

The Mphatlalatsane Initiative

Evaluation: Objective 4

Report 1

Consortium baseline interviews: February - May 2020

The history, implementation contexts and processes until early March 2020

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Summary

This is the first Objective 4 evaluation report to the Mphatlalatsane Project Management Committee (PMC), that reflects on the Mphatlalatsane milestones, and the contexts and processes that shaped its implementation since its earliest antecedents up to the beginning of March 2020. The report is based on 18 baseline interviews conducted between February and May 2020, with at least one participant from all the consortium partners. We also reviewed a set of programme documentation from the quality improvement (QI) advisors, as well as other project documents, presentations, and meeting minutes available to us. With this report, we offer insights that are aimed at strengthening the next implementation phases of the Mphatlalatsane Initiative, and the first of what we intend will be regular reports to PMC.

In the main, we found that Mphatlalatsane has many promising features that could set it on a path to become ‘the bright morning star that will herald a new dawn’ for sexual, reproductive, maternal and neonatal health services (SRMNH) in South Africa. It is transformative in its goals and has adopted an integrated and inclusive design, seeking to leverage homegrown strengths and experiences in a holistic, systems approach. In a short period of implementation, the QI methodologies have shown their potential, unlocking teamwork, health worker agency and meaningful action at the facility level. The evaluation also surfaced the complex challenge of managing a multi-stakeholder partnership and offers some thinking on how to mobilise and coordinate existing initiatives in a synergistic and complementary fashion. In addition, experiences of implementation so far have highlighted the crucial role of leadership, coordination and ‘quality governance’ at the district (‘meso’) levels, and the importance of provincial buy-in and stewardship. There was consensus amongst interviewees that this represents the main next challenge for Mphatlalatsane. We believe that the following recommendations may strengthen Mphatlalatsane: (i) creating opportunities for the consortium partners to reflect on partnership synergy, (ii) consolidate district leadership involvement, and (iii) enable the QI teams to address the contextual factors that strengthen or challenge their performance.

This report discusses these themes in more detail. It is important to state that the findings reported here represent a partial picture as we have been unable so far to conduct the baseline study in the three Mphatlalatsane provinces, and are thus missing their crucial perspectives on the initiative so far. We hope that we will be able to capture these perspectives over the coming months.

Finally, this report is intended for the PMC and not for a wider audience, and in the interests of learning we have adopted a forthright style. We welcome any feedback on facts or interpretation. We are also keen to consider ways in which the initial experiences we report here could be written up and disseminated, in conjunction with members of PMC.

Acknowledgements

We are grateful to all the participants for the extremely generous and positive sharing of their time and experiences that made this report possible. We want to specifically acknowledge the contributions of Degratia Masenya, Azukile Nzuzo, and Tabisa Silere-Maqetseba, as QI advisors, whom we consulted with on numerous occasions regarding the detail of QI team activities and processes.

1. Introduction

This is the first Objective 4 evaluation report of the Mphatlalatsane Initiative, concerned with the implementation processes and contexts at sub-district, district, and regional levels, referred to as meso and macro levels, (Objective 4a), and at the facility, i.e. micro level (Objective 4b). Objective 4 aims to describe the factors that may explain variation in the uptake and outcomes of Mphatlalatsane and the implications for scale-up and spread. As such, this report reflects on the implementation milestones, as well as the contexts and processes that shaped its implementation since its origins in 2016 - 17 and formalisation in 2018 up to early March 2020.

Purpose

This report serves as the first of what we intend will be regular feedback reports to the Mphatlalatsane Programme Management Committee (PMC). By reflecting on the implementation processes to date, as shared by national stakeholders, we offer insights to assist the PMC with building on current successes and strengths and dealing with future challenges. It should be noted that the findings reported here are not a full baseline evaluation report, which was intended to include the perspectives of provincial and catchment area, as well as sub-district and district managers, and facility-level quality improvement teams and operational managers of 15 purposively selected facilities.

Methodology

The report is based primarily on a preliminary analysis of 18 baseline interviews conducted by the Objective 4 evaluation team, comprising Prof Helen Schneider as lead, Dr Solange Mianda, and Mr Arrie Odendaal. The team jointly interviewed 16 PMC members, with at least one from each of the implementation partners. The evaluation team interchangeably led the interviews, which were on average an hour-long, conducted through online meeting platforms, and mostly individual. We regarded the quality improvement (QI) advisors (hereafter referred to as 'advisors'), as the main source of information for the micro / facility level, which is reflected in the six interviews we had with them. Our second information source came from a set of programme documentation provided by the advisors, which included their fieldwork reports, meeting minutes of, and QI team stationery such as their Plan-Do-Study-Analyse (PDSA) tracker. Finally, we reviewed available project documentation and presentation and minutes of PMC meetings. More detail on the methods can be found in Appendix 1.

Report structure

The first section provides an overview of the Mphatlalatsane timeline since inception and the main milestones until early March 2020. We then explore three key themes emerging from the data, one each from the micro, meso and macro dimensions of Mphatlalatsane. We firstly document the QI teams' achievements, led by the advisors, and then reflect on factors that shape team functioning. This is followed by our analysis of the district level leadership and governance, and its critical role in sustaining and improving past successes. We then turn to the complexities of managing the national Mphatlalatsane consortium of partners. We contextualise our macro level findings with insights from the literature on partnership synergies, to strengthen the synergy in the consortium. We conclude the report with our main findings and recommendations. In the findings we report extensively on the words of participants interviewed. Following initial feedback, we opted to remove any indication, even anonymous, which might point to any specific attribution of quotes to maximise confidentiality. However, it is important to note that we have drawn on the full diversity of opinions we encountered during the interviews.

2. Mphatlalatsane history and milestones

Antecedents

Although the Mphatlalatsane Initiative was formalised in mid-2018, its design draws on nearly a decade of interventions and experiences with strengthening maternal, neonatal and child and women's health (MNCWH) services.

These include, amongst others:

- the formulation of a Strategic Plan for MNCWH and nutrition,
- the appointment of District Clinical Specialist Teams (DCSTs),
- the dissemination and standardization of the Essential Steps in Managing Obstetric Emergencies (ESMOE) 'drills' in health facilities,
- a programme for strengthening newborn health (Limpopo Initiative for Newborn Care (LINC)); improvement initiatives and structures governing maternal, neonatal, and child health (MNCH) quality and outcomes at sub-district and district levels, known as Monitoring and Response Forums, and
- "health system strengthening" ('phase 0') workshops in some of the intervention districts.

These build on the back of the more longstanding Perinatal Problem Identification Programme (PIPP) and Child Healthcare Problem Identification Programme (CHIPP) surveillance and response systems in frontline health facilities, and the national committees on maternal, neonatal and child mortality.

In addition to these, Mphatlalatsane seeks to draw on and assimilate a range of other experiences such as the "CLEVER" and Respectful Maternal Care (RMC) projects to improve quality and outcomes of maternal health care, and quality improvement strategies in the HIV-TB field. These are contextualised in a wider set of system level processes, such as the National Health Insurance, new approaches to District Health Planning and national quality strategies.

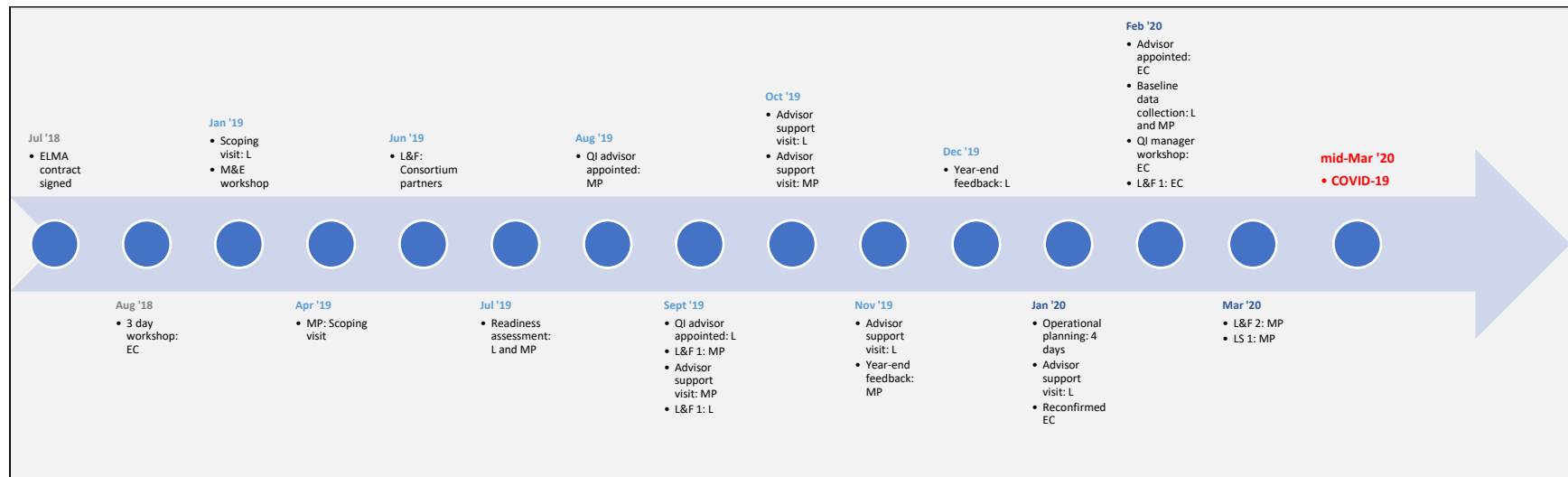
Timeline since inception in 2018

The Mphatlalatsane agreement was signed with the funder (ELMA) in July 2018, and in the months that followed ("Pre-implementation Phase"), senior managers in the three provincial governments were engaged, site visits conducted, and workshops held with key stakeholders. These preparatory and buy-in activities extended into the first quarter of 2019. 'Readiness assessments' for QI were also conducted in the three provinces, by members of the national consortium, and the model of quality improvement finalised between consortium partners.

Implementation of Mphatlalatsane began in earnest in the second half of 2019 with the first training and site activities in Mpumalanga and Limpopo, and in early 2020 in the Eastern Cape. The first important micro level milestone was the appointment of the first two QI advisors, between August and September 2019, which led to the first tangible QI events in the form of training through the Leading and Facilitation Workshop 1 (L&F 1), and establishing the QI teams, in Limpopo and Mpumalanga in September 2019. With support from the advisors, these teams developed the first of their change ideas and commenced with testing these through PDSA cycles. The remaining important milestones were reconfirming the participation of the Eastern Cape in January 2020, the appointment of the third advisor in February 2020, and L&F 1 in the Eastern Cape. With the third advisor, each province has now a designated advisor to train and mentor their respective teams. The timeline below provides more detail

of the in-between events. The outbreak of COVID-19 put a hold on L&F 2 and Learning Workshop 1 in Limpopo and the Eastern Cape, see Figure 1 for more detail. The original intentions were for the QI teams and management structures in the three catchment areas to have been well established towards the middle of 2019, that would have allowed the beginning of the scale-up phase in the provinces in July 2020 (Appendix 2). We reflect on the reasons for delay with implementation progress in Section 5: Partnership synergy.

Figure 1: July 2018 - March 2020 timeline



Legend

EC: Eastern Cape

L: Limpopo

L&F 1 and 2: It is the Institute for Healthcare Improvement’s (IHI) Leading and Facilitation workshops where attendees are trained in QI methodology. After Workshop 1, the trainees return to their workplace to practice the theory of QI. Workshop 2 is consolidating the practical experience and the final training in QI methodology

LS 1: Learning session workshop 1 is when the QI teams from the same province spend time together to present their respective change ideas and how it was tested through PDSA cycles

M: Mpumalanga

3. Quality improvement teams

In this section, we firstly describe training attendance, team composition and functioning, and observed differences between the Limpopo and Mpumalanga teams, and secondly, reflect on what we see as key drivers of micro level implementation success.

The key concepts we will refer to in this section, are defined as follows:

A locked / adapted change idea is a change idea through which the QI team successfully solved the problem they identified. A locked idea can be adopted as standard care in the facility. The *QI lead* assumes the leader role for the quality improvement team and is the person with whom the QI advisors interact about team progress. In the Eastern Cape and Limpopo, they attended the Institute for Healthcare Improvement's (IHI) L&F Workshop 1, and in Mpumalanga, L&F Workshops 1 and 2. The Limpopo QI leads are therefore technically QI coaches. We defined *core team members* as the health workers who are 'permanent' members of the QI team, irrespective of the change idea that is being tested. They are also the staff who usually identify the problems that the team want to solve. *Ad hoc team members* are health workers recruited for a specific change idea and once it has been locked, may not be called upon to participate in the next change idea. The *QI advisors* are employed by the Clinton Health Access Initiative (CHAI) to oversee and mentor the QI teams. They, in turn, are supported by IHI.

QI advisors and their QI teams: Training, Processes, and Achievements

On returning from L&F 1 in Limpopo and Mpumalanga, the attending staff set out to establish the teams and commence with the QI work in their respective facilities. A total of 22 teams were established, with one team each in 20 of the facilities, and one Limpopo facility having two teams. 65 facility staff members were attending the L&F 1 training across the three provinces, and in the case of MP, also L&F 2.

In general, the teams in the hospitals don't have a specific cadre who serves as QI lead, whereas the leads in the community health centres (CHCs) and primary healthcare (PHC) clinics are almost always the operational managers. In the hospitals and some CHCs, the teams comprise of core and ad-hoc members, with the core members representing the different MNCH units and services at that facility. In the PHC clinics and some CHCs, core teams are absent, as the leads involve all staff in the QI processes; more detail on team composition can be found in Appendix 3.

Teams were expected to meet weekly when starting with their QI activities until all were comfortable with their roles and responsibilities in the team. This did not happen in all facilities and is a main concern for the advisors. For the remainder of this section, we excluded the Eastern Cape teams, as they had merely existed for three weeks - established and functioning after their L&F 1 training - when COVID-19 disrupted Mphatlalatsane activities.

Table 1 summarises the numbers of facility staff trained, core members, change ideas, and PDSA cycles conducted. Detail of the staff cadres who are in the teams up to early March 2020, and a summary of the problems addressed through the change ideas, can be found in Appendix 4. Addressing hypertension in pregnancy was the most prevalent problem across the provinces. The following interesting comparisons are noted from these summaries: Eastern Cape had 26, of the 65 facility staff who were trained, and in Mpumalanga, 24 staff were trained. These numbers were notably higher, compared to the 15 staff from Limpopo that were trained. In Mpumalanga, with two exceptions, the same staff attended both L&F 1 and 2. As can be expected given the difference in size, 46 of the trainees came

from the hospitals, with the remaining 19 from the CHCs and PHC clinics, see Appendix 5. Only 5 of the 18 tested ideas were adopted as successful, and detailed descriptions for two of these were found, see Appendix 4.

Table 1: Teams and change ideas across provinces

Province	Staff trained	Staff left	Lead + core team	Change ideas tested	Change ideas locked	PDSAs conducted
E Cape	26	n/a	n/a	n/a	n/a	n/a
Limpopo	15	2	9	8	2	22
Mpumalanga	24	0	18	10	3	28
Total	65	2	27	18	5	50

In March 2020 we asked the Limpopo and Mpumalanga advisors to rate their respective teams for the September - November 2019 period, using the following as measures of uptake.

- Does the team communicate adequately with them?
- Do they receive team documentation when they request it?
- Is the team implementing PDSA cycles?
- Has the team set QI targets for themselves and are they meeting these?
- Does the team find solutions when they encounter problems?
- Is the team improving care?

Across the 15 teams, the uptake was rated as very good and good in six and three facilities, respectively, as average in two, with three facilities were the uptake raised concern. The next section reflects on the contexts that were shaping the performance of the QI teams.

The shaping of team functioning

Given the short implementation period, and without qualitative data from catchment area participants, it is difficult to be definitive on what shapes team performance and drawing causal links to QI uptake. We tentatively offer the following factors as micro level contexts and processes that may explain uptake.

Agency vs compliance

Participants agreed that Mphatlalatsane holds the promise to improve the quality of maternal, neonatal, and child health (MNCH) services, because the QI methodology is an effective, in the sense that improvement is recorded, and empowering intervention. It promotes agency in frontline health workers, and encourage them to take ownership to solve their unique problems.

“... so obviously that [QI methodology] works very well and it does boost the morale of the facility staff when they see themselves implementing this [sic] new things and it works.”

“... Mphatlalatsane was opening their eyes to say that there are certain things that as a facility that they can do that does not need money.”

This optimism is balanced with accounts of a prevailing ‘compliance culture’, that undermines the opportunity that Mphatlalatsane offers frontline workers to take ownership of their work:

“I think sometimes here and there, what my experience was at some of these facilities, was that people say what you want to hear, and not necessarily what the truth is ... They also don't want to raise alarms that they might not be doing certain things, that they, you know, should be doing ...”

It comes therefore as no surprise that some see the most important Mphatlalatsane objective as:

“... to work out how to give people back their agency ... What is it that is stopping people, that is making people feel that they can do nothing? So, I think what we are trying to do, is to help people through very practical things through looking at real problems, real delivery, real challenges, real blockages and for them to work out how they themselves can solve these problems.”

The ‘escalation protocol’ that encourages staff to document the steps they are taking to solve problems so that the point of “hitting a brick wall” (Participant), can be identified, is a step in the right direction and become standard practice.

Leadership

Uptake requires strong facility level leadership, commitment to the methodology, and teamwork, to set a conducive environment. From an example cited by the advisors where junior doctors had challenges in getting senior staff to support the change idea, we conclude that seniority in this leadership may improve uptake. We were unable to assess the extent to which the MNCH staff had good relationships and experiences as teams, pre-Mphatlalatsane, but it is likely to have an impact on their performance.

“I think the first thing that I would want to put across is that no two places are similar.... my experience is that where leadership is strong, involved and committed, it translates to ... the project moving forward.”

“... if that is not in the custody or power of the operational manager of the labour ward then that defeats the purpose of having micro system level changes that actually can make a big difference in outcomes. So, and the only way to do this is to get the CEO, the zonal matron and the sub-district manager that's overseeing those hospitals to buy into the idea that agency doesn't have to sit at meso level”.

In one facility, the advisors noted that in addition to leadership challenges, QI uptake was also compounded by serving a difficult community:

“They've [the facility] got a lot of issues, leadership issues, staff. They are dealing with a very difficult community. There are always complaints. Every time when I'm there the CEO is dealing with complaints from the community. So, they've got a very difficult community. And staff, it's very difficult, there's no teamwork, Even, during [the workshop], like they never agreed on anything, it's that bad I'm actually thinking that most teams that are strong, were strong even before Mphatlalatsane.

Other issues

From the many examples cited by the advisors of teams finding the time for team work, it can be concluded that the QI methodology can be integrated into the delivery of routine services. Yet, a common complaint from the advisors is the lack of responsiveness from teams when they request progress reports and QI stationery from teams. Even the teams whom the advisors rated as very good, have not settled into a rhythm of meeting advisor requests for reporting team activities, and their day-to-day work:

“They [QI team X] are good, ja. The only thing is, sometimes it’s a struggle to get documents from them. Generally, they are very active. They meet regularly. They are organised ... but when you request you don’t get things ... Ja, that’s the only thing with them. So, I think it’s maybe an issue of time, but when you go for a facility visit, everything is there.”

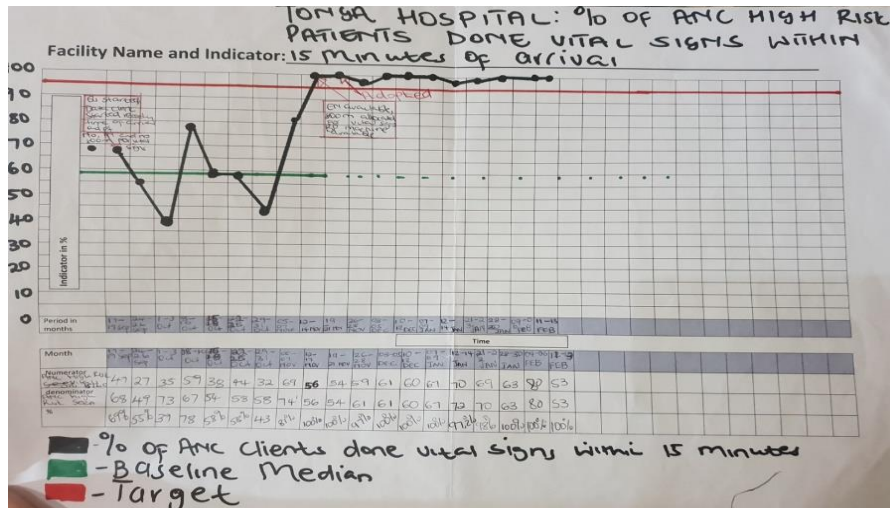
The advisors also concur that it makes team performance, and their support to the team, very challenging, when there is night - and day shift staff on the team. Furthermore, it seems that it is not the number of trained staff or team size, that determines QI productivity, as attested by the advisors, who experience the uptake in the hospitals more challenging, despite, or perhaps because of, having larger teams and more complex services delivery arrangements. On the other hand, having two staff trained and assuming responsibility for the QI activities, as in the case of the Mpumalanga CHCs and PHC clinics, renders uptake less vulnerable should a trained staff member be absent or transferred. Though it is unclear what the impact is of having facility managers who attended the training and then are unable to commit themselves to either teamwork or oversight of the QI activities, given the said importance of leadership, it is probably not the ideal situation.

“Cause even the times we have gone there, he’s [facility manager] only attended maybe two meetings and that was the time we were still doing file audits. The rest of the time, even when we want to go and feedback, he’s either not there in the facility or busy with some or other meetings.”

Finally, Mphatlalatsane is not following the conventional IHI QI implementation framework. In promoting sustainability, the Mphatlalatsane management deliberately opted for a model in which they, through the advisors, oversee the functioning of the teams. Normally IHI will be directly involved in mentoring the staff they trained and supporting the QI teams.

“... the model that is ultimately going to come out of this is going to be uniquely what a middle-income country like South Africa has, that can translate its existing resources into better outcomes through process optimisation.”

Figure 2: Example of the QI tools kept by the teams



It is difficult to know what the effect will be of IHI not having direct access to the teams. Given that the teams have not been functioning for very long, Mphatlalatsane management could consider a hybrid

model with IHI being periodically present when the advisors engage with the teams. This may serve as an additional measure to strengthen team functioning.

In the next section, we continue discussing the importance of leadership and governance as manifested at the meso level.

4. Enabling district environment for quality improvement

The meso-level of district and sub-district is recognised as the immediate enabling environment in the Mphatlalatsane initiative. We asked questions on engagement with and mobilization of actors, the champions, the governance structures, and the extent of distributed leadership at this level in different sites and provinces. The themes presented in this section were selected because they emerged strongly in the interviews. Note that the responses reflect those of consortium actors, and not the meso level actors who have not been interviewed yet.

Buy-in, ownership and engagement

Almost all the respondents acknowledged leadership at the district and sub-district level as an essential component in the implementation of Mphatlalatsane, and as key to unlocking implementation processes and making resources available:

“The people who make decisions, these are district managers and facility CEOs, these are key decision-makers and for any improvement work or activity to even begin, these two need to become the sponsors or drivers of that improvement activity”.

“... senior managers are the tools to get the resources, so if they do not understand – and resources remember includes everything, time, material, capacity. So, they will not make those resources available. So, it is very key that senior managers on different levels should be there and we should get buy in.”

Lack of buy-in at this level was a key reason for the delayed start in the Eastern Cape, in contrast to Mpumalanga:

“In Eastern Cape, there was not buy-in in my point of view to get the things going. When we were going to organize our visit to districts, we were told that they have got their own programmes, so they do not need any of the trainings. I do not think there was buy-in or a good understanding in that bout.”

“In fact, we had challenges with the Eastern Cape. The Eastern Cape is about seven months behind, simply because we couldn’t get leadership buy-in.”

“In Ehlanzeni, they always see a good representation but the main difference there is that their representation is district and provincial. So, you can see that there is good buy-in from district and from provincial people.”

The subsequent concerted (and successful) efforts to engage the senior (including provincial) leadership in a comprehensive fashion the Eastern Cape, in early 2020, were providing important lessons for other provinces:

“Eastern Cape has engaged at a leadership level even though it might have been a little bit later, which is regarded as very important.”

“Mpumalanga and Limpopo didn’t have the same level of engagement ... it was mainly people that are dealing with maternal health programmatically and the doctors and the specialists. But they didn’t include the other essential departments that contribute to the maternal work.”

Most respondents regarded meso-level leadership, structures, and systems of support for improvement processes as poorly developed in the implementation of Mphatlalatsane thus far.

“What they are lacking is that envelope that talks to them through leadership, accountability and ownership. That meso-level, the district is missing from this equation.”

“So, we then proposed ... that besides just building improvement capability on the ground at the micro level, that we actually pay attention to the district level and provide an induction orientation to what it actually means to lead an improvement initiative, an improvement project. What does it require a leader to do to create that environment for improvement to happen, so processes can be changed without feeling like the operational manager in the clinic or in the facility doesn’t have to feel intimidated or oppressed that she is breaking the rules, so ways in which environments are created.”

Key district and sub-district actors

The locus of responsibility at district and sub-district levels varied considerably across the three provinces. As indicated, in Mpumalanga, Mphatlalatsane drew in a range of actors, with participation from the district manager, MCWH coordinators, DCST obstetrician, operational managers, representatives from HR, EMS and supporting departments. In Limpopo, the meso-level was regarded as largely absent.

All respondents commented on the role of DCSTs as important vehicles to introduce QI projects and processes in different provinces.

“The district clinical specialist introduced a number of quality improvement projects. And they had a system already going, where they were doing some quality improvements with the whole district with ... [the] hospital’s drainage area”.

However, DCSTs were not present in all provinces, and they needed the support of other players to be effective.

“But the other dynamic issue is there are provinces where there are DCSTs, there are provinces where there are no DCSTs, and there are provinces where DCSTs are actually calling the shots, they actually dictate terms and they are very enthusiastic and very motivated and they are very clear what their mandate is, but then (they don’t realize) that they have got some limitations, that there are certain point that they cannot go beyond” (Participant).

Table 2 below reports on the different roles played by the DCST in the three provinces.

Table 2: DCST leadership (presence and absence)

Province	DCSTs leadership
Eastern Cape	<p>“So, I think in EC the project was given to the DCSTs, that was my fault, and thus it became peripheral, yeah. So, the leader is really critical ... whomever is leading is very, very important, if you don’t have somebody who says, “ok I will push it”, it doesn’t really ...”</p> <p>“As I indicated in EC our initial meeting had a lot of senior managers, the HODs were there, the clinicians, senior clinicians in the hospitals and different levels. They fell between the cracks; I do not know what happened and the project was left to the district clinical specialist and it did not move at all.”</p>
Limpopo	<p>“For example, in Limpopo they just decided, well, national policies (DCSTs), we don’t think we need DCSTs here so we’re disbanding DCSTs. And yet, they were very instrumental in training and clinical governance for maternal, new-born health.”</p> <p>“When one looks at Mopani, when we went there to do planning on the hypertensive disorders and pregnancy guidelines their biggest problem is that they do not have district clinical specialists, they have been stopped and there is shortage of staff and there is really not much or not much communication between the various sites.”</p>
Mpumalanga	<p>“Mpumalanga, we were getting more of a cooperative situation where we have the DCST obstetrician playing cautiously, being there but allowing the CEO and the clinical managers at hospital level to be taking the lead.”</p> <p>“In Ehlanzeni it was very different in that there were district clinical specialists. There was a process that was working, there was communication, and everyone more or less knew what they were getting involved with.”</p>

District governance

Overall, there are no coherent mechanisms of coordinated and collaborative governance of MNH at the meso level. The health system is very fragmented, at programme, management and governance level, and people are still working in silos. Interviewees believed that Mphatlalatsane presented an opportunity for the integration of programmes and to create coherent governance structures that can coordinate a wide variety of actors.

"Programme managers, MCH and others work in silos, there is no integration e.g. with HIV. They see our QI work as the start of the integration".

“But what I think is a game-changer for Mphatlalatsane is bringing all the stakeholders into the quality improvement, where like I indicated where strategic planning sees why he/she should be part. Where supply chain sees why, where everyone is able to see the part that he/she plays as a program in this whole system, in the cascade actually I will call it the cascade. In the cascade of sexual, maternal and neonatal and reproductive health. So, I think what is a really a game changer is that idea of bringing everybody together”.

“I think districts, the provinces and the hospitals should not see themselves as separate entities. And they must have a forum in which they are able to address [quality]. It sort of is in the district management forum, but I think we but I think we need something in the catchment area, which should be very apparent to everyone in the system - sitting at a district or district hospital or sitting in a CHC or a PHC.”

The learning sessions planned for the catchment areas were seen as the mechanism to catalyse coordination and collaboration in the catchment area:

“But for MNH, we’re already starting our learning sessions, which is basically bringing in multiple stakeholders who are currently involved in the project. Actually, to sit together and say, oh, this is what we discovered, and these are our challenges, how has it worked, for your side, how has it worked. But we’re really at the first, early stages of that. Perhaps in 2 or 3 months, I’ll be able to answer whether it’s been effective or not.”

Where a variety of quality improvement forums already exist, Mphatlalatsane is as an opportunity to bring them together:

“Okay. So, for the Eastern Cape, I think it’s because they were saying that we have a lot of QI work that’s being done in the district and the province. So, we end up having too many different forums that discuss different things, but they are doing QI work. So, the agreement from the province was that the already existing QI forums must continue but must include Mphatlalatsane.”

5. Partnership synergy

Mphatlalatsane: multi-faceted, multi-level, multi-partner

In many ways, the Mphatlalatsane project is a departure from previous initiatives to improve maternal, neonatal and child health (MNCH) outcomes in South Africa. In the first instance, it seeks to assimilate the lessons from several different interventions, implemented over nearly a decade, into one consolidated and inclusive approach. Mphatlalatsane is thus an integrated and comprehensive approach to the ‘continuum’ of reproductive, maternal and neonatal health (although not including child health). In bringing the different approaches together, the designers of Mphatlalatsane sought to create an overarching systems-oriented framework, leveraging existing initiatives into “a whole that is more than the sum of the parts.”

Mphatlalatsane is designed, led and championed by senior players in the National Department of Health (NDOH), to create coordinated action across all levels of government - national, provincial, district, sub-district and facility. Ensuring integration and coordination has the benefit of “people at the coal-face” being spared managing multiple, parallel and competing initiatives.

This combination of features – multi-faceted and multi-level – means that Mphatlalatsane is by nature a complex intervention. As emphasized by one senior player: “It’s got so many initiatives, it’s got so many levels that were learned from previous interventions that need to be incorporated because we cannot ignore them. It is complex, that’s the thing actually.”

Adding to the complexity is that, although NDOH-led, Mphatlalatsane is donor-funded and ‘partner’ managed. The partnership includes an international non-governmental managing partner (CHAI), two established university-based programmes of support (UP-SAMRC and ULT), a quality improvement

The challenges of partnership

Writing on the advantages of collaborative partnerships, Lasker et al. (2001:184) echo the words and intentions of Mphatlalatsane’s designers: “By combining the individual perspectives, resources, and skills of the partners, the group creates something new and valuable together—a whole that is greater than the sum of its individual parts.” They refer to this as “partnership synergy”, the characteristics of which are outlined in Box 1.

Box 1: Characteristics of partnership synergy

(adapted from: Lasker et al 2001)

The partnership:

- Thinks about its work in creative, holistic and practical ways
- Is driven by a common vision and framing of problems and solutions (‘theory of change’, Appendix 6)
- Develops realistic goals that are widely understood and supported
- Plans and carries out comprehensive interventions that connect multiple programs and services
- Understands and documents the impact of its actions
- Incorporates the perspectives and priorities of frontline providers and managers, and obtains their support

However, the authors also point out that “because collaboration requires relationships, procedures, and structures that are quite different from the ways many people and organisations have worked in the past, building effective partnerships is time consuming, resource intensive, and very difficult.” (Ibid:180)

Partnerships can operate with different degrees of synergy (Stibbe et al. 2018). They can function at a relatively simple level, where the roles of partners complement each other in an additive and simple way, such as the introduction of a technical solution into service delivery; they can combine or integrate different interventions into a comprehensive whole, such as the reproductive, maternal, neonatal continuum

of care; or they can strive to be transformative “tackling a challenge in an innovative and multi-faceted way that results in systemic change”. These latter partnerships “are often in a complex environment... where partners bring differing world views and perspectives to the issues. The problem and path... must be negotiated... [and] partners will need to iterate and adapt to collectively find a solution that is feasible and politically acceptable to all.” (Ibid:8) As a result, partnership building typically goes through phases: formation, implementation, maintenance; or in the language of team development, involves stages of: forming, storming, norming and performing (Tuckman, 2001). Partnership synergy is thus not a given, it has to be built.

The national partnership in Mphatlalatsane

We have cited this literature to recognise that the Mphatlalatsane partnership, as a system-wide, transformative and complex intervention, was bound to require “a lot of to-and-fro” (Participant), adaptation and negotiation in order to move forward. Not surprisingly, a key theme in the baseline interviews related to the experiences of the national partnership since its formation in 2018. These experiences provide lessons and have implications for the partnership moving forward, once they resume after the COVID-19 interruptions. These lessons are spelt out below:

- 1) finding common ground takes time:

While the plans for Mphatlalatsane were well formulated (at least on paper) and initial engagements with provinces conducted by late 2018, the first quality improvement activities at facility level began much later than anticipated, in September 2019. This was because, in the words of one interviewee:

“...it took us about 6 to 8 months trying to find a common ground. And for me, I think it was a good thing because it’s a lesson to say, previously coming from where we expose the people at the coalface to be dealing with the complexity that it took us 6 to 8 months to manage ...”

Although there was agreement on the PDSA cycles at the core methodology, how QI was to be introduced in the sites needed to be agreed between the key players:

“And so the idea of accompaniment which is a central piece of the ... method was something that needed to be socialized and explained and adopted finally and accepted. And so that took a lot of time.”

Common ground also needed to be found with senior leadership in provinces for activities to proceed. This particularly affected the start of the project in the Eastern Cape.

2) competing priorities impact on implementation:

Interviewees spoke of managing different and shifting priorities in the partnership and the impact of this on frontline players.

“We will have an engagement with mothers, and they will say we are actually not that interested in mothers, but then the government would say we are really interested in HIV. And we would go back to the donors, and they will say but we are not interested in HIV, at all.”

“As we are engaging with the facilities, we realise what the priorities of the facilities are, and also we are marrying these with the priorities of the donor, and the priorities of National.”

“At the end of the day you are being contracted to support specific area or catchment site, and the catchment site does not need your support the way you want [are mandated] to support them.”

3) competing methodologies and assumptions need to be resolved:

The key implementing partners – CHAI, IHI, ULT and UP-SAMRC - all have well-established methodologies and tools for engaging frontline players, honed in previous initiatives. In addition to these core approaches, the NDOH sought to amalgamate QI with enabling district level approaches in the form of the mortality reviews, monitoring and response forums and district health plans. While all partners saw themselves as improving quality, they varied in their emphases, reflecting some of the well-known debates and differences within the field of quality – such as between audit and measurement-oriented (often referred to as quality assurance) and process-oriented (often referred to improvement) approaches. These translated into different styles of engagement with facilities and models of implementation. The project designers sought to accommodate this in a “hybrid across the three dimensions of quality, which is quality improvement, quality control and then we also built in national quality forums, quality planning” .

With time, however, Mphatlalatsane settled on one main approach for the ‘QI intensive sites’, namely, the process-oriented collaborative learning and improvement approach based on PDSA cycles. This was to be accompanied by enabling district-level interventions, implemented in a ‘wedge’, the prototype of which would be scaled up to the remainder of each district and province. However, provision was made for ‘national learning collaboratives’, that would bring together the variety of different QI approaches across the country in dialogue.

The approach in the intensive sites proved challenging for some partners when they were required to engage frontline players, with whom they had developed longstanding relationships, in new ways:

“Our model..., we also call it a quality improvement model but then they said, no, they want the actual ... model. So that sort of obviously went into a spin, because number one, we do not know the ... we have heard of it but we are not PDSA experts. And we also have no idea how we are going to try to take [our model] and implement it using the PDSA model.”

In the Eastern Cape, there was some resistance to implementing new models of newborn health, when the previous model was regarded as effective and impactful.

There was also debate within the partnership on the assumptions regarding how change leading to impacts is achieved— between, for example, ‘train-the-trainer’ and direct ‘accompaniment approaches’; and between short-term, intensive, saturation models involving all district players (referred to as ‘campaign-style’ by one interviewee) and slower models of iterative learning and improvement, with gradually widening circles of implementation.

An approach targeting only a few facilities (‘the wedge’) will not be able to demonstrate proof of concept in reduced mortality:

“If one is aiming to reduce maternal mortality by fifty per cent it is not going to be possible to observe that, because we are not seeing anything like the numbers that are required at the individual clinics and district hospitals [in the wedge]. It would have to be done on a whole district basis... and fifty percent is way too ambitious.”

4) finding the appropriate model of partnership governance:

From the start, the need for the sound governance of Mphatlalatsane was identified as key, and decision-making and coordination mechanisms were outlined for all levels (see Appendix 7). National partnership governance structures include a National Steering Committee, a Project Management Committee (PMC) with an Executive Committee (ExCo), and a Technical Team. From interviews and meeting minutes we were able to source, the functioning of these structures has been uneven – for example, we were unable to locate minutes of the PMC for the second half of 2019 (resuming again in 2020). However, meetings of the ExCo may have substituted for this. The first Steering Committee Meeting, intended to meet every 6 months, was convened in November 2019.

This unevenness may reflect a broader set of issues related to the distribution of decision-making roles in the partnership. The channeling of funding through one partner (as the ‘secretariat’), but designed and steered by NDOH principals, is an inherently complex model of partnership management, with fuzzy boundaries between ‘strategic’ and ‘operational’ decision-making. The initial organograms depicted a hierarchical mode of governance with CHAI as the primary decision-maker and implementer, albeit with oversight by the NDOH, which in many ways overlooked the complexity of the partnership. Although not explicitly reported as such in interviews, it is our impression that with time, roles have had to be negotiated and adjusted. In the process senior NDOH players (and their two technical advisors) have assumed clear leadership of the project and its processes, including stakeholder management, convening regular ExCo meetings, shaping and adapting designs, directing the work of the quality advisors and visibly championing Mphatlalatsane. In the process, CHAI’s role has also become clearer, functioning in a more networked and enabling mode rather than sole decision-maker. Overall, decision-making and governance in Mphatlalatsane have shown signs of evolving towards more negotiated and collaborative approaches.

Looking ahead

The long inception phases of the national Mphatlalatsane partnership appears to have enabled some progress towards synergy along the criteria outlined in Box 1. The advent of COVID-19, and recent changes in the Department of Health – the departure of the overseeing DDG and one of the two technical advisors - and the appointment of a new DG, have necessitated the temporary suspension and a rethink of the Mphatlalatsane initiative. When Mphatlalatsane eventually resumes, in whatever form, it will be worth considering how best to draw on the lessons so far in managing the partnership going forward. This is especially important in the face of the multiple challenges of vertical coordination and fragmentation across levels of government, described in other parts of this report.

Table 3 outlines the factors that influence partnership synergy proposed by Lasker and others. In a partnership such as Mphatlalatsane, all stakeholders have resources – financial, convening, expertise, networks – which are key to realizing the collaborative advantage. The more diverse the resources the more potential for added value. However, resources also imply power, and therefore capacity to cooperate with or thwart efforts. The effective mobilization of collective resources into a truly transformative partnership rests on trust, mutual respect and legitimacy; it cannot be engineered or forced, only nurtured and negotiated through deliberate and *deliberative* processes. Key will be creating regular opportunities for reflection and honest dialogue between players.

Table 3: Factors influencing partnership synergy*

Factor	Elements
Resources	Material resources Skills and expertise Information Networks Convening power
Partner characteristics	Heterogeneity Level of involvement
Relationships amongst partners	Trust Respect Conflict Power differentials
Partnerships characteristics	Leadership Admin and management Governance
Partnership processes	Discovery Deliberation Definition Determination
External environment	Health system Public sector/governmental

* Adapted from Lasker et al (2001) and Emerson (2018)

6. Conclusions and Recommendations

Mphatlalatsane has many promising features that could set it on a path to become 'the bright morning star that will herald a new dawn' for sexual, reproductive, maternal, neonatal, and child health services in South Africa. It is transformative in its goals and has adopted an integrated and inclusive design, seeking to leverage homegrown strengths and experiences in a holistic, systems approach. In a short period of implementation, the QI methodologies have shown their potential, unlocking teamwork, health worker agency and meaningful action at facility level. The complex and multi-stakeholder partnership offers many lessons for thinking about how to mobilise and coordinate existing initiatives in a synergistic and complementary fashion. Experiences of implementation so far have highlighted the crucial role of leadership, coordination and quality 'governance' at the district ('meso') and area levels, and the importance of provincial buy-in and stewardship. The meso-level of district and sub-district is the enabling environment for the Mphatlalatsane initiative. Ensuring buy-in and involvement of key actors, developing meso-level leadership structures, and systems; and strengthening district level governance are required to support the Mphatlalatsane improvement processes.

Recommendations going forward are as follows:

Implementation of quality improvement

1. *Collate lessons learned and good practises*

The advisors are keeping a comprehensive record of the QI teams and activities, with many examples of lessons learned and good practises. However, these are in separate documents and kept for each province. We recommend that these be collated into one report, distilling the key learnings and successes to guide the next implementation phases.

2. *Tailored support to teams*

Linked to this is the need for tailored interventions to support teams that are not performing optimally, and to sustain well-performing teams.

3. *Testing diffusion*

There are five locked change ideas, and detailed descriptions of two of those were found. These adopted change ideas should be considered as offering the first opportunity to test the diffusion of change ideas that work.

4. *Identifying and addressing contextual barriers*

The PMC could consider building a session into the next QI team training or workshop, that will allow teams to discuss the contextual factors that have experienced to date, that strengthen or challenge their performance, such as having day - and - night shift staff in one team, or who to deal with staff attrition. The Objective 4 team offers to assist with facilitation suggestions in this regard.

Enabling district environment for quality improvement

1. *Quality forums*

Establish forums focused on quality at district and area level, that articulate with core decision-making structures and processes such as District Health Management Teams and District Health Plans.

2. *Focus on key actors*

Ensure the buy-in and involvement of key actors (senior and middle managers, the range of clinicians, and information and public health functions) in decision-making on quality.

3. *Promote integration*

Integrate existing quality improvement processes and forums and mortality surveillance and response.

4. *Establish an enabling climate*
Seek to shift cultures of engagement at the frontline from punitive to enabling, with support and supervisory players going from “being gatekeepers to being gateways”
5. *Strengthen coordination*
Strengthen mechanisms of referral and coordination across levels (what happens in the facilities needs to link to what happens in the sub-district, district and area levels).
6. *Promote distributed leadership*
Invest in strengthening distributed leadership for quality at facility, sub-district and district levels and provincial stewardship of district level processes.

Partnership synergy

1. *Partnership synergy*
Create regular opportunities of reflection on partnership synergy in Mphatlalatsane, with skilled facilitation
2. *Joint strategy development*
 - Create opportunities for joint strategy development and planning, as has happened with COVID-19, for other components of Mphatlalatsane.
 - Convene inclusive national learning collaboratives on scaling up, methodologies for building enabling environments for quality at district, area and provincial levels, and leadership development.

References

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Appendices

Appendix 1: Evaluation methodology

Interviews

- Of the 18 analysed interviews, four were with \geq two participants interviewed together, and 14 were individual interviews
- Six of the interviews were with quality improvement advisors

Table 4: Participants

Institution	Participants
National Department of Health	6
Clinton Health Access Initiative	5
University of Limpopo - Limpopo Initiative for Newborn Care	1
South African Medical Research Council - University of Pretoria, Maternal & Infant Care Unit	2
Institute for Healthcare Improvement	2
Total	16

Interview questions

We explored the following topics, with examples of the questions, in a lesser and greater extent, depending on the participant:

Intervention/ processes/ actors/ outcomes

- What is *Mphatlalatsane*? What do you see as the overall purpose of *Mphatlalatsane*?
- What has been your role in the implementation of *Mphatlalatsane*?
- What have been the key achievements of *Mphatlalatsane* so far?

Governance structures /processes/ teamwork

- Can you please describe the existing structures for decision making related to MNH in the three intervention areas?

Leadership

- In your opinion who are the official/ unofficial champions driving the implementation process of *Mphatlalatsane* at sub-district/ district / regional hospital level?

Cooperation

- How would you describe participation and buy-in to *Mphatlalatsane* in the three areas? Amongst partners?

Knowledge & Information

- Can you please tell me about *Mphatlalatsane* data management and data use at sub-district, district, regional level?

Resource flows

- Are there mechanisms to ensure the provision of resources and support?

Coordinated actions

- Are all the actors at sub-district / district/ hospital level part of the implementation process of *Mphatlalatsane*?

Sustainability

- What is your view on the sustainability of *Mphatlalatsane*? Will it survive once the external facilitation is no longer there?

Programme documentation

We reviewed minutes of meetings, reports, presentations, and a comprehensive set of QI advisor documents, to establish timelines and technical details of events.

Interview analysis

- All the interviews were audio-recorded, and these recordings were verbatim transcribed. Thereafter we verified the accuracy of the transcriptions by comparing it against the audio recordings.
- The transcriptions were loaded onto a qualitative analysis programme, Atlas.ti, version 8, and thematically analysed.

Appendix 2: Steering Committee planning - Nov 2019

(Source: Steering Committee presentation, November 2019)

Phase	Timeline	Activity
Phase 0	1 Apr 2017 - 30 Nov 2018	Introduction of QI methodologies
Pre-Implementation Phase	1 Dec 2018 - 30 Sep 2019	Establish consortia, scoping of facilities, design of QI approach and recruitment
Phase 1: Implementation	1 Oct 2019 - 31 Dec 2020	Four districts covering three catchment areas (Sara Baartman, Nelson Mandela Bay Metropolitan, Mopani, Ehlanzeni Districts)
Phase 2: Scale-up	1 July 2020 - 30 Sep 2022	Expansion from the catchment areas into 13 districts (overlap with Phase 1)
Phase 3: Gov Handover National Scale-up	1 Oct 2022 - 31 Dec 2022	Government handover of the prototype, optimisation case for National Scale-up

Appendix 3: QI team composition

Province / facility type	Team members
Regional hospitals	
E Cape: Regional hospital Staff trained: 8	<u>Attended L&F 1</u> Dr O&G; operational managers from Postnatal, Women's clinic, Paediatrics, Labour ward, High Risk, theatre Professional nurses <u>Team leader</u> Operational manager of the maternity ward
Limpopo: Regional hospital - Team 1 Staff trained: 4 of which 1 has left	<u>L&F 1</u> Obstetrician (left) + unit manager + sister from labour and labour of ward + information officer <u>Team lead</u> Was obstetrician, now unit manager <u>Core team</u> Unit manager + midwife
Limpopo Regional hospital - Team 2 Staff trained: 1	<u>L&F 1</u> Sister who manages the neonatal unit <u>Team lead</u> Same sister <u>Core team</u> Professional nurses in unit + paediatrician
Mpumalanga: Regional hospital Staff trained: 6	<u>L&F 1</u> Nursing service manager, maternity ward supervisor, operational managers from PNC, ANC, labour <u>L&F 2</u> Same 5 staff + doctor from the maternity ward <u>Team lead</u> Nursing service manager <u>Core team</u> Maternity ward supervisor, operational managers from PNC, ANC, labour
District hospitals	
E Cape: District hospital 1 Staff trained: 5	<u>Attended L&F 1</u> Dr O&G; operational managers from Postnatal, Women's clinic, Pediatrics, Labour ward, High Risk Professional nurses Quality assurance staff <u>Team leader</u> Operational manager of the maternity ward
E Cape: District hospital 2 Staff trained: 7	<u>Attended L&F 1</u> Dr O&G; operational managers from Postnatal, Women's clinic, Pediatrics, Labour ward, High Risk

Province / facility type	Team members
	Professional nurses Quality assurance staff
Limpopo: District hospital 1 Staff trained: 3	<u>L&F 1</u> 2 nurses + hospital clinical manager <u>Team lead</u> One of the nurses <u>Core team</u> 2 nurses + hospital clinical manager (in the beginning)
Limpopo: District hospital 2 Staff trained: 2 of which 1 has left	<u>L&F 1</u> Obstetrician (left) + Area manager <u>Team lead</u> Area manager <u>Core team</u> Unit managers
Mpumalanga: District hospital 1 Staff trained: 5	<u>L&F 1 and 2</u> Ward doctor, clinical manager, operational managers of the labour ward and PNC respectively <u>Team lead</u> PNC operational manager <u>Core team</u> Staff who attended the training
Mpumalanga: District hospital 2 Staff trained: L&F 1: 4 L&F 2: 2, of which only 1 attended L&F 1	<u>L&F 1</u> 2 intern doctors, CEO, operational manager <u>L&F 2</u> Nursing services manager, operational manager <u>Team lead</u> Was CEO, now nursing services manager <u>Core team</u> None
CHCs	
E Cape: CHC 1 Staff trained: 2	Attended <u>L&F 1</u> Operational manager-maternity Professional nurses <u>Team leader</u> OM
E Cape: CHC 2 Staff trained: 2	Attended <u>L&F 1</u> Operational manager-maternity Professional nurses <u>Team leader</u> OM
Limpopo CHC 1 Staff trained: 1	<u>L&F 1</u> 2 nd in charge of CHC <u>Team lead</u> 2 nd in charge of CHC <u>Core team</u>

Province / facility type	Team members
	2 nd in charge + operational manager
Limpopo CHC 2 Staff trained: 1	<u>L&F 1</u> Acting operational manager <u>Team lead</u> Acting operational manager <u>Core team</u> None
Mpumalanga: CHC 1 Staff trained: 2	<u>L&F 1 and 2</u> Operational manager + maternity supervisor <u>Team lead</u> Operational manager <u>Core team</u> Staff who attended the training
Mpumalanga: CHC 2 Staff trained: 2	<u>Attended L&F 1 and 2</u> Operational manager + supervisor from maternity <u>Team lead</u> Operational manager <u>Core team</u> Staff who attended the training
PHC clinics	
E Cape: PHC clinic 1 Staff trained: 1	<u>Attended L&F 1</u> Operational manager-maternity Professional nurses <u>Team leader</u> OM
E Cape: PHC clinic 2 Staff trained: 1	<u>Attended L&F 1</u> Operational manager-maternity Professional nurses <u>Team leader</u> OM
Limpopo PHC clinic 1 Staff trained: 2	<u>Attended L& F 1</u> Operational manager + midwife <u>Team lead</u> Operational manager <u>Core team</u> None
Limpopo PHC clinic 2 Staff trained: 1	<u>Attended L&F 1</u> Operational manager <u>Team leader</u> Operational manager <u>Core team</u> None

Province / facility type	Team members
Mpumalanga: PHC clinic 1 Staff trained: 2	<u>Attended L&F1 and 2</u> Operational manager + ANC nurse <u>Team lead</u> Operational manager <u>Core team</u> Staff who attended the training
Mpumalanga: PHC clinic 2 Staff trained: 2, of which 1 attended both trainings	<u>L&F 1</u> Operational manager <u>L&F 2</u> Operational manager + another nurse <u>Team lead</u> Operational manager <u>Core team</u> Staff who attended the training

Appendix 4: Problems addressed through the change ideas

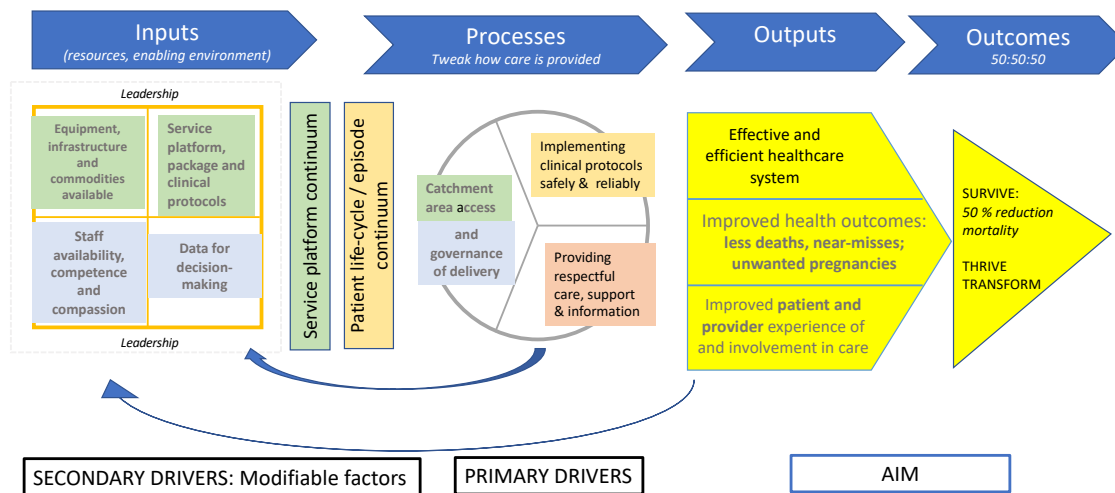
Province	Problem	Locked change idea
Eastern Cape	Neonatal infections; unsuppressed viral load of women in labour, intrapartum asphyxia, x3 ANC booking, immunisation, monitor labour by partogram, cervical screening	
Limpopo	Monitoring high-risk patients, neonatal sepsis, x2 Hypertension, x2 Anaemia, Post-partum Hemorrhage (PPH), ANC booking	<ul style="list-style-type: none"> • PPH (detailed description) • Anaemia (detailed description)
Mpumalanga	Triaging of walk-in patients, taking vital signs high-risk clinic, doctors' response time, x4 Hypertension, ANC booking	<ul style="list-style-type: none"> • Triaging of walk-in patients (no detailed description found) • Taking vital signs in high-risk clinic (no detailed description found) • Managing hypertension in pregnancy (no detailed description found)
All	Monitoring high-risk patients, x2 neonatal sepsis, x6 Hypertension, x2 Anaemia, PPH, x5 ANC booking, triaging walk-ins, vital signs in high-risk clinic, doctors' response time, unsuppressed viral load of women in labour, intrapartum asphyxia, immunisation, monitor labour by partogram, cervical screening	

Appendix 5: Teams per facility type

Facility type	Staff trained	Lead + core team	Change ideas tested	Change ideas locked	PDSAs conducted
Regional hospitals	19	8	3	1	8
District hospitals	27	9	5	2	14
CHCs	10	6	6	1	14
PHC clinics	9	4	4	1	14
Total	65	27	18	5	50

Appendix 6: Diagrammes representing Mphatlalatsane

Theory of change related to driver diagram
Developing a prototype for scaling



Appendix 7: Governance structures and roles in Mphatlalatsane
 (Source: Steering Committee presentation, November 2019)

Governance and roles	Structure	Composition	Status & Functioning
	National	Steering Committee	DDG, NDOH CDs and Ds PMC members
Project Management Committee		NDOH: CD and managers SRMNH Consortium partners Technical team	Meets monthly (plus EXCO – meets weekly)
Provincial	Technical team	Technical advisors; QI coaches IHI; partners; CHAI programme managers, staff Specialist advice	Meets weekly / fortnightly
	Designated focal point(s)	Nominated by HOD – generally MCWH manager; may have a team	Nominated for each province; ad hoc meetings
District	DEM, DMT MRF	(existing) MRF may need to be constituted	Existing or routine processes; “Driver, Navigator, Expert”
	District QI team	Nominated by DEM from among: MCH, PHC, Hospitals, M&E, EMS DCSTs	To discuss
Facilities	Facility QI teams	Nominated by DEM / CEO from interested and capable staff <ul style="list-style-type: none"> • Hospitals: CEO, Clinical manager, Nursing manager, medical officers, Operational managers, professional staff • PHC: Operational managers, professional staff 	To discuss