Article title: Mapping the Multiple Health System Responsiveness Mechanisms in One Local Health System: A Scoping Review of the Western Cape Provincial Health System of South Africa

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Supplementary file 4. Table of Included Items From Scoping Review.

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.[1]
	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.[2]
	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.[3]
	Nicaragua	Structural adjustments have accompanied health service decentralization, leading to a lack of equity and accountability. Deeper analysis of political and economic factors needed.[4]
	Pakistan	Study of decentralisation (authority, institutional capacities and accountability to local authorities), showing it occurs differently depending on local context.[5]
	Tanzania	Decentralisation of expanded programme on immunization (EPI). Shows community support depends on health provider availability and awareness of target population.[6]
		Researchers investigate the decentralisation and control of tropical diseases, showing that devolution occurs more in theory than in practice.[7]
	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.[8]
		Factors that influence how accountability mechanisms function and relationships within the district health system, importance of organisational culture. [9]
		Links between governance mechanisms and health outcomes. Health system decentralisation is one key governance mechanisms that enables responsiveness to local needs and values.[10]
		Challenges in health system strengthening interventions, applying a model of health governance, including principal-agent linkages. [11]
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.[12]
	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). [13]
Community Health Insurance (CHI) (<5 studies)	India	Assesses patient satisfaction after hospitalisation for insured and uninsured patients. In reality, health insurance does not always lead to higher satisfaction. [14]
	Ghana	Assesses Ghana´s NHIS, challenges include sustainability, questions around equity, structure and accountability.[15]
	LMICs	Describes origins, formats and evolution of CHI in Africa, Asia & Latin America, including strengths & weaknesses. [16]
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.[17]
		Assesses feasibility and constraints of community-based management of acute malnutrition (CMAM), recommends it for MAM and SAM.[18]

	Brazil	Assesses feasibility and effectiveness of CHW programmes through a desktop review.[19]
	Cambodia	Assesses if investment into Community Systems Strengthening has improved effectiveness, efficiency, results of HIV, TB, malaria programs.[20]
	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.[21]
	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.[22]
	South Africa	Explores history of CHWs to inform policy-making frameworks for CHWs going forward. [23] .
		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.[24]
		Compares CHW programmes, finds investment in resources, training and support is needed [25].
		Summarizes key features of CHW programme and response to HIV/AIDS.[26]
	Sub-Saharan Africa	Compares ´hidden´ community/village level volunteers with formal, paid CHWs, finds need to recognise hidden volunteers.[27]
	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. [21]
	Zambia	Examines appropriate incentive package for provision of care at community level and argues CHW Programme Development and Implementation Committee should be established.[28]
	LMICs	Examines various incentives to motivate and retain CHWs, recommends more systematic use of multiple incentives, emphasizes importance of relationships between CHW and community.[29]
		Examines growth, geographical distribution and programmatic orientations of literature on CHWs over 10 years. [30]
Committees (>10 studies)	Asia	Finds community participation (through community health structures, decentralization, community financing) needs more investment by the state, stronger evidence. [31]
	Bangladesh	Health Watch Committees improved community health service awareness/advocated for better service provision, hindered by lack of legal accountability/authority.[32]
	Kenya	Leaders should be nurtured across governance structures to improve resilience in health systems. [33]
		Examines facility management committees, highlighting feasibility and challenges of engaging community in health planning process. [34]
	Nigeria	Community health committees found to be strong support for PHC. [35]
	South Africa	Overview of health committee functioning and recommendations going forward, including identifying capacity and training needs.[36]
		Leaders should be nurtured across governance structures to improve resilience in health systems. [33]
		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. [37]
		Describes three-year health committee intervention and critical factors for enhancing their potential to drive community participation. [38]
	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. [39]
	Zambia	Examines effect of HIV service scale-up on mechanisms of accountability in primary health facilities, calls for greater research/understanding. [40]
	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. [41]
		Addresses gap between external accountability and bureaucratic accountability mechanism and interactions between them. [9]
		Systematic literature review on evidence on health facility committees´ effectiveness and factors that influence performance/effectiveness. [42]
	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.[43]

	Uganda	Describes three-year health committee intervention and critical factors for enhancing their potential to drive community participation. [38]
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).[44]
	Guatemala	Analyses social participation from perspective of power relations in historical, social, economic context of Guatemala.[45]
	India	Assesses functionality of National Rural Health Mission (NRHM) in terms of Community-Based Monitoring, which needs to be institutionalized on a larger scale.[46]
		Evaluates community monitoring program, challenges include limited representation, lack of involvement and no chairperson/convenor. Finds need for evaluation framework in planning.[47]
		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.[48]
		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.[49]
		Explores power relationships and ethical dilemmas when developing community monitoring systems, highlighting considerations (meanings of autonomy/consent, documentation for transparency, minimizing risks to individuals).[50]
		Examines effectiveness of social audit as accountability tool and impact on implementation of National Rural Employment Guarantee Scheme.[51]
	Kenya	Reviews evidence on literature/secondary evidence on community participation, including community voice, district functionality, wider contexts/processes.[52]
	Uganda	Randomized field experiment on community-based monitoring of public primary healthcare providers, finding increases in utilization and improved health outcomes.[53]
	Zambia	Reviews evidence on literature/secondary evidence on community participation, including community voice, district functionality, wider contexts/processes.[52]
	Zimbabwe	Focuses on progress and challenges in health equity, finding weak monitoring and social accountability.[54]
	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).[13]
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.[55]
	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).[56]
	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).[13]
		Addresses gap between external accountability and bureaucratic accountability mechanism and interactions between them.[9]
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.[57]
	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.[58]
Exit interviews (>10 studies)	India	Assessing users´ and providers´ perspectives in challenges faced in the provision of quality care.[59]
	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.[60]
	Lao PDR	Comparing health system responsiveness between two hospitals.[61]
	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.[62]
	South Africa	Determining patient satisfaction.[63]
	Zambia	Exploring how users and providers perceive low utilization of health facilities.[64]

Human/patient rights (<10 studies)	LMICs	Explores evidence on community accountability mechanisms, finding not enough empirical data and future studies needed.[65]
	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.[66]
	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.[67]
	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.[68]
		Explores if human rights paradigm can create space for civil society action, arguing human rights provide a means to contest globalisation constraints.[69]
	Uganda	Assess levels of awareness, responsiveness, practice of Uganda Patients´ Charter among patients and health workers, finding limitations.[70]
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.[71]
		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.[72]
	Indonesia	Details Expanding Maternal and National Survival (EMAS) project, an SMS and web-based system used to capture, analyse and address citizen feedback.[73]
	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.[74]
		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.[75]
	LMICs	Reviews IS research and benefits from ICTs, highlighting key themes (failure, outsourcing, strategic value, socio-economic contexts).[76]
Call centre / hotlines / SMS hotlines (<10 studies)	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.[77]
	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.[78]
	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.[71]
	South Africa	Analysed feedback through MomConnect, mHealth initiative giving pregnant women information via SMS. 74% of all complaints resolved.[79]
	Uganda	Reports on two SMS-based platforms to generate real-time information from citizens/health providers, providing evidence on health service delivery.[80]
	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).[56]
Legal (<10 studies)	LMICs	Assesses social accountability approaches in human development, including national-level legal frameworks providing for access to information.[81]
	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.[69]
	Kenya	Evaluates integration of legal literacy and legal services into healthcare, finding increase in knowledge and awareness.[82]
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.[83]

	Kenya	Documents contributions of NGO sector to Kenya´s health goals with potential for higher levels of collaboration.[84]
	Mozambique	Reviews evidence on literature/secondary evidence on community participation, including community voice, district functionality, wider contexts/processes.[52]
	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.[85]
	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.[86]
		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.[87]
	Southern Africa	Evaluates civil service organisations (CSOs) in improving HIV prevention efforts at community level with recommendations.[88]
	Uganda	Examines case for donors providing financial incentives to NGOs to increase community participation. Finds higher community participation consistent even with reduced beneficiary welfare.[89]
	LMICs	Investigates practice of nutrition advocacy and suggests ways to strengthen capacities/practices in the future through three case studies.[90]
	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).[13]
Patient advocate/ expert patient (<10 studies)	Malawi	Expert patients trained to assist with HIV clinic tasks studies, showing they add value to ART services.[91]
	South Africa	Examines access to medicines (ATM) context supply/demand barriers from provider perspectives (availability, accessibility, accommodation, acceptability, affordability).[92]
Report cards (<10 studies)	LMICs	Examines universal design options for report cards, summarizes evidence base, presents LMIC examples, reviews challenges, outlines implementation steps.[93]
		Assesses social accountability approaches in human development, including report cards [81].
		Explores evidence on community accountability mechanisms, finding not enough empirical data and future studies needed.[94]
	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).[95]
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.[96]
	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.[97]
	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.[98]
	Malawi	Reviews experience with Community Score Card, finding contributions to citizen empowerment, service provider and power-holder effectiveness, accountability, responsiveness, spaces of negotiation.[99]
		Reviews evidence on literature/secondary evidence on community participation, including community voice, district functionality, wider contexts/processes.[52]
	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).[95]
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.[100]
		Household data combined with other data to estimate demand for outpatient health care.[101]
		Measures responsiveness in private/public hospitals, comparing performance to determine impact/relevance for public health.[102]

	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.[103]
	Tanzania	Studies health system responsiveness to examine relationship with patient factors and visit non-adherence, finds more evidence needed.[104]
		Surveys health system responsiveness in private clinics serving HIV patients. Finds high levels of satisfaction. Confidentiality, communication, respect highly rated.[105]
		Studies patient satisfaction in the out-patient department, finds overall dissatisfaction on quality of care.[106]
	South Africa	Describes economic framework for analysis/planning of health system reform to achieve productivity/responsiveness.[107]
		Population-based survey conducted based on WHO health system performance assessment, identifies health care access, communication, autonomy, discriminatory experiences as priority areas.[108]
	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.[109]
		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.[110]
		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.[111]
	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.[112]
		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.[113]
		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.[114]
		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).[13]
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.[85]
	Nepal	Researches complaint management systems, finds few complaints by service users, recommends establishment of proper complaints mechanisms.[115]
	LMICs	Explores evidence on community accountability mechanisms, finding not enough empirical data and future studies needed.[65]

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