on Patients' Rights Charter, including right to complain (English, Sesotho, Sepedi, Afrikaans, Tswana, Xhosa, Zulu)	https://www.idealhealthfacility.org.za/	Available (have)	Phase 1, 2, 3 and 4
Posters on steps to submit a complaint/compliment/suggestion (Afrikaans, English, Ndebele, Sepedi, Sesotho, Setswana, Siswati, Venda, Xhosa, Xitsonga, Zulu)	https://www.idealhealthfacility.org.za/	Available (have)	Phase 1, 2, 3 and 4
National and provincial health facility satisfaction surveys and survey reports[2]	SADOH, WCDOH	Not easily available	Phase 1, 2, 3 and 4
Media reports	https://www.news24.com/ https://www.timeslive.co.za/ https://ewn.co.za/ https://www.media24.com/newspapers/ http://www.national.archives.gov.za/ https://www.sabinet.co.za https://www.newsbank.com	Available (have)	Phase 2, 3 and 4
Client/patient satisfaction guides and reports	Health Systems Trust & SADOH	Available (have)	Phase 1 and 2
Other theses on similar topics, focusing on LMICs	Academic institutions including University of Cape Town	Available (have)	Phase 1, 2, 3 and 4

Quantitative data: The quantitative data, considered descriptive data, extracted from secondary literature, institutional reports, policy documents, survey data, registries and reports and media reports will be arranged into themes via a cross-sectional study design, which will include the national guidelines for the feedback process and the national context and policies around these, each mechanism that exists and the feedback process around each mechanism in the context of the Western Cape Province of South Africa and factors that support or hinder the feedback process facilitated by each mechanism. These themes will be descriptively captured in an excel spreadsheet.

Qualitative data: Descriptive data from Phase 1 scoping, and the expert checking process in Phase 4 will both produce qualitative data. The expert 'interviews' will produce data which will be arranged in the same excel spreadsheet according to the themes identified above as well as any other themes that may emerge throughout the analysis of the data.

Existing data collected and synthesized will be integrated and interpreted through the convergent study design. This means that the qualitative and the quantitative data will be compared, creating a synthesized descriptive map. This will be further supported by ongoing literature review and final expert-checking. By documenting and clearly outlining the final study process, confirmability will be addressed so that a descriptive mapping of feedback mechanisms in this study may be replicated again in the future.

Rigour

The mixed-methods nature of the study means that care must be taken to ensure rigour across both quantitative and qualitative data and methods utilised so that there is validation across the study – a process

that can be complex (Giddings and Grant, 2009). However, by legitimising the research, quality can be determined (Wium and Louw, 2018).

To determine quality, the quantitative findings and the qualitative findings will be critically reviewed, before the integration and synthesis of these findings is assessed by the research team. Triangulation thus plays a key role in this mixed methods study, with the different measures in the phases of the study, including the scoping review and the quantitative and qualitative methods, facilitating a more robust exploration (Gugsa et al., 2016). The multiple forms of data used further strengthens this.

Throughout this process, the aims and objectives of the research as well as the research question will be discussed in relation to the conclusions reached in the study. Integration of the multiple forms of data will be outlined carefully, while any limitations will be discussed thoroughly. Any insights that the mixed-methods study design has yielded will be described (O'Cathain et al., 2008).

In the quantitative data stream, rigour will be ascertained through validity, reliability and trustworthiness. Validity determines if the study measured what it was supposed to, (Wium and Louw, 2018) reliability determines if the research would produce similar results at different times with different measures (Wium and Louw, 2018) while generalisability determines if the findings can be applied across the wider population (Wium and Louw, 2018). Replicability is another important factor that will be discussed (Brown et al., 2015).

The multiple sources used to gather the qualitative data will enhance triangulation and by not limiting the resources used for this evidence, reliability, generalisability and replicability will be addressed. Throughout the collection of quantitative data, the study will be transparent in its description of data collection, analysis and interpretation so that the reader may determine the quality of the study (Brown et al., 2015). The use of the excel spreadsheet to descriptively categorize the themes and data gathered will generate key trends, which will be checked by the supervisor of this study and reviewed several times by the researcher, allowing for clear analysis that will enhance the trustworthiness of the study.

In the qualitative data stream, credibility, transferability, dependability and confirmability will need to be determined (Brown et al., 2015). All methods of data collection and analysis will be reported on in order to ensure credibility (Gilson, 2012), while multiple forms of data and their categorisation will enhance dependability and confirmability (Brown et al., 2015). This will be further enhanced by triangulation with the quantitative data gathered and the final expert-checking process[6] (Brown et al., 2015), which will also address potential interpretation bias.

Transferability will be determined by adequate and detailed descriptions throughout this process and the synthesis of the qualitative data will promote the contextual understanding of the overall evidence.

Self-reflexivity

Study reflexivity will also contribute to the quality of this research, providing "transparent information about the positionality and personal values of the researcher that could affect data collection and analysis" (Walker, 2013). For this reason, a reflective research diary will be kept for observations and for the researcher to critically appraise findings against the methods utilised.

Supervisor and peer debriefing will also occur in order to recognise any potential effect that the researcher´s background and social identity may have on the data (Robson, 2002). The reflective research diary can assist

[6] See explanation on limitations to obtain this data in Box 2

with and be used during this debriefing and will be shared with readers, allowing for any personal perspectives that may influence the study to be identified and analysed (Robson, 2002).

The mixed-method study design is relevant to the research question, however owing to the complexity of rigour in these types of studies, every effort will be made to determine the strength of evidence (Brown et al., 2015).

Ethical considerations

This is a low-risk, primarily desk-based study that will synthesize existing accessible data, and complement this with a small expert-checking process. It will not include vulnerable populations as participants.

Confidentiality will be protected throughout data collection and this research will be approved through the following ethical and research clearance bodies before research commences: The University of Cape Town, Faculty of Health Sciences, Human Research Ethics Committee and the WCDOH Research Clearance protocol. All standard ethical guidelines will be followed, especially when engaging with stakeholders.

Every effort will be made to mitigate any questionable practices that occur in social research, including involving people without their knowledge or consent, coercing them to participate, withholding information about the true nature of the research, otherwise deceiving the participant, inducing participants to commit acts diminishing their self-esteem, violating rights of self-determination, exposing participants to physical or mental stress, invading privacy, withholding benefits from some participants and not treating participants fairly or with consideration or with respect (Robson, 2002). Considering the low-risk nature of participant involvement, this is not expected to pose a threat.

The research is intended to be of value to researchers and policy makers both in the South African and other LMIC health system settings. It is not intended to result in commercially exploitable results. The research undertaken will take into account all ethical considerations including the nature of the relationships established and the preservation of the health system within which the study will operate, as well as the potential influence on policy, interventions and decision-making.

Expert checking[7]

Less than five experts, including policymakers and members of the WCDOH or SADOH, will be asked for input a low-risk way, in order validate the findings from the desk-based evidence gathered. All communication around the expert checking will stress the voluntary nature of participation. No coercion or force will be used. While this is a low-risk study, privacy, confidentiality and anonymity are strategies that will be enforced throughout the expert checking process.

All participants will also be asked to keep their correspondence with the researcher private and to avoid discussions around the mechanism mapping with colleagues in order to further guarantee confidentiality. Email identifiers, along with contact details, will be unavailable to anyone apart from the research team. The database of experts (including contact details) will be stored in a password protected electronic folder and will be permanently deleted after feedback of the study has been sent out. Audio recordings will also be saved in a password protected electronic folder and deleted permanently once transcribed. Transcriptions will be associated with the participant status (i.e. Policymaker, Complaint Manager etc) so that they cannot be traced

[7] See Box 2 explanation of adaptation made above

back to the participant and will also be saved in a password protected digital folder. Throughout the expert checking process, a foundation of "do no harm" will be employed with the following ethical principles applied: respect for persons, beneficence, justice and respect for communities (Center for Innovation in Research and Teaching, 2019).

Data use

All data collected during the study will be available only to the researcher and the study supervisor, stored in a password protected digital file. Any unpublished data, including from the scoping review and expert checking transcripts, will be deleted permanently after five years.

Risks and benefits

This is a low-risk, exploratory and descriptive study with very few threats.

The only human participants are a very small group of senior experts, who will support study validation, and will only respond to evidence already gathered in the public space. There are no direct risks or benefits for these experts.

It is hoped that this research may create a foundation for more detailed and exploratory and explanatory studies into health system responsiveness and the mechanisms that facilitate it in the South African health system. The descriptions of the feedback mechanisms in the context of the Western Cape Province and South Africa as a whole may help inform future decision-making in health, especially if utilised in the larger South Africa-Kenya study (Appendix 6). Although a descriptive mapping study of the Western Cape Province health system responsiveness mechanisms cannot be replicated in other countries, it is hoped that this research will provide a study framework for similar research in other LMICs so that descriptive mapping of feedback mechanisms can become more prominent, enhancing a deeper understanding of the feedback loops and processes that occur in health system responsiveness.

Study limitations

This study is unique to the Western Cape Province and South African context and thus cannot be generalised to other settings. However, the methods utilised may inform future research in similar LMIC settings.

The expert-checking process might impose some limitations. These are very senior and expert officials, and their time is limited for research participation. There is also risk of responder bias. However, the triangulation across multiple forms of data should mitigate this, and expert participants will be encouraged to be honest and clear in their feedback. The fact that they will be reviewing gathered, synthesized and critically appraised evidence is also expected to further lower this possibility.

Lastly, the limited time for the rapid scoping review may hinder the study, restricting it from answering all of the research questions. The limited time may also increase the potential for bias in the scoping review process.

[Note added: see Box 2 above – the coronavirus pandemic of 2020 imposed a significant limitation on this study, as all related research activities were halted during Phase 4. We have sought to mitigate these limitations by drawing on additional forms of evidence to balance out the missing expert-checking process, which became impossible during pandemic conditions.]

Timeframe

The study is expected to take 12 months, from initial protocol design and ethics approval request, to data collection, analysis and synthesis and then final write-up and dissemination of findings. Table 4 provides a schedule for these activities.

Table 4: Timeframe and schedule of activities

Milestone	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Write/edit protocol															
Submit protocol to ethics															
Conduct literature review															
Write/edit literature review															
Data collection															
Data synthesis & analysis															
Write up															
Expert checking															
Submission examination															
Dissemination to stake-holders															

Budget

The information and data will mostly be extracted from a desk-based literature review and expert checking and thus no funding to descriptively map or analyse these data is required. The primary researcher declares no conflict of interest.

Dissemination to key stakeholders

While this mixed-method study will be used to write up the researcher´s Master of Public Health mini-thesis, the flexible nature of the study as well as its role in the larger study presents an opportunity for wider and more flexible dissemination.

Experts who participate in the expert checking will receive an email notification thanking them for their contributions, with a link to the final study for their perusal. Anonymity of these participants will be upheld throughout dissemination.

The final study will be submitted to the relevant stakeholders via email, including the University of Cape Town, Faculty of Health Sciences, WCDOH and the SADOH as well as the researchers engaged on the broader study.

Researchers working on the broader study may utilise the descriptive mapping and data gathered, resulting in the dissemination of this evidence through other formats such as recommendations, reports, presentations, policy briefs or publications. Discussions around wider dissemination will occur with the South Africa-Kenya research team, including in health policy and health system conferences as well as to academic journals and online publications.

References

Adam T, Hsu J, de Savigny D, Lavis JN, Rottingen J-A, Bennett S. (2017). Evaluating health systems strengthening interventions in low-income and middle-income countries: are we asking the right questions? *Health Policy Plan* 27 (4):iv9-iv19. doi:10.1093/heapol/czs086

Adesanya, T., Gbolahan, O., Ghannam, O., Miraldo, M., Patel, B., Verma, R., Wong, H. (2012). Exploring the responsiveness of public and private hospitals in Lagos, Nigeria. *Journal of Public Health Research*, Vol. 1: e2. doi: 10.4081/jphr.2012.e2

Ahmed, F., Khizar Memon, M., Memon, S. (2018). Violence against doctors, a serious concern for healthcare organizations to ponder about. *Annals of Medicine and Surgery* 25: 3–5. https://doi.org/10.1016/j.amsu.2017.11.003

Arksey, H., O'Malley, L., (2005). Scoping studies: towards a methodological framework. *Int. J. Social Research Methodology* Vol. 8, 19–32. https://doi.org/10.1080/1364557032000119616

Askari, R., Arab, M., Rashidian, A., Akbari-Sari, A., Hosseini, S.M., Gharaee, H., (2016). Designing Iranian model to assess the level of health system responsiveness. *Iran. Red Crescent Med. J* 18. https://doi.org/10.5812/ircmj.24527

Brown, K.M., Elliott, S.J., Leatherdale, S.T., Robertson-Wilson, J., (2015). Searching for rigour in the reporting of mixed methods population health research: a methodological review. *Health Educ. Res*. 30, 811–839. https://doi.org/10.1093/her/cyv046

Center for Innovation in Research and Teaching. (2019). *Ethical considerations*. Accessed 10 March 2019. https://cirt.gcu.edu/research/developmentresources/research_ready/mixed_methods/ethics

Cheng, H.G and Phillips, M.R. (2014). Secondary analysis of existing data: opportunities and implementation. *Shanghai Arch Psychiatry* v. 26 (6). Doi: 10.11919/j.issn.1002-0829.214171

Cleary, S.M., Molyneux, S., Gilson, L. (2013). Resources, attitudes and culture: an understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings. *BMC Health Serv. Res*. 13. https://doi.org/10.1186/1472-6963-13-320

Creswell, J.W. (2013). Steps in conducting a scholarly mixed methods study. *DBER Speaker Series*. Paper 48. Lincoln: Discipline-Based Education Research Group.

de Silva, A. (2000). A framework for measuring responsiveness. *GPE Discussion Paper Series*. No. 32.World Health Organization. Accessed 22 November 2018. https://www.who.int/responsiveness/papers/papers32.pdf

Dijkers, M. (2015). What is a scoping review? *KT Update*. Vol 4. No 1.

Ebenso, B., Huque, R., Azdi, Z., Elsey, H., Nasreen, S., Mirzoev, T. (2017). Protocol for a mixed-methods realist evaluation of a health service user feedback system in Bangladesh. *BMJ Open* (6): e017743. https://doi.org/10.1136/bmjopen-2017-017743

Feruglio, F., Nisbett, N. (2018). The challenges of institutionalizing community-level social accountability mechanisms for health and nutrition: a qualitative study in Odisha, India. *BMC Health Serv. Res* 18. https://doi.org/10.1186/s12913-018-3600-1

Flores, W., Ruano, A.L., Funchal, D.P. (2009). Social participation within a context of political violence: implications for the promotion and exercise of the right to health in Guatemala. *Health Hum. Rights* 11 (1): 37. https://doi.org/10.2307/40285216

George, A. (2009). 'By papers and pens, you can only do so much': views about accountability and human resource management from Indian government health administrators and workers. *Int. J. Health Plann. Manage.* (3): 205–224. https://doi.org/10.1002/hpm.986

Giddings, L.S., Grant, B.M. (2009). From rigour to trustworthiness: validating mixed methods, in: Andrew, S., Halcomb, E.J. (Eds.), *Mixed Methods Research for Nursing and the Health Sciences*. Wiley-Blackwell, Oxford, UK: 119–134. https://doi.org/10.1002/9781444316490.ch7

Gilson, L. (2012). Alliance for health policy and systems research. *Health policy and systems research: a methodology reader.* Word Health Organization, Geneva.

Gugsa, F., Karmarkar, E., Cheyne, A., Yamey, G. (2016). Newspaper coverage of maternal health in Bangladesh, Rwanda and South Africa: a quantitative and qualitative content analysis. *BMJ Open* (1): e008837. https://doi.org/10.1136/bmjopen-2015-008837

Health Systems Trust. (2017). *South African Health Review 2016*. Accessed 16 December 2018.

Health Systems Trust. (2018). *South African Health Review 2017.* Accessed on 8 March 2019. http://www.hst.org.za/publications/South%20African%20Health%20Reviews/SAHR%202016.pdf

Katuu, S. (2018). Healthcare systems: typologies, framework models, and South Africa's health sector. *Int. J. Health Gov*. 23, 134–148. https://doi.org/10.1108/IJHG-10-2017-0054

Koon, A.D., Nambiar, D., Rao, K.D. 2012. "Embedding of research into decision-making processes." *The Alliance for Health Policy and Systems Research*.

Libakova, N.M., Sertakova, E.A. (2015). The method of expert interview as an effective research procedure of studying the indigenous peoples of the north. *J. Sib. Fed. Univ. Humanit. Soc. Sc*i: 114–129. https://doi.org/10.17516/1997-1370-2015-8-1-114-129

Lodenstein, E, et al. (2013). A realist synthesis of the effect of social accountability interventions on health service providers´ and policymakers´ responsiveness. *Systematic Reviews* 2;98. http://www.systematicreviewsjournal.com/content/2/1/98

Malhotra, C., Do, Y.K. (2013). Socio-economic disparities in health system responsiveness in India. *Health Policy Plan*. 28 (2): 197–205. https://doi.org/10.1093/heapol/czs051

Mertens, D.M., Hesse-Biber, S. (2012). Triangulation and mixed methods research: provocative positions. *J. Mix. Methods Res*. (2): 75–79. https://doi.org/10.1177/1558689812437100

Miake-Lye, I.M., Hempel, S., Shanman, R., Shekelle, P.G. (2016). What is an evidence map? A systematic review of published evidence maps and their definitions, methods, and products. *Systematic Reviews* 5. https://doi.org/10.1186/s13643-016-0204-x

Mirzoev, T., Kane, S. (2017). What is health systems responsiveness? Review of existing knowledge and proposed conceptual framework. *BMJ Glob. Health* 2 (4): e000486. https://doi.org/10.1136/bmjgh-2017-000486

Morrison, A., Polisena, J., Husereau, D., Moulton, K., Clark, M., Fiander, M., Mierzwinski-Urban, M., Clifford, T., Hutton, B., Rabb, D. (2012). The effect of English-language restriction on systematic review-based meta-analyses: a systematic review of empirical studies. *International Journal of Technology Assessment in Health Care*. Vol 28, Issue 2. https://doi.org/10.1017/S0266462312000086

O'Cathain, A., Murphy, E., Nicholl, J. (2008). The quality of mixed methods studies in health services research. *J. Health Serv. Res. Policy* (2): 92–98. https://doi.org/10.1258/jhsrp.2007.007074

O'Leary, B.C., Woodcock, P., Kaiser, M.J., Pullin, A.S. (2017). Evidence maps and evidence gaps: evidence review mapping as a method for collating and appraising evidence reviews to inform research and policy. *Environ Evid* 6, 1–9. https://doi.org/10.1186/s13750-017-0096-9

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

Onwuegbuzie, A.J., Combs, JP. (2011). Data analysis in mixed research: a primer. *Int. J. Educ* 3 (1): 13. https://doi.org/10.5296/ije.v3i1.618

Palinkas, L.A., Horwitz, S.M., Green, C.A., Wisdom, J.P., Duan, N., Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Adm. Policy Ment. Health Ment. Health Serv. Res*. 42 (5): 533–544. https://doi.org/10.1007/s10488-013-0528-y

Robone, S., Rice, N., Smith, PC. (2011). Health systems' responsiveness and its characteristics: a cross-country comparative analysis. *Health Serv. Res*. 46 (6 Pt 2): 2079–2100. https://doi.org/10.1111/j.1475-6773.2011.01291.

Robson, C. (2002). *Real World Research: A resource for social scientists and practitioner researchers*. 2nd Edition. Wiley: United Kingdom.

Roth, S. (2019). *Research Guides: Systematic Reviews & Other Review Types: What is a Rapid Review?* Accessed 6 March 2019. https://guides.temple.edu/c.php?g=78618&p=4156608 (accessed 3.6.19).

Schardt, C., Adams, MB., Owens, T., Keitz, S., Fontelo, P. (2007). Utilization of the PICO framework to improve searching PubMed for clinical questions. *BMC Medical Informatics and Decision Making* 7, 16. https://doi.org/10.1186/1472-6947-7-16

Sheikh, K., George, A., Gilson, L. (2014). "People-centred science: strengthening the practice of health policy and systems research." *Health Res. Policy Syst* 12 (1): https://doi.org/10.1186/1478-4505-12-19

South African National Department of Health. (2017). *National Guideline to Manage Complaints Compliments and Suggestions in the Public Health Sector of South Africa.* Accessed 17 March 2019. http://www.health.gov.za

Tricco, A.C., et al. (2015). A scoping review of rapid review methods. *BMC Med* 13, 224. https://doi.org/10.1186/s12916-015-0465-6

Tricco, A.C., et al. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): checklist and explanation. *Ann. Intern. Med* 169, 467: https://doi.org/10.7326/M18-0850

van Olmen, J., et al. (2012). The health systems dynamics framework: the introduction of an analytical model for health system analysis and is application in two case studies. *Health Culture and Society* 2(1).

Walker, S., Read, S., Priest, H. (2013). Use of reflexivity in a mixed-methods study. *PubMed - NCBI*. https://doi.org/ 10.7748/nr2013.01.20.3.38.c9496

Western Cape Government Department of Health. (2011). *2020. The future of healthcare in the Western Cape*. Accessed on 8 March 2019. https://www.westerncape.gov.za/other/2011/12/healthcare_2020_-_9_december_2020.pdf

WHO. (2007). *Everybody´s Business: Strengthening health systems to improve health outcomes: WHO´s framework for action*. World Health Organization, Geneva. Accessed 6 February 2019. https://www.who.int/healthsystems/strategy/everybodys_business.pdf?ua=1

WHO. (2008). *Now more than ever. World Health Report: Primary Health Care.* World Health Organization, Geneva. Accessed 4 January 2019. https://who.int(whr/2008/en/.

WHO. (2019). *World Health Survey*. World Health Organization, Geneva. Accessed 1 November 2018. http://www.who.int/responsiveness/reports/en/

WHO. (2015). *Global Strategy on People-centred and Integrated Health Services*. World Health Organization, Geneva. Accessed 3 March 2019. https://www.who.int/servicedeliverysafety/areas/people-centred-care/global/strategy/en/.

Wium, A.-M., Louw, B. (2018). Mixed-methods research: A tutorial for speech-language therapists and audiologists in South Africa. *S. Afr. J. Commun. Disord.* 65. https://doi.org/10.4102/sajcd.v65i1.573

ARTICLE

Targeted Journal: *Health Policy and Planning*

Mechanisms for receiving and responding to citizen feedback in the Western Cape Province of South Africa

Tammy Sutherns[1]

Abstract

Introduction: Despite governments striving for responsive health systems and the implementation of mechanisms to foster citizen feedback, and strengthen accountability, stewardship and community participation, current evidence does not adequately address the full array of responsiveness mechanisms and interventions in low-income and middle-income countries (LMICs), nor show their interaction with each other. Furthermore, these mechanisms do not always function in an effective way, facilitating the voicing of citizen concerns equitably or efficiently.

Methods: This mixed-method descriptive and exploratory study 'maps' types of health system responsiveness mechanisms (such as complaints processes, suggestion boxes, hotlines or Health Ombuds) and their functionality in the South African health system, with a focus on the Western Cape Province as a case of available evidence. Multiple forms of evidence were scrutinized, synthesized, and checked in order to provide a contextualized understanding of ´formal´ responsiveness mechanisms that are mandated in national and provincial policies and guidelines. Research processes included a scoping review (of peer-reviewed and grey materials, including reports), policy analysis, and secondary data analysis of available quantitative and qualitative data. Various forms of analysis were applied during the synthesis phase, including thematic and time-series analysis.

Results: While national, provincial and district policies make strong provision for health system responsiveness, including mechanisms to foster citizen feedback; in reality, implementation is not always standardised or effective, and mechanisms are often non-functional. Mechanisms do not provide an equitable platform for citizen feedback, with those who are often most in need not heard or responded to, nor do the feedback loops operate seamlessly together, or through/between different levels. This is particularly significant in a country marred by historic disparities in human rights. Many mechanisms exist in isolation, failing to feed into an overarching strategy or comprehensive 'health system responsiveness', where feedback mechanisms might complement one another and lead to quality improvement in the whole health system. It is also not clear who the responsible key actors are in the functioning of mechanisms – both in isolation and as a larger responsiveness strategy - for receiving and responding to citizen feedback. This is a missed opportunity, and more effective collation of complementary data could strengthen the health system and improve accountability and participation. While there are some instances of effective and well-functioning mechanisms for receiving and responding to citizen feedback; at all levels, government is hampered by resource and capacity constraints. While some mechanisms offer effective solutions to capacity constraints, there has not been adequate investment across the different levels of government, with roles and responsibilities unclear.

[1] *For the purpose of this thesis, the student is the sole and first author of the work.*

Conclusions: This study shows a complex map of overlapping and sometimes non-functioning responsiveness mechanisms in the same health system. It demonstrates the importance of taking a broader view, and offers insights into ways that government stewardship and capacity can be strengthened through better alignment. A focus on the actors responsible for mechanism implementation and functioning, and broader health system responsiveness, could be beneficial. Improved evidence alignment and gathering can contribute to a health system where all citizens´ voices are heard and responded to, and community having a more active role in government prioritisation.

Key words: *Feedback mechanisms; health system responsiveness; accountability; stewardship; mixed-methods; Western Cape Province; national health system; provincial health system; health systems research.*

Key lessons

- The gap between health research and policymaking is a critical issue in health systems and needs to be addressed in LMIC contexts.
- The Western Cape Province, within the South African health system, includes health system responsiveness as a key policy aim, with mechanisms in place for receiving and responding to citizen feedback.
- Despite the existence of these mechanisms in both national and provincial legislature, there is a major gap in knowledge of how these mechanisms operate in local realities with a shortfall between policy and implementation, a finding that is reflected across LMIC literature and can be utilised for future research agendas.
- There is also a lack of evidence on how these mechanisms operate within a health system's responsiveness strategy, if at all, with mechanisms often described in isolation. Clearer understandings of mechanism interaction is needed.
- Mechanisms evaluation needs to occur at the ground level of implementation in order to assess functionality in terms of both the mechanism itself and the role it plays in health system responsiveness.
- It is important to understand the barriers to the effective functioning of mechanisms better, in particular resource constraints. While there are promising cases of successful feedback mechanisms, there are further opportunities for strengthening.

Wordcount: 10 960

Introduction

Despite the context specific nature of health systems (WHO, 2007), the World Health Organization (WHO) has in place six building blocks for improving and strengthening health systems: service delivery, health workforce, information, medical products, vaccines and technologies, financing and leadership and governance (stewardship). The overall goals or outcomes of this include improved health (level and equity), responsiveness, social and financial risk protection and improved efficiency (WHO, 2007).

Patient, citizen or community participation is a core concept for health systems, promulgated in the Alma Ata Declaration, and more recently gaining renewed attention, visible in national policies and guidelines across the world, especially in high income countries (Crawford, 2002). While definitions and concepts are not standardised, participation is commonly understood as an intervention or mechanism for fostering health system responsiveness, leading to improvement health outcomes, among other advantages.

Health system responsiveness can be defined as, "The extent to which a health provider or health policymaker demonstrates receptivity to the ideas and concerns raised by citizens by implementing changes to the decision-making or management structure, culture, policies or practices" (Lodenstein et al., 2013). It is generally understood that health system responsiveness and the mechanisms that foster it lead to citizen health improvements as well as societal and rights advances, including improved health outcomes, citizen satisfaction, health service equity, health rights, service utilisation, among other benefits, which is why it is increasingly included in national health policies (Ebenso et al., 2017; Lodenstein et al., 2013; Reader et al., 2014). Interaction and feedback, such as complaints/compliments or suggestion processes, are key to health system responsiveness, where citizens can provide feedback on experiences and perceptions and the health system can utilise the feedback for improvements (Ebenso et al., 2017).

There are many ways that health systems collect user feedback, including through data collection that is driven by service providers, via researchers and managers, through case studies or interviews, or where service users are able (or actively requested to) provide feedback through suggestion boxes, telephone hotlines or online surveys (Phillips et al., 2014). In terms of health services, patient satisfaction is often relied on as a main feedback measure (de Silva, 2000), commonly seeking service user feedback at point of exit (Phillips et al., 2014), while other feedback mechanisms include health committees (Molyneux et al., 2012).

A scoping review shows that there is literature available on accountability and citizen participation in health systems, but in LMICs in particular, health system responsiveness has not been thoroughly researched (Mirzoev and Kane, 2017; Adam et al., 2012). There is also limited empirical and evaluative work on feedback mechanisms and their functioning in LMICs and evidence on more commonly implemented formal mechanisms such as complaints, compliments and suggestion processes is lacking, especially in LMICs (Thi Thu Ha et al., 2015). Reliable and valid tools are also absent in terms of measuring health systems responsiveness (Phillips et al., 2016) and analysing feedback, such as complaints (Reader et al., 2014). This makes it difficult to evaluate the effect of feedback mechanisms on health system responsiveness functioning as comparing data across countries or even between mechanisms is challenging (Lodenstein et al., 2013).

Furthermore, just because feedback mechanisms exist or are implemented does not mean they are in fact functioning in terms of responsiveness. Phillips et al. (2014) points out, for example, that even with it becoming increasingly common in health systems to generate feedback from citizens, how this is utilised for health system quality improvement is unclear. Feedback mechanisms also tend to focus on the patient (Debona and Travaglia, 2009). Yet, a health system and the formal mechanisms required for receiving and responding to citizen feedback is made up of many actors, including health providers, those responsible for managing feedback processes, those responsible for redressing feedback and those who facilitate feedback playing a role in improving or contributing to broader health system improvements. It is only by understanding these actors more closely and how they both utilise feedback mechanisms and facilitate mechanism processes that we can begin to grapple with health system responsiveness in real-world settings, including how contextual factors such as citizen values, the political climate and gender relations impacts these processes on the operational level of the health system (Cleary et al., 2013, Lodenstein et al., 2013, Scott et al., 2014). This will support more robust evaluations of health system equity (Baez and Barron, 2006, Lodenstein et al., 2013). Current research approaches focus on mechanisms in isolation rather than as related to one another in a health system responsiveness strategy, within a local systems context. This leads to information gaps, including how feedback mechanisms foster equity. In LMIC settings evidence can also be difficult to gather due to resource, funding and capacity constraints (Adam et al., 2012).

Therefore the primary aim of this study is to explore and map the formal mechanisms for receiving and responding to citizen feedback in the public health system, in the Western Cape (WC) Province of South Africa (SA), while positioning these mechanisms within a national context by synthesizing existing data in a low-risk, mixed-methods approach. This will allow for a deeper and more engaging way to grapple with these mechanisms in an LMIC setting as part of a broader health systems responsiveness strategy, where there is limited research, (Mirzoev and Kane, 2017; Ebenso et al., 2017). It will also allow for the operationalisation of mechanisms, including the formal, legislated mechanisms that are utilised (or not utilised) by citizens, while acknowledging the non-legislated mechanisms that citizens resort to, including media platforms, protest action and even violence.

Box 1: Defining Formal Feedback Mechanisms
For the purposes of this study, we utilise the George (2009) definition of feedback mechanisms, as:
Measures that support a broad range of activities that include information dissemination, monitoring, norm setting, peer pressure, mediation, contestation and institutionalized coproduction between various actors in both public and private sectors.
Source: George, 2009

This will contribute to continued and committed research in this field in order to generate research-driven knowledge (WHO, 2012) to understand and improve feedback interventions, enhancing health system responsiveness in settings that need it the most.

Methods

A low-risk, desk-based, mixed-methods evidence mapping study was conducted in 2018-2019, which gathered, assessed, and integrated existing literature, and synthesized this with secondary analysis of multiple forms of existing qualitative and quantitative. This was done in order to describe and explore what mechanisms are in place in the WC Province of SA for receiving and responding to citizen feedback, and what effect these mechanisms can be seen to have on provincial and national health system functioning.

Data was gathered in a convergent parallel mixed-methods design, then synthesised in order to generate a description of the health systems responsiveness mechanisms in this particular context. The mixed methods approach fostered the exploration of these mechanisms from many different sources, enabling triangulation of the study results (Brown et al, 2015). This study is an initial step towards understanding of health system responsiveness in SA and the mechanisms that exist to support it.

Table 1 depicts the varied publicly available data that was gathered and assessed in various ways.

Table 1: Overview of data used. Source: authors.

Data type	Type and No Accessed	Location
Secondary literature: peer-reviewed articles	*Quant & qual* [No= 301] PRIMSA: 134 included studies (Appendix 7)	PubMed, EMBASE, CINHAL, other academic platforms & portals
Secondary literature: institutional reports [showing internal review]	*Quant & qual* [No= 76]	AMREF, ARNOVA, CADRE, CREHS, Centre for Health Policy, Center for Global Development, EQUINET, Global Health Workforce Alliance, Harvard University, Health Systems Trust, International Institute for Labour Studies, Khulamani Support Group, MRC, SA Department of Health (SADOH), TAC, The Alliance for Health Policy and Systems Research, The Global Fund, The Learning Network, The World Bank, UNDP, UNFPA, UN Global Pulse, USAID, WC Department of Health (WCDOH), WHO, Zimbabwe Equity Watch
Current or ongoing studies	*Quant & qual* [Accessed no= 71]	The National Health Research Database (NHRD)
SA/WC policy documents, including primary materials [e.g. forms, posters] and SA National Guideline to Manage Complaints, Compliments, Suggestions in the Public Health Sector of SA (2017)	*Quant & qual* [No= 129] PRISMA: 51 policy docs analysed (Appendix 7)	SADOH, WCDOH https://www.idealhealthfacility.org.za/, SA National guideline accessible online: https://tinyurl.com/s4s9v6k
Survey data, guides, reports, client/patient satisfaction & complaints guides and reports	*Quant & qual* [No=29]	Cape Area Panel Study, General Household Survey (GHS), Health Stats SA, SA Demographic and Health Survey, World Health Survey, CADRE, SADOH, WCDOH, HST
Media reports	*Qual* [No=10]	www.news24.com | www.timeslive.co.za | www.ewn.co.za | www.media24.com/newspapers | www.national.archives.gov.za | www.sabinet.co.za |www.newsbank.com |www.iol.co.za/capetimes
Theses	*Quant & qual* [No=8]	University of Cape Town, University of Witwatersrand

A retrospective review of materials relating to ´feedback mechanisms in LMIC health systems´ and then in ´SA and the Western Cape´ more specifically, was undertaken across several databases, including peer-reviewed journal articles, theses, institutional reports, and policy documents. The review of LMIC literature contextualized the local evidence, and provided the frame for thematic

analysis, and substantiated local findings – especially important considering the lack of research on health system responsiveness in LMIC settings. The search was limited to English-language materials, published from 2000-2019, although earlier relevant materials identified through trace-searching were also included. All materials were assessed for relevance in first round review, and quality in second round review. Appendixes showing the search terms and variations, PRISMA diagram, and output table are provided.

A policy review assessed publicly available content in 75 SA and WC policy documents, with 51 identified as key to this study (Appendix 2). This included primary materials, which were gathered and assessed, including the information, education and communication (IEC) materials produced by national and provincial government, and forms, guides and posters related to feedback mechanisms. Some local government reports, including district health plans, were also reviewed (Appendix 2).

Available survey data from the latest General Household Survey (2018), the Cape Area Panel Study, Health Statistics SA, the SA Demographic and Health Survey (2016) and the World Health Survey was identified and compiled . The South African National Health Research Database (NHRD) was reviewed for ongoing studies relating to responsiveness or feedback mechanisms within SA (we found 79 relevant open studies).[2] Media reports were located via key search terms, which offered further insight into platforms utilised by citizens for providing feedback (including the media itself).

Each collected data-type was assessed for relevance and quality independently, and then synthesized with other forms of data using a thematically organized extraction sheet and framework, developing a descriptive map (Appendix 1 and 2). Data was categorized according to type, SA/WC, general responsiveness or individual mechanisms, and broken down by extracting data focus (e.g. responsiveness vs CHWs), abstract/summary, publication/source, title and date and first author. This was further categorized into a typology of mechanisms, with responsiveness and functionality assessed for each mechanism (functionality, when data allowed).

The triangulation of varied data is an important component of rigor/confirmability. As a further measure to ensure integrity and credibility, the lead researcher (as an actor in the local health system) kept a reflective research diary for observations; regular research team debriefs were held; and joint review of identified materials were conducted. Although this was a minimal risk study, ethical clearance was obtained from the University of Cape Town´s Human Research Ethics Committee (HREC reference 790/2019).

Background: policy analysis and secondary literature

This article does not follow for standard article logic as some of the study outputs are necessarily descriptive, and make more sense as part of a 'background' description. Therefore, in this next section, we provide important background on the policy context in which this case example and further mixed method analytics is situated. This section draws from the policy analysis phase (Appendix 2), while drawing on secondary analysis on peer-reviewed literature and institutional reports, and positions the WC within the SA context as well as mechanisms within provincial and national legislature.

The national and provincial policy context in SA

[2] The submitted feedback through mechanisms such as suggestions boxes, written submissions and hotlines was also requested from the WCDOH, for both provincial and national registries – however it was not accessed in time for this study completion.

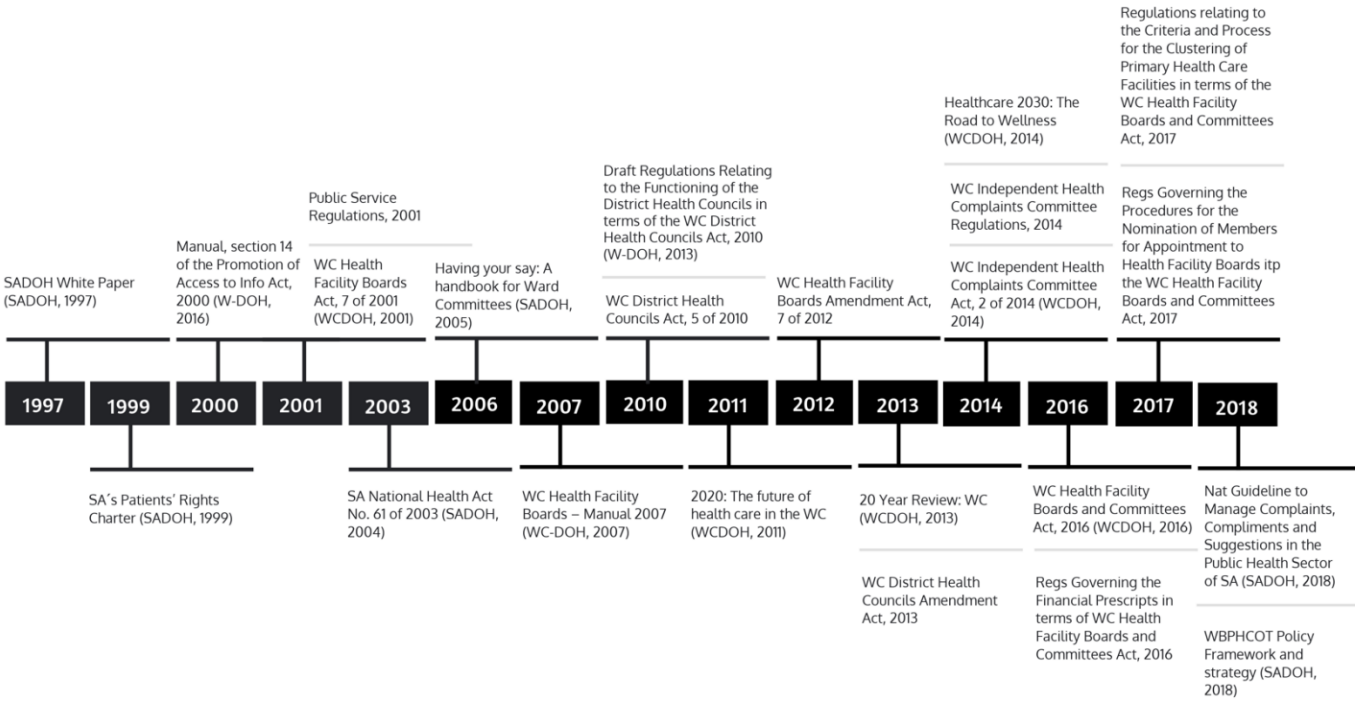
The WC Province is one of nine legislated provinces in SA with three spheres of governance: national, provincial and local (Government of SA, 1996). The National Health Act, 61 of 2003 (NHA) "sets out principles of co-operative governance between the three spheres and adopts a primary health care (PHC) approach in transforming the health system using a district health system model" (Scott et al., 2014). Despite the existence of the NHA, the national health system has been criticized for institutional weaknesses, inadequate information systems and a lack of policy implementation (DBSA, 2008).

The SA health system features the *Patients´ Right Charter*, which emphasizes that every citizen has a right to participate in decision-making (including the in the development of health policies) and the right to complain and for the complaint to be investigated and responded to (SADOH, 1999). This Charter is important to understand in terms of the context of SA´s history, where prior to the 1996 *Constitution of the Republic of SA*, many of the country´s citizens were denied basic human rights, including health care services (SADOH, 1999).

Community participation is a concept that appears in many national health policies and guidelines, including in the context of mechanisms such as district health councils, community health workers, health committees and civil society organisations (Meier et al., 2012; Friedman, 2006). Policies highlight that each sphere of SA ´s government features elected political representation and there are thus "three political lines through which community members are represented at national, provincial and local government levels," (Hall and Roberts, 2006). Provincial governments, such as the provincial government of the WC, are tasked with the monitoring and evaluation of national policies, while local government is the level of implementation of policy – considered the district health system (Hall and Roberts, 2006). SA also features a National Health Council, Provincial Health Council and District Health Council. Despite efforts by the SA government to foster community participation through decentralisation and other health system responsiveness mechanisms, research has found the system lacking (Meier et al., 2012).

The timeline in Figure 1 depicts how, over time, legislation has transitioned from broader concepts of participation and engagement to a more narrowed focus, address mechanisms in isolation from each other – most recently focusing almost exclusively on complaints procedures, Ward-based Primary Health Care Outreach Teams (WBPHCOTs), committees, and Health Facility Boards (HFBs). A broader mandated strategy for taking these all into account has not been published on a provincial level since 2014, or at a national level since the 2003 NHA. [This information is also provided in a different tabular format as Appendix 2, showing the policy mechanism-focus in full detail].

Figure 1: Timeline of national, provincial and district policies/reports addressing feedback mechanisms. Source: authors.



There is, however, provision for health system accountability, participation and responsiveness in national and provincial policy and legislation, and support for the institutionalization of mechanisms for receiving and responding to citizen feedback.

The WC provincial context

In the WC, there is a Premier of the WC and 13 provincial departments, and the province is governed by the Democratic Alliance (DA) (WC Government: Overview, 2019). With the national government ruled by the African National Congress (ANC), researchers have argued that the national government and the provincial government of the WC are not always politically aligned (Grootes, 2016).

The NHA outlines structures for District Health Councils in order to decentralise government and promote accountability and participation (Meier et al., 2012). In the WC, these structures make provisions for a National Health Council, a WC Provincial Council and six District Health Councils, with representatives under each council from each province (Box 2).

Provincial policies and guidelines build upon national policies, intended to foster community participation and health system responsiveness, with attention paid to mechanisms such as health committees and Hospital Facility Boards. Yet despite strong policies, there remain challenges in effective planning and implementation, with experts arguing that there needs to be improved co-operation between the different levels of government (Khulamani, 2015).

Box 2: NHA Structures for District Health Councils

National Health Council:
- Head of Dept of Health from each province
- Other govt officials
- Chair: Minister of Health
- MEC for Health from each province

Western Cape Provincial Health Council
- Local govt representatives
- Councillor from each District
- Head of Dept. of Health
- Chair: MEC for Health

District Health Councils
- Other local representatives
- Chair: Member of Metro or District Council
- Representative of MEC for Health
- Member of each municipality within District

Source: Meier et al., 2012

Provincial formal feedback mechanisms within the policy environment

The mechanisms visible in the WC (Box 3) can be loosely divided into those that directly support/channel *complaints;* and those that more channel feedback in support of *accountability and community participation* processes. Synthesized materials and data suggest there are at least 15 formal mechanism types currently in place in the WC, for receiving and responding to citizen feedback, as mandated across all levels of legislation.

Box 3: Formal mechanisms for receiving and responding to citizen feedback in the WC

Those immediately supporting complaints processes
- Complaints Committee
- Health Ombud
- ICT mechanisms (hotlines, SMS-hotlines & health information systems)
- Suggestion boxes
- Patient satisfaction surveys (PSS)
- Staff surveys

Those supporting broader accountability and participation processes
- District Health Council
- Health Facility Boards
- [Health-related] Committees
- Community Health Workers programs
- National Health Council
- NGOs
- Office of Health Standards Compliance

Many of SA´s foundational legislation focuses on accountability, community participation and responsiveness (Figure 1), highlighting or mentioning feedback mechanisms that can support this, including the NHA. The Act promotes the rights of patients to lay a complaint and have the complaint investigated, and outlines the roles of the Health Councils on each level of government, including that all provincial governments must develop legislation that stipulates the functioning of health committees (SADOH, 2004).

The NHA builds on the 1999 *Patients´ Rights Charter*, which is also utilised as a mechanism in itself, posted in health facilities and handed out to patients in order for them to be educated and informed about their rights, in terms of participation and complaints. The *Charter* underpins the existence of other feedback mechanisms, including suggestion boxes and complaint hotlines. The WCDOH adopts the charter, using it as an entry point to inform citizens about their rights as well as provide citizens with contact centre details and times for information and assistance by the department (WCDOH, 2015).

The 1997 *White Paper for the Transformation of the Health System in* SA is another key national document, emphasising the importance of decentralisation through the district health system and the value of non-governmental organisations (NGOs) in the collaboration between the government and the private sector (SADOH, 1997).

The *National Core Standards* are used on all levels of government as a benchmark for quality health services, based on six standards (SADOH, 2011). Mechanisms used to measure these standards include an audit tool and audit report, an assessment tool and the measures, and an Auditor General. The standards overlap with other mechanisms, for example, criteria includes governance structures such as a Hospital Facility Board and Community Health Forums and a public health domain, such as working with NGOs. These standards work conjunction with the Office of Health Standards Compliance (OHSC), which conducts inspections on public health facilities in SA to evaluate if standards of care are being met (OHSC, 2017).

Annual reports are a way for the health system to respond to citizens, potentially showing how their feedback has been utilised as well as what progress has been made. The OHSC annual reports (Appendix 2) are an example of this, publicizing results on well performing health establishments and highlighting areas of non-compliance, which can be used to guide quality improvement plans (OHSC, 2017; OHSC, 2018). The latest *SADOH Annual Reports* (Appendix 2) is also an example of this, highlighting progress and challenges in the health system. The national annual reports also shows results of patient complaints processes and compliments and patient satisfaction surveys (PSS).

The Western Cape Department of Health´s (WCDOH) 2030 strategy has been documented in *Western Cape: Healthcare 2030: The Road to Wellness* (WCDOH, 2014) – a process that highlights community participation in

itself. A draft document was made available for public comment in both 2012 and 2013, along with dialogue sessions, with all comments taken into account (WCDOH, 2014). Apart from district councils, facility boards and clinic committees, there are numerous other feedback mechanisms mentioned throughout the strategy including an annual PSSs, mechanisms for written, oral or telephonic complaints and compliments, rapid surveys and a Health Hotline. A further theme to note in the 2030 strategy is that of "The Voice of the Patient – placing the patient at the centre of service delivery and a recognition that their perspectives and opinions, no matter how diverse, matter" (WCDOH, 2014).

The *WCDOH Annual Reports* detailed in Appendix 2 trace the development of mechanisms such as Health Facility Boards (HFB), complaint mechanisms, hotlines and PSS. The 2030 strategy concept "patient voice" is echoed in annual reports from 2016/2017.

In the WC, there are six district health councils, each with their own district health plan based on the needs of their community, which feed into the provincial health council (WCDOH, 2012). Members of the council are tasked with addressing health issues and health service issues on their communities´ behalf, while disseminating relevant health information to their districts. Table 2 shows the order in which the District Health Councils were introduced.

Table 2: District Health Councils introduced in the WC. Source: WCDOH, 2012.

District Health Council	**Date**
Cape Winelands District Health Council	5 March 2012
Eden District Health Council	12 March 2012
Overberg District Health Council	19 March 2012
West Coast District Health Council	23 March 2012
Metro District Health Council	13 April 2012
Central Karoo District Health Council	23 April 2012

As seen in Appendix 2, each District Health Council currently has a 2018/2019 to 2020/2021 District Health Plan. Similarly to provincial and national annual reports and strategies, these highlight mechanisms such as patient complaints (and if they are resolved within 25 days), the development of a complaint and compliment register, measures against the *National Core Standards* and engagement with clinic committees and facility boards.

These documents, policies, reports and evidence position the below study´s findings within the context of the WC and SA context.

Findings: from mixed methods synthesis

This findings section presents analysis and synthesized findings across the multiple forms of data, describing the types of formal feedback mechanisms visible in the WC, for receiving and responding to citizen feedback. The synthesized data allows for further themes to be explored.

Varied complaints, compliments and suggestion mechanisms: Complaint/compliment/suggestion processes in the WC involve several national and provincial mechanisms, mainly channeling patient feedback and relating to quality assurance strategies. The 2017 National Guideline was developed to facilitate information gathering, responsiveness and quality improvements (SADOH, 2017) - demonstrating the assumed close link between complaints processes and health system responsiveness. The SADOH outlines a system to manage complaints (Box 4), showing a flow of information from local to district/provincial to national levels of government, detailing 'steps'

Mechanisms intended to facilitate these three steps include a health establishment level Standard Operating Practice (SOP), a Complaint, Compliment and Suggestion Committee (CCSC), standardized feedback forms, complaint/compliment/suggestion boxes, IEC posters or pamphlets (in all official languages), a record system for complaints (including complaint, timeframe and resolution type) and a complaints register (SADOH, 2017). The process, in terms of the flow of information between levels of government, includes the categorization of formal complaints, which are reported to the Provincial Office, who then submits quarterly reports to the National Office.

Box 4: Steps and stages to manage complaints (SADOH, 2017)

Step 1: Enabling complaints
Step 2: Responding to complaints
Step 3. Accountability and learning

Stage 1:
- Complaint addressed
- If citizen is not mollified by redressal it is escalated
- If complaint flagged as severe, it is escalated

Stage 2:
- Complaint escalated to district or provincial office where it is addressed or further escalated

Stage 3:
- Escalation to national Public Protector, Consumer Commission, legal system, Health Ombud, OHSC or Professional Councils and/or Boards.

This process is detailed but still new, so the degree of integration into the WC health system has not been documented. However, SADOH and WCDOH's annual reports specify how many complaints were received and how many were responded to within 25 working days. No detail is provided on content of complaints or demographic data for those providing complaints, nor is an evaluation of the actual process offered. Measures of success in terms of health system responsiveness and improvements in the health system (quality, outcomes, equity or rights) are notably absent. There is particularly little data relating to Step 3 (accountability and learning)- the part most relevant to HS responsiveness, namely, did the system learn from the feedback, and was there a systems-level response beyond individual patient resolution? (Olivier et al., 2017).

SMS and telephonic hotlines are also mechanisms facilitating complaints, compliments and suggestions in the WC and successfully piloted in 2012, with the plan to expand rollout (WCDOH, 2013). The subsequent year´s annual report makes mention of **email, SMS, telephone and "Please Call Me" services** displayed on facility notice boards, through which 1 984 complaints were reportedly received and 83.2% resolved the following year – with the process supported by a **non-profit organisation (NPO)** (WCDOH, 2014). Post-2014, WCDOH annual reports and plans no longer make mention of these mechanisms, so it is unclear if further rollout occurred (or at least, it does not seem to be monitored). However, comparing 2015 and 2019 WCDOH website contact information (Appendix 3), it is evident that the hotline, SMS and "Please Call Me" numbers still exist and that, in 2019, the department also offers social media platforms and online forms to citizens for feedback. The backend process (who is responsible for each mechanism, how the feedback is categorized and who attends to them) remains unclear and unreported.

A three-person Independent **Health Complaints Committee** was appointed in the WC Province in 2015, in accordance with the WC Independent Health Complaints Committee Act, No 2 of 2014. There were media reports about the appointment in 2015 and mention of the committee in the WCDOH 2010/2011, 2012/2013, 2013/2014 and 2014/2015 annual reports, however the current state of the committee is unclear.

Health Ombud: Forming part of the national complaints process is the Health Ombud[10], who sits in the office of the OHSC as an independent investigator of complaints (Section 27, 2019). There is a clear process established for the Health Ombud - which can be utilised once redressal has occurred at local levels, reported on annually. However, it is worth noting that the Ombud flagged in its latest report that it was struggling to fulfil its functions due to resource constraints (OHO, 2018).

PSS: The WCDOH ´s 2030 strategy emphasises that surveys to hear the voice of the patient (at the point of health service utilisation) should be utilised, "to provide the basis for ongoing improvements" (WCDOH, 2014). PSSs are conducted annually across facilities in the WC and reported on in district and provincial annual reports. The satisfaction rate in the latest report was 86%. The WCDOH annual reports show that PSS are used to develop quality improvement plans for issues such as waiting times and staff attitudes. Percentages of patient satisfaction are shown in the reports each year, however the process for quality improvement plans is not detailed. The WC government PSS template was not available for review for this study; however the latest annual report details that R418 000 was spent on conducting the surveys through a consultancy service by 223 provincial facilities with 59 669 surveys captured (WCDOH, 2019).

Data on patient satisfaction has also been gathered via non-governmental entities such as researchers or NGOs. Routine and household surveys such as the Cape Area Panel Study, General Household Survey (GHS), Health Stats SA, SA Demographic and Health Survey and the World Health Survey do provide information on levels of satisfaction and health outcomes, but no indication was found that this household survey data is utilised further by the WCDOH – to gather feedback and generate a systemic response.

Box 5: Do staff satisfaction surveys lead to quality improvement?

In terms of health providers, who too are citizens within the health system (along with government officials, community health workers, journalists or members of health committees or boards), it is important to note that in 2016 period, only 38.25% of health providers in the WC felt that they receive feedback on their suggestions (WCDOH, 2018). This is little progress from 2013, where only 38.10% of health providers felt they received feedback on their suggestions. Furthermore only 35.58% felt their organisation was open to employee´s feedback and ideas (WCDOH, 2018).

Staff satisfaction surveys: The WCDOH also promotes staff satisfaction surveys and The Barrett Value Survey (conducted every second year), in order to gather feedback from health providers themselves on their experiences and the organisational culture of their health facilities – a mechanism to foster quality improvement plans for the internal health system. The WCDOH is responsible for conducting the non-mandatory surveys (online) every second year (last one 2017, next one 2020) and publishing the results. How these surveys lead to quality improvements is unclear (Box 5) and there is also an apparent disconnect between staff- and ´community´/patient-feedback

[10] The current Health Ombud is Professor Malegapuru William Makgoba, who is accessible through the Health Ombud website: www.healthombud.org.

Committees and HFBs: Committees and HFBs may contribute to a complaint, compliment or suggestion process, but they tend to have a broader scope, including the planning and provision of services in health facilities" (SADOH, 1997). Health committees are supported in the WC by legislation in the form of the *WC Health Facility Boards and Committees Act, 2016* - made up of no more than 12 members who represent the community served by the PHC facility (WCDOH, 2016). Every hospital should have a HFB of no more than 14 members, representing the community served by it (WCDOH, 2016). A provincial *Facility Board Manual* offers guidelines and highlights the board´s accountability to the community and to patients and their families (WCDOH, 2007). Although formalized in legislation more recently (Figure 1), the *2002 – 2003 WC Health Annual Report* highlights that HFBs were achieved throughout the province during this period (WCDOH, 2003). Similarly – showing that there has been a long standing presence of facility committees, mandated by the NHA (SADOH, 2004). Both committees and boards are required by the 2016 Act to provide quarterly reports, written reports of activities within the end of each calendar year and measures for cooperation as well as schedule regular meetings (WCDOH, 2016). A database of health committees or HFB meeting minutes or progress reports is not readily accessible, however a record of a meeting held on 17 April 2018 was located, detailing the introduction of the *WC Health Facility Boards and Committee Act*. In 2018, the WCDOH published a call for community members to volunteer for health committees within the WC districts (WCDOH, 2018). It is currently not clear how many HFBs or Health Committees are operational in the WC since their introduction in 2018. Health facilities in the province do need to have a functional clinic committee in place to meet the criteria to be considered an "Ideal Clinic" (WCDOH, 2018). The latest WCDOH annual report reveals that in 2018/2019, 171 facilities achieved ´Ideal Clinic´ status (WCDOH, 2018), which suggests that there are 171 health facilities in the province with functional clinic committees.

CHWs: This is an area that has received a lot of research attention in LMIC settings, although there is not a lot of formal documentation or legislation on CHWs in the WC. CHWs can be a beneficial mechanisms, however, linking the community with resources and services, disseminating health information, mobilising citizens to be accountable for their health, engaging in health promotion and awareness, treating minor illnesses and referring more serious cases for treatment (Health Systems Trust, 2011).

In SA, the lack of formal legislation around CHWs and their underutilisation is attributed to the post-1994 focus on PHC and the organisation of a "highly diverse community care system that evolved around HIV and TB" (Health Systems Trust, 2011). In the WC, NGOs are often responsible for contracting CHWs, although payment may be subsidised through the government, but resources, standardised roles and responsibilities, training, supervision, monitoring, financing and governance remain challenges (Health Systems Trust, 2011). Without formalisation, CHWs face deficient working conditions, low pay and poor management (Schneider et al., 2018). There have been attempts to formalise Ward-Based Primary Health Care Outreach Teams (WBPHCOT), with the national framework launched in 2017 (SADOH, 2018), building on the success of the HIV-engaged CHW programmes (Health Systems Trust, 2018). Evidence shows that WBPHCOTs have been operating for a decade, but are not fully-functional, with challenges including "varying perceptions of the CHW roles, lack of knowledge and skills and lack of stakeholders and community support" (Mhlongo and Lutge, 2019). A 2017 review shows that there are only 3275 WBPHCOTs submitting information through the District Health Information Software (DHIS) - 42% of the 7800 mandated (Schneider et al., 2018).

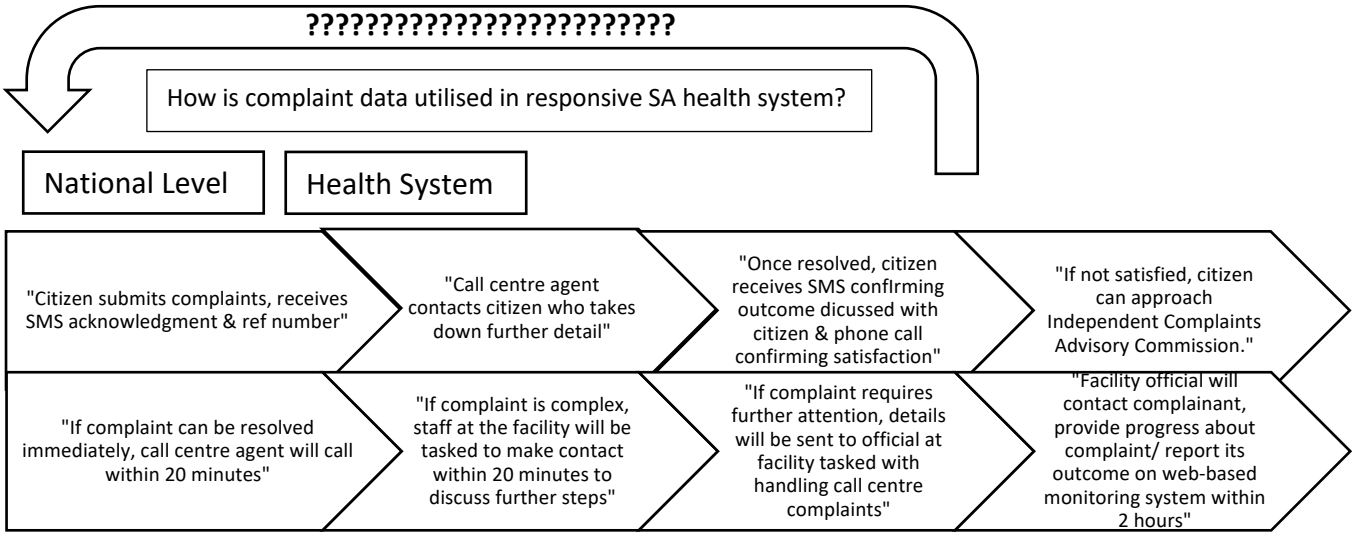
Non-governmental organisations: NGOs and civil society in SA do not feature heavily in legislature, only mentioned briefly in the 1997 *White Paper* as having an important role in the delivery and management of health services (SADOH, 1997). While there are over 50 NGOs listed on the WC web directory of non-profits and civil society organisations (WC Government, 2018) and over 100 000 registered in the country (Matthews, 2017), their role in terms of facilitating feedback in the health system does not appear to be formalised. This is an interesting finding, echoing the lack of CHW formalisation, considering that by 2010 there were more than 70 000 CHWs deployed nationally through nearly 3000 NGOs, due to the dependence on community-based services (Health Systems Trust, 2018).

The contribution of feedback mechanisms to health system functionality and responsiveness

It is evident that feedback mechanisms and their role in health system responsiveness should lead to overall improvements in a setting, including enhanced health outcomes, rights, equity, satisfaction and service utilisation (Ebenso et al., 2017; Lodenstein et al., 2013; Reader et al., 2014). Yet while legislature, information and reports mention mechanisms and may even detail processes – such as the complaints process – a critical step in the feedback or responsiveness loop appears to be missing across all levels of government: how the health system takes into account complaints, compliments and suggestions and uses it to strengthen the system in a responsive way and what improvements are made (such as health outcomes, equity or rights) as a result of this.

Consider the national complaints process, which outlines a very clear information flow between local, district, provincial and national (SADOH, 2017). The current last step in the process is the monitoring and statistical data on complaints (SADOH, 2017), but it would be imperative to learn *how*, once the data is captured, it is utilised in a way that is responsive. On a provincial level, considering a 2019 WCDOH notice *Help us to make our health services even better* (WCDOH, 2019), which details the Complaints Project, there is a clear process: Citizens should send a complaint (via SMS, phone call or email) with the centre for processing complaints open between 07h00 and 19h00 from Monday to Friday, it costs either a standard SMS rate or a local telephone call and citizens should include their name and surname, the name of the facility that they are complaining about, the nature of the their complaint and, if the complaint is about a staff member, the name of the staff member should be provided. The feedback process then looks as follows:

Figure 2: Feedback process in telephone/SMS/email complaint procedure. Source: authors, adapted from WCDOH, 2019.



When the WCDOH reports on complaints procedures in its annual reports and other documents, the objective is on resolutions, including resolution rate and speed. In the latest annual report, improvements in the resolution rate and speed are highlighted as a measure for success, but measures of success in terms of health system responsiveness and improvements in the health system – such as health outcomes, equity or rights are notably absent.

This finding is echoed in WCDOH reports on patient satisfaction. While quality improvement plans are highlighted as ways to address issues that are flagged consistently in this feedback – such as long waiting times and staff attitudes – these plans are very much focused at a local level and do not provide sufficient detail in terms of what they entail or how they feed into broader health system responsiveness.

Considering SA´s context and the values outlined in the NHA, improvements in health rights and equity as a measure of success in responsiveness should be a considerable focus for the health system. However, another valuable piece of information missing in the reporting on mechanisms such as those utilised in complaints processes or patient satisfaction is how these mechanisms are intended to foster equitable feedback from citizens. In 2018, for example, 223 facilities in the WC conducted the annual PSS (WCDOH, 2018). While it is valuable for the public to note that 86% of these respondents were satisfied with health services, it is not clear out of all of those accessing health services, why only 59 669 responses were captured. It would be useful to know how many citizens accessing health services at these health facilities did not participate and why and which citizens those who did participate represent. It is also important to note that, excluding midwife obstetrics units, mobile services, psychiatric hospitals, reproductive health facilities and specialised health care facilities, the WC has 275 health facilities, which means 19% of facilities in the province did not gather feedback from their patients. Yet information on which facilities were not included and who they represent is not available.

Similarly, in the *WCDOH Annual Report 2017/2018* (WCDOH, 2018), it is reported that there were 6.5 million patients accessing services over this period and it received 5 268 complaints during this time (91.4% of which were resolved). This means that only 0.08% of those accessing services in this period provided feedback in the form of complaints. In terms of hotlines, a 2013 WC Government press release reports that over a five-month period, 594 complaints were logged with an average of six calls per day and the majority of complaints originating from the Mitchell´s Plain Community Health Centre (WCDOH, 2013). During this period, the WCDOH is recorded to be serving a population of six million people, which means that less than 0.01% utilised the complaints hotline over this period. Thus information on barriers to accessibility and utilisation of feedback mechanisms is critically missing.

Gleaned from government reports and documents, the lack of evaluation on the effect of mechanisms on health outcomes, such as equity, is supported by broader study findings. The influence of race and socioeconomic status (SES) on perceived quality of care has been explored thoroughly in SA (Myburgh et al., 2005; Jacobsen and Hasumi, 2014), but there is no evidence available on the role these factors play in citizens´ access to feedback mechanisms within the SA or WC health system. With evidence on perceived quality of care showing that “both race and SES were significant predictors of levels of satisfaction with the services of the health care provider”, with white race groups and high SES respondents 3.5 times more likely to rank perceived quality of care as “excellent” compared to black race groups and low SES respondents (Myburgh et al., 2005), it is important that in reporting on the role of feedback mechanisms within health system responsiveness, especially within this specific national context, these factors are taken into account.

How mechanisms in the WC function

In discussing each mechanism that is currently legislated in the WC, it is evident that there are a range of mechanisms in place in policy across the different levels of government. However, as was found when

examining each mechanism, the presence of a feedback mechanism in legislation does not necessarily mean that on the ground, they are functioning and sustainable. The below table shows where there is critical information missing in terms of mechanisms functioning within the WC province for each, which is an important finding not because it highlights limitations but because it enables future and further research agenda setting.

Table 3: Mechanisms in the WC and missing data on functionality (research agenda-setting). Source: authors

Mechanism	Missing data on functionality
Complaints process	• Person/people responsible for investigating, collating feedback, responding to feedback, escalating to next level of government • Person/people responsible for addressing complaint on each level of govt before Ombud/Boards • Cost/resources needed
Facility complaint feedback form	• Person/people responsible for disseminating form • Criteria for who receives a form, in which facilities, barriers • How is data utilised in responsiveness
Suggestion boxes	• Person/people responsible for emptying boxes, investigating, collating feedback • How many available in how many facilities, barriers • How is feedback data utilised in responsiveness
IEC posters/pamphlets detailing feedback process	• Person/people responsible for putting up posters, distributing pamphlets • How many available in how many facilities
Complaints register	• Person responsible for filling out, filing, barriers • How is data utilised in responsiveness
Complaints Committee	• Committee members, process, structure • Who do committee members represent • Meeting frequency, agenda, barriers • Cost/resources needed
SMS/telephone hotline and hotline information	• Person/people responsible for answering phone/texts, investigating, collating feedback, • Person responsible for distributing information on hotline, which facilities, how often, barriers • How is feedback data utilised in responsiveness • Cost/resources needed
Health Ombud	• How is feedback data utilised in responsiveness • Barriers
PSS	• Person responsible for distributing, to who • How does consultancy ensure equity across respondents, facilities, barriers • How is feedback data utilised in responsiveness
Staff satisfaction surveys	• Person responsible for distributing, to who, barriers • How is feedback data utilised in responsiveness • Cost/resources needed
Committees and HFBs	• Does each health facility have an operational HFB • Does each PHC facility have a health committee • Reports of activities, measures for cooperation, records of attendance, minutes, resolutions • Role/process for facilitating feedback, how is it utilised in responsiveness, barriers • Cost/resources needed
CHWs	• How many WBHCOT/CHWs are in operation, where, SOP • Role/process for facilitating feedback, how is it utilised in responsiveness, barriers • Cost/resources needed
NGOs	• Role/process for facilitating feedback, SOP

- How is it utilised in responsiveness, barriers
- Cost/resources needed

If gathered and analysed, the key data highlighted across the mechanisms which would allow for an evaluation of functionality and sustainability as well as a deeper investigation into how the mechanisms interact with one another in health system responsiveness on each level of government. Currently, the missing data and lack of evaluation on mechanisms as effective health system responsiveness interventions make it challenging to demonstrate conclusive findings about the efficiency of these mechanisms. Furthermore, resource, funding and capacity-constraints may also contribute to difficulties for gathering this missing data on each level of government, identified in Table 3. This is important to note for future research, as it identifies areas where research could play a prominent role.

The resourcing of mechanisms

Another gaping hole in the findings of this study are the people responsible for the mechanisms. The actors are critically missing in policy, guidelines, reports and information and because each mechanisms is described in isolation, rather than in relation to an interactive health system responsiveness strategy, it is challenging to conclude how the same or different actors play a role across the different levels of government. Without provision for these actors in the available information, it is challenging to address the gap between policy and implementation because the contextual factors of real-world settings are not taken into account, including values, beliefs, attitudes and trust (Lodenstein et al., 2013).

An example of this in the provincial context is the emphasis that the WCDOH places on timely responses to complaints. If a telephone, SMS or email hotline is utilised by a citizen, the process stipulates that a citizen will be responded to as fast as 20 minutes for simple cases and as long as two hours for more complicated cases (WCDOH, 2019). These are very tight turnaround times in a health system that is already overburdened and under-resourced. Health providers in SA face challenges such as medical equipment shortage (Moyimane et al, 2017), failing infrastructure, a lack of funding, poor management, neglect (Mayosi et al, 2014), poor information management and staff shortages (Malakoane et al, 2020). Yet information on how health providers manage these feedback mechanisms, including tight turnaround times, within their day to day challenges is missing.

Lastly, as shown in in Table 3, cost information as well as detail on other resources needed for mechanisms, such as materials, tools, facilities and equipment are also missing for many of the mechanisms. This makes it challenging to make any sort of cost analysis in these findings.

Mechanisms in the WC functioning in isolation

Findings show that in isolation, despite barriers, there are successful cases of mechanisms functioning as tools to receive and respond to citizen feedback.

In the Cape Metro, researchers trained health committees – an existing mechanism – using a human rights-based approach, finding that it "helped revitalize flagging or defunct committees and gave trainees a sense of empowerment and agency to undertake various social and advocacy actions" (Mulumba et al., 2018). It also highlighted the fact that before the researchers´ involvement, communities had not been utilising health committees nor had they perceived them as part of the health system. While there was no policy framework for committees at the time of the intervention, the Cape Metro District Health Council held public forums to clarify their role. The evidence reinforced the fact that "health committees´ integration into the wider health system has a positive impact on advancing community participation as an underlying determinant of the right to health" (Mulumba et al., 2018). Furthermore, the community pressure as a result of this experience was

one of the catalysts for a draft bill on health committees in the WC as well as the development of national guidelines (Mulumba et al., 2018).

The effective functioning of the OHO during the Gauteng Mental Health Marathon Project nis also noteworthy (OHO, 2018). It is highlighted, "The tragedy of the Gauteng Mental Health Marathon Project can be viewed as a litmus test for the NHA, the OHSC, and the Health Ombud, in that it tested the efficacy and fitness for purpose of these instruments and institutions" (Health Systems Trust, 2018).

The role that NGOs played in deploying CHWs during the height of the HIV/AIDs epidemic as well as their role in advocacy and community mobilisation, shows the value that these entities add to the health system, serving as mechanisms for feedback, while driving responsiveness (Muula, 2008). It has been argued that the national government only (and finally) established a national policy on ART after court action instigated by AIDS activists (Muula, 2008).

Despite the absence of data, it is also promising that complaints mechanisms, PSS and staff satisfaction surveys are being utilised in the WC province, with the WCDOH reporting on them annually. While data gathered from these mechanisms may fail to address improvements in the health system through responsiveness, such as equity, they do demonstrate that citizens are indeed engaging with the mechanisms and utilising opportunities to have voice their perceptions and experiences.

While these cases are promising, it is also not always clear how feedback is meant to function in terms of information flow, especially between community, district and national levels. While some data exists for specific mechanisms, such as complaints procedures, the feedback loops in other mechanism as well as between different levels of government is unclear This finding is supported by data gathered for this study, which highlights that on a national level, community participation is still very underdeveloped and the mechanisms that do exist lack information on how they function or documentation on implementation processes (Baez and Barron, 2006; Mahmud, 2004). In SA, this information flow between levels of government can be challenging in that local authorities and provincial departments are considered separate spheres of government, rather than a different level of government (Baez and Barron, 2006). In the WC, in particular, it has been noted that the national government (the ANC) and the provincial government (the DA) are not always in political synergy (Grootes, 2016).

Formal vs informal mechanisms

Lastly, the findings from this study show that while it is promising that citizens are accessing formal feedback mechanisms, it is also important to highlight the more informal ways that feedback is garnered. A study in Malawi found that "the informal forms of social accountability are considered particularly relevant in contexts where formal direct accountability mechanisms, such as official complaint mechanisms, public ombudsmen, participatory planning and monitoring, and local management committees, are absent or not enforced. Informal social accountability, however, has been least documented" (Lodenstein et al., 2018).

The media data reviewed for this study shows that it is not simply utilised as a `watchdog´ for national and provincial government in terms of health systems (as well as other entities), but also serves a purpose in terms of citizen feedback and their needs when it comes to the health system. A clear example is this was newspaper headlines in 2001, early in the HIV epidemic when the ruling government denied the

Box 4: Informal vs Formal Feedback Mechanisms (Jones et al., 2019)

Formal: "Data purposively collected and collated to capture the patient experience of care (generally at the organisational level, including surveys, complaints and comments)".

Informal: "Informal sources of feedback… recognised alongside the formal data. Usually unsolicited … This type of feedback was more often described as highly emotionally engaging."

facts about HIV/AIDS and dragged its heels in offering antiretroviral therapy (ART) to patients living with HIV, only yielding in 2003 after much international and local pressure (Mayosi and Benatar, 2014; Leclerc-Madlala, 2005). Headlines, however, alerted citizens to the fact that the DA had called for HIV/AIDS to be declared a national emergency, calling the national government´s actions into question (KHN, 2001). A more recent news article has explored the mechanisms of NGOs within the context of the African context, asking "Are they a force for good?" (News24, 2017).

Media advocacy, "the strategic use of media by those seeking to advance a social or public policy initiative," (Treno and Holder, 1997) is thus a prominent approach by citizens for expressing feedback or demanding responsiveness in health systems. An analysis of print media coverage of primary healthcare and related research evidence in SA found that in terms of the national health system, issues most commonly covered were governance arrangement and delivery arrangement issues as well as accountability of the state in terms of financing and delivery. The study found that over a 16 year period, the WC featured the highest amount of coverage in terms of accountability of the state sectors role in financing and delivery as well as strike or job action. In terms of how care is designed to meet consumer needs, the following topics were covered in print media: availability of care (30%), timely access to care (18.5%), culturally appropriate care (1.7%) and package of care (9.8%) (Akintola et al, 2015).

The same print media coverage analysis also found that in the last 16 years, 12% of print newspaper coverage was on strike or protest action. This is a common occurrence in SA´s health sector. For example in 2007, 2009 and 2010, the health sector experienced health provider strikes, including violent strikes among nurses (Dhai et al, 2011). In 2014, *SA Breaking News* reported a story on "Burning Down of Clinics Will Only Chase Away Healthworkers" (SA Breaking News, 2014). Strike or protest action is a clear way for health providers to give feedback to the government when they feel like their voices are not being heard or for citizens to voice their own dissatisfaction with services. Mechanisms in the health system including violence, protests and even discharge against medical advice are other ways that citizens drive feedback, albeit informally.

In 2016, 66.84% of health providers reported experiencing verbal and/or physical abuse from patients in the last year (WCDOH, 2018). In a 2003 study on workplace violence in the health sector in SA, 62% of all health providers in SA reported that they had experienced at least one incident of either physical or psychological workplace violence (Steinman, 2003) . This included verbal abuse, bullying/mobbing, racial harassment or sexual harassment. It was also found that 71% of health providers in public health facilities had faced violence in the workplace.

Discussion

The findings show what mechanisms exist in the WC province SA, raising questions about how they contribute to the functioning of the health system and what gaps exist between policy and implementation in real-world settings. Findings also show that important data on resources, actors and ground-level processes could assist in evaluations of mechanisms both in isolation and as an interactive process, potentially contributing to improvements in the health system such as equity or service utilisation. This descriptive and exploratory study presents an interesting case, showing how in local contexts, mechanisms can be both promising and ineffective and that citizens do not always utilise formal mechanisms for feedback, sometimes resorting to media, violence or strike action to be heard. The findings and the below discussion can be applied to other LMIC settings and contribute to future research agendas.

Policy vs implementation

The findings of this study point to a gap between policy and implementation with important sources of information missing in order to understand how mechanisms instilled in government documents and guidelines unfold in real-world settings, including a lack of evaluation of processes, systems, roles and responsibilities and outcomes at local levels. This is supported by evidence. In the Health Systems Trust latest report, authors point to a fracture between policy and the implementation of quality improvements (Health Systems, 2018). Similarly, Gilson et al looked at "instability and daily disruptions managed at the frontlines of the district health system" in 2017, including patient complaints, unpredictable staff, compliance demands, organisational instability and changing/unclear policy imperatives (Gilson, 2017). They concluded that resources and governance structures are not enough and that leadership needs to be fostered (Gilson, 2017).

For some mechanisms, the gap between policy and implementation can result in unintentional outcomes on the ground, when mechanisms are in place. The recent tragedy involving the Life Esidimeni patients, referred to as the Gauteng Mental Health Marathon Project is a poignant example of this. While not relevant to the WC provincial context, it reveals a failure in the functioning of health system mechanisms on all levels of government. The Gauteng Mental Health Marathon Project saw 144 mental health patients die after "being transferred from long-stay residential facilities to under-regulated and unlicensed facilities" and was the first case of such magnitude referred to the OHO (Health Systems Trust, 2018). In 2017, the Health Ombud released findings of the investigation, noting that all of the patients who died at NGO facilities (95%) did so under "unlawful´ circumstances" (Durojaye and Agaba, 2018). The gross errors made during this case highlight the fracture between departments, with researchers arguing, "While it has exposed major deficiencies in both governance and management, it has also focused attention on the gap between policy and implementation, and between intentions and consequences"" (Health Systems Trust, 2018).

Policy and implementation gaps are not unique to SA. In Kenya, a 2003 study found that decentralisation was ineffective due to a lack of emphasis on process (Oyaya and Rifkin, 2003), while in Pakistan, researchers found that decentralisation occurred differently depending on local contexts (Bossert and Mitchel, 2011). Evidence from Cuba, for example, shows that creating functioning around feedback mechanisms is not a simple feat: "It demands a systematic approach and consistency, which is greatly aided by the degree to which it is incorporated into the social culture, the availability and the use of tools for evaluation and the use of legitimate, participative management techniques" (Serrate et al, 2007). Across LMIC settings in general, research has been conducted focusing on exploring factors influencing mechanism implementation (Berlan and Shiffman, 2012, Cleary et al., 2013, Ciccone et al, 2014, Brinkerhoff and Bossert, 2014).

A lack of evaluation of the functionality of mechanisms

This missing evidence, information or detail identified in the WC case is not uncommon in LMIC settings. In the Grenada health system, for example, researchers highlight the fact that "In many cases health system information is incomplete or does not exist, limiting transparency" (Hatt et al., 2012). In fact, in this setting, researchers were not able to gather data on any real mechanisms that may foster engagement between citizens and health providers at a community level (Hatt et al., 2012).

Without adequate evaluation on how feedback is tracked, if the process is equitable and what the channels are for ensuring that feedback across mechanisms result in responsiveness, functionality is hard to assess. In the Grenada setting again, for example, this is highlighted when looking at the complaint system at the General Hospital: "Patients take their complaints to a nurse who forwards it up to the Directors of Nursing Services. Interviewees noted that complaints are rarely tracked to ensure resolution and that the Quality Improvement Coordinator is not informed of complaints. Patients with complaints will often call radio stations in order to voice their grievances" (Hatt et al., 2012).

This is important because the presence of mechanisms within national and provincial policies does not necessarily mean that these mechanisms are functional on the ground or are adding any value to the health system. In the WC case, while having a functional health committee was a criteria for Ideal Clinic status, the only information available is that the criteria has been met, rather than an evaluation of what a functional health committee is. As Loewenson (1999) points out, "The simple assembly of stakeholder fora to elicit view or gather information does not constitute the form of participation in the governance of health systems that is increasingly being demanded." In Bangladesh, for example, evidence on citizen participation highlights the fact that citizens will choose not to participate if the perception is that it will not have any impact. Thus even if the mechanisms are in place, they will not be utilised if these mechanisms cannot be accessed on citizen terms (Mahmud, 2004).

Strengthened monitoring and evaluation in terms of mechanism implementation is needed across levels of government in order to evaluate how the mechanisms are being utilised in a responsive way – both in isolation and as complementary tools - and how this may be enhancing the health system as a whole (or potentially hindering it). This data would prove vital for placing actors at the centre of these mechanisms and understanding the contextual factors that play a role in policy implementation (Cleary et al, 2013).

Furthermore, while the WC in particular has exhibited effectiveness in terms of gathering data on both patient and staff feedback, utilising annual surveys throughout its public health facilities, it would be useful to compare findings from the patient and staff satisfaction surveys with data from other feedback mechanisms, including suggestion boxes, complaints and compliments hotlines and even feedback provided to the Ombud or health professional councils, as well as compare patient and staff satisfaction surveys with each other. Cross-cutting feedback would allow stronger themes to emerge, including where the biggest weaknesses in the health system sit, and create a more informed framework for quality improvement, strengthening the responsiveness of the health system. This is an area that is notably absent in LMIC literature (Appendix 1).

Actors framed in mechanism policy, plans and processes

In a review looking at the factors that influence the functioning of accountability mechanisms in primary health care LMIC settings, researchers found that "trusting interpersonal relationships between providers and citizen representatives" were key to the functioning of these mechanisms as well as aligned values and beliefs of the health system and local communities with the participatory values that the mechanism are based upon (Cleary et al, 2013). Yet it has been found, "Despite its importance, few studies have provided an in-depth understanding of the accountability responsibilities and practices of frontline health facility providers and managers within decentralised systems, and the implications for service delivery" (Nxumalo et al., 2018).

This is a layered area as actors need to be taken into account in several ways: policy makers legislating and creating guidelines and resources for mechanisms, those implementing and managing the feedback mechanisms, those utilising the feedback mechanisms, those responsible for evaluating the mechanisms and those responsible for driving the feedback into the health system and demonstrating a responsive health system. However, the actors in these processes could be the important piece needed to understand the gap between policy and implementation. For example, during the HIV epidemic in SA, it was argued, "Ultimately it may not be the gap between policy and implementation that presents the most formidable challenge to SA´s fight against AIDS and the future of the democratic state, but rather the growing gap between government and increasingly ill and estranged populace" (Leclerc-Madlala, 2005).

While considering all of these different types of actors is challenging, evidence from real-world settings and mechanisms implementation would assist in a greater understanding of each. This is important because the functionality of mechanisms – both in isolation and as an interactive process – depends on the interaction between actors. Interaction, however, is not a simple or lateral flow of information and is impacted by

contextual factors (Lodenstein et al., 2013; Cleary et al., 2013; George, 2009). It is only through these actors that a clearer picture will emerge on local realities of policy implementation and an evaluation of health system responsiveness can occur.

Addressing equity

With greater investment in the understanding of actors in these processes, critical areas in health systems can be addressed – such as health equity. Considering SA´s unequal and inequitable past, it is critical in this particular health system context, but is applicable to many similar settings. There needs to be deeper investigation into a) whose voices are being heard and b) are they in fact being heard, responded to or taken into account. Furthermore, where communities are represented, such as in Health Committees, there needs to be stronger evidence that those committee members represent the voices of all members of the community.

Evidence shows that it is often the "urban-born and educated elites" who end up being represented in engagement mechanisms in LMICs (Glattstein-Young and London, 2010). In SA, it is has been found that participation is "largely spectator politics, where ordinary people have mostly become endorsees of pre-designed planning programmes" (Williams, 2006).

Barriers need to be taken into account when it comes to feedback mechanisms. An example is that in SA, there are 11 official languages. While the SADOH features posters on complaints mechanism posters in each of these languages (SADOH, 2019), the *Patient´s Rights Charter* is only available for health facilities to display in seven languages: English, Sesotho, Sepedi, Afrikaans, Tswana, Xhosa and Zulu. *The National Guideline* (2017) highlights that procedures should be made known to the public in appropriate languages, that information should be provided to a complainant in a language he/she understands and that posters or pamphlets should be available in "official language(s) most commonly understood by the communities that are served by the health establishment and the procedure is explained to first time users" (SADOH, 2017). Yet, there is no standard operating practice (SOP) in place for what this should look like practically within health clinic contexts nor who is responsible for explaining the procedure to first time users. It is also unclear how the official languages most commonly understood by communities served by the health establishment are decided upon.

While the *National Guideline* call on health facilities to develop mechanisms for accessibility, it is unclear what those mechanisms are, including how they ensure language barriers are overcome. Furthermore, it is also worth noting that the guidelines themselves, along with the registry for complaints, summary form on outcome of complaint investigation and template for statistical data on complaints are in English (SADOH, 2017), which is a reminder once again that accessibility does not just need to be considered in terms of the client or patient, but also in terms of the health provider when utilising these mechanisms.

Language as a barrier is an important consideration in the context of the SA health system. Berg (2016) has pointed out its importance in equitable health service provision. This is echoed by a survey undertaken in a large, urban paediatric hospital in Cape Town, where 94% of medical interviews with the parents of patients were conducted in their second or third language, where "parents cited language and cultural barriers, rather than structural and socioeconomic barriers, as the major barriers to their effective participation in the health car rendered to their children" (Berg, 2016, Levin, 2006). Another study, where a survey was also administered but in a district hospital in the WC, found that language barriers hindered effective workings within the hospital and created misunderstandings between patients and staff, despite the fact that an official language policy is in place in the province (Schlemmer and Mash 2006).

While language has been used as an example of a potential barrier, both policy makers and researchers need to examine other barriers more effectively within local contexts. Further research should be conducted into

the functioning of feedback in urban versus rural health facilities as well as how vulnerable populations including children, undocumented migrants or foreign speakers are able to access a responsive health system.

Informal mechanisms and health system responsiveness

Understanding informal mechanisms is another key area in LMIC settings, as the findings have shown, where mechanisms such as the media need to be understood and evaluated more extensively, including how they interact with formal feedback mechanisms and have the potential to increase health system responsiveness. For example, Gugsa et all conducted a 2015 study on media coverage of maternal health in Bangladesh, Rwanda and SA through a quantitative and qualitative newspaper content analysis. Their findings suggested an association between the amount and type of media coverage of maternal health and progress on the Millennium Development Goal 5 (Gugsa et al., 2016). In sub-Saharan Anglophone countries, researchers have explored how media systems play a determining role in the degree to which journalists can independently advocate for social change when covering HIV/AIDS (D'Angelo et al., 2013) while in Indonesia, researchers have looked at how insights from complaint systems and social media citizen feedback impacts local government decision-making (UNAIDS, 2015). Yet, while "mass media (such as television, radio, newspapers, social networks) represents a type of feedback mechanism or channel that can facilitate interaction between the public and the health system", deeper investigation into the topic is needed (Gopal, 2018). In LMIC settings, including South Africa this data is lacking. Yet in other countries, evidence of the media´s influence on community participation is emerging. In the United States of America, for example, there is evidence that social media is revolutionising health-seeking behaviour and practice, including on the quality, efficacy and equitability of health care delivery (Hawn, 2017). These trends need to be explored in the LMIC context, where a review of the SA NHRD database shows not a single current health study focusing on social media, apart from one investigating the use of social media among nursing students in KwaZulu Natal (NHRD, 2020).

Another area that should be explored more closely is violence. In Pakistan, for example, a questionnaire was distributed to 769 primary care physicians addressing their level of safety, where it was found that a considerable number of physicians who participated in the study have faced mild violence in which verbal abuse was the most common (Ahmed et al., 2018). In China and India, which researchers point out are countries "where failures to effectively redress patient grievances are observed" (Mirzoev and Kane, 2018), violence towards health staff is increasing significantly (Mirzoev and Kane, 2018). In two Indian states, a Medical Protection Act has been implemented to punish violent attacks against doctors after a gastroenterologist was beaten by relatives of a patient who had died (Pulla, 2015). Protests are a mechanism through which citizens as well as health providers express dissatisfaction with the health system, in a very overt form of feedback, studied in countries such as India (Sri et al., 2012) and other LMICs. This presents a space for further research opportunity.

Conclusion

The study focused on mechanisms for receiving and responding to citizen feedback in the WC Province of SA and aims to contribute to a more nuanced understanding of health system responsiveness. While findings show that the WC has strong policies and guidelines in place for feedback mechanisms, the synergy between national, provincial and local levels in terms of implementation and implementation in general may be a challenge. There is also a need for a greater understanding of these mechanisms not simply in isolation, but in relation to one another as well as in people-centred terms. Evaluation on the ground level of policy implementation is needed in order to evaluate functionality as well as health system responsiveness and its role in strengthening the health system.

Gilson et al argues,

> "*The tendency in public health is to portray policy reform as a technocratic or economic process. Both economics and health policy analysts tend to provide detailed prescriptions on what should be done, but without clear instructions on how to do it and without good explanations of why things go wrong. Yet international evidence of reform efforts in other sectors clearly highlights the range of actor and process influences over reform implementation*" (Gilson et al, 2003).

This study has attempted to address, with the information and data that is available, what effect mechanisms can be seen to have on health system functioning in both national and provincial spheres of health, however deeper contextualised research is needed to position and evaluate these mechanisms in relation to one another and identify the feedback loops across mechanisms. This will enable greater investigation into feedback mechanisms and their role in strengthening the health system through improved health outcomes, health rights, health equity and service provision. This will enable a determination as to if mechanisms are indeed health system responsiveness mechanisms or are simply window dressings, a consideration that can be applied to other LMIC settings.

In particular, this study´s findings have contributed to the topic of health equity, showing that while feedback mechanisms are intended to improve health, including health equity, critical data and information is missing. There is a need to grapple with all of the actors who are involved in a feedback process as well as investigate the different time points of community participation, where feedback may be fostered. This study has also demonstrated that citizens do not always utilise formal mechanisms in order to be heard in the health system.

The methods applied to this study will be useful for other settings and contexts, supporting an initial investigation in the mechanisms that exist within a local health system. However, in order to understand feedback mechanisms on a more systemic level, qualitative interviews with the actors utilising or not utilising the feedback mechanisms need to occur, along with in-depth interviews with those operating within the feedback loops.

While all research questions posed for this study have been addressed, individual experiences of feedback mechanisms were not able to be included. It was originally intended for three WCDOH experts to review the findings of this study and offer insight, however due to the COVID-19 pandemic, this was not possible. A reflective diary and regular debriefs with the study team allowed for reflection on all of the data that had been synthesized, with the decision made that triangulation was robust and adequate to report on.

Missing information was highlighted in this study as a way to point to future research agendas. Information on the cost analysis of each mechanism, where staff time and resources is evaluated within the context of a health system, could be a critical area of study. Deeper insight into barriers of feedback mechanism accessibility could also be utilised.

This is relevant for both researchers and policy makers, offering oversight and implementation lessons within the daily challenges of contextualised health system realities. This work can contribute to deeper understandings of the interaction between people and their health system, recognition of the wider determinants of health system responsiveness and a shift away from the focus on health services, instead taking into account the institutional arrangements, processes and relations within health systems, including accountability (Mirzoev and Kane, 2017).

References

Abimbola, S., Negin, J., Jan, S., Martiniuk, A. (2014). Towards people-centred health systems: a multi-level framework for analysing primary health care governance in low- and middle-income countries. *Health Policy Plan* 29: ii29–ii39. https://doi.org/10.1093/heapol/czu069

Adam, T., Hsu, J., de Savigny, D., Lavis, J.N., Rottingen, J.-A., Bennett, S. (2012). Evaluating health systems strengthening interventions in low-income and middle-income countries: are we asking the right questions? *Health Policy Plan*. 27, iv9–iv19. https://doi.org/10.1093/heapol/czs086

Adesanya, T., Gbolahan, O., Ghannam, O., Miraldo, M., Patel, B., Verma, R., Wong, H. (2012). Exploring the responsiveness of public and private hospitals in Lagos, Nigeria. J*. Public Health Res*. Vol 1: e2. doi: 10.4081/jphr.2012.e2

Agyepong, I.A, et al. (2014). Advancing the application of systems thinking in health: provider payment and service supply behaviour and incentives in the Ghana National Health Insurance Scheme – a systems approach. *Health Res. Policy Syst.* 12, 35. https://doi.org/10.1186/1478-4505-12-35

Ahmed, F., Khizar Memon, M., Memon, S. (2018). Violence against doctors, a serious concern for healthcare organizations to ponder about. *Ann. Med. Surg*. 25, 3–5. https://doi.org/10.1016/j.amsu.2017.11.003

Akin, J., Guilkey, D., Hazel-Denton, E. (1995). Quality of services and demand for health care in Nigeria: A multinomial probit estimation. *Soc. Sci. Med*. 40, 1527–1537. https://doi.org/10.1016/0277-9536(94)00274-W

Akintola, O., Lavis, J.N., Hoskins, R. (2015). Print media coverage of primary healthcare and related research evidence in South Africa. *Health Res. Policy Syst*. 13, 68. https://doi.org/10.1186/s12961-015-0051-6

Arksey, H., O'Malley, L (2005). Scoping studies: towards a methodological framework. *Int. J. Soc. Res. Methodol*. 8, 19–32. https://doi.org/10.1080/1364557032000119616

Askari, R., Arab, M., Rashidian, A., Akbari-Sari, A., Hosseini, S.M., Gharaee, H. (2016). Designing Iranian Model to Assess the Level of Health System Responsiveness. *Iran. Red Crescent Med. J.* 18. https://doi.org/10.5812/ircmj.24527

Assegaai, T., Schneider, H. (2019). National guidance and district-level practices in the supervision of community health workers in South Africa: a qualitative study. *Hum. Resour. Health* 17. https://doi.org/10.1186/s12960-019-0360-x

Ataguba, J.E., Day, C., McIntyre, D. (2014). Monitoring and Evaluating Progress towards Universal Health Coverage in South Africa. *PLoS Med*. 11, e1001686. https://doi.org/10.1371/journal.pmed.1001686

Avgerou, C. "2008". Information systems in developing countries: a critical research review. *J. Inf. Technol*. 23, 133–146. https://doi.org/10.1057/palgrave.jit.2000136

Baez, C., Barron, P. (2006). *Community voice and role in district health systems in east and southern Africa: A literature review.* EQUINET Discussion Paper 39.

Baidya, M., Gopichandran, V., Kosalram, K. (2014). Patient-physician trust among adults of rural Tamil Nadu: A community-based survey. *J. Postgrad. Med*. 60, 21. https://doi.org/10.4103/0022-3859.128802

Barrett, G. (2017) *Community-Managed Clinics and Health Watch Committees (Bangladesh).* Participedia. Accessed 24 October 2019. https://participedia.net/case/16

Barron, P., Pillay, Y., Fernandes, A., Sebidi, J., Allen, R. (2016). The MomConnect mHealth initiative in South Africa: Early impact on the supply side of MCH services. *J. Public Health Policy* 37, 201–212. https://doi.org/10.1057/s41271-016-0015-2

Bauhoff, S., Tkacheva, O., Rabinovich., Bogdan, O. (2016). Developing citizen report cards for primary care: evidence from qualitative research in rural Tajikistan. *Health Policy Plan* (2): 259 – 66. http://www.ncbi.nlm.nih.gov/pubmed/26082392

Begley, C.E., et al. (2007). Cross-Country Measures for Monitoring Epilepsy Care. *Epilepsia* 48, 990–1001. https://doi.org/10.1111/j.1528-1167.2007.00981.x

Berman P. et al. (1995). *Kenya: Non-Governmental Health Care Provision; Data for Decision Making Project, Department of Population and International Health, Harvard School of Public Health, and African Medical Research Foundation (AMREF)*.

Bernhart, MH., Wiadnyana, IG., Wihardjo, H., Pohan, I. (1999). Patient satisfaction in developing countries. *Soc Sci Med* 48(8): 989-96. http://www.ncbi.nlm.nih.gov/pubmed/10390039

Berlan, D., Shiffman, J. (2012). Holding health providers in developing countries accountable to consumers: a synthesis of relevant scholarship. *Health Policy Plan*. 27, 271–280. https://doi.org/10.1093/heapol/czr036

Berg, V.V. (2016). Still lost in translation: language barriers in South African health care remain. South Afr. Fam. Pract.

Bhattacharyya, S., Issac, A., Rajbangshi, P., Srivastava, A., Avan, B.I. (2015). Neither we are satisfied nor they -users and provider's perspective: a qualitative study of maternity care in secondary level public health facilities, Uttar Pradesh, India. *BMC Health Serv*. Res. 15, 1–13. https://doi.org/10.1186/s12913-015-1077-8

Biermann, O., Eckhardt, M., Carlfjord, S., Falk, M., Forsberg, B.C. (2016). Collaboration between non-governmental organizations and public services in health – a qualitative case study from rural Ecuador. *Glob. Health Action* 9. https://doi.org/10.3402/gha.v9.32237

Birn, AE., Zimmerman, S., Garfield, R. (2000). To decentralize or not to decentralize, is that the question? Nicaraguan health policy under structural adjustment in the 1990s. *Int J Health* Serv 30(1): 111-28. http://www.ncbi.nlm.nih.gov/pubmed/10707302

Björkman, M., Svensson, J. (2009). Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda. *Q. J. Econ*. 124, 735–769. https://doi.org/10.1162/qjec.2009.124.2.735

Blake, C., Annorbah-Sarpei, N.A., Bailey, C., Ismaila, Y., Deganus, S., Bosomprah, S., Galli, F., Clark, S., 2016. Scorecards and social accountability for improved maternal and newborn health services: A pilot in the Ashanti and Volta regions of Ghana. Int. J. Gynecol. Obstet. 135, 372–379. https://doi.org/10.1016/j.ijgo.2016.10.004

Bond, V., et al. (2019). Being seen´ at the clinic: Zambian and South African health worker reflections on the relationship between health facility spatial organisation and items and HIV stigma in 21 health facilities, the HPTN 071 (PopART) study. *Health Place* 55, 87. https://doi.org/10.1016/j.healthplace.2018.11.006

Bonino, F., Warner, A. (2014). What makes humanitarian feedback mechanisms work? Literature review to support an ALNAP-CDA action research into humanitarian feedback mechanisms. *ALNAP Working Paper*. London: ALNAP/ODI.

Boros, A. (2008). Clinics and Home-based Care: The Interface Between the Formal and the Informal Health Sectors. *Thesis: Masters of Arts in Development Studies.* University of the Witwatersrand.

Bossert, T.J., Mitchell, A.D. (2011). Health sector decentralization and local decision-making: Decision space, institutional capacities and accountability in Pakistan. *Soc. Sci. Med.* 1982 72, 39–48. https://doi.org/10.1016/j.socscimed.2010.10.019

Botes, L. (2000). Community participation in development: nine plagues and twelve commandments. *Community Dev. J.* 35, 41–58. https://doi.org/10.1093/cdj/35.1.41

Braun, R., Catalani, C., Wimbush, J., Israelski, D. (2013). Community Health Workers and Mobile Technology: A Systematic Review of the Literature. *PLOS ONE* 8, e65772. https://doi.org/10.1371/journal.pone.0065772

Brinkerhoff, D.W., Bossert, T.J. (2014). Health governance: principal–agent linkages and health system strengthening. *Health Policy Plan*. 29, 685–693. https://doi.org/10.1093/heapol/czs132c3c83f1784a3dbf2ff108b84f927ec9f6d8f.pdf.

Brown, K.M., Elliott, S.J., Leatherdale, S.T., Robertson-Wilson, J. (2015). Searching for rigour in the reporting of mixed methods population health research: a methodological review. *Health Educ. Res*. 30, 811–839. https://doi.org/10.1093/her/cyv046

Burger, R., Dasgupta, I., Owens, T. (2015). Why pay NGOs to involve the community? *Ann. Public Coop. Econ*. 86, 7–31. https://doi.org/10.1111/apce.12065

Bussiek, P.-B.V., De Poli, C., Bevan, G. (2018). A scoping review protocol to map the evidence on interventions to prevent overweight and obesity in children. *BMJ Open* 8, e019311. https://doi.org/10.1136/bmjopen-2017-019311

Cheng, H.G and Phillips, M.R. (2014). Secondary analysis of existing data: opportunities and implementation. *Shanghai Arch Psychiatry* v. 26 (6). Doi: 10.11919/j.issn.1002-0829.214171

Chimbindi, N., Bärnighausen, T., Newell, M.-L. (2014). Patient satisfaction with HIV and TB treatment in a public programme in rural KwaZulu-Natal: evidence from patient-exit interviews*. BMC Health Serv. Res*. 14, 32. https://doi.org/10.1186/1472-6963-14-32

Choudhury, N et al. (2014). Community-based management of acute malnutrition in Bangladesh: feasibility and constraints. *Food Nutr Bull* 35 (2): 277-85. http://www.ncbi.nlm.nih.gov/pubmed/25076775

Cleary, S.M., Molyneux, S., Gilson, L. (2013). Resources, attitudes and culture: an understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings. *BMC Health Serv. Res*. 13. https://doi.org/10.1186/1472-6963-13-320

Community Workers Co-operative. (2003). *Organising for Change.* Galway: Community Workers Co-operative. Pg 11.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *The Lancet* 374, 817–834. https://doi.org/10.1016/S0140-6736(09)60951-X

Crawford, M.J. (2002). Systematic review of involving patients in the planning and development of health care. *BMJ* 325, 1263–1263. https://doi.org/10.1136/bmj.325.7375.1263

Ciccone, D., Vian, T., Maurer, L., Bradley, E.H. (2014). Linking governance mechanisms to health outcomes: A review of the literature in low- and middle-income countries. *Soc. Sci. Med*. 117, 86–95. https://doi.org/10.1016/j.socscimed.2014.07.010

Criel, B., Waelkens, M., Soors, W., Devadasan, N., Atim, C. (2008). Community Health Insurance in Developing Countries. *Int. Encycl. Public Health*. https://doi.org/10.1016/B978-012373960-5.00159-3

D'Angelo, P., Pollock, J.C., Kiernicki, K., Shaw, D. (2013). Framing of AIDS in Africa: Press-state relations, HIV/AIDS news, and journalistic advocacy in four sub-Saharan Anglophone newspapers. *Polit. Life Sci*. 32, 100–125.

Dasgupta, J., Sandhya, Y.K., Lobis, S., Verma, P., Schaaf, M. (2015). Using Technology to Claim Rights to Free Maternal Health Care: Lessons about Impact from the My Health, My Voice Pilot Project in India. *Health Hum. Rights* 17, 135–147.

Deane, J., Parks, W. (2006). *Advocacy, communication and social mobilization to fight TB: a 10-year framework for action*. World Health Organization, Stop TB Partnership, Geneva.

Debona, D., Travaglia, J. (2009). *Complaints and patient satisfaction: a comprehensive review of the literature.* The Centre for Clinical Governance Research in Health. Sydney: University of New South Wales.

Decision Support Service Co., Ltd. (2013). *Community Feedback and Response Mechanism (CFRM)*. End project evaluation report. Prepared for Monitoring & Evaluation Unit UNDP Yangon, Myanmar.

Department of Administrative Reforms and Public Grievances, Government of India. (2019). *Citizens´ Charters in Government of India.* Accessed 10 July 2019. https://www.goicharters.nic.in/

de Silva, A. (2000). A Framework for Measuring Responsiveness. *GPE Discussion Paper Series*. No. 32.World Health Organization. Accessed 22 November 2018.

Development Bank of South Africa (DBSA). (2008). *A roadmap for the reform of the South African health system: Draft Final Report*

Dhai, et al. (2011). The public´s attitude towards strike action by healthcare workers and health services in South Africa. *The South African Journal of Bioethics & Law* Vol 4, No 2. http://www.sajbl.org.za/index.php/sajbl/article/view/163/159

Dinakaran, P., Mehrotra, S., Bharath, S. (2014). "Interactional aspects of care during hospitalization: Perspectives of family caregivers of psychiatrically ill in a tertiary care setting in India." *Asian J. Psychiatry* 12, 63–68. https://doi.org/10.1016/j.ajp.2014.06.013

Douangvichit, D and Liabsuetrakul, T. (2012). "Obstetric care and health system responsiveness for hospital-based delivery in Lao People's Democratic Republic." *J Med Assoc Thai* 95(9): 1126-35. http://www.ncbi.nlm.nih.gov/pubmed/23140028

Durojaye, E., Agaba, D.K. (2018). Contribution of the Health Ombud to accountability: The Life Esidimeni Tragedy in South Africa. *Health Hum. Rights* 20, 161.

Ebenso, B., Huque, R., Azdi, Z., Elsey, H., Nasreen, S., Mirzoev, T. (2017). Protocol for a mixed-methods realist evaluation of a health service user feedback system in Bangladesh. *BMJ Open* 7, e017743. https://doi.org/10.1136/bmjopen-2017-017743

Edward, A., Osei-Bonsu, K., Branchini, C., Yarghal, T. shah, Arwal, S.H., Naeem, A.J. (2015). Enhancing governance and health system accountability for people centered healthcare: an exploratory study of community scorecards in Afghanistan. *BMC Health Serv*. Res. 15. https://doi.org/10.1186/s12913-015-0946-5

Falisse, J.-B., Meessen, B., Ndayishimiye, J., Bossuyt, M. (2012). Community participation and voice mechanisms under performance-based financing schemes in Burundi: Community participation under PBF. *Trop. Med. Int. Health* 17, 674–682. https://doi.org/10.1111/j.1365-3156.2012.02973.x

Fazaeli, S., Ahmadi, M., Rashidian, A., Sadoughi, F. (2014). A Framework of a Health System Responsiveness Assessment Information System for Iran. *Iran. Red Crescent Med. J.* 16. https://doi.org/10.5812/ircmj.17820

Feruglio, F., Nisbett, N. (2018). The challenges of institutionalizing community-level social accountability mechanisms for health and nutrition: a qualitative study in Odisha, India. *BMC Health Serv. Res.* 18. https://doi.org/10.1186/s12913-018-3600-1

Fiorentini, G., Ragazzi, G., Robone, S. (2015). Are bad health and pain making us grumpy? An empirical evaluation of reporting heterogeneity in rating health system responsiveness. *Social Science & Medicine* Volume 144: 48 – 58. https://doi.org/10.1016/j.socscimed.2015.09.009

Flores, W., Ruano, A.L., Funchal, D.P. (2009). Social Participation within a Context of Political Violence: Implications for the Promotion and Exercise of the Right to Health in Guatemala. *Health Hum. Rights 11,* 37. https://doi.org/10.2307/40285216

Freyens, P., Mbakuliyemo, N., Martin, M. (1993). How do health workers see community participation? *PubMed – NCBI.* Accessed 8 June 2019. https://www.ncbi.nlm.nih.gov/pubmed/8397730

Friedman, S., Mottiar, S. (2004). A moral to the tale: The Treatment Action Campaign and the politics of HIV/AIDS. *Globalisation, marginalization & new social movements in post-apartheid South Africa*.

Friedman, S. (2006). *Participatory governance and citizen action in post-apartheid South Africa*. Geneva: International Labour Organization (International Institute for Labour Studies).

Fusheini, A., Eyles, J. (2016). Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision*. BMC Health Serv. Res*. 16. https://doi.org/10.1186/s12913-016-1797-4

Garai, A., Ganesan, R. (2010). Role of Information and Communication Technologies in Accelerating the Adoption of Healthy Behaviors. *The Journal of Family Welfare.* Vol. 56. http://ssrn.com/abstract=1943597

Garg, S., Laskar, A.R. (2010). Community-Based Monitoring: Key to Success of National Health Programs. *Indian J. Community Med. Off. Publ. Indian Assoc. Prev. Soc. Med*. 35, 214. https://doi.org/10.4103/0970-0218.66857

George, A. (2009). By papers and pens, you can only do so much: views about accountability and human resource management from Indian government health administrators and workers. *Int. J. Health Plann. Manage*. 24, 205–224. https://doi.org/10.1002/hpm.986

George, A., Scott, K., Garimella, S., Mondal, S., Ved, R., Sheikh, K. (2015). Anchoring contextual analysis in health policy and systems research: A narrative review of contextual factors influencing health committees in low and middle income countries. *Soc. Sci. Med.* 133, 159–167. https://doi.org/10.1016/j.socscimed.2015.03.049

George, A.S., Mehra, V., Scott, K., Sriram, V. (2015). Community Participation in Health Systems Research: A Systematic Review Assessing the State of Research, the Nature of Interventions Involved and the Features of Engagement with Communities. *PLOS ONE* 10, e0141091. https://doi.org/10.1371/journal.pone.0141091

Giddings, LS., Grant, BM. (2009). From rigour to trustworthiness: validating mixed methods. Chapter 7 in *Research for Nursing and the Health Sciences*. United Kingdom: Blackwell Publishing Ltd.

Gill, S.D., Redden-Hoare, J., Dunning, T.L., Hughes, A.J., Dolley, P.J. (2015). Health services should collect feedback from inpatients at the point of service: opinions from patients and staff in acute and subacute facilities. *Int. J. Qual. Health Care* 27, 507–512. https://doi.org/10.1093/intqhc/mzv081

Gilson, L., Barasa, E., Nxumalo, N., Cleary, S., Goudge, J., Molyneux, S., Tsofa, B., Lehmann, U. (2017). Everyday resilience in district health systems: emerging insights from the front lines in Kenya and South Africa. *BMJ Glob. Health* 2, e000224. https://doi.org/10.1136/bmjgh-2016-000224

Gilson, L., Erasmus, E. (2006). *Trust and accountability in health service delivery in South Africa*. Final Technical Report.

Ginneken, N. van, Lewin, S., Berridge, V. (2010). The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Soc. Sci. Med*. 1982 71, 1110. https://doi.org/10.1016/j.socscimed.2010.06.009

Glattstein-Young, G., London, L. (2010). Community health committees as a vehicle for participation in advancing the right to health. *Crit Health Perspect* 2, 1–2.

Gohou, V., et al. (2004). Responsiveness to life-threatening obstetric emergencies in two hospitals in Abidjan, Côte d'Ivoire. *Trop Med Int Health* 9(3): 406 - 15.

Gopal, T. (2018). Health systems in the news: The influence of media representations on health system functioning in the Western Cape health system. *Thesis: Masters of Public Health.* University of Cape Town.

Goodman, C., Opwora, A., Kabare, M., Molyneux, S. (2011). Health facility committees and facility management - exploring the nature and depth of their roles in Coast Province, Kenya. *BMC Health Serv. Res.* 11. https://doi.org/10.1186/1472-6963-11-229

Grootes, S. (2016). *Analysis: DA vs ANC – shattering myths, creating new perceptions*. Daily Maverick. Accessed 15 August 2016. https://www.dailymaverick.co.za/article/2016-08-15-analysis-da-vs-anc-shattering-myths-creating-new-perceptions/

Gruskin, S., Safreed-Harmon, K., Ezer, T., Gathumbi, A., Cohen, J., Kameri-Mbote, P. (2013). Access to justice: evaluating law, health and human rights programmes in Kenya. *J Int AIDS Soc* 16(3 Suppl 2). http://www.ncbi.nlm.nih.gov/pubmed/24242267

Gullo, S., Galavotti, C., Altman, L. (2016). A review of CARE's Community Score Card experience and evidence. Health Policy Plan. 31, 1467. https://doi.org/10.1093/heapol/czw064

Gunst, C., Mash, R.J., Phillips, L.C. (2016). A reflection on the practical implementation of the clinical governance framework in the Cape Winelands District of the Western Cape. *South Afr. Fam. Pract*. 58, 236–241. https://doi.org/10.1080/20786190.2016.1151642

Gugsa, F., Karmarkar, E., Cheyne, A., Yamey, G. (2016). Newspaper coverage of maternal health in Bangladesh, Rwanda and South Africa: a quantitative and qualitative content analysis. *BMJ Open 6, e008837*. https://doi.org/10.1136/bmjopen-2015-008837

Gurung, G., Derrett, S., Gauld, R., Hill, P.C. (2017). Why service users do not complain or have 'voice': a mixed-methods study from Nepal's rural primary health care system. *BMC Health Serv. Res*. 17. https://doi.org/10.1186/s12913-017-2034-5

Haakenstad, A., Johnson, E., Graves, C., Olivier, J., Duff, J., Dieleman, J.L. (2015). Estimating the Development Assistance for Health Provided to Faith-Based Organizations, 1990–2013. *PLOS ONE* 10, e0128389. https://doi.org/10.1371/journal.pone.0128389

Hall, W., Roberts, J. (2006). *Understanding the impact of decentralisation on reproductive health services in Africa (RHD): South Africa Report*. Durban: Health Systems Trust.

Hammerstrøm, K., Wade, A., Hanz, K., Jørgensen, A.-M.K. (2008). *Searching for studies: Information retrieval methods group policy brief* 74.

Haricharan, H.J. (2010). *Extending participation: Challenges of health committees as meaningful structures for community participation*. Human Rights Division, School of Public Health, University of Cape Town and The Learning Network on Health and Human Rights.

Hassim, A., Heywood, M., Berger, J. (2007). *Health & Democracy: a guide to human rights, health law and policy in post-apartheid South Africa*. Cape Town, South Africa: SiberInk.

Hatt, L., Altman, D., Chankova, S., Narcisse, C., Pena, DL., Riley, P., Tuchman, J., Williamson, T., Won, A. (2012). *Grenada Health Systems and Private Sector Assessment 2011*. Bethesda, MD: Health Systems 20/20 project and SHOPS project, Abt Associates Inc.

Hawn, C. (2017). Take two aspirin and Tweet me in the morning: how Twitter, Facebook, and other social media are reshaping health care. *Health Aff. (Millwood).* https://doi.org/10.1377/hlthaff.28.2.361

Hecht, R., Tanzi, V. (1993). *The role of Non-Governmental Organizations in the Delivery of Health Services in Developing countries.* World Bank Development Report Background Papers. Washington DC: World Bank Group.

Hernández, A., Ruano, A.L., Hurtig, A.-K., Goicolea, I., San Sebastián, M., Flores, W. (2019). Pathways to accountability in rural Guatemala: A qualitative comparative analysis of citizen-led initiatives for the right to health of indigenous populations. *World Dev*. 113, 392–401. https://doi.org/10.1016/j.worlddev.2018.09.020

Herringshaw, V. (2017). Addressing failure in ICT-enabled 'citizen voice – government responsiveness' interventions: unpacking core assumptions and essential components. *Making All Voices Count Programme Learning Report*. Brighton: IDS.

Heywood, M. (2009). South Africa's Treatment Action Campaign: combining law and social mobilization to realize the right to health. *J. Hum. Rights Pract*. 1, 14–36. https://doi.org/10.1093/jhuman/hun006

Hlafa, B., Sibanda, K., Hompashe, D.M. (2019). The impact of public health expenditure on health outcomes in South Africa. *Int. J. Environ. Res. Public. Health* 16. https://doi.org/10.3390/ijerph16162993

Ho, L.S., Labrecque, G., Batonon, I., Salsi, V., Ratnayake, R. (2015). Effects of a community scorecard on improving the local health system in Eastern Democratic Republic of Congo: qualitative evidence using the most significant change technique. *Confl. Health 9*. https://doi.org/10.1186/s13031-015-0055-4

ICF International. (2012). *Global Fund-Supported Community systems Strengthening Programs in Cambodia: Evaluation Report.* Submitted to The Global Fund to Fight AIDS, Tuberculosis and Malaria.

International Telecommunication Union. (2019). *Citizen Feedback Mechanisms*. ITU. Accessed 5 July 2019. https://www.itu.int/net4/wsis/archive/stocktaking/Project/Details?projectId=1429064305

Jacobsen, K.H., Hasumi, T. (2014). Satisfaction with healthcare services in South Africa: results of the national 2010 General Household Survey. *Pan Afr. Med. J.* 18. https://doi.org/10.11604/pamj.2014.18.172.4084

Jewkes, R., Murcott, A. (1998). Community representatives: representing the "community"? *Soc. Sci. Med.* 1982 46, 843–858.

Jones, J., et al. (2019). Reflection in practice: How can patient experience feedback trigger staff reflection in hospital acute care settings? *Health Expectations* 23. 2: 396-404. doi: 10.1111/hex.13010

Kagoya, HR., Kibuule, D., Mitonga-Kabwebwe, H., Ekirapa-Kiracho, E., Ssempebwa, JC. (2013). Awareness of, responsiveness to and practice of patients' rights at Uganda's national referral hospital. *Afr J Prim Health Care Fam Med* 5(1). http://www.ncbi.nlm.nih.gov/pubmed/24563777

Kakade, D. (2012). Community-based monitoring as an accountability tool: influence on rural health services in Maharashtra, India. *BMC Proc*. 6, O9. https://doi.org/10.1186/1753-6561-6-S1-O9

Kalter, H.D., Salgado, R., Babille, M., Koffi, A.K., Black, R.E. (2011). Social autopsy for maternal and child deaths: a comprehensive literature review to examine the concept and the development of the method. *Popul. Health Metr*. 9, 45. https://doi.org/10.1186/1478-7954-9-45

Kaiser Health News (KHN). (2001). *South Africa's Democratic Alliance Calls Declaration of AIDS as National Emergency*. KHN. Accessed 13 December 2019. https://khn.org/morning-breakout/dr00002836/

Kelly, K., Rau, A., Stern, E. (2010). *Community entry points: opportunities and strategies for engaging community supported HIV/AIDS prevention responses.* Geneva: Global Fund.

Khamis, K., Njau, B. (2014). Patients' level of satisfaction on quality of health care at Mwananyamala hospital in Dar es Salaam, Tanzania. *BMC Health Serv. Res*. 14. https://doi.org/10.1186/1472-6963-14-400

Khan, Whyle, Schaay, Olivier. (2019). Health Systems Responsiveness Annotated Bibliography. University of Cape Town.

Khanna, R. (2013). *Ethical Issues in Community Based Monitoring of Health Programmes: Reflections from India*. Society for Health Alternatives India (SAHAJ) with Community of Practitioners on Accountability and Social Action in Health (COPASAH)

Kilewo, E.G., Frumence, G. (2015). Factors that hinder community participation in developing and implementing comprehensive council health plans in Manyoni District, Tanzania. *Glob. Health Action* 8, 26461. https://doi.org/10.3402/gha.v8.26461

King, NB., Harper, S., Young, M.E. (2013). Who cares about health inequalities? Cross-country evidence from the World Health Survey. *Health Policy Plan* 28 (5): 558-71. https://www.ncbi.nlm.nih.gov/pubmed/23059735

Kruk, M.E., Rockers, P.C., Varpilah, S.T., Macauley, R. (2011). Population Preferences for Health Care in Liberia: Insights for Rebuilding a Health System. *Health Serv. Res*. 46, 2057. https://doi.org/10.1111/j.1475-6773.2011.01266.x

Lali, B.V. (2019). *Community healthcare workers demand recognition as public servants*. GroundUp News. Accessed 12 December 2019. https://www.groundup.org.za/article/community-healthcare-workers-demand-recognition-public-servants/

Larson, E., Vail, D., Mbaruku, G.M., Kimweri, A., Freedman, L.P., Kruk, M.E. (2015). Moving Toward Patient-Centered Care in Africa: A Discrete Choice Experiment of Preferences for Delivery Care among 3,003 Tanzanian Women. *PLOS ONE 10,* e0135621. https://doi.org/10.1371/journal.pone.0135621

Lechat, L., Bonnet, E., Queuille, L., Traoré, Z., Somé, P.-A., Ridde, V. (2019). Relevance of a Toll-Free Call Service Using an Interactive Voice Server to Strengthen Health System Governance and Responsiveness in Burkina Faso. *Int. J. Health Policy Manag*. 8, 353–364. https://doi.org/10.15171/ijhpm.2019.13

Leclerc-Madlala, S. (2005). Popular responses to HIV/AIDS and policy. *JSTOR* vol 31, 4. https://www.jstor.org/stable/25065050

Leon, N., Sanders, D., Van Damme, W., Besada, D., Daviaud, E., Oliphant, NP., Berzal, R., Mason., J., Doherty, T. (2015). The role of "hidden" community volunteers in community-based health service delivery platforms: examples from sub-Saharan Africa. *Glob Health Action*. 12;8:27214. doi: 10.3402/gha.v8.27214

Leon, N., Schneider, H. (2012). *MHealth4CBS in South Africa: A review of the role of mobile phone technology for the monitoring and evaluation of community based health services*. Cape Town, Medical Research Council and University of Western Cape.

Lehmann, U., Sanders, D. (2007). *Community Health Workers: What Do We Know About Them? The State of the Evidence on Programmes, Activities, Costs an Impact on Health Outcomes of Using Community Health Workers*. World Health Organization. Accessed 3 July 2019. https://www.hrhresourcecenter.org/node/1587.html

Levesque, J.-F., Harris, M.F., Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int. J. Equity Health* 12, 18. https://doi.org/10.1186/1475-9276-12-18

Levin, M.E. (2006). Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital. *South Afr. Med. J.* Suid-Afr. Tydskr. Vir Geneeskd. 96, 1076–1079.

Lexico Dictionaries. (2019). *Definition of feedback in English by Lexico Dictionaries*. Lexico, by Oxford. Accessed 1 June 2019. https://www.lexico.com/en/definition/feedback

Lodenstein, E., Dieleman, M., Gerretsen, B., Broerse, J.E. (2013). A realist synthesis of the effect of social accountability interventions on health service providers' and policymakers' responsiveness. *Syst. Rev*. 2. https://doi.org/10.1186/2046-4053-2-98

Lodenstein, E., Dao, D., (2011). Devolution and human resources in primary healthcare in rural Mali. *Hum. Resour. Health 9, 15*. https://doi.org/10.1186/1478-4491-9-15

Lodenstein, E., Dieleman, M., Gerretsen, B., Broerse, J.E.W. (2017). Health provider responsiveness to social accountability initiatives in low- and middle-income countries: a realist review. *Health Policy Plan*. 32, 125–140. https://doi.org/10.1093/heapol/czw089

Lodenstein, E., et al. (2018). Informal social accountability in maternal health service delivery: A study in Northern Malawi. *PLoS One.* 13(4): 1-17. doi.10.1371/journal.pone.0195671

Loewenson, R. (1999). Public participation in health: making people matter. *IDS Working Papers* 84. Brighton: IDS.

Loewenson, D.R., Rusike, I. (2004). Assessing the impact of Health Centre Committees on health system performance and health resource allocation. *EQUINET discussion paper 18*.

Loewenson, R., Rusike, I., Zulu, M. (2005). The impact of Health Centre Committees on health outcomes in Zimbabwe. *Paper presented to Forum 9, Global Forum for Health Research*.

London, L. And Schneider, H. (2012). Globalisation and health inequalities: can a human rights paradigm create space for civil society action? *Soc Sci Med* 74(1):6-13. http://www.ncbi.nlm.nih.gov/pubmed/21511377

Lunsford, S.S., Fatta, K., Stover, K.E., Shrestha, R. (2015). Supporting close-to-community providers through a community health system approach: case examples from Ethiopia and Tanzania. *Hum. Resour. Health* 13, 1–9. https://doi.org/10.1186/s12960-015-0006-6

Magadzire, B.P., Budden, A., Ward, K., Jeffery, R., Sanders, D. (2014). Frontline health workers as brokers: provider perceptions, experiences and mitigating strategies to improve access to essential medicines in South Africa. BMC *Health Serv. Res*. 14, 1–10. https://doi.org/10.1186/s12913-014-0520-6

Mahapatra, T. (2013). A cross-sectional study on patient satisfaction toward services received at a rural health center, Chandigarh. *Annals of Tropical Medicine and Public Health*. 6.3: 267

Mahmud, S. (2004). Citizen participation in the health sector in rural Bangladesh: perceptions and reality. *IDS Bull.* 35, 11–18. https://doi.org/10.1111/j.1759-5436.2004.tb00116.x

Malakoane, B., et al. (2020). Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening. *BMC Health Services Research* 20. Article number: 58. https://doi.org/10.1186/s12913-019-4862-y

Malhotra, C., Do, Y.K. (2013). Socio-economic disparities in health system responsiveness in India. *Health Policy Plan*. 28, 197–205. https://doi.org/10.1093/heapol/czs051

Mani, MK. (2008). Violence against doctors. *Natl Med J India* (3): 148. https://www.ncbi.nlm.nih.gov/pubmed/19004148

Maphumulo, W.T., Bhengu, B.R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis* 42. https://doi.org/10.4102/curationis.v42i1.1901

Martinez, M.G., Kohler, J.C. (2016). Civil society participation in the health system: the case of Brazil's Health Councils. *Glob. Health* 12. https://doi.org/10.1186/s12992-016-0197-1

Mayosi, B.M., Benatar, S.R. (2014). Health and Health Care in South Africa — 20 Years after Mandela. *The New England Journal of Medicine*. http://dx.doi.org/10.1056/NEJMsr1405012.

McCoy, D.C., Hall, J.A., Ridge, M. (2012). A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. *Health Policy Plan*. 27, 449–466. https://doi.org/10.1093/heapol/czr077

Mcnamara, P. (2006). Provider-specific report cards: a tool for health sector accountability in developing countries. *Health Policy Plan*. 21, 101–109. https://doi.org/10.1093/heapol/czj009

McIntyre, D. (2008). Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania. *Bulletin of the World Health Organ*. 86, 871–876. https://doi.org/10.2471/BLT.08.053413

Meier, B.M., Pardue, C., London, L. (2012). Implementing community participation through legislative reform: a study of the policy framework for community participation in the Western Cape province of South Africa. *BMC International Health and Human Rights* 12: 15. http://www.biomedcentral.com/1472-698X/12/15

Mello, M.M., Studdert, D.M., Kachalia, A.B., Brennan, T.A. (2006). Health Courts and Accountability for Patient Safety. *Milbank Q*. 84, 459. https://doi.org/10.1111/j.1468-0009.2006.00455.x

Mhlongo, EM and Lutge, E. (2019). The roles, responsibilities and perceptions of community health workers and ward-based primary health care outreach teams (WBPHCOTs) in South Africa: a scoping review protocol. *Systematic Reviews* 8. 193. https://doi.org/10.1186/s13643-019-1114-5

Miller, J.S., Mhalu, A., Chalamilla, G., Siril, H., Kaaya, S., Tito, J., Aris, E., Hirschhorn, L.R. (2014). Patient satisfaction with HIV/AIDS care at private clinics in Dar es Salaam, Tanzania. *AIDS Care* 26, 1150–1154. https://doi.org/10.1080/09540121.2014.882487

Mirzoev, T., Kane, S. (2018). Key strategies to improve systems for managing patient complaints within health facilities – what can we learn from the existing literature? *Glob. Health Action* 11. https://doi.org/10.1080/16549716.2018.1458938

Mirzoev, T., Kane, S. (2017). What is health systems responsiveness? Review of existing knowledge and proposed conceptual framework. *BMJ Glob. Health* 2, e000486. https://doi.org/10.1136/bmjgh-2017-000486

Mohammed, S., Bermejo, J.L., Souares, A., Sauerborn, R., Dong, H. (2013). Assessing responsiveness of health care services within a health insurance scheme in Nigeria: users' perspectives. *BMC Health Serv. Res*. 13, 1–13. https://doi.org/10.1186/1472-6963-13-502

Molyneux, S., Atela, M., Angwenyi, V., Goodman, C. (2012). Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. *Health Policy Plan*. 27, 541–554. https://doi.org/10.1093/heapol/czr083

Moyimane, MB., Matlala, SF., Kekana, MP. (2017). Experiences of nurses on the critical shortage of medical equipment at a rural district hospital in South Africa: a qualitative study. *The Pan African Medical Journal* 28:100. doi:10.11604/pamj.29/09/2017 .28.100.11641

Mubyazi, G.M., Hutton, G. (2012). Rhetoric and reality of community participation in health planning, resource allocation and service delivery: a review of the reviews, primary publications and grey literature. *Rwanda J. Health Sci*. 15.

Mubyazi, G., Kamugisha, M., Mushi, A., Blas, E. (2004). Implications of decentralization for the control of tropical diseases in Tanzania: a case study of four districts. *Int J Health Plann Manage* 19 Suppl 1: S167-85. http://www.ncbi.nlm.nih.gov/pubmed/15686068

Mubyazi, GM., Mushi, AK., Shayo, E., Mdira, K., Ikingura, J., Mutagwaba, D., Malecela, M., Njunwa, KJ. (2007). Local Primary Health Care Committees and Community-Based Health Workers in Mkuranga District, Tanzania: Does the Public Recognise and Appreciate Them? *Ethno-Med* 1(1): 27-35.

Mulumba, M., London, L., Nantaba, J., Ngwena, C. (2018). Using health committees to promote community participation as a social determinant of the right to health: lessons from Uganda and South Africa. *Health Hum. Rights* 20, 11.

Muraleedharan, VR. (2007). *Community Health Workers: A review of concepts, practice and policy concerns*. International Consortium for Research on Equitable Health Systems (CREHS).

Murthy, R.K., Klugman, B. (2004). Service accountability and community participation in the context of health sector reforms in Asia: implications for sexual and reproductive health services. *Health Policy Plan*. 19, i78–i86. https://doi.org/10.1093/heapol/czh048

Muula, A. (2008). South Africa's national response to HIV and AIDS treatment: popular media's perspective. *Croat. Med. J*. 49, 114. https://doi.org/10.3325/cmj.2008.1.114

Myburgh, N.G., Solanki, G.C., Smith, M.J., Lalloo, R. (2005). Patient satisfaction with health care providers in South Africa: the influences of race and socioeconomic status. *Int. J. Qual. Health Care* 17, 473–477. https://doi.org/10.1093/intqhc/mzi062

Naimoli, J.F., Perry, H.B., Townsend, J.W., Frymus, D.E., McCaffery, J.A. (2015). Strategic partnering to improve community health worker programming and performance: features of a community-health system integrated approach. *Hum. Resour. Health* 13, 46. https://doi.org/10.1186/s12960-015-0041-3

News24. (2017). *The role of NGOs in Africa: are they a force for good?* News24. Accessed 13 December 2019. https://www.news24.com/Africa/News/the-role-of-ngos-in-africa-are-they-a-force-for-good-20170426

Ngulube, TJ., Mdhluli, L., Gondwe, K., Njobvu, CA. (2004). *Governance, participatory mechanisms and structures in Zambia´s health system: An assessment of the impact of Health Centre Committees (HCCs) on equity in health and health care*. EQUINET Discussion Paper Number 21.

NHRD. (2020). National Health Research Database. Accessed 18 February 2020. https://nhrd.hst.org.za/

Nickerson, J.W., Adams, O., Attaran, A., Hatcher-Roberts, J., Tugwell, P. (2015). Monitoring the ability to deliver care in low- and middle-income countries: a systematic review of health facility assessment tools. *Health Policy Plan*. 30, 675–686. https://doi.org/10.1093/heapol/czu043

Nkrumah, Y., Mensah, J., Bujoreanu, L. (2014). *Crowdsourcing Feedback to Improve Healthcare Systems*. The World Bank.

Nxumalo, N., Gilson, L., Goudge, J., Tsofa, B., Cleary, S., Barasa, E., Molyneux, S. (2018). Accountability mechanisms and the value of relationships: experiences of front-line managers at subnational level in Kenya and South Africa. *BMJ Glob. Health* 3. https://doi.org/10.1136/bmjgh-2018-000842

Nxumalo, N., Goudge, J., Thomas, L. (2013). Outreach services to improve access to health care in South Africa: lessons from three community health worker programmes. *Glob. Health Action* 6, 19283. https://doi.org/10.3402/gha.v6i0.19283

Nxumalo, N. (2013). Community health workers, community participation and community level inter-sectoral action: the challenges of implementing primary health care outreach services. *Thesis submitted to the Faculty of Health Sciences University of the Witwatersrand.*

OECD. (2019). *DAC List of ODA Recipients*. OECD. Accessed 9 November 2018. http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/daclist.htm

Office of Health Standards Compliance. (2016). *Annual Inspection Report 2016/2017*.

Office of Health Standards Compliance. (2017). *Annual Inspection Report 2017/2018*.

Office of the Health Ombud. (2019). OHO. Accessed 12 December 2019. http://healthombud.org.za/

Office of the Health Ombud. (2019). *Office of the Health Ombud Annual Report 2018/2019.*

O'Meara, W.P., Tsofa, B., Molyneux, S., Goodman, C., McKenzie, F.E. (2011). Community and facility-level engagement in planning and budgeting for the government health sector – A district perspective from Kenya. *Health Policy Amst. Neth*. 99, 234. https://doi.org/10.1016/j.healthpol.2010.08.027

Oyaya, C., Rifkin, S. (2003). Health Sector Reforms in Kenya: an examination of district level planning. *Health Policy Amst. Neth*. 64, 113–27. https://doi.org/10.1016/S0168-8510(02)00164-1

Padarath, A., Friedman, I. (2008). *The Status of Clinic Committees in Primary Level Public Health Sector Facilities in South Africa*. Health Systems Trust.

Paez, A. (2017). "Grey literature: An important resource in systematic reviews." *J Evid. Based Med*. doi: 10.1111/jebm.12265

Palinkas, L.A., Horwitz, S.M., Green, C.A., Wisdom, J.P., Duan, N., Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Adm. Policy Ment. Health Ment. Health Serv. Res*. 42 (5): 533–544. https://doi.org/10.1007/s10488-013-0528-y

Pelletier, D., Haider, R., Hajeebhoy, N., Mangasaryan, N., Mwadime, R., Sarkar, S. (2013). The principles and practices of nutrition advocacy: evidence, experience and the way forward for stunting reduction: Principles and practices of nutrition advocacy. *Matern. Child. Nutr.* 9, 83–100. https://doi.org/10.1111/mcn.12081

Peltzer, K., (2009). Patient experiences and health system responsiveness in South Africa. *BMC Health Serv. Res*. 9, 117. https://doi.org/10.1186/1472-6963-9-117

Peters, D.H., Kanjilal, B. (2011). Health insurance & responsiveness to communities & patients: The future of health systems in India. *Indian J. Med. Res*. 133, 9.

Peterson, J., Pearce, P.F., Ferguson, L.A., Langford, C.A. (2017). Understanding scoping reviews: Definition, purpose, and process. *J. Am. Assoc. Nurse Pract*. 29, 12–16. https://doi.org/10.1002/2327-6924.12380

Phillips, N.M., Street, M., Haesler, E. (2014). Measuring patient participation in health care: a comprehensive systematic review protocol. *JBI Database Syst. Rev. Implement. Rep*. 12, 68–88. https://doi.org/10.11124/jbisrir-2014-1380

Phillips, N.M., Street, M., Haesler, E. (2016). A systematic review of reliable and valid tools for the measurement of patient participation in healthcare. *BMJ Qual Saf* 25, 110–117. https://doi.org/10.1136/bmjqs-2015-004357

Phiri, S.N., Fylkesnes, K., Ruano, A.L., Moland, K.M. (2014). Born before arrival': user and provider perspectives on health facility childbirths in Kapiri Mposhi district, Zambia. *BMC Pregnancy Childbirth* 14, 1–10. https://doi.org/10.1186/1471-2393-14-323

Poles, G., et al. (2014). Factors associated with different patterns of nonadherence to HIV care in Dar es Salaam, Tanzania. *J Int Assoc Provid AIDS Care* 13(1): 78 – 84. https://www.ncbi.nlm.nih.gov/pubmed/23269515

Pulla, P. (2015). Two Indian states promise to enforce act that punishes violent attacks against doctors. *BMJ* 350, h2725–h2725. https://doi.org/10.1136/bmj.h2725

Raman, VR., Sheikh, K. (2016). Generating momentum towards community roles in universal health coverage: key outcomes of a series of state-civil society consultative processes. *BMJ Global Health* 1(Suppl 1) A2-A43.

Ramiro, L.S, et al. (2001). Community participation in local health boards in a decentralized setting: cases from the Philippines. *Health Policy Plan*. 16, 61–69. https://doi.org/10.1093/heapol/16.suppl_2.61

Reader, T.W., Gillespie, A., Roberts, J. (2014). Patient complaints in healthcare systems: a systematic review and coding taxonomy. *BMJ Qual. Saf*. 23, 678–689. https://doi.org/10.1136/bmjqs-2013-002437

Renedo, A., Marston, C.A., Spyridonidis, D., Barlow, J. (2015). Patient and Public Involvement in Healthcare Quality Improvement: How organizations can help patients and professionals to collaborate. *Public Manag. Rev.* 17, 17–34. https://doi.org/10.1080/14719037.2014.881535

Ringold, D., Holla, A., Koziol, M., Srinivasan, S. (2012). Citizens and Service Delivery : Assessing the Use of Social Accountability Approaches in the Human Development Sectors. *World Bank*. https://doi.org/10.1596/978-0-8213-8980-5

RTI International-University of North Carolina Evidence-based Practice Center. (2009). Outcomes of Community Health Worker Interventions. *Evidence Report/Technology Assessment Number 181*.

Ruff, B., Mzimba, M., Hendrie, S., Broomberg, J. (2011). Reflections on health-care reforms in South Africa. *J. Public Health Policy* 32, S184–S192. https://doi.org/10.1057/jphp.2011.31

SA Breaking News. (2014) *Burning down of clinics will only chase away healthworkers – DENOSA.* SA Breaking News.

Sahovic, NV. (2010). *The Role of Civil Society in Implementing the General Measures of the Convention on the Rights of the Child*. UNICEF Innocenti Working Paper. Accessed 7 June 2019. https://www.unicef-irc.org/publications/603-the-role-of-civil-society-in-implementing-the-general-measures-of-the-convention.html

Saprii, L., Richards, E., Kokho, P., Theobald, S. (2015). Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles. *Human Resour Health* 13:95. http://www.ncbi.nlm.nih.gov/pubmed/26646109

Satia, JK., Mavalankar, DV., Sharma, B. (1994). Micro-level planning using rapid assessment for primary health care services. *Health Policy Plan* 9(3): 318-30. https://www.ncbi.nlm.nih.gov/pubmed/10137744

Schneider, H., Hlophe, H., van Rensburg, D. (2008). Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. *Health Policy and Planning* 23. Doi: 10.1093/heapol/czn006

Schneider, H., Okello, D., Lehmann, U. (2016). The global pendulum swing towards community health workers in low- and middle-income countries: a scoping review of trends, geographical distribution and programmatic orientations, 2005 to 2014. *Hum. Resour. Health* 14. https://doi.org/10.1186/s12960-016-0163-2

Schneider H, Et al. (2018). Ward-based primary health care outreach teams in South Africa: developments, challenges and future directions. In: *South African Health Review 2018*. South Africa: Health Systems Trust.

Schlemmer, A., Mash, B. (2006). The effects of a language barrier in a South African district hospital. *South Afr. Med. J.* Suid-Afr. Tydskr. Vir Geneeskd. 96, 1084–1087.

Serrate, CF., Luasanne, RC., Jean-Claude, MM., Espinosa, CS., Gonzalez., TC. (2007). *Study on intersector practices in health in Cuba.* Report to the Pan American Health Organization Stage One.

Sheikh, K., Saligram, P., Prasad, L.E. (2013). Mapping the regulatory architecture for health care delivery in mixed health systems in low- and middle-income countries. *Working Paper Series Number 26*. Australia: Nossal Institute for Global Health.

Sheikh, K., George, A., Gilson, L. (2014). People-centred science: strengthening the practice of health policy and systems research. *Health Res. Policy Syst*. 12. https://doi.org/10.1186/1478-4505-12-19

Sheikh, K., Gilson, L., Agyepon, IA., Hanson, K., Ssengooba, F., Bennett, S. (2011). Building the field of health policy and systems research: framing the questions. *PLoS Med* 8 (8): e1001073. https://doi.org/10.1371/journal.pmed.1001073

Scott, V., Schaay, N., Olckers, P., Nqana, N., Lehmann, U., Gilson, L. (2014). Exploring the nature of governance at the level of implementation for health system strengthening: the DIALHS experience. *Health Policy Plan*. 29, ii59. https://doi.org/10.1093/heapol/czu073

Singh, R and Vutukuru, V. (2015). *Enhancing accountability in public service delivery through social audits: A case study of Andhra Pradesh, India.* Namati. Accessed 25 October 2019. https://namati.org/resources/enhancing-accountability-in-public-service-delivery-through-social-audits-a-case-study-of-andhra-pradesh-india/

Skinner, D., Delobelle, P., Pappin, M., Pieterse, D., Esterhuizen, T.M., Barron, P., Dudley, L. (2018). User assessments and the use of information from MomConnect, a mobile phone text-based information service, by pregnant women and new mothers in South Africa. *BMJ Glob. Health* 3. https://doi.org/10.1136/bmjgh-2017-000561

Smith, T., de Visser, J. (2009). *Are ward committees working? Insights from six case studies*. Western Cape: Community Law Centre

Sri, B.S., Sarojini, N., Khanna, R. (2012). An investigation of maternal deaths following public protests in a tribal district of Madhya Pradesh, central India. *Reprod. Health Matters* 20, 11–20.

Srivastava, A., et al. (2016). Are village health sanitation and nutrition committees fulfilling their roles for decentralised health planning and action? A mixed methods study from rural eastern India. *BMC Public Health* 16. https://doi.org/10.1186/s12889-016-2699-4

Standing, H and Choudhury, A. (2008). Producing Effective Knowledge Agents in a Pluralistic Environment: What Future for Community Health Workers? *Social science & medicine* 66. 2096-107. 10.1016/j.socscimed.2008.01.046.

Steinman, S. (2003). *Workplace violence in the health sector country case study: South Africa.* Accessed 2 December 2019. https://www.who.int/violence_injury_prevention/violence/interpersonal/en/WVcountrystudysouthafrica.pdf

South African Department of Health. (2017). *Annual Report 2016/2017*.

South African Department of Health. (2018). *Annual Report 2017/2018.*

South African Department of Health. (2018). *National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa.*

South African Department of Health. (2005). *Having your say: A handbook for Ward Committees*.

South African Department of Health. (2019). *Ideal Clinic South Africa*. Accessed 10 February 2019. www.idealhealthfacility.org.za

South African Department of Health. (2019). *National Health Insurance Bill 2019*.

South African Department of Health. (2019). *What is MomConnect?* SADOH. Accessed 9 December 2019. http://www.health.gov.za/index.php/mom-connect

South African Department of Health. (2018). *Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Team* 2018/19 – 2023/24.

South African Department of Health. (2001). *The District Health System in South Africa: Progress made and next steps*.

South African Department of Health. (2011). "Towards quality care for patients". *National Core Standards for Health Establishments in South Africa.*

South African Department of Health. (2018). *WBPHCOT Policy Framework and Strategy.*

South African Department of Health. (1997). *White paper for the transformation of the health system in South Africa*.

South African National Department of Public Service and Administration. 2013. *Public Service Regulations, 2001.*

South African National Government. (1999). *South Africa´s Patients' Rights Charter.*

South African National Government. (2004). *South African National Health Act No. 61 of 2003.*

Sunkutu, K. and Nampanya-Serpell, N. (2009). *Searching for common ground on incentive packages for Community Workers and Volunteers in Zambia.* World Health Organization. Accessed 28 October 2019. https://www.who.int/workforcealliance/knowledge/resources/incentives_zambia/en/

Tenthani, L., Cataldo, F., Chan, A.K., Bedell, R., Martiniuk, A.L., Lettow, M. van (2012). Involving expert patients in antiretroviral treatment provision in a tertiary referral hospital HIV clinic in Malawi. *BMC Health Serv. Res*. 12, 1–8. https://doi.org/10.1186/1472-6963-12-140

Thi Thu Ha, B., Mirzoev, T., Morgan, R. (2015). Patient complaints in healthcare services in Vietnam's health system. *SAGE Open Med*. 3, 205031211561012. https://doi.org/10.1177/2050312115610127

Topp, S.M., Black, J., Morrow, M., Chipukuma, J.M., Van Damme, W., (2015). The impact of human immunodeficiency virus (HIV) service scale-up on mechanisms of accountability in Zambian primary health centres: a case-based health systems analysis. *BMC Health Serv. Res*. 15. https://doi.org/10.1186/s12913-015-0703-9

Treatment Action Campaign, (2019). *About the TAC*. TAC. Accessed 13 December 2019. https://tac.org.za/category/about/

Treno, AJ., Holder, HD. (1997). Community mobilization, organizing, and media advocacy. A discussion of methodological issues. *PubMed – NCBI*. Accessed 8 July 2019. https://www.ncbi.nlm.nih.gov/pubmed/10183273

Tripathy, J.P., Aggarwal, A.K., Patro, B.K., Verma, H (2015). "Process evaluation of community monitoring under national health mission at Chandigarh, union territory: Methodology and challenges." *J. Fam. Med. Prim. Care* 4, 539. https://doi.org/10.4103/2249-4863.174282

Tsolekile, L.P., Puoane, T., Schneider, H., Levitt, N.S., Steyn, K. (2014). The roles of community health workers in management of non-communicable diseases in an urban township. *Afr. J. Prim. Health Care Amp Fam. Med.* 6, 1–8. https://doi.org/10.4102/phcfm.v6i1.693

UNAIDS Global Pulse. (2015). *Mining citizen feedback data for enhanced local government decision-making.* Global Pulse Project Series no. 16.

Üstün, T.B., et al. (2001). *WHO Multi-country Survey Study on Health and Responsiveness 2000-2001*. World Health Organization. Accessed 1 October 2019. WWW.WHO-Multi-country-Survey-Study-on-Health-and-%C3%9Cst%C3%BCn-Chatterji/5e6db20961c15c0c349ff37d779e5c1d7ac21d2f

van Ginneken, N., Lewin, S., Berridge, V. (2010). The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Soc. Sci. Med*. 71, 1110–1118. https://doi.org/10.1016/j.socscimed.2010.06.009

van Teeffelen, J., Baud, I. (2011). Exercising Citizenship: Invited and Negotiated Spaces in Grievance Redressal Systems in Hubli–Dharwad. *Environ. Urban. ASIA* 2, 169–185. https://doi.org/10.1177/097542531100200203

Walker, S., Read, S., Priest, H. (2013). Use of reflexivity in a mixed-methods study. *PubMed - NCBI*. https://doi.org/10.7748/nr2013.01.20.3.38.c9496

Walt, G., Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy Plan*. 9, 353–370. https://doi.org/10.1093/heapol/9.4.353

Weimann, E and Stuttaford, M.C. (2014). Consumers' perspectives on national health insurance in South Africa: using a mobile health approach. *JMIR Mhealth Uhealth* 2(4). http://www.ncbi.nlm.nih.gov/pubmed/25351980

Western Cape Department of Health. (2013). *20 Year Review*: *Western Cape.*

Western Cape Department of Health. (2013). *Patient Complaints Line to Roll Out Across the Province.* Accessed 7 November 2019. https://www.westerncape.gov.za/node/9263

Western Cape Department of Health. (2013). *New project connects expectant moms to government health services*. Accessed 25 October 2019. https://www.westerncape.gov.za/general-publication/new-project-connects-expectant-moms-government-health-services

Western Cape Department of Health. (2011). *2020: The future of health care in the Western Cape.*

Western Cape Department of Health. (2018). *Cape Metro District 2018: District Health Plan 2018/2019 to 2020/2021*.

Western Cape Department of Health. (2018). *Cape Winelands District 2018: District Health Plan 2018/2019 to 2020/2021*.

Western Cape Department of Health. (2018). *Central Karoo District 2018: District Health Plan 2018/2019 to 2020/2021*.

Western Cape Department of Health. (2018). *Eden District 2018: District Health Plan 2018/2019 to 2020/2021*.

Western Cape Department of Health. (2014). *Healthcare 2030: The Road to Wellness.*

Western Cape Department of Health. (2016). *Western Cape Health Facility Boards and Committees Act, 2016*.

Western Cape Department of Health. (2016). *Manual in terms of section 14 of the Promotion of Access to Information Act, 2000.*

Western Cape Department of Health. (2018). *Overberg District 2018: District Health Plan 2018/2019 to 2020/2021*.

Western Cape Department of Health. (2013). *Western Cape District Health Councils Amendment Act, 2013*.

Western Cape Department of Health. (2003). *Western Cape Government Health Annual Report 2002 – 2003*.

Western Cape Department of Health. (2005). *Western Cape Government Health Annual Report 2004 – 2005*.

Western Cape Department of Health. (2007). *Western Cape Government Health Annual Report 2006 – 2007*.

Western Cape Department of Health. (2008). *Western Cape Government Health Annual Report 2007 – 2008*.

Western Cape Department of Health. (2009). *Western Cape Government Health Annual Report 2008 – 2009*.

Western Cape Department of Health. (2010). *Western Cape Government Health Annual Report 2009 – 2010*.

Western Cape Department of Health. (2011). *Western Cape Government Health Annual Report 2010 – 2011*.

Western Cape Department of Health. (2013). *Western Cape Government Health Annual Report 2012 – 2013*.
Western Cape Department of Health. (2014). *Western Cape Government Health Annual Report 2013 – 2014*.
Western Cape Department of Health. (2015). *Western Cape Government Health Annual Report 2014 – 2015*.
Western Cape Department of Health. (2016). *Western Cape Government Health Annual Report 2015 – 2016*.
Western Cape Department of Health. (2017). *Western Cape Government Health Annual Report 2016 – 2017*.
Western Cape Department of Health. (2018). *Western Cape Government Health Annual Report 2017 – 2018*.
Western Cape Department of Health. (2019). *Western Cape Government Health Annual Report 2018 – 2019*.
Western Cape Department of Health. (2001). *Western Cape Health Facility Boards Act, 7 of 2001.*
Western Cape Department of Health. (2016). *Western Cape Health Facility Boards and Committees Act, 2016.*
Western Cape Department of Health. (2007). *Western Cape Health Facility Boards – Manual 2007.*
Western Cape Department of Health. (2014). *Western Cape Independent Health Complaints Committee Act, 2 of 2014*.
Western Cape Government. (2019). *Western Cape Government: Overview.* Western Cape Government. https://www.westerncape.gov.za/your_gov/70 (accessed 7.24.19).
Western Cape Department of Health. (2018). *West Coast District 2018: District Health Plan 2018/2019 to 2020/2021*.
Western Cape Department of Health. (2019). *Help us make our services even better*. Accessed 4 January 2020. https://www.westerncape.gov.za/general-publication/help-us-make-our-health-services-even-better
Western Cape Department of Health. (2018). *Clinic Committees.* Accessed 2 September 2019. https://www.westerncape.gov.za/general-publication/clinic-committees
Western Cape Department of Health. (2018). *Learn where and how to lay a complaint*. Western Cape Government. Accessed 8 July 2019. https://www.westerncape.gov.za/general-publication/learn-where-and-how-lay-complaint

WHO. (2007). *Everybody's business: strengthening health systems to improve health outcomes : WHO's framework for action*. World Health Organization, Geneva.

WHO. (2012). *Changing mindsets: strategy on health policy and systems research*. World Health Organization, Geneva.

WHO, Global Health Workforce Alliance. (2010). *Global experience of community health workers for delivery of health related Millennium Development Goals: A systematic review, country case studies and recommendations for integration into national health systems.* World Health Organization, Geneva.

WHO. (2015). *What is the role of the non-state provider in achieving universal health coverage?* World Health Organization, Geneva. Accessed 7 June 2019. http://www.who.int/alliance-hpsr/news/2015/nonstate/en/

Williams, J.J. (2006). Community participation: Lessons from post-apartheid South Africa. *Policy Stud.* 27, 197–217. https://doi.org/10.1080/01442870600885982

Witter, S and Garshong, B (2009). "Something old or something new? Social health insurance in Ghana*." BMC International Health and Human Rights* 9 20. https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-9-20

Training and Research Centre and Ministry of Health and Child Care, Zimbabwe. (2014). *Zimbabwe Equity Watch 2014.* TARSC, MoHCC, EQUINET Harare

Appendices

Appendix 1:

MECH	COUNTRY	OVERVIEW OF STUDY FOCUS AND FINDINGS
Decentralisation (>10 studies)	India	Village Health Sanitation and Nutrition Committees, participatory forums, intended to decentralise planning/action to improve community health, sanitation and nutrition. Lacking education, mobilisation and monitoring (Srivastava et al., 2016).
	Mali	Gov of Mali´s decentralization of local health centre management to local institutions through delegation to community health association and the devolution of decisions to local govs. Key is responsiveness to local needs, downward accountability and health provider retention (Lodenstein and Dao, 2011).
	Kenya	Gov of Kenya´s 1994 Health Policy Framework, including decentralisation to the district level. There is not enough emphasis on process, health sector reforms unsustainable (Oyaya and Rifkin, 2003).
	Nicaragua	Structural adjustments have accompanied health service decentralization, leading to a lack of equity and accountability. Deeper analysis of political and economic factors needed (Birn et al., 2000).
	Pakistan	Study of decentralisation (authority, institutional capacities and accountability to local authorities), showing it occurs differently depending on local context (Bossert and Mitchell, 2011).
	Tanzania	Decentralisation of expanded programme on immunization (EPI). Shows community support depends on health provider availability and awareness of target population (Semali et al., 2005).
		Researchers investigate the decentralisation and control of tropical diseases, showing that devolution occurs more in theory than in practice (Mubyazi et al., 2004.).
	LMICs	Factors influencing health provider accountability (oversight mechanisms, revenue sources and competition in the health sector). Findings show evidence is thin, official community participation mechanisms in context of health service decentralisation can improve responsiveness (Berlan and Shiffman, 2012).
		Factors that influence how accountability mechanisms function and relationships within the district health system, importance of organisational culture (Cleary et al., 2013).
		Links between governance mechanisms and health outcomes. Health system decentralisation is one key governance mechanisms that enables responsiveness to local needs and values (Ciccone et al., 2014).
		Challenges in health system strengthening interventions, applying a model of health governance, including principal-agent linkages (Brinkerhoff and Bossert, 2014).
Case review/audit (<5 studies)	**Côte d'Ivoire**	Frequency of severe obstetric illness, intervals between admission or decision and life-saving surgery, factors contributing to delays – reported in case reviews in two hospitals (Gohou et al., 2004).
	LMICs	Theory-driven review of collective citizen engagement/advocacy cases, insight into perspectives, reasoning, agency, abilities of health providers to respond to citizens. Must evaluate intermediate effects (attitudinal/behavioural changes or social accountability initiatives) (Lodenstein et al., 2017).
Community Health Insurance (CHI)	India	Assesses patient satisfaction after hospitalisation for insured and uninsured patients. In reality, health insurance does not always lead to higher satisfaction (Peters and Kanjilal, 2011).
	Ghana	Assesses Ghana´s NHIS, challenges include sustainability, questions around equity, structure and accountability (Witter and Garshong, 2009).
	LMICs	Describes origins, formats and evolution of CHI in Africa, Asia & Latin America, including strengths & weaknesses (Criel et al., 2008).
Community Health Workers (CHWs) (>10 studies)	Bangladesh	Examines how poor populations can access trusted knowledge and services in pluralistic health systems and role of CHWs, based on past successes and failures. Suggests four potential models of community-based health agents (Standing and Choudhury, 2008).
		Assesses feasibility and constraints of community-based management of acute malnutrition (CMAM), recommends it for MAM and SAM (Choudhury et al., 2014).
	Brazil	Assesses feasibility and effectiveness of CHW programmes through a desktop review (Lehmann and Sanders, 2007).
	Cambodia	Assesses if investment into Community Systems Strengthening has improved effectiveness, efficiency, results of HIV, TB, malaria programs (ICF International, 2012).
	Ethiopia	Community Health Systems Strengthening (CHSS) model utilises formal/informal networks in communities to address gaps in services. Can support and legitimise CTC (close-to-community) providers and create sustainable community-based programmes (Lunsford et al., 2015).
	India	Explores perceptions/experiences of ASHA scheme (Accredited Social Health Activists) – a cadre of India´s CHW programme. Finds scheme is beneficial but faces challenges (Sapril et al., 2015).
	South Africa	Explores history of CHWs to inform policy-making frameworks for CHWs going forward (van Ginneken et al., 2010) .
		Compares three case studies to examine experiences of CHWs in efforts to improve access to care through community participation/outreach services. Finds strengthened institutional contexts needed (Nxumalo, 2013).
		Compares CHW programmes, finds investment in resources, training and support is needed (Nxumalo et al., 2013).
		Summarizes key features of CHW programme and response to HIV/AIDS (Schneider et al., 2008).
	Sub-Saharan Africa	Compares ´hidden´ community/village level volunteers with formal, paid CHWs, finds need to recognise hidden volunteers (Leon et al., 2015).
	Tanzania	Community Health Systems Strengthening (CHSS) model utilises formal/informal networks in communities to address gaps in services. Can support and legitimise CTC (close-to-community) providers and create sustainable community-based programmes (Lunsford et al., 2015).
	Zambia	Examines appropriate incentive package for provision of care at community level and argues CHW Programme Development and Implementation Committee should be established (Sunkutu and Nampanya-Serpell, 2009).

MECH	COUNTRY	OVERVIEW OF STUDY FOCUS AND FINDINGS
	LMICs	Examines various incentives to motivate and retain CHWs, recommends more systematic use of multiple incentives, emphasizes importance of relationships between CHW and community (Bhattacharyya et al., 2001).
		Examines growth, geographical distribution and programmatic orientations of literature on CHWs over 10 years (Schneider et al., 2016).
Committees (>10 studies)	Asia	Finds community participation (through community health structures, decentralization, community financing) needs more investment by the state, stronger evidence (Murthy and Klugman, 2004).
	Bangladesh	Health Watch Committees improved community health service awareness/advocated for better service provision, hindered by lack of legal accountability/authority (Barret, 2010).
	Kenya	Leaders should be nurtured across governance structures to improve resilience in health systems (Gilson et al., 2017).
		Examines facility management committees, highlighting feasibility and challenges of engaging community in health planning process (O'Meara et al., 2011).
	Nigeria	Community health committees found to be strong support for PHC (Abimbola et al., 2014).
	South Africa	Overview of health committee functioning and recommendations going forward, including identifying capacity and training needs (Haricharan, 2010).
		Leaders should be nurtured across governance structures to improve resilience in health systems (Gilson et al., 2017).
		Explores relationship between participation and right to health, lessons of best practice for community participation from health committees: balance of power, intersectoral activity, apprenticeship, link between action and change, use of sources of information (Glattstein-Young and London, 2010).
		Describes three-year health committee intervention and critical factors for enhancing their potential to drive community participation (Mulumba et al., 2018).
	Tanzania	Explores views of villagers on PHC committees, village health workers, skills staff and responsiveness to community health needs, finds more regular feedback on health service delivery constraints and existing community-based health organisations is needed for participation (Mubyazi, 2007).
	Zambia	Examines effect of HIV service scale-up on mechanisms of accountability in primary health facilities, calls for greater research/understanding (Topp et al., 2015).
	LMICS	Narrative review to understand contextual features relevant to committees, develops contextual framework of context (community, health facilities, health administration, society) and cross-cutting issues e.g. trust, awareness, benefits, resources etc (George et al., 2015).
		Addresses gap between external accountability and bureaucratic accountability mechanism and interactions between them (Cleary et al., 2013).
		Systematic literature review on evidence on health facility committees´ effectiveness and factors that influence performance/effectiveness (McCoy et al., 2012).
	Zimbabwe	Explores relationship between Health Centre Committees, finds they lead to improved health outcomes/PHC services, but weak formal recognition, poorly resourced/trained, no influence on health budgets (Loewenson et al., 2005.).
	Uganda	Describes three-year health committee intervention and critical factors for enhancing their potential to drive community participation (Mulumba et al., 2018).
Community-based monitoring (>10 studies)	Bangladesh	Explores Community Groups (CGs), finds effective community participation requires individual and community empowerment. CGs are functional but constrained by many factors (bias member selection, lack of official recognition, poor leadership/authority) (Mahmud, 2004).
	Guatemala	Analyses social participation from perspective of power relations in historical, social, economic context of Guatemala (Flores et al., 2009).
	India	Assesses functionality of National Rural Health Mission (NRHM) in terms of Community-Based Monitoring, which needs to be institutionalized on a larger scale (Garg and Laskar, 2010).
		Evaluates community monitoring program, challenges include limited representation, lack of involvement and no chairperson/convenor. Finds need for evaluation framework in planning (Tripathy et al., 2015).
		Literature review on social autopsy (social, behavioural, health systems contributors) of maternal/child deaths, explores Maternal and Perinatal Death Inquiry and Response program. Finds social autopsy powerful for raising awareness, providing evidence, motivating action (Kalter et al., 2011).
		Examines framework for community-based monitoring and improvement of local health services and limitations. Suggests it is accepted as an accountability principle at all levels of governance (Kakade, 2012).
		Explores power relationships and ethical dilemmas when developing community monitoring systems, highlighting considerations (meanings of autonomy/consent, documentation for transparency, minimizing risks to individuals) (Khanna, 2013).
		Examines effectiveness of social audit as accountability tool and impact on implementation of National Rural Employment Guarantee Scheme (Singh and Vutukuru, 2010).
	Kenya	Reviews evidence on literature/secondary evidence on community participation, including community voice, district functionality, wider contexts/processes (Baez and Barron, 2006).
	Uganda	Randomized field experiment on community-based monitoring of public primary healthcare providers, finding increases in utilization and improved health outcomes (Björkman and Svensson, 2009).
	Zambia	Reviews evidence on literature/secondary evidence on community participation, including community voice, district functionality, wider contexts/processes (Baez and Barron, 2006).
	Zimbabwe	Focuses on progress and challenges in health equity, finding weak monitoring and social accountability (Training and Research Centre and MHCC, Zimbabwe, 2014).
	LMICS	Theory-driven review of collective citizen engagement/advocacy cases, insight into perspectives, reasoning, agency, abilities of health providers to respond to citizens. Must evaluate intermediate effects (attitudinal/behavioural changes or social accountability initiatives) (Lodenstein et al., 2017).

MECH	COUNTRY	OVERVIEW OF STUDY FOCUS AND FINDINGS
Complaints (<5 studies)	South Africa	National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa: Based on the Patients´ Rights Charter, guidelines/standards monitor whether health facilities adhere to this (Department of Health, 2017).
	Vietnam	Investigates patents´ complaint handling processes and main influences on their implementation in public hospitals. Proposes policy implications for improvement (improving service provider accountability/better utilisation of information on complaints) (Thi Thu Ha et al., 2015).
	LMICs	Theory-driven review of collective citizen engagement/advocacy cases, insight into perspectives, reasoning, agency, abilities of health providers to responds to citizens. Must evaluate intermediate effects (attitudinal/behavioural changes or social accountability initiatives) (Lodenstein et al., 2017).
		Addresses gap between external accountability and bureaucratic accountability mechanism and interactions between them (Cleary et al., 2013).
Discreet choice experiment (<5 studies)	Liberia	DCE designed to assess preferences for structure and process of care at health clinics. Choice of clinic most influenced by provision of thorough physical exam and consistent available medicine. Respectful treatment and government management played a role (Kruk et al., 2011).
	Tanzania	DCE used to investigate women´s preferences for places of delivery of care. Greatest predictor of health facility preference was kind treatment by a doctor, followed by a doctor with excellent medical knowledge, followed by modern medical equipment and drugs (Larson et al., 2015).
Exit interviews (>10 studies)	India	Assessing users´ and providers´ perspectives in challenges faced in the provision of quality care (Bhattacharyya et al., 2015).
	Ghana	Describing provider behaviour related to supply of health services to insured clients in Ghana and the influence of provider payment methods on incentives and behaviour (Agyepong et al., 2014).
	Lao PDR	Comparing health system responsiveness between two hospitals (Douangvichit et al., 2012).
	Sierra Leone	Understanding the factors that influence the selection of a healthcare provider once the decision to seek care has been made, considering cost, location and reputation (Jacobsen et al., 2012).
	South Africa	Determining patient satisfaction (Chimbindi et al., 2014).
	Zambia	Exploring how users and providers perceive low utilization of health facilities (Phiri et al., 2014)
Human/patient rights (<10 studies)	LMICs	Explores evidence on community accountability mechanisms, finding not enough empirical data and future studies needed (Molyneux et al., 2012).
	India	Citizens´ Charter in Government of India lets people know mandate of Ministry/Department/Organisation, how to get in touch with its officials, what to expect from services and how to seek a remedy if something goes wrong (Government of India, 2019).
	Kenya	Examines experiences of health facility charter and awareness of it, with challenges including non-adherence to charter provisions by health workers, illegibility/language issues, lack of expenditure records, no time to read or understand them, socio-cultural limitations (Atela et al., 2015).
	South Africa	Highlights key issues that constitute/affect health law in post-apartheid South Africa, examining the health system from a rights perspective and making recommendations for future policy and legislative development (Hassim et al., 2007).
		Explores if human rights paradigm can create space for civil society action, arguing human rights provide a means to contest globalisation constraints (London and Schneider, 2012).
	Uganda	Assess levels of awareness, responsiveness, practice of Uganda Patients´ Charter among patients and health workers, finding limitations (Kagoya et al., 2013).
Information systems (<10 studies)	India	Assess My Health, My Voice project – technology used to monitor/display online data regarding informal payments for maternal health care, including hotline where women could report health providers´ demands for informal payments. Enhanced knowledge of entitlements, confidence to claim rights (Dasgupta et al., 2015).
		Assessed use of ICT in health sector including potential for further use. Findings include Health Management Information Systems, data collection by frontline health workers, community feedback systems, ICT-based education and skill development for healthcare providers, decision-making systems and changing the behaviour of end-users (Garai and Ganesan, 2010).
	Indonesia	Details Expanding Maternal and National Survival (EMAS) project, an SMS and web-based system used to capture, analyse and address citizen feedback (ITU, 2019).
	South Africa	Reviews role of mobile phone technology for monitoring and evaluation of community-based health services, finds insufficient evidence and challenges in implementation and a need for a systems perspective that does not separate technology from its implementation environment (Leon and Schneider, 2012).
		Uses Mxit as mobile phone-based social media network to encourage comments on proposed NHI and raise awareness on rights to free and quality healthcare (Weimann and Stuttaford, 2014).
	LMICs	Reviews IS research and benefits from ICTs, highlighting key themes (failure, outsourcing, strategic value, socio-economic contexts) (Avgerou, 2008).
Call centre / hotlines / SMS hotlines	Bangladesh	Assesses existing evidence on patient complaints management systems and provides practical options for future policy and practice, identifies key outstanding gaps in existing literature. Finds need for comprehensive, integrated, context-specific systems that addresses unequal power relations and information asymmetry (Mirzoev and Kane, 2018).
	Burkina Faso	Evaluates a toll-free call service and interactive voice server in improving health system governance. Functional but may be negatively impacted by cultural context, fear or reprisal (Lechat et al., 2019).

MECH	COUNTRY	OVERVIEW OF STUDY FOCUS AND FINDINGS
	India	Asses My Health, My Voice project – technology used to monitor/display online data regarding informal payments for maternal health care, including hotline where women could report health providers´ demands for informal payments. Enhanced knowledge of entitlements, confidence to claim rights (Dasgupta et al., 2015).
	South Africa	Analysed feedback through MomConnect, mHealth initiative giving pregnant women information via SMS. 74% of all complaints resolved (Barron et al., 2016).
	Uganda	Reports on two SMS-based platforms to generate real-time information from citizens/health providers, providing evidence on health service delivery (Nkrumah et al., 2014).
	Vietnam	Investigates patents´ complaint handling processes and main influences on their implementation in public hospitals. Proposes policy implications for improvement (improving service provider accountability/better utilisation of information on complaints) (Thi Thu Ha et al., 2015).
Legal (<10 studies)	LMICs	Assesses social accountability approaches in human development, including national-level legal frameworks providing for access to information (Ringold et al., 2012).
	East & Southern Africa & South Africa	Explores if human rights paradigm can create space for civil society action, arguing human rights provide a means to contest globalisation constraints (London and Schneider, 2012).
	Kenya	Evaluates integration of legal literacy and legal services into healthcare, finding increase in knowledge and awareness (Gruskin et al., 2013).
NGO (>10 studies)	Ecuador	Explores how an NGO and its health services are perceived by population it services and contributions to reducing barriers to care. Finds positive perceptions but unrealistic expectations at time (Biermann et al., 2016).
	Kenya	Documents contributions of NGO sector to Kenya´s health goals with potential for higher levels of collaboration (Berman et al., 1995).
	Mozambique	Reviews evidence on literature/secondary evidence on community participation, including community voice, district functionality, wider contexts/processes (Baez and Barron, 2006).
	Myanmar	Community Feedback and Response Mechanism (CFRM) delivers mechanism for community feedback and seek responses in relation to UNDP and other development activities. Promotes accountability (Decision Support Services Co., 2013).
	South Africa	Explores Advocacy, Communication and Social Mobilization (ACSM) Working Group of the Stop TB Partnership to mobilize political, social and financial resources, sustain/expand global movement to eliminate TB, foster development of effective programming (Deane et al., 2006).
		Summarizes experiences and results of Treatment Action Campaign (TAC), which mobilized people to campaign for the right to health using human rights education, HIV treatment literacy, demonstration and litigation, with significant results (Heywood, 2009).
	Southern Africa	Evaluates civil service organisations (CSOs) in improving HIV prevention efforts at community level with recommendations (Kelly et al., 2010).
	Uganda	Examines case for donors providing financial incentives to NGOs to increase community participation. Finds higher community participation consistent even with reduced beneficiary welfare (Burger et al., 2015).
	LMICs	Investigates practice of nutrition advocacy and suggests ways to strengthen capacities/practices in the future through three case studies (Pelletier et al., 2013).
	LMICs	Theory-driven review of collective citizen engagement/advocacy cases, insight into perspectives, reasoning, agency, abilities of health providers to respond to citizens. Must evaluate intermediate effects (attitudinal/behavioural changes or social accountability initiatives) (Lodenstein et al., 2017).
Patient advocate/ expert	Malawi	Expert patients trained to assist with HIV clinic tasks studies, showing they add value to ART services (Tenthani et al., 2012).
	South Africa	Examines access to medicines (ATM) context supply/demand barriers from provider perspectives (availability, accessibility, accommodation, acceptability, affordability) (Magadzire et al., 2014).
Report cards (<10 studies)	LMICs	Examines universal design options for report cards, summarizes evidence base, presents LMIC examples, reviews challenges, outlines implementation steps (Mcnamara, 2006).
		Assesses social accountability approaches in human development, including report cards (Ringold et al., 2012).
		Explores evidence on community accountability mechanisms, finding not enough empirical data and future studies needed (Molyneux et al., 2012).
	Tajikistan	Reports on results from focus groups/key informant interviews with regards to three initial considerations for developing a report card initiative for primary health care (selecting indicators for report card, collecting data, working with existing institutions/stakeholders) (Bauhoff et al., 2016).
Scorecard (<10 studies)	Afghanistan	Assesses community scorecards (CSC) feasibility through joint engagement of service providers/community members in design of patient-centred services, assesses impact on service delivery/perceived quality of care. Finds skilled facilitators needed (Edward et al., 2015).
	Congo	Describes implementation of community scorecards, challenges include transparency, community participation, improved quality of care. Findings are positive, users and providers able to work together to develop solutions (Ho et al., 2015).
	Ghana	Uses scorecards to access and improve maternal/newborn health services and effectiveness of engaging multiple stakeholders. Shows improvements in accountability, community participation, transparency, clarity of lines of accountability among decision-makers (Blake et al., 2016).
	Malawi	Reviews experience with Community Score Card, finding contributions to citizen empowerment, service provider and power-holder effectiveness, accountability, responsiveness, spaces of negotiation (Gullo et al., 2016).

MECH	COUNTRY	OVERVIEW OF STUDY FOCUS AND FINDINGS
		Reviews evidence on literature/secondary evidence on community participation, including community voice, district functionality, wider contexts/processes (Baez and Barron, 2006).
	Tajikistan	Reports on results from focus groups/key informant interviews with regards to three initial considerations for developing a report card initiative for primary health care (selecting indicators for report card, collecting data, working with existing institutions/stakeholders) (Bauhoff et al., 2016).
Survey/questionnaire (>10 studies)	Nigeria	Uses out-patient questionnaire from WHO responsiveness survey to evaluate NHIS. Autonym, communication, prompt attention are priority areas for improving responsiveness (Mohammed et al., 2013).
		Household data combined with other data to estimate demand for outpatient health care (Akin et al., 1995).
		Measures responsiveness in private/public hospitals, comparing performance to determine impact/relevance for public health (Adesanya et al., 2012).
	Indonesia	Surveys patients on satisfaction, finding continuity of provider, waiting time, availability of amenities, cost and social interaction with provider at bottom of the list (Bernhart et al., 1999).
	Tanzania	Studies health system responsiveness to examine relationship with patient factors and visit non-adherence, finds more evidence needed (Poles et al., 2014).
		Surveys health system responsiveness in private clinics serving HIV patients. Finds high levels of satisfaction. Confidentiality, communication, respect highly rated (Miller et al., 2014).
		Studies patient satisfaction in the out-patient department, finds overall dissatisfaction on quality of care (Khamis and Njau, 2014).
	South Africa	Describes economic framework for analysis/planning of health system reform to achieve productivity/responsiveness (Ruff et al., 2011).
		Population-based survey conducted based on WHO health system performance assessment, identifies health care access, communication, autonomy, discriminatory experiences as priority areas (Peltzer, 2009).
	India	Uses rapid assessment technique in micro-level planning for primary health services, collecting household-level data to estimate client needs, coverage of services and unmet needs to formulate micro-level plans aimed at improving service coverage and quality (Satia et al., 1994).
		Surveys family caregivers of hospitalized psychiatrically ill to explore perceived importance of various aspects of interactions, finds provision of informational inputs and addressing of concerns raised as priority areas (Dinakaran et al., 2014).
		Explores concept of patient-physician trust and patient satisfaction through descriptive household survey. Finds trust influences patient´s self-reported satisfaction and is independent of other factors assessed in study (Baidya et al., 2014).
	Global /LMIC comparison	Describes WHO study as common survey instrument in nationally representative populations with modular structure for assessing health of individuals in various domains, health system responsiveness, household health care expenditures, additional modules (Üstün et al., 2001).
		Uses data from World Health Survey to assess individual preferences for prioritizing reductions in health/health inequalities in primary health system goal. Finds individuals prioritize health system goals related to overall improvement (King et al., 2013).
		Assesses nature, strengths, limitations of treatment gap and resource availability measures that are currently used to assess adequacy of epilepsy care and applicability of WHO new measures. Finds WHO measures conceptually superior but requires data not yet available (Begley et al., 2007).
		Theory-driven review of collective citizen engagement/advocacy cases, insight into perspectives, reasoning, agency, abilities of health providers to responds to citizens. Must evaluate intermediate effects (attitudinal/behavioural changes or social accountability initiatives) (Lodenstein et al., 2017).
Suggestion boxes (<10 studies)	Myanmar	Community Feedback and Response Mechanism (CFRM) delivers mechanism for community feedback and seek responses in relation to UNDP and other development activities. Promotes accountability (Decision Support Service Co., Ltd, 2013).
	Nepal	Researches complaint management systems, finds few complaints by service users, recommends establishment of proper complaints mechanisms (Gurung et al., 2017).
	LMICs	Explores evidence on community accountability mechanisms, finding not enough empirical data and future studies needed (Molyneux et al., 2012).

Appendix 2: Full table of South African national, provincial and district policies, guidelines, legislature and documents outlining mechanisms for receiving and responding to citizen feedback. Source: authors.

Policy/ evidence	Mechanisms	Responsiveness	Level
SA National Health Act No. 61 of 2003 (SADOH, 2004)	Decentralisation District health councils Hospital Boards Health Committees Health Professional´s Council Ombud Office of Health Standards Compliance (OHSC)	Governance between national/provincial/local spheres, PHC approach/district health system model, decentralisation.	National, provincial, district

SA´s Patients' Rights Charter (SADOH, 1999)	Information material		National, provincial, district
SADOH White Paper (SADOH, 1997)	Comprehensive Primary Health Care Decentralization (District Health System) NGOs Committees Community-based information systems Health summits	Transformation of national health system, community participation in planning/provision of health care on each level of government.	National, provincial, district
SADOH Annual Report 2016/2017 (SADOH, 2017)	Complaints/compliments procedures *MomConnect* programme National Toll-Free Complaints Call Centre	Benchmarks SADOH progress, including improvement in responsiveness.	National
SADOH Annual Report 2017/2018 (SADOH, 2018)	*MomConnect* programme OHSC National Health Council (NHC) Complaints/compliments procedure National Survey: to measure Patient Experience of Care	Management of client complaints, suggestions and compliments, annual health facility surveys of patients´ experience of care, health facility monitoring and reporting of Patient Safety Incidents.	National
"Towards Quality Care for Patients" National Core Standards for Health Establishments in SA (SADOH, 2011)	District Health Information System, audit tool & audit team Hospital Board Clinic Committee Community Health Forums PSS Patient complaints Feedback & forums	Standards for quality health services, measures compliance on six standards.	National
Annual Inspection Report 2016/2017 and Annual Inspection Report 2018/2019 (OHSC, 2017; OHSC, 2018)	OHSC Annual Inspection Report Complaint process Complaints management and Ombud	Monitors delivery of safe, quality care in compliance with the National Core Standards.	National
Healthcare 2030: The Road to Wellness (WC-DOH, 2014)	SOP Public engagement Social protest action Community communication mechanisms PSS Mechanisms for written, oral or telephonic complaints & compliments Rapid surveys Health hotline District councils Facility boards Clinic committees	Department´s values include responsiveness.	Provincial
20 Year Review: WC (WC-DOH, 2013)	Ward committees SMS-hotline Complaints & compliments process Client satisfaction surveys	Reviews transformation since 1994 against the Batho Pele Principles.	Provincial
Manual in terms of section 14 of the Promotion of Access to Information Act, 2000 (WC-DOH, 2016)	Citizen rights	Right of access to information.	Provincial
National Health Insurance Bill 2019 (SADOH, 2019)	Complaints Stakeholder Advisory Committee	To achieve universal access to quality health care services.	
Healthcare 2030: The Road to Wellness (WC-DOH, 2014)	District councils	Enable effective communication within the community.	Provincial

Draft Regulations Relating to the Functioning of the District Health Councils in terms of the Western Cape District Health Councils Act, 2010			Provincial
Western Cape District Health Councils Act, 5 of 2010			District
WC District Health Councils Amendment Act, 2013 (WC-DOH, 2013)	District Health Councils	Amend 2010 Act to include members of health subdistricts in a district health councils.	District
Cape Metro District 2018: District Health Plan 2018/2019 to 2020/21 (WC-DOH, 2018)	Patient complaints National Core Standards Complaint and Compliment Register District Health Committee Clinic Committee and Facility Boards NPOs	Highlights priorities against National Core Standards. Monitors complaints resolved within 25 days.	District
Cape Winelands District 2018: District Health Plan 2018/2019 to 2020/21 (WC-DOH, 2018)	Patient complaints National Core Standards Complaint and Compliment Register District Health Committee Clinic Committee and Facility Boards	Highlights priorities against National Core Standards. Monitors complaints resolved within 25 days.	District
Central Karoo District 2018: District Health Plan 2018/2019 to 2020/21 (WC-DOH, 2018)	Patient complaints National Core Standards Complaint and Compliment Register District Health Committee Clinic Committee and Facility Boards	Promotes principles of Community Orientated Primary Care. Highlights priorities against National Core Standards. Monitors complaints resolved within 25 days.	District
Eden District 2018: District Health Plan 2018/2019 to 2020/21 (WC-DOH, 2018)	Patient complaints National Core Standards Complaint and Compliment Register Clinic Committee and Facility Boards	Promotes principles of Community Orientated Primary Care. Highlights priorities against National Core Standards. Monitors complaints resolved within 25 days.	District
Overberg District 2018: District Health Plan 2018/2019 to 2020/21 (WC-DOH, 2018)	Patient complaints National Core Standards Complaint and Compliment Register Clinic Committee and Facility Boards	Highlights priorities against National Core Standards. Monitors complaints resolved within 25 days.	District
West Coast District 2018: District Health Plan 2018/2019 to 2020/21 (WC-DOH, 2018)	Patient complaints National Core Standards Complaint and Compliment Register Clinic Committee and Facility Boards	Highlights priorities against National Core Standards. Monitors complaints resolved within 25 days.	District
2020: The future of health care in the WC (WC-DOH, 2011)		CHWs as direct link between family, community and health service.	Provincial
WBPHCOT Policy Framework and strategy (SADOH, 2018)	Ward-based Primary Health Care Outreach Teams (WBPHCOT)	WBPHCOT intended to support delivery of PHC in South Africa.	National
Having your say: A handbook for Ward Committees (SADOH, 2005)	Ward committees	Representative structure of community/citizens, need to inform the municipality about aspirations, potentials and problems of the people.	Provincial, District
WC Government Health Annual Report 2016- 2017 (WC-DOH, 2017)	Provincial Health Council, District Health Councils, Hospital Boards	Consultations/meetings with Health Committee, including Community	District

	WC Health Facility Boards and Clinic Committees Act Regulations Community Care Workers Health Committee Patient Satisfaction Survey Complaint Resolution Rate National Core Standards	Questions Answers Session.	
WC Government Health Annual Report 2017 – 2018 (WC-DOH, 2018)	Community Care Workers National Core Standards Complaint system & Resolution Rate Patient Satisfaction Survey Waiting Time Survey Report Health Facility Boards Clinic Committees	Intention to have committees up and running by new financial year.	District
WC Government Health Annual Report 2018 – 2019 (WC-DOH, 2019)		With WC Health Facility Boards and Committee Act promulgated in 2016, establishment of clinic committees commenced in January 2018 and implementation work in progress.	District
Regulations Governing the Financial Prescripts in terms of Western Cape Health Facility Boards and Committees Act, 2016			District
Regulations relating to the Criteria and Process for the Clustering of Primary Health Care Facilities in terms of the Western Cape Health Facility Boards and Committees Act, 2017			District
WC Health Facility Boards and Committees Act, 2016 (WC-DOH, 2016)	Health Facility Boards Committees	Committee duties.	Provincial legislation
SA National Health Act No. 61 of 2003 (SADOH, 2004)		Minister must appoint hospital boards for each central hospital or group of hospitals, including 3 representatives of the communities served by the hospitals.	National
Healthcare 2030: The Road to Wellness (WC-DOH, 2014)		Facility boards enable effective communication within the community.	Provincial
WC Government Health Annual Report 2002 – 2003 (WC-DOH, 2003)		Creation of Health Facility Boards achieved throughout the province, promotes representation, accessibility, openness and transparency.	Provincial
WC Government Health Annual Report 2017 – 2018 (WC-DOH, 2018)	Community Care Workers National Core Standards Complaint system Complaint Resolution Rate Patient Satisfaction Survey Waiting Time Survey Report Health Facility Boards Clinic Committees	The WC Health Facility Boards and Committee Act was promulgated in 2016 and regulations gazetted on 7 December 2017.	Provincial
Regulations Governing the Financial Prescripts in terms of Western Cape Health Facility Boards and Committees Act, 2016			Provincial
Regulations relating to the Criteria and Process for the Clustering of PHC Facilities			Provincial

in terms of the WC Health Facility Boards and Committees Act, 2017			
Regulations Governing the Procedures for the Nomination of Members for Appointment to Health Facility Boards in terms of the Western Cape Health Facility Boards and Committees Act, 2017			Provincial
WC Health Facility Boards Act, 7 of 2001 (WC-DOH, 2001)	Health Facility Boards	Ensure accountability of health facility management to community, responsiveness to needs of patients/their families.	Provincial
WC Health Facility Boards – Manual 2007 (WC-DOH, 2007)		Highlights how Board is accountable to community, patients, their families.	Provincial
WC Health Facility Boards Amendment Act, 7 of 2012			
WC Health Facility Boards and Committees Act, 2016 (WC-DOH, 2016)	Health Facility Boards	Health Facility Board duties.	Provincial
Public Service Regulations, 2001 (SA National Department of Public Service and Administration, 2013)	Citizens' Complaints and Compliments Framework, March 2013	Stipulates exec authority shall establish/sustain service delivery programme for his/her dept– one key element is system or mechanism for (managing) complaints & compliments.	National
National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa (SADOH, 2018)	Complaint, complement, suggestion procedure Public Protector Consumer Commission Human Rights Commission Legal System Ombud in the OHSC Professional Councils/Boards Feedback forms Complaint/compliment/suggestion boxes Posters & pamphlets detailing feedback process Complaint, Compliment and Suggestion Committee (CCSC)	Right to complain about healthcare received, guidelines/standards monitor whether health facilities adhere.	National
Annual Inspection Report 2016/2017 and Annual Inspection Report 2017/2018 (OHSC, 2017; OHSC, 2018)	OHSC Team of inspectors Annual Inspection Report Complaint process Complaints management and Ombud	OHSC protects health/safety of users by investigating complaints.	National
WC Government Health Annual Report 2002 – 2003 (WC-DOH, 2003)	Monitoring client/patient complaints and compliments	To identify the strengths/weaknesses of service delivery	Provincial
WC Government Health Annual Report 2008 – 2009 (WC-DOH, 2009)	Annual PSS – every 12 months	Performance measure indicator looks at how many complaints resolved within 25 days	Provincial
WC Government Health Annual Report 2009 – 2010 (WC-DOH, 2010)	Annual PSS – every 12 months Complaints mechanism: Departmental complaints procedure and suggestion box	All complaints should be responded to within one month Suggestion box serves a mechanism where suggestions are recorded and discussed	Provincial

		weekly with action plans developed by Facility Management	
WC Government Health Annual Report 2010 – 2011 (WC-DOH, 2011)	Annual PSS – every 12 months Complaints committee Independent Complaints Commission	MEC/Head of Department can refer complaints when internal processes for dealing with complaints have not addressed the issues to satisfaction of complainant.	Provincial
WC Government Health Annual Report 2012 – 2013 (WC-DOH, 2013)	Annual client satisfaction surveys (CSS)– every 12 months Complaints SMS and telephone hotline Draft Western Cape Independent Health Complaints Committee Bill Independent Complaints Committee	Hotline piloted, complaints logged/tracked. A system for the referral of complaints.	Provincial
WC Government Health Annual Report 2013 – 2014 (WC-DOH, 2014)	Annual CSS – every 12 months Complaints hotline Independent Health Complaints Committee NGO/NPOs Assessments against National Core Standards	Complaints referred to Committee for consideration. Report looks at number of compliments/complaints received. Information/complaints process displayed on notice boards at clinic. NGO utilised.	Provincial
WC Government Health Annual Report 2014 – 2015 (WC-DOH, 2015)	Annual CSS – every 12 months Western Cape Independent Complaints Committee Act Designated complaints champion/officer	Complaints champion/officer ensures compliance with the 25 day resolution date.	Provincial
WC Government Health Annual Report 2018 – 2019 (WC-DOH, 2018)	Community Care Workers National core standards self-assessment rate Complaint system Complaint Resolution Rate Patient Satisfaction Survey Waiting Time Survey Report Health Facility Boards Clinic Committees	Complaint resolution rate measured. Monthly Data Review and Facility Manager meetings. The National Guideline implemented.	Provincial
WC Independent Health Complaints Committee Act, 2 of 2014 (WC-DOH, 2014)	Independent Health Complaints Committee	Establishment of Independent Health Complaints Committee.	Provincial
WC Independent Health Complaints Committee Regulations, 2014			Provincial
Annual Inspection Report 2016/2017 and Annual Inspection Report 2017/2018 (OHSC, 2017; OHSC, 2018)	OHSC	Ombud reviews annual inspections.	National
Office of the Health Ombud website http://healthombud.org.za/ (OHO, 2020)	Online complaints submission portal Complaints Call Centre	Online platform for citizens to learn more about the Health Ombud, lay complaints, access reports, publications, other resources.	National
Office of the Health Ombud Annual Report 2018/2019 (OHO, 2019)	OHSC Health Ombud	Reports on progress of the OHO to protect and promote the health/safety of users of healthcare in SA by	National

		investigating & reporting on complaints.	
What is MomConnect? (SADOH, 2019): http://www.health.gov.za/index.php/mom-connect	MomConnect	Interactive mechanism to provide feedback on services.	National
WC Government Health Annual Report 2002 – 2003 (WC-DOH, 2003)	Assessment of client satisfaction launched, with rollout intended by end of financial year	Findings of annual survey analysed, addressed with quality improvement plans formulated.	Provincial
WC Government Health Annual Report 2004 – 2005 (WC-DOH, 2005)	CSS	Report evaluates percentage of facilities that conducted external client satisfaction survey, published results, developed action plans for improvement.	Provincial
WC Government Health Annual Report 2006- 2007 (WC-DOH, 2007)	Annual CSS – every 12 months	Negative feedback reported on, including client safety, waiting times, public transport, along with strategies for addressing these.	Provincial
WC Government Health Annual Report 2007 – 2008 (WC-DOH, 2008)	Annual PSS – every 12 months Staff satisfaction survey	Analysis of patient satisfaction survey, interventions planned for responses & for results of staff survey.	Provincial
WC Government Health Annual Report 2008 – 2009 (WC-DOH, 2009)	Annual PSS – every 12 months	Findings of annual survey analysed, addressed with quality improvement plans formulated.	Provincial
WC Government Health Annual Report 2009 – 2010 (WC-DOH, 2010)	Annual PSS – every 12 months Complaints mechanism: Departmental complaints procedure and suggestion box	Findings of annual survey analysed, addressed with quality improvement plans formulated.	Provincial
WC Government Health Annual Report 2010 – 2011 (WC-DOH, 2011)	Annual PSS – every 12 months Complaints committee	Findings of annual survey analysed, addressed with quality improvement plans formulated.	Provincial
WC Government Health Annual Report 2012 – 2013 (WC-DOH, 2013)	Annual CSS – every 12 months Complaints SMS and telephone hotline Draft Western Cape Independent Health Complaints Committee Bill Independent Complaints Committee	Findings of annual survey analysed, addressed with quality improvement plans formulated.	Provincial
WC Government Health Annual Report 2013 – 2014 (WC-DOH, 2014)	Annual CSS– every 12 months Complaints hotline Independent Health Complaints Committee NGO/NPOs	Reports on patient satisfaction.	Provincial
WC Government Health Annual Report 2015 – 2016 (WC-DOH, 2016)	Annual CSS – every 12 months	Findings of annual survey analysed, addressed with quality improvement plans formulated.	Provincial

Appendix 3: Contact information for complaints, compliments & suggestions in the Western Cape – a comparison of 2015 and 2019. Source: WCDOH, 2019.

2015: (WCDOH, 2015)	**2019:** (WCDOH, 2019)
For more information or assistance of any kind, please contact the: Western Cape Government Contact Centre: • **Call:** 0860 142 142 - Monday to Sunday 07:00 - 19:00 - cost of a local telephone call from anywhere in South Africa • **Fax:** 021 483 7216 • **SMS:** Help to 31022 • **Please Call Me:** 079 769 1207 • **Email:** service@westerncape.gov.za Department of Health • **Tel:** 021 483 3245 • **Fax:** 021 483 6169	**Contact Centre** Queries or complaints about Western Cape Government services can be directed to the Western Cape Government Contact Centre. You can contact us through the channel that suits you such as social media, the walk-in centre or the call centre. You can also email us, or submit your enquiry or complaint with our contact centre form. The contact centre will help direct your complaint or enquiry and make contact with the relevant agencies. Please note that we will try to deal with your matter as fast as possible, but turn-around times may vary depending on the complexity of your complaint or enquiry. You can visit our Walk-in Centre at 9 Wale Street, Mondays to Fridays, between 7:30am and 4pm. **Call:** 0860 142 142 **Fax:** 021 483 7216 **SMS:** Help to 31022 **Please Call Me:** 079 769 1207 **Email:** service@westerncape.gov.za Facebook: www.facebook.com/WesternCapeGovernment Tweet us: twitter.com/WesternCapeGov Or, alternatively, you can also complete an online form. **Department of Health Complaints** The Western Cape Government Department of Health offers a wide range of healthcare facilities across the province. Should you feel that they are not delivering services of sufficient standard, you are welcome to contact them via their patient complaints line. • **SMS** the word "Help" – followed by your name, the nature of your complaint, facility and, if applicable, the name of a staff member to 31022. • **Call:** 0860 142 142 and press "1". • **Please Call Me:** 079 769 1207 • Send an **email** to service@westerncape.gov.za

Appendix 4: Expert information sheet. Source: authors.

EXPERT CHECK-IN: STUDY INFORMATION SHEET

Study title: ***"Mechanisms for receiving and responding to citizen feedback in LMIC health systems: a mixed methods review and mapping study of the Western Cape Province, in South Africa."***

Researcher: Tamaryn Sutherns **Principal Investigator:** Dr Jill Olivier

Introduction

You are invited to assist in the above study, which forms part of a broader research study initiated by the Department of Health (South Africa) and county Departments of Health in the Kilifi and Mombasa Counties (Kenya), which aims to better understand the processes of and environment within which service users´ feedback is collected in South Africa and Kenya. In the longer term, this evidence will contribute to the implementation and assessment of a comprehensive intervention at larger scale, to improve responsiveness of the health systems in South Africa and Kenya.

Purpose of the study

The purpose of the study is to inform understandings of mechanisms that exist in South Africa´s health system for receiving and responding to citizen feedback by reviewing current literature on health responsiveness mechanisms in low- and middle-income countries (LMICs), exploring and descriptively mapping the feedback mechanisms that exist in the South African health system as well as the Western Cape Province of South Africa, to trace the functioning of health responsiveness mechanisms in South Africa, identifying any policy reforms and innovations as well as describe the functioning and processes of feedback mechanisms in the Western Cape.

Explanation of procedures

If you agree to assist in this study, I, the researcher, would like to send you a first draft of the study findings, including the mapping of mechanisms for receiving and responding to citizen feedback in the Western Cape Province of South Africa. I will also send a short set of guided questions, which you may respond to over email or a telephone call discussion. This process is intended to assist me in ensuring that the findings of my study are relevant and align with your experience of feedback mechanisms in this context, as well as identify any missing evidence or information.

Potential risks and benefits

The study is low risk. You, as a participant, will not be vulnerable to any physical or psychological risks and will not be caused any personal discomfort or distress. You are also under no obligation to answer questions that make you feel uncomfortable in any way. While there are no immediate tangible benefits to be gained from the study, the resulting descriptive mapping may be used to improve health system responsiveness policies and processes in the long-term.

Confidentiality

The expert checking process, including every answer or comment that you provide, will be kept strictly anonymous. All statements will be attributed to participants´ designation (eg. Policymaker, Complaint Manager, etc) to protect anonymity. Data will be stored electronically and password protected. Access to this data will be limited to the primary researcher and the study supervisor, as well as one research colleague working on the same broader study. To further ensure confidentiality, we request that you keep the details of your interview participation private from colleagues and associates.

Withdrawing participation

Your assistance in this study is entirely voluntarily and you may choose to withdraw at any stage during the study, without fear or risk of penalty. You may also decline to answer any questions. If you choose to withdraw from the study, any information that you have shared will be permanently deleted and will no longer be featured as part of the study records. If you choose, the information can also be returned to you.

Contacts for queries or concerns

Should you have any concerns or queries about the study, the researcher or your rights as a participant please feel free to contact the relevant person below:

1. **Questions/Concerns about the study**

   Tamaryn Sutherns – Researcher

   Email: STHTAM003@myuct.ac.za

   Tel: +27 (0)60 993 8971

2. **Questions/Concerns about the researcher**

   Dr Jill Oliver – Principal Investigator & Supervisor

   Email: jill.olivier@uct.ac.za

   Tel: +27 (0)21 406 6489

3. **Questions/Concerns about your rights as a participant and the ethical approval for the study**

   University of Cape Town

   The Faculty of Health Sciences

   Human Research Ethics Committee

   E 52, Room 24, Old Main Building,

   Groote Schuur Hospital,

   Observatory, 7925

   Telephone: +27 21 406 6492

   Fax: +27 21 406 6411

Permission for the study

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

Appendix 5: Expert checking question guide. Source: Koon et al., 2012.

EXPERT CHECKING QUESTION GUIDE
Expert Number: _____ **Date:_____**

Introduction:
Hello, my name is Tamaryn Sutherns and I am from the Health Policy and Systems Division at the University of Cape Town´s School of Public Health. Thank you for taking the time to talk to me.
On behalf of the University of Cape Town, I am conducting a study on mechanism for receiving and responding to citizen feedback in the Western Cape Province in South Africa. The study seeks to descriptively map what feedback mechanisms for receiving and responding to citizen feedback exist in the Western Cape, what the processes and functions of these mechanisms are and how they fit into the South African health system context, including the guidelines that exist for the process and management of receiving and responding to citizen feedback. We would like to generate a descriptive map that outlines these provincial mechanisms, their processes and functions as well as a map of the national policies and guidelines that facilitate these mechanisms.
The following questions are intended to assist the researchers in ensuring that the first draft of the descriptive map of feedback mechanisms (attached) align with your experience and understanding of the Western Cape and South African health system and highlight any missing information or evidence. If you at any stage would like to choose to no longer assist with the study, you are free to do so.
You are welcome to either respond to these questions over email or schedule a short telephone call with the researcher. Please feel free to talk openly and honestly and communicate with me at any time if you feel that there are any issues you do not wish to discuss. I will be attributing your statements to your designation (eg. Policy Maker, Complaints Manager) and your confidentiality and anonymity will remain a critical priority throughout the study. You can also let me know if there is another way you would prefer me to attribute your statements in the writing up of the study results.

Please find the below questions and let me now if you have any questions. Once those are addressed, we can get started.

A. Socio-demographic information

Could you tell me the following information

1. Designation: eg. Policy Maker, Complaints Manager

---

2. Department/Institution:

---

3. No. of years in current position: _____
4. No. of years in health/government sector: _____

B. Role in health system feedback mechanisms

1. What is your experience of health system feedback mechanisms?
For example:
- Have you helped to design policy or processes around feedback mechanisms?
- Have you implemented or managed a feedback mechanism process?
- Have you captured, reported or managed a registry around feedback?

Answer:

2. What to you is a formal feedback mechanism, could you provide an example?
For example:
- Complaint hotlines, suggestion boxes etc
- What if someone complains to the media and media report is published, forcing the government to intervene?
- What if there is violent protest at a health facility, forcing the government to intervene?

Answer:

C. Experience in health system feedback mechanisms: Please refer to the attached draft mapping of the mechanisms for receiving and responding to citizen feedback in the Western Cape of South Africa

1. Are you aware of what mechanisms exist in the Western Cape for receiving and responding to citizen feedback and if so, could you name them or provide some examples:

For example:

- Complaint hotlines, suggestion boxes etc
- Is there a way to know how many exist and how they operate in a complimentary way?

Answer:

2. In your experience, do the feedback mechanisms operate in a complimentary way?

For example:

- Is there a strategy or overview of all of the different types of mechanisms?
- How do they work together?

Answer:

3. In your experience, are there adequate processes around feedback mechanisms, ensuring that they function how they should?

For example:

- Have you experienced processes around feedback mechanism that did not flow the way that they should?
- What happened in those cases?

Answer:

4. Do you have an example of an experience you have had where the process that was meant to occur around a feedback mechanism occurred in a different way?

For example:

- Instead of filling in a complaint form in a Western Cape health facility, a client calls the National Department of Health office directly

Answer:

D. Experience in the health system: Please refer to the attached draft mapping of the mechanisms for receiving and responding to citizen feedback in the Western Cape of South Africa

1. In your experience, does the draft mapping of mechanisms align with your understanding of the Western Cape health system or is there missing evidence or information?

Answer:

2. If there is missing evidence or information, could you list some sources of information that the researcher should be accessing to further describe the mechanisms for receiving and responding to citizen feedback in the Western Cape Province of South Africa?

Answer:

3. In your experience, what factors play a role in ensuring that the feedback mechanisms function the way that they should in the Western Cape?

Answer:

- Eg. Clear policies, robust guidelines …

4. In your experience, what factors play a role in hindering feedback mechanisms and how they function in the Western Cape?

For example:

- Lack of management, misalignment with national guidelines

Answer:

5. How do you think health systems feedback mechanisms could improve in the Western Cape?

Answer:

- Can the mechanisms themselves be improved?
- Can the processes and guidelines around the mechanisms be improved?

E. Conclusion of the interview

1. Is there anything else you would like to add that I have not asked about regarding mechanisms for receiving and responding to citizen feedback in the Western Cape?
2. Is there anything that you think should be included in the study and the descriptive mapping of feedback mechanisms, according to the draft that you have been provided with?

Conclusion

Those are all of my questions for now. Thank you so much for taking the time to share your experiences. If any clarification is needed on something that you have shared, do you consent to us contacting you again depending on your convenience? Y/N

Appendix 6: Brief on South Africa and Kenya health systems responsiveness research study

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

Western Cape Government
BETTER TOGETHER.

MRC Medical Research Council

University of the Western Cape
School of Public Health

KEMRI | Wellcome Trust

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

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

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

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

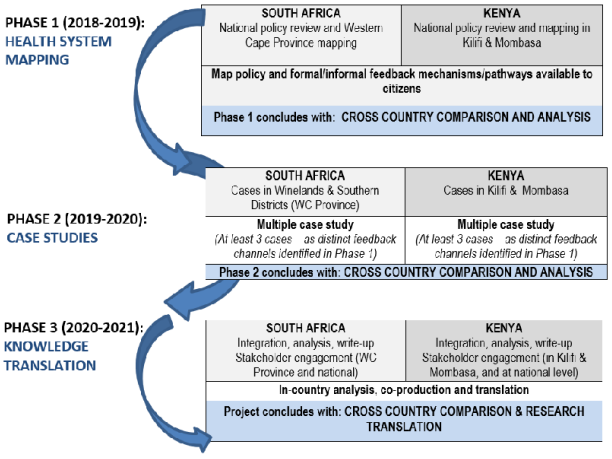
This is a mixed method, multiple case study, conducted in two countries, in three phases:

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

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

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

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



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

Principal investigator: AProf Jill Olivier
University of Cape Town, Health Policy and System Division, School of Public Health and Family Medicine, Anzio road, Observatory, 7925, South Africa
Tel: +27 (0) 214066489 Cell: 072 547 5005
Jill.Olivier@uct.ac.za

Human Research Ethics Committee
University of Cape Town, Faculty of Health Sciences, E52, Room 24, Old Main Building, Groote Schuur Hospital, Observatory, 7925
Tel: +27 (0) 214066492

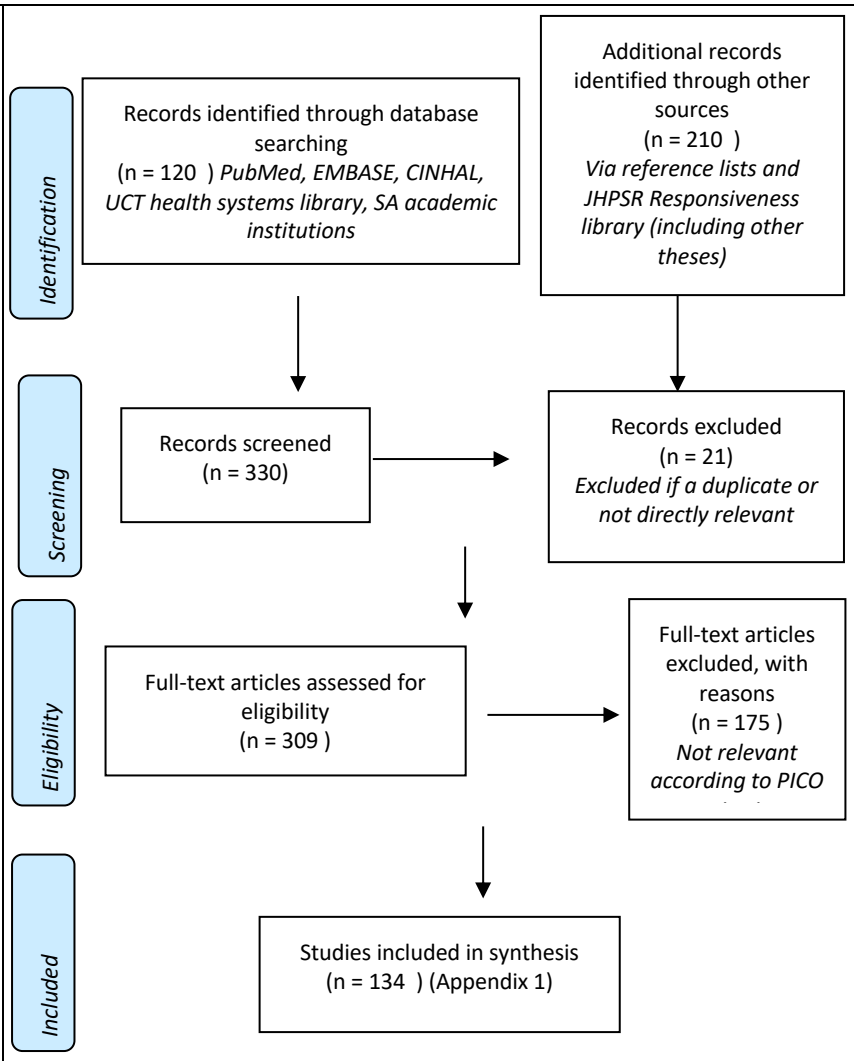
Other Investigators:
Co-Invest (UCT): Prof Lucy Gilson lucy.gilson@uct.ac.za
Co-Invest (UWC): Ms Nikki Schaay schaay@mweb.co.za
Researcher (UCT): Gadija Khan gadija.khan@uct.ac.za
Co-Invest (KEMRI): Prof Sassy Molyneux SMolyneux@kemri-wellcome.org
Researcher (KEMRI): Nancy Kagwanja NKagwanja@kemri-wellcome.org

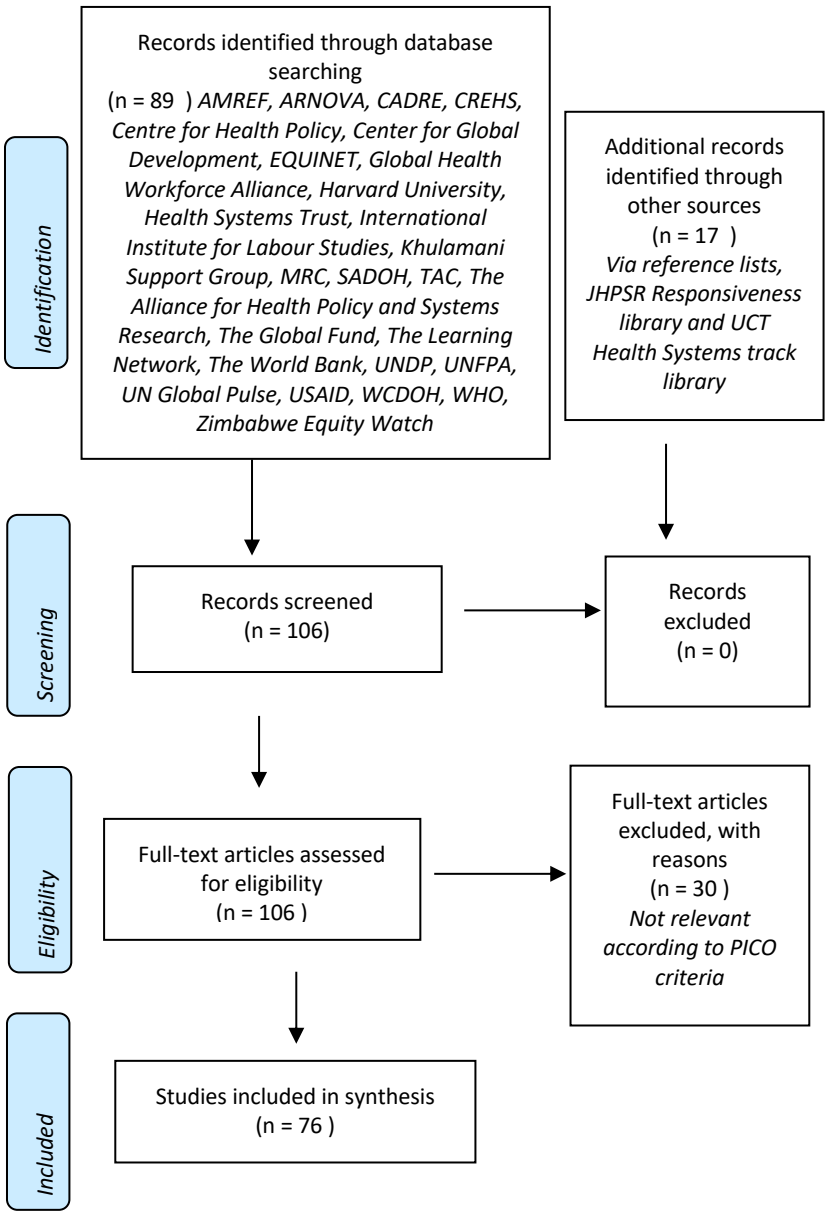
Appendix 7: PRISMA checklist and diagrams

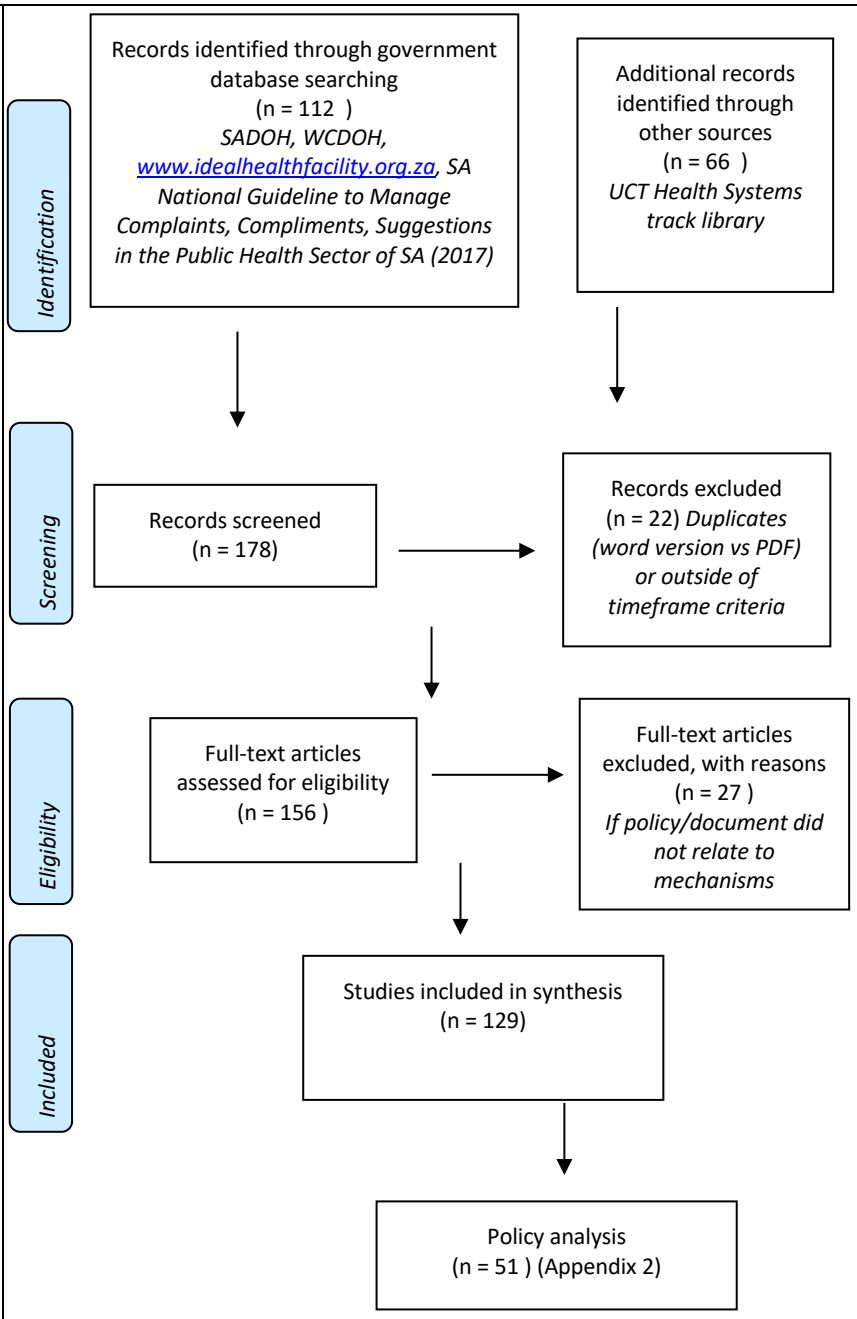
Adapted from: Moher D, Liberati A, Tetzlaff J, Altman DG. (2009). The PRISMA Group. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med*; 6:1 -6. doi.org/10.1371/journal.pmed.1000097

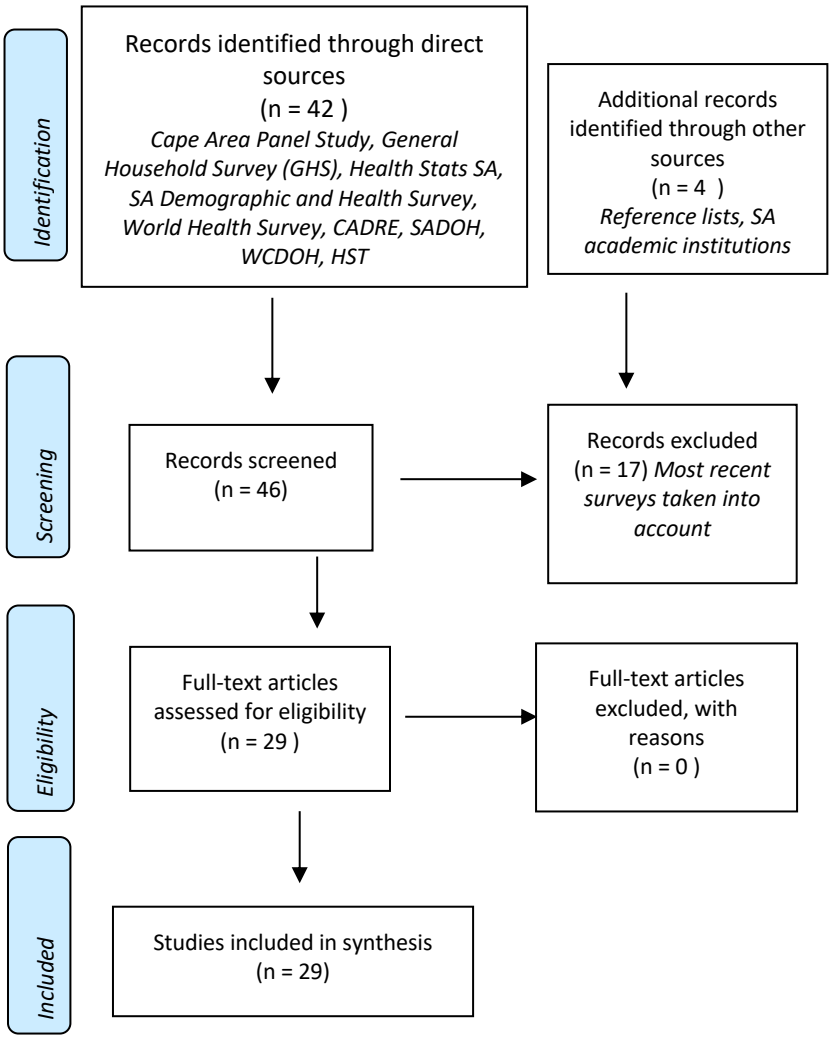
Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Propose a short take-home title. The title should explicitly state that the review included different types of evidence	Part B, Pg 1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	Part B, Pg 1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	Part B, Pg 2
Objectives	4	Formulate questions and/or objectives (qualitative, quantitative or both) being addressed by your review.	Part B, Pg 3
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	Part B, Pg 4
Justification	6	Justify the use of a review of qualitative and quantitative evidence.	Part B, Pg 4
Eligibility criteria	7	Specify the inclusion and exclusion criteria and the rationale for supporting these criteria.	Appendices
Information sources	8	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	Part B, Pg 4
Search	9	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated. Describe the process for removing duplicates	Appendices
Study selection	10	Describe the process for selecting studies (eg. Screening based on titles and abstracts, and eligibility based on full-text, number of reviewers, software used)	Appendices
Data collection process	11	Describe the method of data extraction from included studies (e.g number of reviewers involved, piloted forms, etc). List the data extracted	Appendices
Appraisal	12	Describe the process for appraising included studies (e.g., number of reviewers involved), and specifically for assessing the methodological quality or risk of bias of included qualitative, quantitative and mixed methods studies Specify how results of this appraisal are used in the synthesis	Appendices
Synthesis	13	Describe the synthesis design used Describe and justify the synthesis method (s) used	Appendices
RESULTS			
Study selection	14	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	Appendices

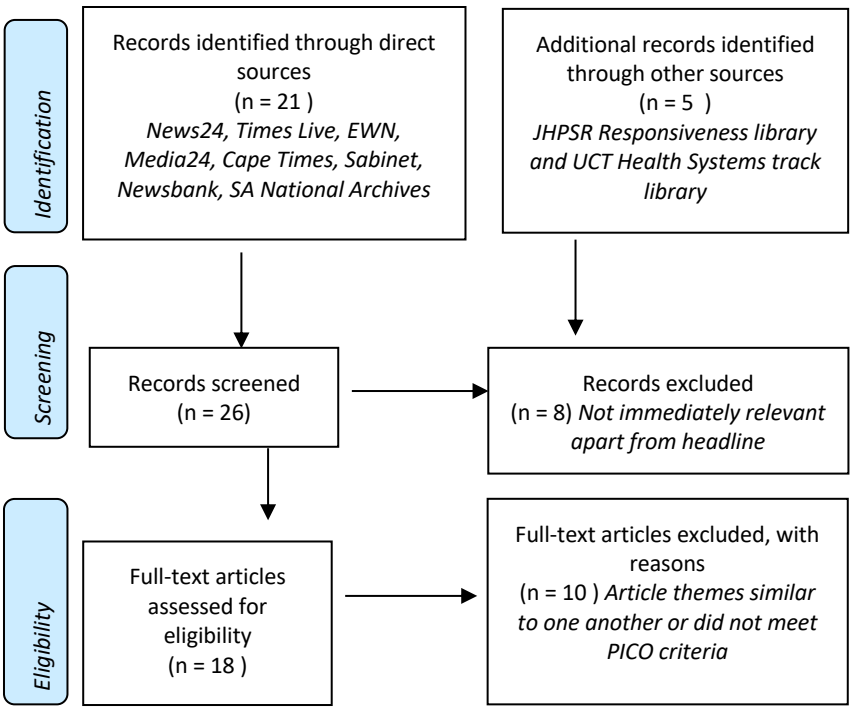
Study characteristics	15	For each study, present characteristics for which data were extracted (e.g., tables of characteristics included studies) and provide citations Specify common information across all included studies	Appendices
Results of synthesis	16	Present results of synthesis	Part B, Pg 5
DISCUSSION			
Summary of evidence	17	Summarize an overall summary of results (take-home messages) from the qualitative and/or quantitative synthesis State the main results for each main theme or category, and/or key process/outcome variable Consider their relevance and importance for knowledge users (e.g., health care providers, managers, and decision/policy makers) Take into account the methodological quality across studies (when applicable) Describe insight gained from the integration of qualitative and quantitative evidence	Part B, Pg 20
Contribution	18	Describe the contribution of the review (compared to what is already known) with respect to: review methods, scientific knowledge, practice, program planning and evaluation, policy making or else.	Part B, Pg 23
Limitations	19	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	Part B, Pg 24
Conclusions	20	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	Part B, Pg 24
REFERENCES			
References	21	List all of the references cited in the text	Part B, Pg 25
APPENDICES			

Flow diagram: Secondary literature: Peer-reviewed articles	22		

Flow diagram: Secondary literature: Institutional reports	23		

Flow diagram: SA/WC policy documents	24		

Flow diagram: Survey data	26		

Flow diagram: Media reports	27		
Table of inclusion criteria	28	Table 1: PICO framework for inclusion criteria **P** — Stakeholders in LMIC health systems, notably in South Africa **I** — Any mechanism that facilitates citizen feedback in the health system. Due to the variety of feedback mechanisms that do exist, they will also be searched for individually, including patient / client satisfaction surveys, health surveys, suggestion boxes, health committees, satisfaction interviews, media reports, protests, scorecards **C** — Any or no comparator between health system responsiveness mechanisms will be eligible for inclusion **O** — These include feedback being recorded or tracked as well as responded to or resolved **Extra criteria** — • English materials • Published from 2000 – 2019 (unless reference or trace-searching resulted in earlier relevant materials)	

PICO framework source: Schardt C, Adams MB, Owens T, Keitz S, Fontelo, P. (2007). Utilization of the PICO framework to improve searching PubMed for clinical questions. *BMC Med Inform Decis Mak*;7:1-6. doi: 10.1186/1472-6947-7-16

Appendix 8: HPP Journal Author Guidelines

Instructions for Authors

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

review policy. All types of papers are peer reviewed and all article abstracts from each issue are translated into French, Spanish and Chinese. Before you submit please make sure you have followed all the relevant instructions. A checklist for authors is available here.

Guidance

Improving chances of publication

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

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

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

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

Manuscript format and style for all articles

Only articles in English are considered for publication.

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

The **title page** should contain:

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

In the **acknowledgements**, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

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

Figures will not be relettered by the publisher. The journal reserves the right to reduce the size of illustrative material. Any photomicrographs, electron micrographs or radiographs must be of high quality. Wherever possible, photographs

should fit within the print area or within a column width. Photomicrographs should provide details of staining technique and a scale bar. Patients shown in photographs should have their identity concealed or should have given their written consent to publication. When creating figures, please make sure any embedded text is large enough to read. Many figures contain miniscule characters such as numbers on a chart or graph. If these characters are not easily readable, they will most likely be illegible in the final version.

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

For useful information on preparing your figures for publication, go to http://cpc.cadmus.com/da.

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

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

Manuscript Preparation

Page 1: **Title Page** – as above.

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

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

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

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

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

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

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

References. References must follow the Harvard system and must be cited as follows:
Baker and Watts (1993) found...

In an earlier study (Baker and Watts 1993), it...
Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus:
Baker S, Watts P. 1993. Paper/chapter title in normal script. Journal/book title in italics **Volume number in bold** : page numbers.
Baker S, Watts P. 1993. Chapter title in normal script. In: Smith B (ed). *Book title in italics*. 2nd edn. Place of publication: Publisher's name, page numbers.

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

Types of papers

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

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

ORIGINAL RESEARCH

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

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

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

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

For acknowledgements, figures and measures see above.

REVIEW ARTICLES

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

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

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

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

COMMENTARIES

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

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

HOW TO DO...OR NOT TO DO

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

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

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

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

10 BEST RESOURCES

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

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

For acknowledgements, figures and measures see above.

METHODOLOGICAL MUSINGS

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

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

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

INNOVATION AND PRACTICE REPORTS

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

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

Submission process

- Pre-submission language editing
- Authorship
- Originality
- Online submission

PRE-SUBMISSION LANGUAGE EDITING

HPP asks all authors to ensure that their papers are written in as high a standard of English as possible before submission to the journal. If your first language is not English, to ensure that the academic content of your paper is fully

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

AUTHORSHIP

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

ORIGINALITY

Manuscripts containing original material are accepted for consideration with the understanding that neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted for publication elsewhere. This restriction does not apply to abstracts or short press reports published in connection with scientific meetings. Copies of any closely related manuscripts should be submitted along with the manuscript that is to be considered by *HPP. HPP* discourages the submission of more than one article dealing with related aspects of the same study. . For further information on the prior publication policy
see https://academic.oup.com/heapol/pages/Prior_Publication.
During the online submission procedure, authors are asked to provide:

- information on prior or duplicate publication or submission elsewhere of any part of the work;
- a statement of financial or other relationships that might lead to a conflict of interest or a statement that the authors do not have any conflict of interest;
- a statement that the manuscript has been read and approved by all authors (see also section on authorship);
- name, address, telephone and fax number of the corresponding author who is responsible for negotiations concerning the manuscript;
- copies of any permissions to reproduce already published material, or to use illustrations or report sensitive personal information about identifiable persons.

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

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

ONLINE SUBMISSION

Prior to submission please carefully read instructions on each type of paper and closely follow instructions on word count, abstract, tables and figures and references. This will ensure that the review and publication of your paper is as efficient and quick as possible. The Editorial Office reserve the right to return manuscripts that are not in accordance with these instructions.
All material to be considered for publication in Health Policy and Planning should be submitted in electronic form via the journal's online submission system. Once you have prepared your manuscript according to the instructions below, instructions on how to submit your manuscript online can be found by clicking here.

Conflict of interest

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

Ethical approval

A requirement of publication is that research involving human subjects was conducted with the ethical approval of the appropriate bodies in the country where the research was conducted and of the ethical approval committees of affiliated research institutions elsewhere. A clear statement to this effect must be made in any submitted manuscript presenting such research, specifying that the free and informed consent of the subjects was obtained.

Funding

The following rules should be followed:

- The sentence should begin: 'This work was supported by …'
- The full official funding agency name should be given, i.e. 'the National Cancer Institute at the National Institutes of Health' or simply 'National Institutes of Health' not 'NCI' (one of the 27 subinstitutions) or 'NCI at NIH' - see the full RIN-approved list of UK funding agencies for details
- Grant numbers should be complete and accurate and provided in brackets as follows: '[grant number ABX CDXXXXXX]'
- Multiple grant numbers should be separated by a comma as follows: '[grant numbers ABX CDXXXXXX, EFX GHXXXXXX]'
- Agencies should be separated by a semi-colon (plus 'and' before the last funding agency)
- Where individuals need to be specified for certain sources of funding the following text should be added after the relevant agency or grant number 'to [author initials]'. An example is given here: 'This work was supported by the National Institutes of Health [P50 CA098252 and CA118790 to R.B.S.R.] and the Alcohol & Education Research Council [HFY GR667789].

Oxford Journals will deposit all NIH-funded articles in PubMed Central. See Author self-archiving policy for details. Authors must ensure that manuscripts are clearly indicated as NIH-funded using the guidelines above.

Permissions

Authors are reminded that it is their responsibility to comply with copyright laws. It is essential to ensure that no parts of the submission have or are due to appear in other publications without prior permission from the copyright holder and the original author. Materials, e.g. tables, taken from other sources must be accompanied by a written statement from both author and publisher giving permission to HPP for reproduction.

Copyright

Upon receipt of accepted manuscripts at Oxford Journals authors will be invited to complete an online copyright licence to publish form. Please note that by submitting an article for publication you confirm that you are the corresponding/submitting author and that Oxford University Press ("OUP") may retain your email address for the purpose of communicating with you about the article. You agree to notify OUP immediately if your details change. If your article is accepted for publication OUP will contact you using the email address you have used in the registration process. Please note that OUP does not retain copies of rejected articles

It is a condition of publication in Health Policy and Planning that authors assign licence to publish to Oxford University Press. This ensures that requests from third parties to reproduce articles are handled efficiently and consistently and will also allow the article to be as widely disseminated as possible. In assigning licence to publish, authors may use their own material in other publications provided that the Journal is acknowledged as the original place of publication, and Oxford University Press is acknowledged as the original Publisher.

Third-party content in open access papers

If you will be publishing your paper under an Open Access licence but it contains material for which you **do not** have Open Access re-use permissions, please state this clearly by supplying the following credit line alongside the material:

Title of content

Author, Original publication, year of original publication, by permission of [rights holder]

This image/content is not covered by the terms of the Creative Commons licence of this publication. For permission to reuse, please contact the rights holder.

Prior publication policy

Please review our prior publication policy. We expect authors to disclose any prior dissemination including via a website or at national meetings.

Offprints

All authors are supplied with a free URL linking you to a press-ready PDF version of your article. If you wish to order offprints please visit the Oxford Journals Author Services site.

Change of address

Please notify the editors of any change of address. After manuscript acceptance, please also notify the publishers: Journals Production Department, Oxford University Press, Great Clarendon Street, Oxford, OX2 6DP, UK. Telephone +44 (0) 1865 556767 , Fax +44 (0) 1865 267773.

Important notes to authors

The manuscripts will not be returned to authors following submission unless specifically requested.

Proofs

Authors are sent page proofs by email. These should be checked immediately and corrections, as well as answers to any queries, returned to the publishers as an annotated PDF via email or fax within 3 working days (further details are supplied with the proof). It is the author's responsibility to check proofs thoroughly.

Permission to reproduce figures and extracts

Permission to reproduce copyright material, for print and online publication in perpetuity, must be cleared and if necessary paid for by the author; this includes applications and payments to DACS, ARS and similar licensing agencies where appropriate. Evidence in writing that such permissions have been secured from the rights-holder must be made available to the editors.

It is also the author's responsibility to include acknowledgements as stipulated by the particular institutions. Please note that obtaining copyright permission could take some time. Oxford Journals can offer information and documentation to assist authors in securing print and online permissions: please see the Guidelines for Authors section at https://academic.oup.com/journals/pages/access_purchase/rights_and_permissions.

Should you require copies of this then please contact the editorial office of the journal in question or the Oxford Journals Rights department on journals.permissions@oup.com .

For a copyright prose work, it is recommended that permission is obtained for the use of extracts longer than 400 words; a series of extracts totalling more than 800 words, of which any one extract is more than 300 words; or an extract or series of extracts comprising one-quarter of the work or more. For poetry: an extract of more than 40 lines; series of extracts totalling more than 40 lines; an extract comprising one-quarter or more of a complete poem.

Supplementary data

Supporting material that is not essential for inclusion in the full text of the manuscript, but would nevertheless benefit the reader, can be made available by the publisher as online-only content, linked to the online manuscript. The material should not be essential to understanding the conclusions of the paper, but should contain data that is additional or complementary and directly relevant to the article content. Such information might include more detailed methods, extended data sets/data analysis, or additional figures.

It is standard practice for appendices to be made available online-only as supplementary data. All text and figures must be provided in suitable electronic formats. All material to be considered as supplementary data must be submitted at the same time as the main manuscript for peer review. It cannot be altered or replaced after the paper has been accepted for publication, and will not be edited. Please indicate clearly all material intended as supplementary data upon submission and name the files e.g. 'Supplementary Figure 1', 'Supplementary Data', etc. Also ensure that the supplementary data is referred to in the main manuscript where necessary, for example as '(see Supplementary data)' or '(see Supplementary Figure 1)'.

Return to top of page.

Oxford open access

HPP authors have the option to publish their paper under the *Oxford Open* initiative; whereby, for a charge, their paper will be made freely available online immediately upon publication.

After your manuscript is accepted the corresponding author will be required to accept a mandatory licence to publish agreement. As part of the licensing process you will be asked to indicate whether or not you wish to pay for open access. If you do not select the open access option, your paper will be published with standard subscription-based access and you will not be charged.

Oxford Open articles are published under Creative Commons licences. Authors publishing in *Health Policy and Planning* can use the following Creative Commons licences for their articles:

- Creative Commons Attribution licence (CC BY)
- Creative Commons Non-Commercial licence (CC BY-NC)
- Creative Commons non-Commercial No Derivatives licence (CC BY-NC-ND)

Please click here for more information about the Creative Commons licences.

You can pay Open Access charges using our Author Services site. This will enable you to pay online with a credit/debit card, or request an invoice by email or post. The open access charges applicable are:

- Regular charge - £1680/$2678/€2205
- Health Systems Global member charge - £1260/$2048/€1628
- Reduced Rate Developing country charge* - £840/$1139/€1103
- Free Developing country charge * - £0/$0/€0

*Visit our Developing Countries page for a list of qualifying countries

Please note that these charges are in addition to any colour/page charges that may apply.

Orders from the UK will be subject to the current UK VAT charge. For orders from the rest of the European Union, OUP will assume that the service is provided for business purposes. Please provide a VAT number for yourself or your institution, and ensure you account for your own local VAT correctly.

Ethics

Health Policy and Planning is a member of the Committee on Publication Ethics (COPE), and strives to adhere to its code of conduct and guidelines. Authors are encouraged to consult http://publicationethics.org/resources/guidelinesfor more information.

In reports of investigations in humans or animals, authors must explicitly indicate (in the appropriate section of the Methods) their adherence to ethical standards and note the approval of an ethics committee when this is relevant.

Crossref funding data registry

In order to meet your funding requirements authors are required to name their funding sources, or state if there are none, during the submission process. For further information on this process or to find out more about the CHORUS initiative please click here.