Title: Forms and functioning of local accountability mechanisms for maternal, newborn and child health: A case study of Gert Sibande District, South Africa

Interview Guide – Accountability – Review meetings	
A. ACCOUNTABILITY	
Introduction	▪ Can you tell me about your current position/role in the (district) health system? *Probes: For how long have you been in that position?*
Accountability definition	▪ Could you describe to me what accountability means to you? *Probes: What does it make you think of accountability? What does it mean 'being accountable to?'* *How* would *you relate your definition of accountability to MNCH?*
Challenges	Can you share some of the challenges that you face while performing your tasks as a health professional (or mid-level manager) within your district? *Probes: Health Systems challenges/Challenges related to clients & Community/Personal challenges*
- **Line/forms,** - **Guidelines** - **Enablers** - **Barriers** - **Complaints**	▪ In your working area, to whom do you think you are accountable and why? *Probes:* - *Tell me about the reporting structure with regard to your role in the health systems?* - *To/from whom do you report/receive order/provide information/provide technical support/training/supervision* ▪ Are there any accountability guidelines/framework from the DOH that you are using? [*If yes, please describe*] ▪ What are the enabling and limitation factors of the current accountability processes? ▪ Does the District/Sub-district/Hospital/PHC Management Team have a mechanism in place to handle clients' complaints? How does it work? ▪ Can you describe how voice of the vulnerable (and of the community) is being represented within the Health System/clinic committee/ Hospital Board?
Team	▪ What's your experience/perception regarding teamwork and accountability for MNCH? *Probes:* - *Can you tell me about the team members/actors involved in the accountability processes for MNCH (Probe: Level)* - *How will you characterise the attitude and commitment of teamwork regarding MNCH* - *What's your beliefs regarding MNCH and the value of accountability*

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	▪ How do you perceive the performance of the team with regard to MNCH? *Probes:* - *Do you share the same goals? How do you set up these goals [decision making process]* - *Can you comment on the level of participation and collaboration work environment?* - *How do you monitor group accountability for MNCH*
Adverse events	▪ How do you perceive a case of adverse event (e.g. maternal or child death) as a team and/or individual? *Probes:* - *Please elaborate* - *How is the climate within your team when it comes to adverse event?* ▪ When you have to justify/explain/answer on an adverse event, how do you perceive the role of team members (peers)?
	▪ How would you characterise the role of the investigation team regarding an adverse event? [Team: DCST, Province, or other] *Probes:* - *Does the investigation result in sanctions and/or learning? [Please elaborate]* - *If learning, how often does the training happen? By Whom?* - *How do you identify areas for improvement [beside when an adverse event occurs]?*
Improvement	▪ If you are given all the means to improve accountability, how would you go for it and what would you prioritize? ▪ In your view, what can be done regarding accountability to improve MNCH outcomes?
B. DEATH REVIEW MEETINGS	
Actors/Who?	▪ Can you please describe who attends the meeting? *Probe:* - *Who are the actors from district office, hospital, PHC? Doctors vs Nurses and/or others?*
Meeting	▪ How would you describe the structure of the meeting? *Probe:* - *Who chairs, the agenda, how long, frequency, participation/engagement?* - *What are the drivers/facilitators/barriers to this [name] meeting and related processes?*

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	- *What, from your perspective, is the difference between MRU, PPIP/CHIP and other review meetings [name]?*
Decision process	▪ How would you describe the decision process during the [name] meeting? *Probes:* - *What happens? What do you discuss? How do the discussions of the meetings lead to decision or [positive] results (for actions)?*
Dealing with adverse events (deaths)	▪ How do you deal with adverse events e.g. maternal or child death? *Probes:* - *Can you describe the situation of maternal, neonatal and child death (mortality) in this area since you started in your position?* - *Can you share from your experience an example of an adverse event (maternal or child death) and how was the process of enquiry?* - *How do you see the problem of death in terms of accountability?* - *Do you have/know any policy/guideline for dealing with death event?*
	▪ How do you see the role of the [name] meeting as a structure that is facilitating/supporting accountability processes for MNCH? *Probes:*
	▪ How would you describe the role of communities in addressing MNCH problems? ▪ How would you describe the role and level of engagement of PHC facilities? *Probes:* - *Referral processes* - *Role of Provincial and National department of Health*
Actions/Outcomes	▪ What from your perspective are some of the key actions and outcomes on MNCH as a result of the [name] meeting? *Probes:* - *How sustainable are these actions? [Please elaborate]*
Conclusion	- Remind Ethics and right to withdraw from the study at any time - Thanking the informant

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