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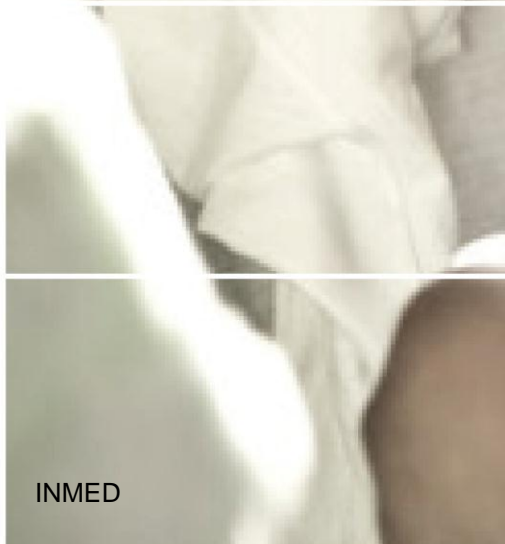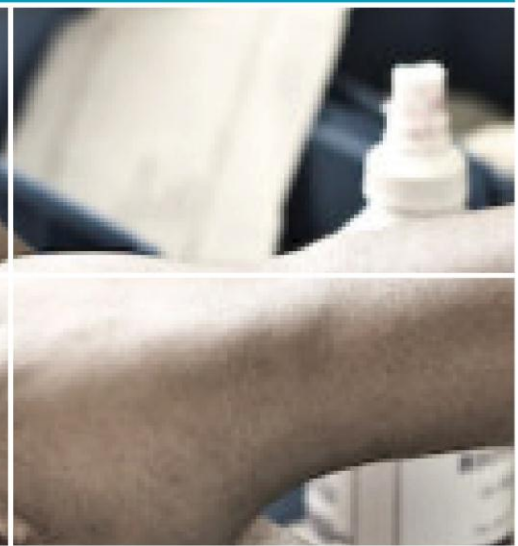SPECIALISTS IN DEVELOPING COMMUNITIES

Mid-Term Evaluation of the SARRAH programme

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INMED

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ANNEXES

LIST OF ACRONYMS

AGSA	Auditor General of South Africa
A-Plan	PMTCT Accelerated Plan
APP	Annual Performance Plan
ART	Antiretroviral Therapy
CBO	Community Based Organisation
CD4	Cluster of Differentiation 4
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CG	Conditional Grants
CSO	Civil Society Organisation
CSP	Comprehensive Service Plan
DA	Democratic Alliance
DBSA	Development Bank of Southern Africa
DDG	Deputy Director General
DG	Director General
DFID	Department for International Development (UK)
DHIS	District Health Information System
DHM	District Health Manager
DORA	Division of Revenue Act
DPSA	Department of Public Service and Administration
EDMS	Electronic Document Management System
FDA	Food and Drug Administration
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HISP	Health Information Systems Programme
HIV	Human Immunodeficiency Virus
HLSP	HLSP is a trading name of Mott MacDonald Ltd.
HR	Human Resources
HSRC	Human Sciences Research Council
ICT	Information & Communication Technology
KPA	Key Performance Areas
KZN	KwaZulu-Natal
M&E	Monitoring and Evaluation
M&OD	Management and Organisational Development
MCC	Medicines Control Council
MCWH	Maternal Child and Women's Health
MDG	Millennium Development Goal
MFMA	Municipal Financial Management Act
MMC	Medical Male Circumcision
MRA	Medical Research Affairs
MTCT	Mother-to-Child Transmission

MTE	Mid-Term Evaluation
MTEF	Medium Term Expenditure Framework
M&E	Monitoring & Evaluation
M&OD	Management & Organisational Development
NCE	New Chemical Entities
NDOH	National Department of Health (South Africa)
NGO	Non-Governmental Organisation
NHC	National Health Council
NHI	National Health Insurance
NHIC	National Health Information Centre (now known as NHIRD)
NHIRD	National Health Information Repository and Data Warehouse
NSDA	Negotiated Service Delivery Agreement
NSP	National Strategic Plan
OSD	Occupation Specific Dispensation
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
POC	Parliamentary Oversight Committee
QA	Quality Assurance
SAHPRA	South African Health Products Regulatory Authority
SANAC	South African National AIDS Council
SARRAH	Strengthening South Africa's Revitalised Response to HIV and Health
SCOPA	Standing Committee on Public Accounts
STI	Sexually Transmitted Infection
TA	Technical Assistance
TAC	Treatment Action Campaign
TB	Tuberculosis
TOC	Theory of Change
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV and AIDS
VFM	Value for Money

EXECUTIVE SUMMARY

Introduction

SARRAH is a five-year DFID funded programme, delivered by HLSP, and which provides technical advice, funding and support to strategic national initiatives that aim to strengthen South Africa's response to HIV and health. SARRAH's main focus is to support the National Department of Health (NDOH) in efforts to strengthen and coordinate the national response to HIV and AIDS and make it more accountable to the South African public, and strengthen the health systems overall and their ability to provide quality healthcare to all. It is designed to support the achievement of the targets set out in the government's Negotiated Service Delivery Agreement (NSDA) for health.

SARRAH is based on partnerships with leading national players in HIV and health. Key partners include NDOH and the South African National AIDS Council (SANAC). The programme also supports civil society through the Treatment Action Campaign (TAC) and the work of the Joint Committee on HIV and the Parliamentary Portfolio Committee on Health.

SARRAH commenced in January 2010 and is expected to finish delivering its activities in December 2014. This mid-term evaluation covers the period from January 2010 to December 2012. The total value of SARRAH when it commenced in 2010 was £13,500,000. SARRAH was allocated a further £6,852,217 in December 2011, bringing the total programme value at the end of December 2012 to £20,352,217.

Evaluation approach and methods

The detailed approach and methodology for the evaluation of SARRAH are presented in Section 1.4 and 1.5. SARRAH is structured around a series of initiatives or "work-streams" that are different in scope, scale, timing and objectives. The SARRAH Mid-Term Evaluation (MTE) recognised this diversity and considered the work-streams individually in the first instance, before making an attempt to aggregate and synthesise findings at the programme level. Evidence was collected for each work-stream by different evaluation leads and using different tools and techniques drawing on in a wide array of sources of data.

To enable the evaluation team to conduct this assessment rigorously, the following approach was adopted:

1. Individual evaluations of work-streams, or groups of work-streams were conducted using appropriate methodologies, and exploiting potential synergies and complementarities between initiatives;

2. A quality assurance of the evidence collected was undertaken centrally by Coffey to ensure that evidence was of a sufficient standard to assess the overall performance of SARRAH; and

3. A synthesis of the various individual work-stream reports, complemented by a qualitative analysis of circa one hundred interview notes using Atlas.ti, was conducted in order to inform conclusions and answer the key evaluation questions.

The evaluation team used the OECD-DAC criteria[1] of Relevance, Effectiveness, Efficiency, Impact and Sustainability as the core evaluation framework of the MTE. The inception phase shed light on the nature of the SARRAH programme and made it clear to the evaluation team that the realisation of tangible and sustainable impacts on the South African health system would only be measurable towards the end of the programme in 2014-2015. Therefore the Impact criterion was not assessed to the same extent as the other DAC criteria, but will be the core focus of the final evaluation of SARRAH.

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[1] OECD (1991), *DAC Principles for the Evaluation of Assistance*

Moreover, a numerical scoring tool was developed by the evaluation team as an analytical tool to support the findings emerging from the qualitative research and to enable comparison between different work-streams against the key performance criteria. This numerical tool was used as a supporting mechanism to the synthesis of individual work-stream evaluation findings, not as its primary analytical framework, which involved a more qualitative assessment of SARRAH's performance against the evaluation criteria. For each work-stream, a score of 1 to 4 was awarded against each evaluation criterion.

Key findings and conclusions

Relevance

The programme's relevance is probably **the most consistently praised aspect of SARRAH's performance. The average weighted relevance score of SARRAH work-streams is 3.7 on a scale of 1 to 4**. All work-streams have scored 3 or 4 against the relevance criterion.

All of the SARRAH supported initiatives were jointly selected by NDOH and DFID to address high priority areas requiring immediate attention and support. These initiatives all followed a sound process of evidence gathering and analysis, and/or the adaptation of international best practice to the South African context. Furthermore, the vast majority all of the stakeholders interviewed during the mid-term evaluation acknowledged that the initiatives addressed pressing needs identified beyond reasonable doubt. Moreover, all SARRAH work-streams are aligned with one or more of the priorities identified in the Ten Point Plan (see **Table 1**) and the NSDA.

Efficiency

The efficiency with which these various technical assistance activities were delivered by the SARRAH implementing partners and associated sub-contractors was generally perceived to be high. **The average weighted efficiency score of SARRAH work-streams is 2.8**. In total, 9 out of 14 work-streams, representing 72% of SARRAH expenditure evaluated in the MTE, have scored 3 or 4 against the efficiency criterion.

The efficiency of SARRAH is most apparent in the speed with which consultants were contracted through the SARRAH facility to carry out the work, and to the capacity of SARRAH to identify and quickly deploy some of the leading South African and international experts in their respective technical fields. The competence, professional ethos and timeliness of the HLSP technical leads, as well as that of most of the consultants contracted through SARRAH since 2010 generally left the impression among NDOH technical leads and other associated stakeholders that the programme was capable of quickly allocating expert resources to solve short terms problems and complete discrete technical tasks to a high standard of quality.

The generally positive view of SARRAH's efficiency also stems from the perception that most of the work could not have been undertaken directly by NDOH within similarly tight timeframes and to a higher standard of quality, and that other, more traditional procurement routes would have led to the same outputs being delivered much later: **time-efficiency is therefore a key feature** of SARRAH's perceived efficiency.

Effectiveness

SARRAH's **effectiveness in strengthening the South African health systems** and making the national response to HIV & AIDS better coordinated and more accountable **has been variable to date**. The average weighted effectiveness and impact scores of SARRAH work-streams are 2.5 and 2.1 respectively. In total, 7 out of 14 work-streams, representing 57%% of SARRAH expenditure evaluated in the MTE, have scored at least 3 against the effectiveness criterion. For impact, the respective figures are 3 out of 14, and 23%. The relatively low scores achieved are partly due to the proportional weighting system introduced to reflect the relative size of different work-streams in terms

of funds spent, and results from the relatively poor, or short-lived, results on some of the larger work-streams including SAHPRA and SANAC.

SARRAH's perceived contribution to key achievements was very clearly identifiable in some work-streams (e.g. PMTCT[2]) but less apparent in others (e.g. SANAC[3]), while in some cases the claims that SARRAH had made a critical contribution to key achievements were impossible to verify and the evidence base weak (e.g. TAC[4]). However, we also find that the majority of SARRAH-supported initiatives will take a longer period to realise their full effect than the MTE timeframe of 2010 to 2012 allowed for, and that the final evaluation will be able to measure with greater certainty how effective SARRAH was in strengthening different parts of the health system.

Sustainability

SARRAH's sustainability will be investigated in more detail during the final evaluation, although the preliminary assessment undertaken during the MTE suggests a mixed picture. **The average weighted sustainability score of SARRAH work-streams is 2.3.** In total, 5 out of 14 work-streams, representing 25% of SARRAH expenditure evaluated in the MTE, have scored at least 3 against the sustainability criterion.

- **Sustainability of the SARRAH "facility"**.

Little could be said at the mid-term stage with regards to the potential continuation of SARRAH initiatives in one form or another beyond 2015 when DFID (and EU) funding to the programme will come to an end. Interviews conducted suggest that the flexibility and versatility provided by SARRAH's resources is so valued by NDOH that there could be an appetite to maintain it. However, it is not clear how it would be funded (whether by other donors or by NDOH itself, or a combination of both) and the logistical and legal aspects of an NDOH-owned facility have not been fleshed out in any detail at this stage.

- **Sustainability of SARRAH supported initiatives**.

As discussed previously, those work-streams which have relied to a large extent on SARRAH's financial or technical assistance have generally scored relatively poorly on sustainability. This is particularly relevant to the **TAC** work-stream[5]. TAC had historically struggled to obtain funding for its core functions (finance, management and planning, human resource management, monitoring & evaluation, etc.) until DFID began core funding through SARRAH. It is not clear at this stage who will step in to fill this gap post-2015 and the risk that TAC will be unable to maintain the higher standards of internal governance, management and M&E without SARRAH support cannot be dismissed.

The political economy[6] has also been taken into account in our assessment of sustainability. For instance, the **NHI** work-stream[7] was awarded a high sustainability score given the generally supportive environment surrounding this ambitious reform, while the **SAHPRA** work-stream[8] was rated lower given concerns about the authorities' ability to staff this new regulatory entity and empower it to fulfil its regulatory mandate effectively.

Lessons learnt

The lessons learnt from the MTE are presented in more detail in Section 5.

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[2] See section 2.2.9 and Annex 13
[3] See section 2.2.1 and Annex 16
[4] See section 2.2.1 and Annex 19
[5] See section 2.2.1 and Annex 19
[6] Throughout this report, political economy refers to the formal and informal structures and the underlying interests, incentives and institutions that promote or constrain SARRAH's capacity to generate or precipitate change.
[7] See section 2.2.7 and Annex 11
[8] See section 2.2.11 and Annex 15

- **Lesson 1: As for any large health delivery and health governance programme, political economy factors must be assiduously considered and accounted for in the design of initiatives.** The political economy surrounding the various strands of work SARRAH is involved in or supporting seems to have had a significant impact on the programme's ability to reach its intended outcomes. For instance, the relative lack of progress achieved in the design and establishment of SAHPRA resulted partly from an unfavourable political economy surrounding the initiative, characterised by a slow and repeatedly delayed legislative process and inadequate buy-in from experts and industry representatives.

- **Lesson 2: Ensuring that the purpose and mandate of SARRAH are clear to stakeholders will ensure that resources are used to greater effect.** Clarity around the mandate of SARRAH helps set expectations among beneficiary stakeholders and helps it focus its finite resources and activities to greater effect. While SARRAH's flexibility is generally praised and its capacity to become the "ultimate gap-filler" appreciated, limiting its mandate to such ad-hoc support is insufficient to allow SARRAH to create a dynamic of positive change in the larger initiatives.

- **Lesson 3: The size of SARRAH support must be balanced to achieve outcomes while also promoting sustainability.** The size and significance of the SARRAH support relative to the initiative seems to have increased its capacity to contribute more effectively to the intended outcomes. The more control over what the content of the final output will be and over the timings associated with their delivery, the more effective SARRAH's contribution.

- **Lesson 4: SARRAH's flexible approach to providing technical support to strategically important initiatives compensated for the bureaucratic challenges of procuring technical assistance faced by government institutions.** SARRAH is characterised by a very flexible funding mechanism and offers a facility through which relatively small, discrete but strategically important initiatives can be quickly commissioned and implemented. This flexibility was praised by virtually all of the stakeholders interviewed who were able to clearly identify SARRAH and discuss its contribution to their portfolio of initiatives.

- **Lesson 5: Flexible mechanisms for technical assistance are likely to be heterogeneous by nature and therefore will be difficult to evaluate in a rigorous manner.** SARRAH's flexibility makes it more difficult to evaluate than a more conventional technical assistance programme normally would, which is not to be underestimated in a context of increasingly scarce resources and a global push for rigorously generated results on the outcomes and impacts of international development programmes.

- **Lesson 6: Close collaboration between SARRAH and the NDOH improved the responsiveness of SARRAH.** The perception of SARRAH as being to some extent embedded in NDOH is another key characteristic of this programme.

Recommendations

Below is a summary of the overarching recommendations, which are presented in more detail in Section 6:

- **Maintain support to initiatives** which have already absorbed a significant amount of SARRAH resources, provided that the political economy environment surrounding these initiatives is conducive to a positive contribution from SARRAH.

- **Enforce a much higher level of oversight from DFID and HLSP** of activities commissioned and funded under SARRAH.

- **Use SARRAH-funded M&E initiatives to monitor progress and evaluate outcomes** of work-streams which have not yet produced measurable impacts but which might do in the future.

- **Ensure that data collection for the final evaluation of SARRAH takes into account the lessons learned** from the mid-term evaluation in order to fully capture its effectiveness and impacts.

- **Effectively monitor and manage emerging needs and demand** for SARRAH to address gaps through its current work-streams.

1 INTRODUCTION

In April 2011, the UK Department for International Development (DFID) commissioned Coffey International Development (Coffey) and the Human Sciences Research Council (HSRC) to undertake an "Impact Assessment of the Strengthening South Africa's Revitalised Response to HIV and Health (SARRAH) programme". The Terms of Reference (TOR) for this assignment outlined four key objectives (the full TOR is available in Annex 3):

1. Briefly summarise the past 20 year history behind the initiatives supported under SARRAH and describe how DFID support to health & HIV has evolved[9];

2. Clarify the degree to which the SARRAH programme is achieving its objectives and is impacting on health and HIV in South Africa, as part of a government led, joint assessment of the Negotiated Service Delivery Agreement;

3. Use impact assessment methodologies to assess how well specific initiatives supported by the SARRAH programme are being successfully implemented, and assess the 'value for money' of the DFID contribution; and

4. Use the knowledge gained from the work to inform annual reviews of progress in collaboration with principal partners.

Following discussions with DFID and inception interviews conducted with SARRAH delivery partners, the evaluation team concluded that experimental and quasi-experimental evaluation designs would not be appropriate due to the very diffuse and indirect nature of the various types of interventions delivered under each work-stream. It would not be possible to rigorously quantify SARRAH's additional impact over what would have happened had the intervention not taken place (the "counterfactual"). As a result, the decision was made with approval from DFID to change the title of the assignment to the "*Evaluation of SARRAH*" instead of the "*Impact Assessment of SARRAH*".

Consequently, the 2012 Impact Assessment report and the 2014 Impact Assessment report initially referred to in the Terms of Reference were renamed "Mid-Term Evaluation report" (covering the period 2010 to 2012) and "Final Evaluation report" (covering the full term of SARRAH i.e. 2010 to 2014). However, the core research objectives listed above have not changed and therefore still apply to the evaluation.

1.1 Purpose of the Mid-Term Evaluation (MTE)

The inception phase shed light on the nature of the SARRAH programme and made it clear to the evaluation team that the realisation of tangible and sustainable impacts on the South African health system would only be measurable towards the end of the programme in 2014-2015 (see Evaluation Strategy for a more detailed assessment of the programme's "evaluability"). Therefore, the MTE was a mid-term assessment of points 2 and 3 in the TOR (see above) and assessed the extent to which SARRAH has achieved its objectives work-stream by work-stream, as well as overall. The objectives of the MTE are summarised below.

- The MTE's focus was on a **process evaluation** of SARRAH, combined with an attempt to measure **emerging outcomes and impacts** wherever possible. It aimed to contribute to the programme's **accountability** and to provide a range of recommendations for the remainder of its lifetime. The purpose of the MTE was therefore both **formative**, i.e. designed to identify

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[9] Seager, J. (2012), '*Review of DFID's engagement with the South African health sector between 1993 and 2010*', Report prepared for Department for International Development (DFID) South Africa as part of the Impact Assessment on Strengthening South Africa's Revitalised Response to AIDS and Health (SARRAH).

potential deficiencies in the delivery process and enable the implementing organisation to improve the programme where possible, and **summative**, i.e. designed to make an evidence-based and value-based judgment regarding the extent to which SARRAH has been successful in achieving its intended outcomes.

- A total of 14 work-streams (see Table 2 in Section 1.3.3 for an overview) were subject to individual mid-term assessments during the MTE, in line with point 3 of the TOR (see Section 2.2 for summaries).

- A Value for Money assessment was conducted as part of the MTE looking at both individual work-streams and SARRAH overall (see Section 3).

- The MTE work extensively informed Annual Reviews of SARRAH, in line with point 4 of the TOR. This was facilitated by the fact that a key member of the evaluation team also led the annual reviews.

This findings of the MTE presented in this report relate to the period January 2010 to December 2012.

1.2 Governance of the SARRAH Evaluation

1.2.1 DFID

Function

DFID is responsible for the overall funding and direction of the programme, working closely with the South African National Department of Health (NDOH) to align with South Africa's national health priorities. SARRAH has had an exceptionally high level of ownership within the NDOH (especially by the Director General) and is clearly aligned with and contributing to the South African Government's Negotiated Service Delivery Agreement (NSDA).

DFID is responsible for identifying and contracting both the Managing Agent (HLSP) and the evaluation team (Coffey/HSRC) and for managing their work.

Reporting

During the Mid Term evaluation the Managing Agent and the evaluation team reported to the DFID Senior Health Adviser Dr Bob Fryatt who was seconded into the NDOH to coordinate the overall programme and provide direct support and who acted as a key liaison between the NDOH and DFID, ensuring strong links were maintained. SARRAH was additionally supported by the DFID Programme Manager Hilary Nkulu. In 2012, Hilary was replaced by Beaulah Muchira.

1.2.2 SARRAH Managing Agent (HLSP)

Function

The SARRAH Managing Agent's core function is to establish and deliver the programme. It has overall responsibility for delivery against agreed milestones in the logframe and for ensuring effective and efficient management of all elements of the programme. The SARRAH logframe[10] has been amended several times and will need to be amended again in light of an upcoming extension to the programme that will see the introduction of new work-streams. The Managing Agent is also required to provide technical assistance (TA) and establish strong M&E and communications across the programme to ensure that lessons learned through SARRAH are widely shared within South Africa and beyond. As well as a programme management team, the Managing Agent has a series of Technical Leads who work with SARRAH partners and DFID to identify, procure and manage the technical assistance.

The SARRAH programme management team and DFID meet every fortnight, in person or by teleconference, to review progress, address technical and management issues, and discuss new work. Technical Leads attend as appropriate.

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[10] Available on the SARRAH website: http://www.sarrahsouthafrica.org/ABOUTSARRAH/SARRAHLogframe.aspx

The Managing Agent has been required to operate SARRAH as a flexible mechanism, and whilst most SARRAH partners and beneficiaries have reported that they welcome this approach, it has presented significant challenges to programme management and the measurement of its achievement against planned milestones.

Reporting

The Managing Agent uses the logframe for monitoring progress against milestones and reports to DFID on a quarterly basis. The logframe has been shared with the evaluation team.

Milestones are based upon the work-streams that are identified by DFID and SARRAH partners and a milestone matrix covers work to date as well as forecast expenditure, including:

- Milestones completed to date; and
- Funds that have been committed.

The milestone matrix is intended to be updated on a monthly basis to reflect any new milestones agreed during the month, invoices submitted and paid, as well as any amendments to existing milestones.

In the first year, the Managing Agent produced a comprehensive annual report for DFID including an assessment of the progress of work-streams against milestones and alignment with the logframe, as well as financial reporting against payment milestones in the matrix. Following this, quarterly progress and financial reports have been submitted. Reports are published on the programme's website[11].

1.2.3   Evaluation Team of SARRAH (Coffey & HSRC)

Function

The evaluation team was contracted by DFID to deliver the four key evaluation objectives (set out the introduction above) as defined by the Terms of Reference (see Annex 3). The evaluation team focused on assessing the programme's performance with regards to process, outcomes and impacts.

Although the roles of the Managing Agent and the evaluation team are quite distinct, they are explicitly required to work closely together. While the evaluation team had extensive interaction with the Managing Agent throughout the strategy and MTE phases, the evaluation team had no conflict of interest and has maintained complete independence from the Managing Agent at all times.

Reporting

The evaluation team reports to DFID South Africa. The Evaluation Strategy (see Annex 4) and all outputs were shared with the Steering Committee and then published on the SARRAH website[12].

Evaluation outputs to date have been published at the end of each milestone: inception, strategy development and the mid-term evaluation. Steering Committee meetings have largely been tied to these deliverables to aid discussion and dissemination with programme stakeholders.

The evaluation team was further responsible for communicating evaluation outputs to improve the evidence base, share lessons and enable stakeholders to undertake informed decision-making. The recommendations of the evaluation should guide stakeholders to better embed the national Ten Point Plan (see **Table 1**) and ensure that future policy and programming in Health and HIV is supported through:

- reliable evidence and proof of results;
- tangible knowledge of what works for more sustainable implementation; and
- Value for Money principles that maximise impact at best cost.

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[11] http://www.sarrahsouthafrica.org/
[12] http://www.sarrahsouthafrica.org/ABOUTSARRAH/SARRAHEvaluation.aspx

Going forward, the evaluation team will liaise with programme stakeholders about the evaluation process and outputs through:

- publication the core evaluation team profiles on the SARRAH website with a centralised Coffey contact email where queries can be sent so that Coffey can respond within a specified time frame (TBC);

- discussions on any sensitive questions with DFID and the SARRAH team before responding and agree an approach;

- Steering Committee meetings and regular progress reports;

- publication of a quarterly 1-page news updates to SARRAH website and via email to the Steering Committee; and

- publication of guest articles or podcasts (audio/video) on the SARRAH website talking about key topics, implications, expectations of findings, etc.

1.2.4 SARRAH Evaluation Steering Committee

Function

In 2011, DFID and the evaluation team set up an Evaluation Steering Committee with the SARRAH programme's principal partners (NDOH, SANAC and TAC), the Managing Agent HLSP, the Department for Performance Monitoring and Evaluation (DPME) of the South African Presidency, external individuals from the London School of Hygiene and Tropical Medicine (LSHTM) and DFID's Evaluation Department (EvD). The Evaluation Steering Committee provides oversight of the programme evaluation and ensures alignment with the 'joined up' approach to the wider M&E of the NSDA.

One of the most important roles for the Steering Committee has been to demonstrate a deep commitment to the success of SARRAH and to the objectives the programme is aiming to achieve.

Steering Committee members have been expected to:

- attend regular committee meetings;

- review and provide feedback on evaluation outputs;

- help guide the strategic direction of the evaluation and provide advice if appropriate; and

- help communicate findings of the evaluation.

Some of the specific tasks the Steering Committee has undertaken to date include:

- feeding back on evaluation priorities through a traffic light report which guides the strategy of the evaluation.

- HLSP provided Coffey with a list of programme stakeholders and details on budget and spend for all work-streams.

- DFID's EvD gave a peer review of all the work-stream evaluation strategies before they were put into practice.

For the first year, Chairmanship of the Steering Committee rotated at each meeting, with nominations made during the meeting preceding. However, it has now been agreed that DPME will chair the committee on a permanent basis.

Reporting

Minutes of each Steering Committee meeting are circulated within one week of the meeting to all members, including those who did not attend. These are then re-circulated prior to the next meeting to remind members of action points.

As Steering Committee members indicated to the evaluation team that they would like more regular communication between deliverables/meetings, regular progress reports are sent out to the Steering Committee to communicate progress.

In April 2014, the normal Steering Committee meeting will be replaced by a broader Lesson Learning event that will aim to present key findings of the mid-term review.

1.3 Overview of SARRAH

SARRAH is a five-year DFID funded programme that provides technical advice, funding and support to strategic national initiatives that aim to strengthen South Africa's response to HIV and health. SARRAH's main focus is to support NDOH in efforts to achieve the four strategic outputs set out in the government's Negotiated Service Delivery Agreement (NSDA) for health: increasing life expectancy, decreasing maternal and child mortality, combating HIV, AIDS and TB, and strengthening the health system's effectiveness.

SARRAH is based on partnerships with leading national players in HIV and health. Key partners include NDOH and The South African National AIDS Council (SANAC). The programme also supports civil society through the Treatment Action Campaign (TAC) and the work of the Joint Committee on HIV and the Parliamentary Portfolio Committee on Health. Technical support and financial management are provided by an international professional services firm specialising in the health sector.

SARRAH commenced in January 2010 and is expected to finish delivering its activities in December 2014. The total value of SARRAH when it commenced in 2010 was £13,500,000. SARRAH was allocated a further £6,852,217 in December 2011, bringing the total programme value at the end of December 2012 to £20,352,217.

1.3.1 Brief History of SARRAH

A more in-depth analysis of the strategic context which led to SARRAH's formation is available in Annex 2 and a historical review of DFID's work in the South African health sector during the previous 20 years was completed by Coffey during the inception phase of the SARRAH evaluation and published in January 2012.

SARRAH was initiated at a time when South Africa was emerging from a period of controversial health system management, particularly with regard to HIV and AIDS. During President Mbeki's tenure (1999-2008), the Ministry and NDOH were influenced by the 'AIDS denialists' and HIV and AIDS services were severely compromised as a result[13]. This period was characterised by difficulties in getting HIV and AIDS programmes approved within NDOH due to a lack of support at higher levels. Despite successful efforts to make anti-retrovirals (ARV) more readily available and offering them free of charge, the roll-out of this life-saving treatment was slow. Many donors including DFID were therefore forced to look for partners other than the NDOH to respond more rapidly and effectively to the AIDS crisis.

It was thus from a very low base that SARRAH began its work to revitalise the response to AIDS and health in 2010. The programme was launched following the 2009 national elections which opened up an opportunity for revitalised efforts to tackle the main causes of ill health, HIV and AIDS within the South African health system. The SARRAH programme was designed to make the most of this opportunity by supporting the emerging reform plans and strategies.

The Health Roadmap, commissioned by the African National Congress' National Executive Committee's Sub-Committee on Health and Education, in 2008, pointed to the fact that progress towards achieving the health-specific Millennium Development Goals was poor, and in some cases, e.g. maternal mortality, actually negative. South Africa was described as having "war-like death statistics" because so many young adults were dying as a result of AIDS[14]. Overall, South Africa was

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[13] Seager, J. (2012), '*Review of DFID's engagement with the South African health sector between 1993 and 2010*', page 6-8
[14] DBSA (November 2008), *Health Roadmap: summary presentation on the Health Roadmap process.* Accessed 16/7/2013; and DBSA. A Roadmap for the reform of the South African Health System: A process convened and facilitated by the Development Bank of Southern Africa.

achieving poor results relative to cost. The Roadmap report, with its various background papers, allowed reconfiguring priorities and setting an initial focus on:

- prevention and treatment of HIV and TB infection;
- efforts to strengthen effectiveness at all levels of the health system, both public and private, including through better information systems and decision-making; and
- addressing human resource and budget constraints.

This prioritisation process eventually led to what is known as the Ten Point Plan, a document intended "to guide government health policy and identify opportunities for coordinated public and private health sector efforts, in order to improve access to affordable, quality health care in South Africa"[15]. The proposed Ten Point Plan (see **Table 1**) was formalised in the NSDA, which was signed in by the Minister of Health and seven other cabinet ministers in September 2010.

Table 1: Ten Point Plan

Ten Point Plan	
1	Provision of strategic leadership and creation of a social compact for better health outcomes.
2	Implementation of National Health Insurance (NHI).
3	Improving the quality of health services.
4	Overhauling the health care system and improving its management.
5	Improving human resources management, planning and development.
6	Revitalisation of health infrastructure.
7	Accelerated implementation of the National HIV&AIDS and STI National Strategic Plan (2007-2011)[16] and increased focus on TB and other communicable diseases.
8	Mass mobilisation for better health for the population.
9	Review of the drug policy.
10	Strengthening research and development

Moreover, in a series of papers presented by The Lancet in 2009[17,18], a group of South African academics identified multiple shortcomings in the South African Health system while also highlighting that this was "a unique opportunity to implement key health policies to shape South Africa's future".

These documents identified what needed to be done, but it was immediately apparent that gaps in resources would make this difficult to achieve. It was as a result of this situation that DFID, in discussion with the NDOH, began to develop the SARRAH programme as a flexible tool of targeted financial and technical support.

The initial work-plan involved a number of activities to improve directly health service delivery, such as strengthening Prevention of Mother-to-Child Transmission (PMTCT) in clinics. However, with the appointment of the new Director General (DG) in NDOH in 2010, a more strategic orientation was

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[15] Rispel, L, Moorman, J, (2010), *Health Legislation and Policy: Context, Process and Progress*. Chapter 14 in: S. Fonn & A. Padarath. (eds). *South African Health Review 2010*. Durban: Health Systems Trust: 127–142.

[16] Now superseded by the National Strategic Plan 2012-2016

[17] Coovadia, H. Jewkes, R, Barron, P, Sanders, D, McIntyre, D. (2009), *The health and health system of South Africa: historical roots of current public health challenges*. Lancet 200910.1016/S0140-6736(09)60951-X. published online August 25.

[18] Chopra, M, Lawn, JE, Sanders, D, Barron, P, Abdool Karim, S, Bradshaw, D, Jewkes, R, Abdool Karim, Q, Flisher, AJ, Mayosi, BM, Tollman, SM, Churchyard, GJ, Coovadia, H. (2009), *Achieving the health Millennium Development Goals for South Africa: challenges and priorities*. Lancet, 200910.1016/S0140-6736(09)61122-3, published online August 25.

taken. The DG invited Cluster Managers in NDOH to identify strategic initiatives for SARRAH support but made it clear initially that funding should only be used for initiatives which could not be achieved using routine mechanisms. Eventually however, many of the priorities identified by the earlier policy initiatives were to be incorporated into the SARRAH programme.

In response to bespoke policy processes and priorities, SARRAH emerged not as a single large-scale intervention but as a facility to support national reforms, programmes and institutions of the South African health sector through a *range of strategic interventions* identified jointly by DFID and the SARRAH partners, namely NDOH, TAC, SANAC and two parliamentary oversight committees - the Joint Committee on HIV (JCH) and the Portfolio Committee on Health (PCH). SARRAH diversified into a range of activities, each supporting different parts of the healthcare system. SARRAH's work-streams were closely aligned with the NDOH Ten Point Plan to promote the policy framework through which the NSDA is to be achieved.

1.3.2 The SARRAH Theory of Change

What is the problem?

South Africa faces a quadruple burden of disease: On the one hand, it records high mortality and morbidity from health issues that are typical for developing countries such as maternal, new-born and child mortality (first burden), and non-communicable infectious diseases (second burden). On the other hand, it faces two additional burdens that are violence and injuries (third burden), and HIV and AIDS and Tuberculosis (TB).[19] The extent and severity of this quadruple burden means that the South African health sector faces particular challenges in terms of resource allocation, intervention planning and the general structuring of health care delivery and management.[20]

The burden that is probably the most commonly referred to in the international community, is the extraordinarily high prevalence of HIV and AIDS, which make South Africa the epicentre of the global epidemic. In 2009, UNAIDS estimated that nearly 6 million HIV-infected people lived in South Africa, corresponding to an 18% prevalence among those aged 15 to 49. Worldwide, only the neighbouring countries Botswana (24%), Lesotho (23%), and Swaziland (26%) recorded a higher prevalence of HIV infection.[21] The sheer size of South Africa and its interconnectedness with Sub-Saharan Africa and the world make it the central battleground of the international fight against the epidemic.

It is also widely accepted that the fight against HIV and AIDS suffered major setbacks due to the AIDS 'denialism' that prevailed during the Mbeki administration,[22] and delays in providing access to antiretroviral treatment (ART) resulted in an estimated 333,000 AIDS deaths and 180,000 HIV infections that could have been prevented.[23] However, despite these problems, other evidence-based HIV programmes continued to be implemented by resolute policy makers. Moreover, civil society activism culminated in successful challenges to the government in the courts, led by among others the Treatment Action Campaign (TAC), reversed some of the setbacks by forcing the-then South African government to start an ART programme. In particular this led to the piloting of a prevention of mother-to-child transmission (PMTCT) A-plan in some districts which was supported by the SARRAH programme.

A second core problem of public health in South Africa is vastly unequal access to healthcare. Partly the legacy of racial segregation during the apartheid era, the health system comprises a two-tiered delivery model: a world class private health system caters for the 15% of the South African population who can

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[19] The Lancet (2009), Health in South Africa: An Executive Summary for Th e Lancet Series, http://download.thelancet.com/flatcontentassets/series/sa/sa_execsum.pdf.

[20] ECONEX (2009), NHI Note 2: South Africa's Burden of Disease, ECONEX Research Note 17, http://www.mediclinic.co.za/about/Documents/ECONEX%20NHI%20note%202.pdf.

[21] World Health Organisation (2010), World Health Statistics 2010

[22] Nattrass, N. (2012), "The AIDS Conspiracy Science Fights Back". Johannesburg: Wits University Press.

[23] Chigwedere, P. & Essex, M. (2010). AIDS denialism and public health practice. AIDS & Behavior, 14/20, 237-247.

afford to purchase health insurance, while a poorly resourced public system provides care to the majority of South Africans. There is a spatial dimension to inequality in access to public healthcare, as regions with greater spending capacity tend to receive more funding, allowing them to further improve their health infrastructure while regions with less spending capacity but greater health needs fall further behind.[24] Inequitable access to healthcare leads to high mortality and morbidity from preventable and treatable conditions such as tuberculosis which are also diseases of poverty, afflicting mostly impoverished communities. They caused 39 deaths per 100 000 people without HIV infection in South Africa in 2008, compared with only 8.4 deaths in upper middle income countries.[25]

While combatting HIV and improving care for those already infected represents an immediate short-term challenge to South African health policy makers, transforming the health system into a more egalitarian and accessible structure represents a more long-term and systemic challenge.

What is the vision?

Both core problems of the South African health sector must be addressed in order to pursue the vision of a "Long and Healthy Life for All South Africans" that underpins South Africa's NSDA, which focuses on:

- increasing life expectancy;
- decreasing maternal and child mortality;
- decreasing prevalence of HIV, AIDS and tuberculosis; and
- increasingly effective health systems.

How to get there?

The Ten Point Plan for the improvement of the health sector sets out the key policy priorities needed in order to achieve the goals set out above.

A first group of initiatives focuses on one of the major sources of mortality in order to generate short term measurable health impacts. This strand includes policies aimed at tackling the high prevalence of HIV and AIDS in South Africa (e.g. point 7 of the Ten Point Plan) and making the national response more accountable and better coordinated (e.g. point 8).

A second group seeks to support longer term, systemic change in the way healthcare is financed, managed and delivered, to make it more effective, more inclusive and more equitable in a sustainable way. This includes policies that aim to tackle the poor quality of and unequal access to South African healthcare through strengthening health systems (e.g. points 2 and 6).

The two strands of policy priorities are intrinsically intertwined, since stronger and more equitable and inclusive health systems will support the national response to HIV and AIDS, and equally, a decrease in the prevalence of HIV and AIDS will facilitate a shift in the allocation of resources and efforts towards the achievement of more systemic, long term health objectives.

How is DFID contributing?

Through the SARRAH programme, DFID supports the NSDA by providing technical assistance in several policy areas addressing the core problems and priorities set out in the Ten Point Plan and the NSDA. SARRAH is structured around a series of initiatives or "work-streams" that are different in scope, scale, timing and objectives. While attempting to group those work-streams rigidly and based on strict criteria is somewhat problematic, they can broadly be classified into two types, each of which addresses one of the core problem areas:

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[24] Stuckler, D. Basu, S. McKee, M. (2011), *Health care capacity and allocations among South Africa's provinces: infrastructure–inequality traps after the end of apartheid*. American Journal of Public Health, Vol. 101 (1) pp. 165-172.
[25] World Health Organisation (2010), *World Health Statistics 2010*

- Interventions designed to **strengthen and coordinate the national response to HIV and AIDS and make it more accountable**. These include for example technical assistance to SANAC, whose mission is to monitor and coordinate the national response to HIV and AIDS, or support to TAC, a civil society organisation dedicated to advocating for stronger and more decisive response to HIV and AIDS.

- Interventions designed to **strengthen the South African health systems and their ability to provide quality healthcare to all**. These include in particular a range of technical assistance initiatives to support the establishment of the National Health Insurance (NHI), a universal health insurance system designed to provide free health coverage for all South Africans and to be funded entirely through taxes and national insurance contributions. These also include support in setting up the South African Health Product Regulatory Authority (SAHPRA), a health product regulatory authority capable of reviewing large numbers of new drug (and related product) applications in order to make the best treatments available to health facilities and patients rapidly, and the establishment of National Core Standards (NCS) and the Office of Health Standards Compliance (OHSC).

What are the medium and long term anticipated outcomes?

1. SARRAH will ensure that HIV and AIDS remains at the top of the policy agenda in South Africa and that progress against targets is rigorously monitored and gaps/needs are identified in "real-time" so that resources are efficiently allocated to address those needs. This should result in a **stronger and more accountable national response to HIV and AIDS[26]**, which in turn should lead to **measurable reductions in HIV and AIDS prevalence, transmission and mortality in South Africa**. Relevant work-streams are SANAC and TAC which are designed to coordinate the national response to HIV and AIDS and to make it more accountable.

2. Interventions designed to strengthen the South African health system overall will also benefit the national response to HIV and AIDS. However, their scope is not limited to one specific disease. They are designed to **support South African health policy by providing technical assistance to strengthen the strategic planning, management, monitoring and evaluation of the national health system[27]**.

The second group of initiatives vary considerably in size, in scope, and in the time each initiative will need for its effects to become apparent and measurable. For instance, SAHPRA is a new regulatory authority which will help increase, in the medium-term, the number of certified drugs available in the market and potentially decrease the cost of purchase as a wider range of alternative producers compete to serve facilities and patients (see Section 2.2.2 and Annex 15). On the other hand, the National Health Information Repository and Data Warehouse (NHIRD) is a data lab, already operational, which should demonstrate rapid improvements in access to critical medical, financial and operational information for a range of stakeholders including national and provincial NDOH officials and health facilities, making the system better able to serve the people's needs with the resources available (see Section 2.2.2 and Annex 12).

Finally, a range of interventions are designed to help South Africa prepare for implementation of the **National Health Insurance** scheme (a universal and tax-funded insurance scheme modelled on the UK's National Health Service (NHS), see Section 2.2.2 and Annex 11 for more detail), and pave the way for a successful rollout of one of the most significant health reforms ever undertaken in South Africa. As the NHI is not forecast to be fully operational until 2026, the benefits generated by SARRAH initiatives

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[26] This is aligned with Output 2 of the SARRAH logframe: "Strengthened leadership and accountability of the national response to HIV and AIDS"

[27] These are captured under Outputs 3, 4 and 5 of the SARRAH logframe:
Output 3: "Support National interventions to improve access and equity to HIV and health services"
Output 4: "Strengthen performance management & strategic planning for HIV and health at national and provincial level"
Output 5: "Strengthen systems to effectively monitor and evaluate national strategic plans for HIV & AIDS and health"

such as technical support in designing the NHI pilots, the design and roll-out of the National Core Standards (Annex 14) or the Human Resource Strategy for the South African health system (Annex 9) **will be apparent in the long term**, and will materialise through a more effective and equitable health system for all. Although these activities are closely linked to national health sector reform initiatives, there is a risk of not bearing fruit since they rely on the continuity and the sustainability of the national effort over several legislatures, governments and presidencies.

Table 2 presents a list of the SARRAH work-streams that the evaluation team has assessed during the MTE.

What are the assumptions and risks?

Political stability is a key condition for the success of SARRAH or any of the national interventions SARRAH is supporting. While there was a momentum for reform of the health systems and a revitalised response to HIV and AIDS during the transitional government of Motlanthe in 2008/2009 that has subsequently been sustained under the governments of the Jacob Zuma presidency the nature of these initiatives requires a long-term commitment to reform. The conditions for change also include the capacity and will of the South African health sector to undergo a large scale, sector wide up-skilling of its labour force and the sustainability of SARRAH initiatives requires a sustained capacity building effort across the health system.

Who are the key players?

The operational model of the SARRAH programme is that of a partnership between **DFID** (the funding organisation), **NDOH**, and the implementing partner **HLSP**. Funding decisions are made jointly by DFID and NDOH to ensure the programme addresses government priorities. **Provincial governments** and their departments of health are an essential component of the South African health system and will interact significantly with the SARRAH programme, both as beneficiaries and as partners in its implementation. The **South African Parliament** will be involved in particular through the Parliamentary Oversight Committee for HIV & AIDS, which SARRAH has helped establish. The **South African Presidency** is also involved, albeit to a lesser extent, with SARRAH. **SANAC**, itself a beneficiary of SARRAH, also sits on the programme's Steering Committee and will be a key player in ensuring that the national response to HIV and AIDS is closely monitored and effectively coordinated. A range of civil society organisations (**CSO**) will also play a role in ensuring the national response to HIV and health is accountable to the people of South Africa. One of them, **TAC**, is a direct beneficiary of SARRAH and sits on its Steering Committee. Finally, **health facilities** and their management and **medical personnel** will be instrumental in ensuring the success and sustainability of SARRAH.

Table 2: Overview of SARRAH work-streams

Intended effect	Work-stream	Implementation period	Budget (in % of total)	Description	Annex
Coordination, Oversight & Advocacy	South African National AIDS Council (SANAC)	2010-2011	12%	Strengthening SANAC by providing logistical and financial support for meetings and assistance with management and organisational development.	Annex 16
	Treatment Action Campaign (TAC)	2010-2013	11%	Providing TAC with core financial support and technical assistance on management, monitoring and evaluation.	Annex 18
Health Systems Strengthening and preparation for the NHI	Assessment of CEOs and DHMs	2010	8%	Funding 400 assessments of the competency of hospital Chief Executive Officers (CEOs) and District Health Managers.	Annex 5
	Asset Management	2011	16%	Commissioning a service provider to undertake a comprehensive audit and valuation of NDOH assets in the National Office, Eastern Cape, Mpumalanga, and KwaZulu Natal.	Annex 6
	Conditional Grant Management	2010	1%	Assisting the NDOH to strengthen the management of conditional grants to the provinces.	Annex 7
	Provincial Financial Management	2010	2%	Support to the NDOH and provinces to develop provincial financial management improvement plans and a review of procurement policies and procedures.	Annex 8
	Human Resource Strategy	2011	1%	Development of a National Human Resources for Health Strategy (2012/13 – 2016/17),	Annex 9
	Organisational redesign of the NDOH	2010-2011	5%	Funding a redesign of NDOH to improve organisational effectiveness and relevance.	Annex 10
	National Health Insurance (NHI)	2011-2013	11%	Support of preparatory work for NHI including technical reports, selection of pilot sites, Ministerial road shows, NHI costing, District Clinical Specialist Teams, Facility Improvement Teams, Ward-Based Outreach Teams and GP contracting models.	Annex 11
	National Health Information Repository and Data Warehouse (NHIRD)	2011-2012	2%	Support for the development of a national health information centre (NHIRD) that will provide national and provincial health, social and economic data essential for management of NHI.	Annex 12

Intended effect	Work-stream	Implementation period	Budget (in % of total)	Description	Annex
Health Systems Strengthening and preparation for the NHI *(continued)*	Prevention of Mother-to-Child Transmission (PMTCT)	2010	2%	Assisting with coordination of partners in the National PMTCT Accelerated Plan (A-Plan) in 18 districts, mobilising resources, monitoring implementation, and identifying capacity for scale up.	Annex 13
	Quality Assurance	2010-2011	6%	Consultants to assist with drafting National Core Standards for health facilities, scoping the Office of Health Standards Compliance and preparing a business case for submission to Treasury.	Annex 14
	South African Health Products Regulatory Authority (SAHPRA)	2010-2013	22%	A project to address the large backlog of applications to the Medicines Control Council to register medicines and technical assistance to design a new regulatory authority (SAHPRA).	Annex 15
	Service Transformation Plans (STP)	2010-2011	2%	Revision of Service Transformation Plans which define the scope of health services for provincial health authorities over the next ten years (in 8 of the 9 provinces).	Annex 17

Source: Coffey

1.4 Methodology & Analytical Framework

1.4.1 Analytical Framework

The Evaluation Strategy (see Annex 4) has been designed to align with the OECD-DAC[28] evaluation criteria that are presented in **Table 3** below. These criteria have informed the research questions set out in the analytical framework and guided the MTE (research questions can be found in section 3.3 of the Evaluation Strategy report in Annex 4). The Mid-term Evaluation of SARRAH focuses mainly on an assessment of the Relevance, Efficiency, Effectiveness and Sustainability criteria. For many work-streams full impact was not expected at mid-term, although in some cases substantial impacts had already occurred. For this reason, impact was given a lower weighting in the overall evaluation. The Impact criterion will have more significance and therefore a higher weighting in the final evaluation.

Table 3: OECD-DAC criteria

DAC Criteria	Description	Questions
Relevance	The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor.	• To what extent are the objectives of the programme still valid? • Are the activities and outputs of the programme consistent with the overall goal and the attainment of its objectives? • Are the activities and outputs of the programme consistent with the intended impacts and effects?
Efficiency	Efficiency measures the outputs - qualitative and quantitative - in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results.	• Were activities cost-efficient? • Were objectives achieved on time? • Was the programme or project implemented in the most efficient way compared to alternatives?
Effectiveness	A measure of the extent to which an aid activity attains its objectives.	• To what extent were the objectives achieved / are likely to be achieved? • What were the major factors influencing the achievement or non-achievement of the objectives?
Impact	The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended. This involves the main impacts and effects resulting from the activity on the local social, economic, environmental and other development indicators.	• What has happened as a result of the programme or project? • What real difference has the activity made to the beneficiaries? • How many people have been affected?
Sustainability	Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable.	• To what extent did the benefits of a programme or project continue after donor funding ceased? • What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?

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[28] OECD (1991), *DAC Principles for the Evaluation of Assistance*

1.4.2 Research Methodology

The SARRAH programme was designed as a fund to support national reforms, programmes and institutions of the South African health sector through a range of strategic interventions identified jointly by DFID and NDOH. As discussed above, it was not conceived as a single, targeted, large-scale intervention. This has led SARRAH to diversify into a range of different activities, loosely connected with one another, each supporting different parts of the NSDA and the Ten Point Plan. While all work-streams are working towards achievement of the NSDA's targets, this diversity is such that each work-stream could be considered as an intervention in itself. The MTE recognised this diversity and considered the work-streams individually in the first instance, before making an attempt to aggregate and synthesise findings at the programme level. Evidence was collected for each intervention or work-stream by different evaluation leads and using different tools and techniques drawing on in a wide array of sources of data.

To enable the evaluation team to conduct this assessment rigorously, the following approach was adopted:

1. Individual evaluations of work-streams, or groups of work-streams were conducted using appropriate methodologies, and exploiting potential synergies and complementarities between initiatives;

2. A quality assurance of the evidence collected was undertaken by Coffey to ensure that evidence was of a sufficient standard to assess the overall performance of SARRAH; and

3. A synthesis of the various individual work-stream reports, complemented by a qualitative analysis of over one hundred interview notes using Atlas.ti, was conducted in order to inform conclusions and answer the key evaluation questions.

STEP 1 - Work-stream level evaluations

The starting point was to conduct evaluations of individual work-streams. During the Strategy Phase, the evaluation team and the Steering Committee agreed that MTE resources should be prioritised and apportioned to work-streams according to each work-stream's Utility, Proportionality and Evaluability. This approach rested on the understanding that (1) the various initiatives undertaken as part of the SARRAH programme are not all equally strategic, (2) the budget constraints imply a need to prioritise and allocate research activities strategically and (3) a few high quality evaluations are worth more to policymakers than many poor quality ones (a detailed description of the prioritisation system and the assessment methodology is provided in sections 3.1.3 and 4 of the Evaluation Strategy available in Annex 4). Based on this, the following colour scheme was introduced:

- "**Green**" work-streams are considered to be priority activities that should be allocated the largest share of evaluation resources. These have typically involved *significant amount of primary research* and robust assessment of the counterfactual if and when appropriate.

- "**Amber**" work-streams are seen as strategic but are characterised by low levels of proportionality and evaluability, and have therefore been subject to more than "minimal" research activities, but less than full-scale evaluation activities.

- "**Red**" work-streams are not considered a strategic priority and have generally only been subject to minimal, essentially desk-based research to ensure that they are captured in the assessment. These usually involved a limited number of stakeholder interviews.

This colour coding was used in the first instance to prioritise work-streams for the MTE. However, it is important to note that of the 17 work-streams identified in the Evaluation Strategy (see Annex 4), three were not assessed in this MTE, after discussion with DFID, for the following reasons:

- **Parliamentary Oversight Committee**: This work-stream was not evaluated as no committee had been set up and no clear mandate determined prior to the deployment of researchers. The intervention was deemed not sufficiently developed to justify allocating research activities and

resources to its assessment as part of the MTE. This work-stream will, however, form part of the final evaluation of SARRAH.

- **Information and Communications Technology**: This work-stream was not evaluated as the e-Health strategy, which formed its main component, was suspended at the time of writing the Evaluation Strategy (see Annex 4). The latter has now resumed in a different form, and so the evaluation team will consider the possibility of including the ICT work-stream in research activities for the final evaluation of SARRAH.

- **Donor Coordination**: This work-stream was not assessed as part of the MTE as it was deemed too limited in size and scope for an evaluation to comply with the requirement of proportionality with regards to the allocation of research activities.

Mixed-method evaluation approaches were developed by members of the evaluation team for each work-stream, as per Table 4 below (detailed work-stream methodologies are available in the Annexes 5 to 18). These usually involved a combination of desk research, secondary data collation and analysis, key informant interviews (see Annex 19 for full list of interviews conducted), focus groups and in some cases site visits and surveys. Overall, over one hundred interviews were conducted either face to face, over the phone or via email with a range of stakeholders who have interacted with or benefited from SARRAH over the past three years. These included (among others) representatives of NDOH, provincial departments of health, CSOs, SARRAH-appointed consultancies, HLSP and DFID. Work-stream level evaluation findings were then structured around the OECD-DAC criteria of Relevance, Effectiveness, Efficiency, Impact and Sustainability (see Table 3 above).

Table 4: SARRAH Mid-Term Evaluation methodological matrix

Intended Effect	Work-stream	Lead Evaluator	Desk Review	Interviews	Other	OECD-DAC criteria covered					Annex
						Relevance	Effectiveness	Efficiency	Impact	Sustainability	
Coordination, Oversight & Advocacy	**South African National AIDS Council (SANAC)**	Donna Podems	✔	✔	Triangulation	✔	✔	✔	✔	✔	Annex 16
	Treatment Action Campaign (TAC)	Nyameka Mankayi	✔	✔	Focus groups	✔	✔	✔	✔	✔	Annex 18
Health Systems Strengthening and preparation for the NHI	**Assessment of CEOs & DHMs**	Catherine Ndinda	✔	✔	Interviews in Gauteng & KZN	✔	✔	✔	✔	✔	Annex 5
	Asset management	John Seager	✔	✔		✔	✔	✔	✔	✔	Annex 6
	Conditional Grant Management	Nyameka Mankayi	✔	✔		✔	✔	✔	✔	✔	Annex 7
	Provincial Financial management	Ntombizodwa Mbelle	✔	✔	Audit analysis	*Not structured this way*					Annex 8
	Human Resource Strategy	Aziza Mwisongo	✔	✔		✔	✔	✔	✔	✔	Annex 9
	Organisational redesign of the NDOH	John Seager	✔	✔		✔	✔	✔	✔	✔	Annex 10
	National Health Insurance (NHI)	John Seager	✔	✔	Secondary data analysis	✔	✔	✔	✔	✔	Annex 11
	National Health Information Repository and Data Warehouse (NHIRD)	John Seager	✔	✔	Observation; ICT assessment	✔	✔	✔	✔	✔	Annex 12
	Prevention of Mother-to-Child Transmission (PMTCT)	Leickness Simbayi	✔	✔	Comparisons of districts	✔	✔	✔	✔	✔	Annex 13
	Quality Assurance	John Seager	✔	✔		✔	✔	✔	✔	✔	Annex 14
	South African Health Products Regulatory Authority (SAHPRA)	Leickness Simbayi	✔	✔	Group interviews	✔	✔	✔	✔	✔	Annex 15
	Service Transformation Plans (STP)	Donna Podems	✔	✘		✔	✔	✔	✔	✔	Annex 17

Source: Coffey

STEP 2 – Quality assurance of evidence

The evidence collected through the various work-stream evaluations was first reviewed and analysed by the lead evaluators of the respective work-streams. The evaluation team in Coffey then conducted a thorough review and quality assurance of the evidence and analysis. The evaluation team's approach involved the use of explicit quality assurance criteria to ensure that the data and evidence submitted by the work-stream lead evaluators covered the areas required and was of a standard of quality that is consistent with the evaluation requirements.

STEP 3 - Synthesis

The final phase involved synthesising the evidence collected through the various work-stream evaluations using a range of analytical techniques to enable value-based judgements and conclusions to be drawn at the overall SARRAH level. The overarching synthesis approach provided a systematic method for analysing a large amount of qualitative data collected by a range of different evaluators and across work-streams varying in size, scope and strategic importance.

1.5   Synthesis

1.5.1   Numerical tool

A numerical scoring tool was developed by the evaluation team as an analytical tool to support the findings emerging from the qualitative research and to enable comparison between different work-streams against the key performance criteria.

This numerical tool should not be considered as a substitute, or even as a summary, of the more detailed analysis contained in this report. Rather the main function of the numerical tool is to complement the in-depth qualitative analysis, and its corresponding evaluative findings, which are summarised in Section 2 and fully presented in the annexes, with an application that enables the reader to compare the mid-term performance of very different work-streams through a consistent set of criteria.

For each work-stream, a score of 1 to 4 was awarded against each evaluation criterion, as described in **Table 5**.

Table 5: Performance Scoring System

1	Performing poorly against the criteria
2	Not performing well. Significant improvements should be made.
3	Performing well. Some improvements should be made.
4	Performing strongly against the criteria

Source: Coffey

This scoring system is consistent with that used by the UK Independent Commission on Aid Impact's (ICAI) traffic light rating system, and was adapted to the needs of the SARRAH evaluation[29].

Two **weighting schemes** were then applied in the process of synthesising the evaluation findings:

- The criteria were weighted to reflect the fact that the MTE's main focus was the process through which SARRAH was delivered, and the programme's emerging outcomes. **Consequently, the Efficiency and Effectiveness criteria were allocated the greatest weight, with 30% each**. The Relevance criterion was allocated a 20% weight. The Impact and Sustainability criteria were each allocated a 10% weighting, reflecting the fact that evaluating the extent to which SARRAH had delivered sustainable impacts was not the main focus of this evaluation;

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[29] Independent Commission for Aid Impact (2011), *ICAI's Approach to Effectiveness & Value for Money*

- A second weighting system was used to reflect proportionality of financial resources: work-streams were weighted proportionally to the share of SARRAH's resources for which they accounted in order to construct an overall SARRAH score. The strength of the evidence was assessed and was used as an adjustment variable - e.g., very positive findings were adjusted in the final scores when they were based on weak evidence.

Table 6: Evidence Rating System

Weak	There is reporting which relates to the indicator, but there is either no evidence or weak evidence to support the findings.
Medium	The reporting is supported by some evidence, but the evidence is of questionable quality.
Strong	The reporting is supported by robust evidence, i.e., triangulated with other sources of evidence, corroborated by other stakeholders and independently verifiable.

Source: Coffey

The scoring was done centrally by the evaluation team in Coffey after thorough reviews of the individual work-stream evaluation reports and their supporting evidence in raw format that had been supplied by the lead evaluators of each work-stream. The scores were then shared with the individual lead evaluators, providing them with an opportunity to comment on the scores assigned. This verification procedure helped ensure that findings and evidence had not been misinterpreted by the evaluation team and that the scores reflected a fair assessment of the performance of the initiatives evaluated.

1.5.2 Synthesis

This numerical tool was used as a supporting mechanism to the synthesis of individual work-stream evaluation findings, not as its primary analytical framework, which involved a more qualitative assessment of performance against the evaluation criteria. The synthesis was conducted through an in-depth analysis of the contribution of each work-stream to the SARRAH programme outputs, in a narrative form.

1.5.3 Preparation of the MTE report

The MTE report was prepared by the evaluation's core management team, which includes Project Director Simon Griffiths, Team Leader Samy Ahmar, Technical Director Prof Leickness Simbayi, Project Manager Ntombizodwa Mbelle and in-country Coffey Technical Lead Prof John Seager. The report was drafted upon receipt of the fourteen work-stream evaluation reports and corresponding interview notes from the individual lead evaluators. On-going communication with the lead evaluators was maintained to ensure that findings were correctly interpreted when used for the synthesis.

Several drafts of this report were produced and subsequently reviewed by subject matters experts in DFID South Africa and evaluation specialists in DFID's evaluation department. Drafts were also shared with other member of the Steering Committee including representatives of Managing Agent HLSP, the M&E department of the South African Presidency and the representatives of SANAC and TAC. Feedback and comments from all stakeholders involved in reviewing the MTE report were systematically collated and responded to in written.

Moreover, drafts of individual work-stream reports were shared with the relevant technical leads in NDOH as a measure of validation of findings. However to date, no feedback had been received from the NDOH technical leads on these work-stream reports.

1.6 Research Challenges and Limitations

1.6.1 Methodological challenges and limitations

Diversity of work-streams and data sources

One of the main challenges with the evaluation of SARRAH is that the diversity of the initiatives undertaken as part of the programme did not allow for the development of a consistent set of indicators of success that could be aggregated for the purpose of synthesis of their total effects and impacts. Despite attempts to standardise the approach to evaluation, evidence had to be collected for each intervention or work-stream using different tools and techniques resulting in a wide array of sources of

data and information. The challenge was to find a systematic approach for collating and organising the evidence in such a way as to facilitate a high quality, programme level evaluation – in other words ensuring that the evidence produced from various sources is fit for the purpose of assessing the performance of SARRAH as a whole.

For the purpose of the MTE, the evaluation team have addressed this challenge by applying the OECD-DAC criteria framework (see Table 3) to enforce a degree of coherence and rigour across individual work-stream evaluations and to synthesise programme-level findings with the support of the numerical tool (see section 1.5.1). In the run-up to the final evaluation of SARRAH, the evaluation team will draw on lessons learned through the MTE and aim to enforce a higher degree of coherence in data collection activities and closer compliance with the SARRAH Theory of Change, which will eventually replace the OECD-DAC criteria to become the main evaluative framework.

Difficulties in assessing SARRAH's contribution

The MTE has taken a "bottom-up" approach to evaluating SARRAH: work-streams were assessed individually and were each subject to a thorough analysis of process and emerging outcomes, framed by the OECD-DAC criteria. This approach has precluded the MTE from being able to assess in any detail the contribution SARRAH has made to the achievement of higher level outcomes in the programme's theory of change. This assessment of contribution will be the focus of the final evaluation.

Evidence base

Some of the work-stream assessments were based on a relatively weak evidence base, mainly due to difficulties in reaching key stakeholders and accessing documents and data (see paragraph below on "lack of access to NDOH data for confidentiality reasons").

1.6.2   Operational challenges and limitations

Administrative delays

One of the main challenges for any evaluation is the need to convince those being evaluated of the impartial nature of the evaluation and the potential benefits for policy and programmatic decision-making rather than perceived negative effects on the progress of the programme. Despite the best efforts of the evaluation team, there was a tendency for the administration to delay or even prevent access to sensitive information. With hindsight, it is possible that the time allowed to obtain the required formal research permissions and to access the required people, facilities and data required for the research was not sufficient. This will be factored into the work-plan for the final evaluation of SARRAH, which the evaluation team will be developing during the first half of 2014.

Lack of access to NDOH data for confidentiality reasons

Frequently, the data the evaluation team required from NDOH was regarded as politically sensitive or confidential. Despite health being a common good, there are strict protocols governing the access to data in the South African health system which significantly restricted the availability of detailed information during the MTE. Progress reports were not available and information often had to be gleaned from press releases, presentations at conferences and workshops. Information derived from these sources was inevitably in a summarised form and precluded the depth of analysis we would have preferred, which has had a bearing on the level of rigour the evaluation team was able to apply in the MTE and is reflected in the evidence rating of the numerical tool. Upon completion of the MTE, these gaps in information have become apparent and we hope that a more participatory engagement will take place in the future, especially considering the Steering Committee's commitment to help address this issue. The more comprehensive the evaluation, the more likely it is that the information provided will help direct appropriate action.

2   EVALUATION FINDINGS

This section presents summaries of the key findings of the MTE for each of the 14 workstreams included in the evaluation. The full assessments of each work-stream are structured by the OECD-DAC criteria. However, for the purpose of presenting concise and coherent narratives these summaries are not physically structured in the same way but do reflect the approach taken for the full assessments. The scoring system is used, throughout this section, as an analytical tool to support the findings emerging from the qualitative research and to enable some degree of comparison between different work-streams. It should not be used as a substitute or summary of the more in-depth, qualitative findings. References to the relevant Annexes, which contain more granular information on the performance of the various work-streams under scrutiny, are made throughout this section. The summaries of the work-stream assessments are grouped below to reflect the two strands of SARRAH-funded initiatives:

- those designed to improve the coordination, oversight and advocacy of the national HIV & AIDS response; and

- those designed to strengthen the health systems and pave the way for a successful implementation of the NHI.

2.1   Coordination, oversight and advocacy

2.1.1   South African National AIDS Council (SANAC)

The full SANAC assessment report can be found in **Annex 16**.

SANAC is responsible for overseeing and coordinating the national response to HIV and AIDS and is intended to be "the highest body that serves to provide strategic and political guidance as well as support and monitoring for sector programmes for HIV and AIDS and STIs in South Africa"[30]. However, SANAC has struggled to establish itself in this role as a result of shortcomings in organisational structures and human resources, as well as political barriers, which have tainted SANAC with a history of perceived ineffectiveness. SARRAH's input focused on strengthening leadership and organisational capacity and on increasing monitoring and evaluation capacity to make the national response to HIV and AIDS more accountable. It provided specific support to the SANAC Secretariat to strengthen its IT, human resource and governance systems.

Over the course of 2012, SANAC underwent significant restructuring and organisational changes, including:

- SANAC's role in the 2012-2016 National Strategic Plan (NSP) was clarified ;

- new people were appointed for leadership positions;

- the organisational structure was overhauled to focus on strengthening SANAC's work at the province and district level; and

- a three-year budget was approved and legal entity established.

SARRAH is perceived by direct beneficiaries as having played a useful role in this consolidation of SANAC as an organisation, although there is little evidence that SANAC has improved its M&E capacity.

> *"One day we realised we needed a person to do something critical in the process and the next day, there they were…that was SARRAH funding." **MTE Stakeholder Interviews, 2012***

Despite these achievements, there has been little observable progress of SANAC's interaction with, and influence on, the national response to HIV and AIDS. While the above-mentioned changes were viewed as positive by a range of government and civil society representatives, there remain concerns that SANAC may remain an organisation with little actual impact on the ground. Increasing SANAC's

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[30] Consequent. Management Consulting (2010), *Developing a Workable Delivery Model for SANAC and the SANAC Secretariat*

accountability for the national response to HIV and AIDS will require empowering SANAC to fulfil its mandate more effectively, which is beyond SARRAH's brief.

An indication of the challenges and complexity surrounding SANAC's role is evidenced by the mixed opinions of SANAC held by the 22 government, donor, civil society and private sector stakeholder representatives interviewed. Some suggested that SANAC it is too strongly tied to government through finance and politics, some believed that it was heavily influenced by international NGOs and donors, while others described SANAC as too closely tied to civil society. These perspectives vary depending on which sector the stakeholders represent.

The overall score for the SANAC work-stream is 2.3. The score reflects the little progress towards strengthening and empowering SANAC, and the difficulties in identifying SARRAH's additionality.

Recommendations[31]: Indicators must be developed to monitor SANAC internally and externally, including areas such as relationship strengthening to ensure a multi-sectoral approach to combating HIV and AIDS. SARRAH should develop a strategy to support the Secretariat's mandate. NDOH and donors should invest significant resources to help SANAC undertake effective M&E. See **Annex 16** for more detailed recommendations.

2.1.2   Treatment Action Campaign (TAC)

A more detailed TAC assessment report can be found in **Annex 18**.

TAC is a civil society organisation with about 16,000 members and coverage across South Africa that seeks to address the needs of communities who are affected by HIV and related aspects such as stigma and violence. As such, it is well placed to monitor the South African government's renewed commitment to improving health and HIV and AIDS services and is conducting district reviews to monitor progress. To bolster TAC's capacity to monitor the NSP and respond to the needs of communities, SARRAH provided funding for its basic operational costs, such as salaries, and also contributed towards its ability to launch more effective advocacy campaigns by enhancing its policy, research and communications capacity. It was also provided with management support and guidance to improve its M&E capacity.

SARRAH's contribution to TAC helped enable it to streamline its monitoring and reporting functions to donors. As recently as 2010, TAC reported on 25 separate grants, each of which required substantial attention to reporting at competing times. By 2012, SARRAH assisted TAC to consolidate funding amongst 12 donors (with three new funding contracts awaiting signature). This reporting efficiency allowed TAC staff to be more involved in their core business of monitoring and advocacy, instead of spending time writing progress reports in different formats for various funders at different times.

> *"A lot of effort was required for TAC to produce different reports to different funders; some were produced quarterly and other annually". MTE Stakeholder Interviews, 2012*

TAC as an organisation is able to demonstrate efficiency through its approach to forming strategic partnerships that complement and support its activities. For example, in 2010 delays and failures in the justice system for victims of gender-based violence (GBV) prompted TAC, the Justice Coalition and other partners to pool resources and picket at constitutional institutions such as parliament and police stations. Interviews with partner organisations confirmed that TAC is able to deliver campaigns and share its costs with its partners, while also transferring skills. It should be noted however that specific outcomes could not be directly attributed to SARRAH, since TAC was supported through core budget support.

> *"It is definitely strategic to have SARRAH." MTE Stakeholder Interviews, 2012*

TAC as an organisation is also showing signs of increased influence. At the national level, interview data and reports indicate that TAC has played an important role in the development of South Africa's new

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[31] Further information on relevant reports and analysis of SANAC is provided in Annex 16

2012-2016 NSP on HIV and AIDS, STIs and TB. There are also examples of various campaigns organised by TAC that targeted national government shortcomings, such as the lack of new initiatives for patients requiring treatment, and further interruptions to the treatment supplies of patients already on ARVs (South African HIV Clinicians Society, November 2012). There is also evidence of TAC applying pressure at the local level, as demonstrated by several high profile grass roots campaigns such as advocating for better health conditions in a prison, supporting a protracted legal case involving a GBV victim and improving access to hospital for people affected by HIV.

The sustainability of SARRAH's support to TAC will depend on TAC's ability to spend the funds on strengthening its internal structure, its M&E capacity and its ability to raise funds going forward. The final evaluation results will shed more light on whether the SARRAH funding was used strategically to strengthen TAC's organisational capacity or whether it was allocated to core service delivery activities, effectively supporting TAC's capacity to operate its "business as usual". Mid-term findings do suggest that SARRAH's support has contributed significantly to TAC's ability to deliver services more efficiently and more effectively.

The overall score for the TAC work-stream is 2.5. The TAC interventions scored well in terms of relevance, efficiency and effectiveness but less so on impact and there remain questions about sustainability.

Recommendations: SARRAH should support improvements in TAC's M&E capacity to collect data on the extent to which the NSP has been successfully implemented. SARRAH should continue to fund TAC through core funding support, as this allows TAC to respond rapidly to community needs, but should also ensure that checks and balances on the utilisation of funds are strengthened. SARRAH should encourage government, legal organisations, unions, human rights organisations, HIV and AIDS advocacy organisations to work closely with TAC, which has a proven track-record for creating awareness of local issues, promoting them in international fora and helping to get them addressed at the national level. See **Annex 18** for more detailed recommendations.

2.2   Health systems strengthening and NHI

2.2.1   Assessment of CEOs and District Health Managers (DHMs)

A more detailed assessment report can be found in **Annex 5**.

The rationale for the assessment of DHMs and Hospital CEOs was based on the belief that lack of managerial skills and competencies of DHMs and CEOs are partly responsible for shortcomings in the performance of hospitals. Assessing DHMs and CEOs through a standardised test would provide a means of identifying training or staffing needs and ultimately help improve hospital performance. Stakeholders were emphatic that the assessment was relevant to national health policies and strategic frameworks. The test was administered independently by the Development Bank of Southern Africa (DBSA) and approved by the DPSA to ensure that it was aligned to its competency assessments for top management in terms of content and scoring method.

Extensive communication was maintained throughout the process to inform participants about the assessment and provide assurances that managers found to be under-qualified would be offered redeployment. Resonance was high with a response rate of 92% and non-responses were mainly related to staff being unavailable at the time of the assessment. Although provincial summaries were made available, the overall findings of the assessment were considered too sensitive for public release, or to be scrutinised by evaluators, because they contained information that affects the careers of specific individuals. CEOs had to re-apply for their posts and the majority were re-appointed, with 10-20% being new recruits.

The MTE's findings suggest that the assessment of DHMs and CEOs was a costly (R25 million) but useful exercise. It covered all provinces and allowed partial restructuring of the health system in order to prepare for the NHI.

The overall score for the assessment of DHMs and CEOs work-stream is 2.7. The relatively low score is a reflection of the difficulty in assessing the precise effect of the work-stream, partly because staff had not being appointed or redeployed at the time of the evaluation, and the activity itself being unlikely to be sustainable (or repeated) for cost reasons. The final evaluation will look at what effect

SARRAH's contribution has had on the performance of health facilities whose management changed as a result of the assessment. See **Annex 5** for more detailed recommendations.

2.2.2 Asset Management

A more detailed asset management assessment report can be found in **Annex 6**.

The Auditor General has repeatedly identified poor asset control as a cause for concern within NDOH and there were qualified audits in 60% of its facilities in 2012; most of these were the result of a history of poor asset management[32]. In 2010-11, the KwaZulu-Natal Health Department received a qualified audit 'mainly due to weak internal control environments over assets and leave'[33]. Similar findings were reported for the Eastern Cape[34] and Mpumalanga and many were repeat findings from 2009-10. Poor asset control negatively affects the day-today running of health facilities and can lead to unnecessary duplications of equipment and poor maintenance. Addressing this issue was therefore selected as an initiative for the SARRAH programme to support.

SARRAH commissioned consultants to implement a computerised asset management system and demonstrate its efficacy in the National Head Office and selected provincial health departments, namely, KwaZulu Natal, Mpumalanga and the Eastern Cape. SARRAH support allowed about 1.4 million assets at 2,800 sites to be accurately verified and valued.

The approach was to train local people to undertake asset management in terms of counts, condition assessment and valuation when paired with professional staff from the service provider. The work-stream trained 85 asset management staff who can potentially be employed by provincial Asset Management Units. The intervention also worked to ensure that essential information could be provided in more accessible formats (Excel spreadsheets or hard copy) than existing systems, and staff acknowledged that an accurate asset register helps them maintain equipment more effectively and lobby for more equipment when necessary. The national department achieved an unqualified audit opinion with findings for the first time in 2010/11 and signs of improvement were evident for Mpumalanga, which had half as many qualifications as the previous year, most of which could be resolved quickly using the new computerised database.

The SARRAH intervention produced measurable improvements in asset management, in the selected sites. Whether these improvements can be sustained will depend on the ability of the various health departments to incorporate the newly trained staff into their Asset Management Units, some of which are not yet operational. The Asset Management work-stream has improved financial management and planning, which contributes to strengthening the health system. If the systems put in place continue to be used the next Auditor General's reports should show further reductions in qualified audits.

The overall score for the Asset Management work-stream is 3.1. The intervention scored well on all aspects except sustainability, which depends on provincial health departments allocating the necessary budgets for the new system to be adopted by their Asset Management Units.

Recommendations: Finding out what proportion of the 85 trainees have been employed as permanent employees in the provincial Asset management Units will be important in understanding the extent to which SARRAH's contribution has been truly effective in a sustainable way, which will be a focal point for the final evaluation of SARRAH. See **Annex 6** for more detailed recommendations.

2.2.3 Conditional Grant Management

A more detailed CGM assessment report can be found in **Annex 7**.

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[32] QFinance defines a qualified audit as a "statement in the auditor's report of a company's annual accounts indicating a fundamental disagreement with the company to such an extent that the auditor considers the accounts misleading."

[33] Auditor General (2011), *General report on the outcomes of the KwaZulu-Natal Provincial Government 2010-11*

[34] Auditor General (2011), *General report on the outcomes of the Eastern Cape provincial government 2010-11*

About 95% of the total NDOH funding to provinces is disbursed in the form of Health Conditional Grants (CG). NDOH currently manages six CGs, one of which is dedicated to the Comprehensive HIV and AIDS plan. This CG was at the core of the *Conditional Grant Management* work-stream that aimed to address the significant difference between planned and actual expenditure, which has always been a concern for the South African government. Poor grant management has led to grants being regularly under-spent or over-spent. This resulted from:

- poor expenditure control;

- occasional disregard of policies, procedures and processes;

- lack of costing of priority programmes such as ART, Tuberculosis, and Maternal and Child Health; and

- ineffective leadership.

SARRAH's primary focus was to provide technical assistance to NDOH in provinces for business planning, setting up systems for CG spending and for monitoring expenditure. SARRAH also provided support to:

- provinces to develop grant management processes in line with NDOH priorities and Treasury timelines;

- the NDOH to increase its understanding of how provincial spending and reporting on the CGs affects the NDOH's financial audit outcomes; and

- Non-Governmental Organisations (NGOs) on how to comply with relevant government financial laws and policies relating to CG.

SARRAH's support is relevant as it strengthened performance management and strategic planning for HIV and health services and was generally effective, especially in building the capacity of provincial managers and NGOs in legal, financial and regulatory management, and the timely submission of business plans and reports by provincial CG managers. SARRAH was also effective in setting up a functioning financial monitoring system, developing the understanding of CG management including monitoring expenditure, compiling reports to National Treasury, developing indicators, allocating funds to programmes and disbursing funds to institutions. Concerns raised by the Auditor General in 2011/12 were taken seriously as evidenced by their inclusion in the 2012/13 strategic plans.

"SARRAH requested expenditure records in order to interrogate them and assist with developing plans, speak to the concerned parties or report back to the DG. Therefore, SARRAH played a critical catalyst and facilitative role." **MTE Stakeholder Interviews, 2012**

The SARRAH inputs helped to correct deviations, shared information among provinces to increase accountability, and helped to ensure funds where channelled to appropriate AIDS-related programmes. The impact of this work-stream cannot be attributed to SARRAH alone, given that technical and financial support were also provided by NDOH, but the impact was regarded as substantial by stakeholders. After the intervention, NDOH hired the former SARRAH consultant to continue the work. In NDOH, a new unit dealing with the CG for the Comprehensive HIV and AIDS plan was established with a full staff complement.

Hiring a consultant was efficient. When one is a consultant there is a work ethic. A consultant has to submit a time sheet with deliverables. Another thing is that being a consultant was accompanied by limited red-tape. The consultant did not have to follow the protocol. For example, with the signing of the letters, he will take the letter straight to the last person who is supposed to take decisions." **MTE Stakeholder Interviews, 2012**

"Provinces are supposed to submit the expenditure reports 15 days before the month ends, and the NDOH 20 days after the month to the NT. This used not to happen. Thanks to SARRAH support, in meetings the emphasis from the consultant or another senior person was on the importance of compliance." **Stakeholder interviews**

The overall score for the Conditional Grant Management work-stream is 3.2. Most aspects of this work-stream were highly rated highly.

Recommendations: Monthly reports submitted to NDOH by the consultant should also be shared with HLSP for monitoring and evaluation purposes. Close monitoring of performance at provincial level must be on-going to detect areas that may require further support. See **Annex 7** for more detailed recommendations.

2.2.4 Public Financial Management

A more detailed Public Financial Management assessment report can be found in **Annex 8**.

The greater part of the South African national health budget is spent at the provincial level and provinces in South Africa have a substantial degree of autonomy in allocating resources. Consequently, the quality of Public Financial Management (PFM) in the national health system critically depends on the capacity of provinces to manage funds effectively, efficiently, and in a transparent and accountable manner. Past provincial audits in health departments identified various shortcomings in PFM, such as irregular expenditures, undue advantage in the allocation of contracts, unfair procurement, and lack of consequences for poor performance[35].

> *"…we were alarmed by the amount of money government loses to projects owing to poor planning, poor financial resource management, unfair procurement processes and poor project management"*
> **Standing Committee on Public Accounts**

This SARRAH work-stream aimed to build PFM capacity at the provincial level to achieve the following three key outcomes:

- comprehensive and credible budgets that link directly to policy priorities;
- effective financial management systems to ensure that the budget is implemented as intended, in a controlled and predictable way; and
- timely and accurate fiscal reporting.

SARRAH technical support was intended to improve audit outcomes and reduce the number of qualifications raised by the Auditor General. Activities were aligned with the requirements of PFMA and included:

- identifying deficiencies and challenges within the system (such as organisational and institutional weaknesses, staff shortages and unmet training needs);
- providing an oversight role through the early identification of potential progress blockages and budget shortfalls; and
- initiating remedial action.

As the provincial governments of Western Cape and KwaZulu Natal had already launched their own PFM improvement processes, the programme was only rolled out in the remaining seven provinces.

Out of the seven targeted provinces, only North West was able to demonstrate improvement in PFM and budget control by obtaining clean audits during both 2009-2010 and 2010-2011 financial years. The majority of other provinces showed little or no improvement in their PFM despite the support received through SARRAH. High vacancy rates for positions in finance, supply chain management, internal audits and risk management were identified as a key barrier since remedial programmes cannot be implemented without suitably qualified personnel.

This work-stream was seen as highly relevant because PFM is a high profile national concern. However the recommendations formulated by the SARRAH consultants have not been implemented despite a thorough diagnosis of the problems in seven provinces. There is, however, a suggestion that the work-stream's diagnostic reports and recommendations might be used in the future since the Minister of Health referred to some of the SARRAH supported diagnostic work in his 2012 budget speech.

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[35] Auditor-General South Africa (2010), *Consolidated general report on the provincial audit outcomes*

The overall score for the Provincial Financial Management work-stream =is 2.0. Despite its high score for its relevance, this activity scored poorly on effectiveness and efficiency. Although not performing well at this stage there is potential for improvements in terms of its impact and sustainability if the proposals are taken up by NDOH and the provinces.

Recommendations: Any new SARRAH support should include technical assistance for recruiting suitably qualified individuals to occupy vacant posts. See **Annex 8** for more detailed recommendations.

2.2.5   Human Resource for Health Strategy

A more detailed HRH Strategy assessment report can be found in **Annex 9**.

The existing NDOH national human resource strategy for the health sector (HRH strategy) and its policies failed to address the demands of new initiatives such as NHI and primary health care (PHC) restructuring. The situation with regards to human resource management in the health sector in South Africa was characterised in particular by

- a poorly performing and de-motivated workforce;
- the failure to attract the limited resources to rural areas;
- high attrition rates; and
- a preference for private health facilities in comparison to public ones.

"There are capacity constraints: there is no dedicated admin or HR support and generally poor admin and financial support in the NDOH. Funding per se is less of an issue than the lack of staff to do the work. Given the funding, HR needs to recruit the necessary staff but without adequate HR the appointments cannot be made (a vicious circle)." ***MTE Stakeholder Interviews, 2012***

"The minister insisted that the whole system requires an overhaul in order for the new initiatives to function well and key to this is the HR strategy" ***MTE Stakeholder Interviews, 2012***

This SARRAH work-stream aimed to provide NDOH with a draft HRH strategy that would be used to align national health workforce interventions to the objectives of the NDOH annual performance plan and Medium Term Expenditure Framework (MTEF) priorities. SARRAH provided technical assistance through a consultant placed at the NDOH who had sole responsibility for developing the HRH strategy in consultation with the DG and her Cluster Managers. The main activities under the HRH strategy were:

- undertaking a draft audit of existing HRH policies and research at NDOH;
- developing the draft HRH strategy;
- preparing a discussion document for consultation; and
- submitting the final draft HRH strategy report outlining how to more closely align national health workforce interventions to the objectives of the NDOH.

"…the development of the [HRH] strategy hit the time line and was delivered as per plans" ***MTE Stakeholder Interviews, 2012***

The development of the HRH strategy was accomplished in time and all its related objectives were met. The evidence derived from the document review and interviews indicated that development of the HRH strategy was efficient, delivering on time as planned. However, there is also evidence that some stakeholders felt frustration with the process. The development of the HRH strategy received the following criticisms:

- the timeframes of this initiative were too short to enable an appropriate level of consultations and feedback;

"It's a pity that the HR strategy was developed in such a rushed manner, and so we other stakeholders had very limited contribution, despite the fact that we were sent it to comment on, we were given very short time to respond" ***MTE Stakeholder Interviews, 2012***

- the content of the new HRH strategy lacked contextualisation and did not clearly distinguish roles and responsibilities; and

- that the new strategy arose a general tendency to develop additional strategies without evaluating the existing ones to gather lessons on development, implementation and process issues.

It is too early to assess the impact of the HRH strategy, but following its release several initiatives were undertaken to address some of its recommendations. These included:

- the creation of a leadership academy to improve management skills in the health sector;
- the development of an electronic database to assist with HRH planning;
- funding commitments for universities who could increase intake of medical students for 2012; and
- further research into shortages of nurses and strategies to increase the number of trained nurses in South Africa.

Critically however, there was no operational plan or budget for implementation of the strategy and selection of activities has been on an ad-hoc basis. Although the Minister is currently the main driver of the initiative, there is also a lack of manpower within NDOH to carry the HRH strategy forward.

"It is not the fault of the strategy but rather the lack of the manpower especially a DDG to drive the overall process" **MTE Stakeholder Interviews, 2012**

Despite some weaknesses in terms of its effectiveness and efficiency, the HRH strategy is a very relevant document at a time when key policies such as NHI and PHC re-engineering are placing new demands on human resources. There is also strong evidence of immediate outcomes emanating from the HRH strategy such as efforts towards expansion of HRH, improved funding, improved employment and tackling nursing shortages.

The overall score of the Human Resources for Health Strategy work-stream is 2.4. This score is derived from a high score for its relevance, moderate scores for its efficiency but low scores for its effectiveness and sustainability. See **Annex 9** for more detailed recommendations.

Recommendations: There is a need for NDOH to operationalise the HRH strategy. This needs, inter alia, the identification of more capacity within NDOH and higher education to drive the process and quantification of the resources needed to address the current and impending human resource crisis, which, if unresolved, will render all the reforms ineffective.

2.2.6 Organisational Redesign of NDOH

A more detailed NDOH organisational redesign assessment report can be found in **Annex 10**.

NDOH's existing management structure was ineffective and misaligned with strategic policy priorities. Roles and responsibilities lacked clarity leading to duplicative and inflated management structures, and performance and talent management was weak, triggering disillusionment among staff[36]. The Minister of Health and the DG identified the redesign of the NDOH's organisational structure as a core priority in the overall effort to facilitate reform in the health sector.

"It can no longer be business as usual. Planning, organisation, and delivery of health services must reflect an added sense of urgency[37].*"* **Minister of Health**

The SARRAH work-stream set out to restructure NDOH and improve its decision-making capacity for better service delivery in line with the Ten Point Plan, the NSDA, and the requirements of NHI. NDOH restructuring comprised:

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[36] UK Department for International Development (2011), *Overview of Health Sector Reforms in South Africa*
[37] Dr P.A. Motsoaledi, Minister of Health, NDOH Strategic Plan 2010/11–2012/13:4

- the redesign of the organisational structure (from Deputy Director General to Director level) to enable planning processes that align with policy priorities and to improve performance management and accountability;

- the approval of the new structure by the Department for Public Service and Administration (DPSA);

- acceptance of proposals by unions;

- recruitment or internal transfer of staff for new posts; and

- restructuring of lower levels by those appointed.

"The new leadership believed the Department to be unable to deliver on its new mandate. Senior portfolios were not aligned and there were a range of legacy issues which resulted in a mismatch between skills present and those needed." MTE Stakeholder Interviews, 2012

Despite the inevitable anxiety caused by restructuring, staff felt change was long overdue and agreed that senior portfolios were not aligned with their purpose and that skills mismatches existed. NDOH was satisfied with the initial realignment of responsibilities although some respondents felt that decision-making was still too centralised and lacked transparency. There is a sense that organisational effectiveness has improved although there were still a number posts to be filled at the time of the evaluation. The DPSA has approved the new structure and change management teams are in place.

The process is regarded as progressing steadily. 70% of the work has been completed at CD level and should be complete by March 2013. Directors will be addressed after this." Stakeholder Interviews

Although the process is a long one, the restructuring appears to be progressing according to plan, and the new organogram is better aligned to the NSDA. Assuming the necessary human resources can be found and posts filled at all levels, the new structure should strengthen NSDA Output 4: Strengthening Health System Effectiveness.

The overall score for the NDOH Restructuring work-stream is 3.0. This score is derived from high scores for relevance and efficiency but a low effectiveness score due to the considerable work to complete the restructuring at the time of the evaluation.

Recommendations: The evaluation team had limited access to documentation on the restructuring and redeployment of staff owing to its confidential nature. It would be preferable, and almost certainly beneficial to NDOH, if the service provider and evaluation team were given more access to this information for the final evaluation of SARRAH, even if this has to be in the form of 'desensitised reports' or subject to a confidentiality agreement. See **Annex 10** for more detailed recommendations.

2.2.7 National Health Insurance

A more detailed NHI assessment report can be found in **Annex 11**.

The South African government's planning for NHI has been in progress for several years with inputs to its design from many local and international experts. A Green Paper on NHI[38] was released for public comment in August 2011. The scheme aims to achieve equitable access to quality health care, free at the point of use, for all South Africans. NHI is a very ambitious undertaking which is estimated to require 14 years to implement. NHI is a very high priority for the South African government and one which is breaking new ground all the time and requires substantial technical expertise.

Direct support to the NHI process has included:

- research into the technical aspects of NHI including a wide range of international experiences in implementing national health schemes;

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[38] National Department of Health (2011), *National Health Insurance in South Africa: Policy paper*

- supporting the development of a communications strategy for the NHI process;

- providing technical support for (1) the development of district service packages; (2) the Task Team working on the development of District Clinical Specialist Teams; (3) the Ward Based Outreach Teams; (4) the Programme Management Unit in the NDOH; and (5) the selection of the NHI pilot districts (6) ; and

- logistical assistance to (1) the Minister's Advisory Committee on NHI and (2) the Ministerial Road Show.

SARRAH has played a significant role in laying the groundwork for implementing NHI. SARRAH's technical assistance supported decisions by NDOH regarding the basic structure of NHI, helped identify and find solutions for deficiencies in the health system, and assisted with selecting pilot sites where the challenges of NHI implementation can be ironed out.

SARRAH's NHI contributions appear to have filled some critical gaps. Consultants appointed by SARRAH have helped move processes forward and the catalytic nature of SARRAH has been recognised by stakeholders and could result in large impacts over time.

*"There is no risk that SARRAH investments will be wasted, as they all contribute to health system strengthening. Politicians are signed up to NHI and universal access is widely accepted as a public good around the world. Affordability remains a question, and it may take longer than initially planned. The status quo is unsustainable because employers will refuse to pay more and individuals will not be able to afford it." **MTE Stakeholder Interviews, 2012***

The NHI work-stream has included consultations that should increase buy-in and sustainability, including between national and provincial health departments, public and private health service providers and community-based organisations. NHI is considered a very high priority by the government and this should promote sustainability,[39] although there are clearly still challenges to be overcome. Ultimately, NHI is still controlled by Treasury which funds NDOH, which in turn funds the provincial health departments. Thus a key component of successful implementation relies on 'convincing' Treasury of the economic merits and feasibility of the intervention. This process requires hard evidence including both health and economic policy-based arguments - something which SARRAH is well placed to provide.

The overall score for the NHI work-stream is 2.9. There were high scores for Relevance and Sustainability but only medium scores for Effectiveness, Efficiency and Impact.

Recommendations: As reforms cease to be novel and become routine there will be a need for careful change management to ensure sustainability. Systems should be put in place to ensure that suitable baseline information is collected in the pilot districts so that a thorough final evaluation is possible. See **Annex 11** for more detailed recommendations.

2.2.8   NHIRD

A more detailed NHIRD assessment report can be found in **Annex 12**.

The NSDA highlighted the health information system as a target area because it was unable to satisfactorily produce information for management, monitoring and evaluation of the health system. An improved system for procuring and managing Information Communication Technology was called for which would produce reliable health data to strengthen performance management and strategic planning at national and provincial levels.

SARRAH is supporting the development of the NHIRD, which integrates information on all aspects of health in South Africa with social and economic data and is accessible to a wide range of stakeholders. By August 2011, District Health Information Systems (DHIS) data, socio-economic data

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[39] For instance, one senior informant expressed concern that there were not sufficient human resources to manage the NHI.

from Statistics South Africa and financial data from the NDOH had been loaded on to the new system. The NHIRD addresses the information requirements of the Ten Point Plan and will facilitate monitoring and evaluation of the NSPs for HIV and AIDS, STIs and TB, and NHI.

The evaluation found that while some milestones were not achieved on time, the project rapidly expanded in scope and the final product exceeded the initial specifications. At the time of the evaluation, relatively few users had access to the system and no reports directly attributable to NHIRD were available for review. However, confidence was high and the system was endorsed by the Minister of Health at its launch.

The overall score for the NHIRD work-stream is 2.7. The evidence suggested that the system was achieving its objectives, but some of this evidence was weak and therefore final scores were moderated.

Recommendations: Access to NHIRD data was not possible during the initial evaluation but permission has subsequently been granted for a demonstration of the system's capabilities. A more comprehensive assessment must be undertaken during the final evaluation. See **Annex 12** for more detailed recommendations.

2.2.9 Prevention of Mother-To-Child Transmission of HIV (PMTCT)

A more detailed PMTCT assessment report can be found in **Annex 13**.

Multidrug therapy for HIV-infected women and their unborn infants is central to strategies relating to PMTCT as it can reduce the transmission rate to less than 5%. From May 2009 to June 2011, NDOH implemented the pilot 'PMTCT Accelerated Plan' (the A-Plan) to reduce the vertical transmission of HIV. The A-Plan aimed to increase the demand for PMTCT services through a social and community mobilisation strategy and to enhance supply of quality services by improving PMTCT services management. SARRAH support was provided to:

- coordinate partners in selected districts;

- advocate the implementation of the A-Plan;

- mobilise additional partners and resources;

- monitor and reporting on implementation and progress; and

- ensure sufficient capacity for scale up of the A-Plan.

The SARRAH programme was perceived very favourably by national, provincial and district officials as well as other PMTCT partners. SARRAH's support to NDOH in the leadership, management and coordination of the A-Plan was seen as instrumental to:

- achieving intermediate objectives such as integrating PMTCT into existing maternal and child health interventions;

- harnessing relevant networks and partnerships between government, civil society, the private sector and donor partners; and

- strengthening the district-level monitoring, evaluation and reporting of PMTCT intervention outcomes.

"As someone who had worked in NDOH sub directorate and as a partner of NDOH in implementing PMTCT at the time, the purpose of the A-Plan was to strengthen an existing PMTCT programme. In that capacity, SARRAH (DFID) made a big contribution." **MTE Stakeholder Interviews, 2012**

Although the pilot A-Plan was only scaled up nationally from July 2011, there was already clear evidence that mother-to-child transmission had decreased to less than 5%, according to DHIS. In terms of sustainability, alliances and partnerships fostered between PMTCT actors were still strong at the time of the MTE, nearly 2 years after completion of the pilot, and SARRAH has managed to secure funding to continue the work initiated with the A-Plan.

"The plans that were there with the government could have worked over a long time. But then it [SARRAH funding] came to beef up and assist the activities so that they can reach the goal they are meant to reach… within a short period of time." MTE Stakeholder Interviews, 2012

The overall score for the PMTCT work-stream is 3.2. This work-stream was highly rated on most aspects and the evidence found it to have been a successful initiative.

Recommendations: DFID should continue to support NDOH in implementing best practices that promote quality, integrated maternal, child and women's health services. In light of the pronounced success of the PMTCT A-plan, DFID should also consider evaluating other PMTCT interventions. This will entail understanding the operational (e.g. drug safety monitoring, drug supply chain, organisation of services), patient centred (adherence and patient retention) and costing issues in various settings (e.g. urban and rural) with a focus on integration of care and streamlined service delivery. See **Annex 13** for more detailed recommendations.

2.2.10 Quality Assurance

A more detailed Quality Assurance assessment report can be found in **Annex 14**.

Since 2008, health policy makers in South Africa have placed growing emphasis on improving quality of care and setting health care standards. NDOH has developed a set of National Core Standards (NCS) that establish the basic requirements for health establishments to provide quality care in line with the Government's Ten Point Plan. The standards will be used by the new Office of Health Standards Compliance (OHSC) to set performance benchmarks for quality healthcare. Hospitals, clinics and districts will be assessed against these benchmarks to identify deficiencies and appraise strengths. Compliance with the NCS will be a prerequisite for health establishments to participate in the NHI system. Quality assurance is highly relevant because it is a cornerstone of health service delivery and an essential component of the NHI system.

"SARRAH established an 'enabling environment'. It developed standards, questionnaires, measures and a database which could produce preliminary reports for facilities conducting assessments." MTE Stakeholder Interviews, 2012

SARRAH's Quality Assurance work-stream included technical support for designing the NCS and the development of a business case for the establishment of the OHSC. It generated an enabling environment by assisting with developing, refining and piloting the NCS, as well as by designing of a set of assessment tools to measure compliance. The proposal for the OHSC, prepared with SARRAH support, received endorsement from the Ministry of Finance to prioritise funding and support.

Although the NCS address important risks to patients' health and safety stemming from poor quality care, several of the indicators of the proposed assessment tool lack the necessary detail for successful implementation. At the time of the evaluation, the business case for the OHSC was being taken forward by the Treasury Assistance Unit but the public entity will take some time to become fully staffed and operational. The NCS were regarded as useful because they provided facility managers with a better sense of what was required to deliver quality care, but using them as a tool for improving performance was apparently challenging because managers were not always sure how to go about addressing deficiencies, either financially or practically.

Despite some challenges identified by the evaluation, a solid start has been made and the standards and assessment tools have the potential to improve the quality of the South African health system.

The overall score of the Quality Assurance work-stream is 3.1. This work-stream was highly rated on all criteria except on Impact, as questions remain with regards to health facilities' capacity to apply the NCS.

"Quick wins should not distract the focus of the Health Facility Improvement Teams from the major tasks that remain to be done." Head of the Free State Department of Health

Recommendations: NDOH should continue to refine the NCS and correct ambiguities in the wording of assessment indicators. While the 'fast track priorities' provide a focus for initial quality improvements, these quick wins must not distract from the more difficult and systemic challenges which the comprehensive QA system seeks to address. DFID should consider supporting the QA at

heath facilities through SARRAH technical assistance to resolve complex and systemic problems. See **Annex 14** for more detailed recommendations.

2.2.11 SAHPRA

A more detailed SAHPRA assessment report can be found in **Annex 15**.

In 2008, the Medicines and Regulatory Act called for the establishment of a new regulatory authority to replace the existing Medicines Control Council (MCC), which suffered from large backlogs of unprocessed applications for new drug and devices registrations. SAHPRA was initiated to fill this role and to manage the registration, regulation and control of medicines and health related products more efficiently. It was expected that an efficient SAHPRA will make essential drugs more readily available, and potentially reduce prices through increased competition and licensing of generic drugs. SARRAH provided technical assistance on health products regulations and legislation, interacting with both NDOH and MCC in order to facilitate the establishment of SAHPRA.

SARRAH helped implement an electronic document management system and appointed additional (temporary) staff to accelerate the review of applications for new drug and devices registrations. Within 6 months, the registration backlog was reduced by half. In addition, a comprehensive business plan for SAHPRA, covering HR policies and procedures, was submitted to NDOH in 2012.

However, the success has been short-lived and the application backlog has quickly risen again. At the time of the MTE, SAHPRA has not been established fully due to delays relating to negotiations with organised labour and the normal protracted legislative process. There remain questions of sustainability since the necessary expertise in relevant medical and health related topic areas (e.g. toxicology and medicine safety, clinical pharmacology, biotechnology, etc.) is in short supply and it is therefore unlikely that SAHPRA will be able to recruit the required staff complement right away.

> *"NDOH report that the backlog has been reduced to 1,500 but the South Africa Clinical Research Association (SACRA) and pharmaceutical industry disputes this. Instead they report that backlogs have increased due to MCC leaving work for SAHPRA to handle owing to the announcement by the DG that SAHPRA would be operating imminently." MTE Stakeholder Interviews, 2012*

The overall score for the SAHPRA work-stream is 2.7. This score reflects a low effectiveness score due to the recurrent backlog and reservations regarding both impact and sustainability.

Recommendations: Now that SAHPRA has overcome several important regulatory hurdles, SARRAH should continue to support NDOH to help ensure that the effort put in so far comes to fruition. Furthermore, SARRAH should consider the following recommendations (See **Annex 15** for more detailed recommendations):

- Given that the pharmaceutical industry is expected to cover two thirds of the costs of SAHPRA (through registration fees), NDOH should establish an effective communication tool to provide updates on the progress of processing applications for drug and devices registration.

> *"It was felt that money was not used wisely since establishing SAHPRA was based on [a] misconception and did [neither] deal with existing problematic issues [nor] take seriously [the] input from the industry. Funds could have been put into real dialogues between government and the industry." MTE Stakeholder Interviews, 2012*

- A project manager and additional protocol reviewers should be appointed to fast-track the backlog;

- NDOH must review legislation relating to applications for known compounds or compounds already approved by other regulatory bodies such as the US Federal Drug Administration; and

- Funding from NDOH for sustaining SAHPRA should be committed and ring-fenced, particularly as the SAHPRA business case calls for almost three times more staff than is currently employed by the MCC.

2.2.12 Service Transformation Plans (STP)

A more detailed STP assessment report can be found in **Annex 17**.

In 2006, NDOH asked the South African provinces to develop STPs that set out their approaches to improving health service delivery. The STPs were designed to outline the delivery plan with respect to key component areas, including human resources, quality improvement, drug supply and management, information and communication technologies and health information system, communication, research and development and financing. By 2009, most provinces had produced inadequate and unfinished draft plans. SARRAH's STP work-stream was set up to help the provinces finalise their draft STPs and align them with the Government's Ten Point Plan.

SARRAH technical assistance teams completed a desk-based review of all nine provincial draft STPs and assisted with the completion of seven provincial reports by identifying outstanding issues to be finalised with a particular focus on costing and scenario planning. By the end of 2011, eight of the nine provincial STPs had been approved by the respective departments of health, with the exception of the costing component of the Kwazulu-Natal STP. However, it remains unclear to what extent these STPs have been implemented by the provincial departments of health, and it appeared that they were put on hold until the requirements of NHI (specifically the proposed pilot districts) are clear.

The available evidence suggests that SARRAH provided the catalyst and support needed for the completion of the STPs by those provinces that had previously lacked capacity to address the remaining gaps in their drafts.

The overall score of the STP work-stream is 2.5. The low score reflects the weakness of the evidence base supporting SARRAH's contribution. See **Annex 17** for more detailed recommendations.

2.3 Mid-term Evaluation Scoring Sheet

Below is a summary table of SARRAH's meta-evaluation findings as well as a programme score against each of the five OECD-DAC evaluation criteria and overall (see **Table 3** for a more detailed explanation of the OECD-DAC criteria). Overall, **the mid-term rating for SARRAH is 2.8**, which is the average score on a scale of 1 to 4. The nature of the scoring system implies that this score is unlikely to decrease, and much more likely to increase as some of the longer-term outcomes and impacts materialise and become observable at the final evaluation stage. The Relevance and Efficiency scores are essentially summative (statement on past performance) and will remain constant throughout. The Effectiveness, Impact and Sustainability scores are of a more formative nature (designed to inform future development) and therefore may improve as the initiatives start to bear fruit more noticeably.

Table 7 – MTE Scoring Sheet

Work-stream	Criteria	Data Source 1		Spend to date [40]	Weight	Total	Overall score
		Finding	Quality of Evidence				
SANAC	Relevance	3	Strong	£1,568,636	12%	**4**	**2.3**
	Effectiveness	2	Medium			**2**	
	Efficiency	2	Strong			**2**	
	Impact	1	Weak			**1**	
	Sustainability	3	Weak			**2**	
NHI	Relevance	4	Strong	£1,539,513	11%	**4**	**2.9**
	Effectiveness	3	Medium			**3**	

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[40] Budget figures were extracted from the SARRAH Milestone Matrix of Q3 2012, which is the most up-to-date version publicly available. http://www.sarrahsouthafrica.org/LinkClick.aspx?fileticket=e_KlQ-g3XXw%3d&tabid=2318

Work-stream	Criteria	Data Source 1		Spend to date [40]	Weight	Total	Overall score
		Finding	Quality of Evidence				
	Efficiency	3	Weak			**2**	
	Impact	3	Weak			**2**	
	Sustainability	4	Medium			**4**	
SAHPRA	Relevance	4	Strong	£2,958,838	22%	**4**	**2.7**
	Effectiveness	1	Weak			**2**	
	Efficiency	3	Medium			**3**	
	Impact	2	Medium			**2**	
	Sustainability	2	Medium			**2**	
Quality Assurance	Relevance	4	Medium	£820,500	6%	**4**	**3.1**
	Effectiveness	3	Strong			**3**	
	Efficiency	3	Medium			**3**	
	Impact	2	Strong			**2**	
	Sustainability	3	Medium			**3**	
NDOH	Relevance	4	Medium	£633,000	5%	**3**	**3.0**
	Effectiveness	2	Weak			**2**	
	Efficiency	4	Medium			**4**	
	Impact	3	Medium			**3**	
	Sustainability	3	Medium			**3**	
NHIRD	Relevance	4	Medium	£271,000	2%	**4**	**2.7**
	Effectiveness	3	Medium			**3**	
	Efficiency	3	Weak			**2**	
	Impact	4	Weak			**2**	
	Sustainability	3	Medium			**2**	
PMTCT	Relevance	4	Strong	£280,000	2%	**4**	**3.2**
	Effectiveness	3	Medium			**3**	
	Efficiency	3	Medium			**3**	
	Impact	3	Medium			**3**	
	Sustainability	3	Strong			**3**	
TAC	Relevance	3	Medium	£1,511,000	11%	**3**	**2.5**
	Effectiveness	3	Medium			**2**	
	Efficiency	4	Weak			**3**	
	Impact	3	Weak			**2**	
	Sustainability	2	Weak			**2**	
Assessment of CEOs	Relevance	3	Weak	£1,149,437	8%	**3**	**2.7**
	Effectiveness	3	Medium			**3**	
	Efficiency	3	Medium			**3**	
	Impact	2	Medium			**2**	
	Sustainability	1	Weak			**1**	
Provincial Financial Management	Relevance	3	Medium	£215,000	2%	3	**2.0**
	Effectiveness	1	Weak			2	
	Efficiency	1	Weak			2	
	Impact	2	Weak			1	
	Sustainability	2	Weak			1	
Conditional Grant	Relevance	4	High	£72,200	1%	**4**	**3.2**
	Effectiveness	4	Medium			**3**	

Work-stream	Criteria	Data Source 1		Spend to date [40]	Weight	Total	Overall score
		Finding	Quality of Evidence				
Management	Efficiency	3	Medium			**3**	
	Impact	3	Weak			**2**	
	Sustainability	4	Strong			**4**	
STPs	Relevance	4	Weak	£249,800	2%	**3**	**2.5**
	Effectiveness	3	Weak			**2**	
	Efficiency	3	Medium			**3**	
	Impact	3	Weak			**2**	
	Sustainability	2	Weak			**2**	
Human Resources	Relevance	4	Medium	£198,000	1%	4	**2.4**
	Effectiveness	2	Weak			2	
	Efficiency	3	Weak			2	
	Impact	2	Weak			2	
	Sustainability	2	Weak			2	
Asset Management	Relevance	4	Strong	£2,168,523	16%	**4**	**3.1**
	Effectiveness	3	Strong			**3**	
	Efficiency	3	Medium			**3**	
	Impact	3	Medium			**3**	
	Sustainability	2	Weak			**2**	
					100%		
SARRAH	*Relevance*				*0.2*	**3.7**	**2.8**
	Effectiveness				*0.3*	**2.5**	
	Efficiency				*0.2*	**2.8**	
	Impact				*0.15*	**2.1**	
	Sustainability				*0.15*	**2.3**	

3   VALUE FOR MONEY

3.1   Overall Approach

The SARRAH Evaluation Strategy (see Annex 5) sets out a '3Es' approach[41] to assessing the Value for Money of the programme. This is an approach that considers the interplay between three key components of Value for Money defined as:

- *Economy* – the cost of the inputs, or in other words has SARRAH done things at the right price?

- *Efficiency* – the ratio of inputs to outputs, or in other words has SARRAH done things in the right ways?

- *Effectiveness* – the relationship between inputs, outputs and outcomes, or in other words has SARRAH done the right things?

Combining all three of these components enables the evaluation to draw holistic, evidence-based and triangulated conclusions to determine whether SARRAH has *done the right things, in the right ways and at the right price*.

3.2   Scope of this VFM Assessment at the Mid-Term Stage

The Evaluation Strategy (see Annex 5) references an important source of evidence concerning the assessment of SARRAH's Value for Money, which is the 'Value for Money Review of SARRAH' commissioned by DFID South Africa and completed by an independent consultant, Charles Wright in March 2012.[42] This complements three Annual Reviews completed by DFID and Coffey International Development in June 2011, 2012 and 2013, respectively.[43]

The focus of this Value for Money Review was on the 'execution' of the SARRAH contract, i.e. the economy and efficiency of the programme. The review was framed by the following four assessment tool questions:

- *Q1: Are the programme procurement and execution processes, strong and in order, so input and output conversion is done efficiently? (Weight = 15%);*

- *Q2: Are the deliverables fit for purpose? (Weight = 30%);*

- *Q3: Are the deliverables produced at a fair and reasonable cost? (Weight = 20%); and*

- *Q4: Are the deliverables effective – being utilised – and having intended impact? (Weight = 35%).*

The Evaluation Strategy (see Annex 5) determined that given the scope and focus of the Value for Money Review it would be appropriate for this MTE to focus on SARRAH's effectiveness, i.e. the extent to which outputs are translating into desired outcomes.

At this stage in the programme lifecycle of SARRAH, many of the work-stream activities will have been completed or are nearing completion. Many of SARRAH's work-stream activities will take a significant amount of time to have a sustainable effect on the programme's outcomes. For this reason, the Evaluation Strategy (see Annex 5) proposed that this MTE should adopt a process evaluation approach that focuses on what has been delivered, how and with what intermediate results and effects.

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[41] DFID (2011), *DFID's Approach to Value for Money*; and ICAI (2011), *ICAI's Approach to Effectiveness and Value for Money*

[42] DFID (2012), *Value for Money: DFID South Africa Review of the SARRAH Programme November 2011 – January 2012,* http://www.sarrahsouthafrica.org/LinkClick.aspx?fileticket=T-KC2Isulm0%3D&tabid=2518

[43] SARRAH Annual Review 2012: http://iati.dfid.gov.uk/iati_documents/3971744.docx; SARRAH Annual Review 2013: http://iati.dfid.gov.uk/iati_documents/4074752.docx

In this context, the objective of this interim Value for Money assessment is to estimate the value generated by the outputs and intermediate outcomes delivered and how this compares to the investments made to date.

3.3 VFM Assessment Methodology

This MTE used and built on the findings from the Value for Money Review of SARRAH and its three Annual Reviews completed to date at both the work-stream and overall programme level. The evaluation made use of findings on the economy and efficiency of the programme while supplementing these with evidence-based finding on SARRAH's effectiveness in order to arrive at a holistic interim assessment of its Value for Money.

SARRAH's planned contribution of £32.4m over 5 years only represents 1% of South Africa's Annual Health Budget. In this context, the capacity of SARRAH to sustainably strengthen the governance of South Africa's health systems depends on its capacity to influence (through a range of means) other key stakeholders, such as NDOH to change the way that they work. The difficulties in attributing the effects of capacity building programmes such as SARRAH on wider governance outcomes and impacts are widely recognised. It is similarly difficult to attribute programmatic costs beyond the output level because of a wide array of other contextual factors (and costs) that also contribute to delivery of SARRAH's stated outcomes and impacts.

To overcome the difficulties in measuring the cost-effectiveness of SARRAH at this stage in its lifetime, the MTE has used the following Value for Money effectiveness criteria[44]:

- ***1. Leverage:*** the extent to which each work-stream has had intermediate effects that have levered in additional resources to support its theory of change and as such is likely to deliver additional benefits at the scale required. For the purpose of this evaluation, leverage is broadly defined as the investment of additional resources including time, human resources, financial support and political support by key stakeholders to ensure that SARRAH's ability to generate, or precipitate systemic change. Without this type of investment and 'buy-in' by stakeholders it is unlikely that SARRAH funded activities will be able to influence and catalyse a significant amount of improvement in South Africa's health systems. The key VFM questions to assess the degree of leverage achieved by the programme are presented in **Table 8a** below.

Table 8a - Key VFM questions for Leverage

Key VFM Questions (Leverage)	
Q.1.1	What evidence is there that this work-stream has managed to generate, or precipitate systemic change as measured by additional resources invested in the supported policy?
Q.1.2	Are the deliverables fit for purpose?

- ***2. Theory of Change:*** the extent to which the assumptions that underpin SARRAH's effectiveness hold true and that the hypothesis of change for each work-stream is plausible and as such likely to fulfil its intended purpose. They key VFM questions linked to Theory of Change are presented in **Table 8b** below.

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[44] The Value for Money 'effectiveness' criteria have been adapted from a report produced by ITAD for DFID to develop a Value for Money conceptual framework for governance programmes – Source: Barnett, C; Barr, J; Christie, A; Duff, B; Hext, S (2011), *Measuring the Impact and Value for Money of Governance and Conflict Programmes*, DFID (Quest doc: 3120325)

Table 8b - Key VFM questions for Theory of Change

Key VFM Questions (Theory of Change)	
Q.2.1	How credible and realistic are the assumptions underpinning the work-stream?
Q.2.1	What is the likelihood and risk that the work-stream will or will not deliver their intended purpose?

The purpose of the VFM questions set out above is to systematically evaluate SARRAH's effectiveness from the perspective of the 'potential value' of the results delivered to date given the costs that have been incurred.

Each work-stream has been assessed against the above effectiveness criteria using the VFM scoring mechanism[45] set out in **Table 9** below. Evidence supporting this assessment has been drawn from the data and analysis undertaken against the key evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability presented in the previous findings.

Table 9 - Value for Money Assessment Sheet

VFM Criteria	VFM Question	Score Descriptors			
		1	2	3	4
Leverage	1.1 What evidence is there that this work-stream has levered in additional resources (financial or in-kind)?	*No leverage of wider effects identified*	*Some leverage of other activities /investment and wider effects identified*	*Leverage of other activities /investments and wider effects described and supported by strong evidence*	*Leverage of other activities /investments and wider effects described with evidence that shows significant potential for expansion or replication*
	1.2 What is the likelihood (evidence) that this work-stream will have a significant scale of effect?	*No or very low potential for additional benefits (e.g. scale-up, multiplier or replication) identified*	*Limited potential for additional benefits (e.g. scale-up, multiplier or replication) identified*	*Considerable potential for additional benefits (e.g. scale-up, multiplier or replication) identified*	*Very high potential for additional benefits (e.g. scale-up, multiplier or replication) identified*
Theory of Change	2.1 How credible and realistic are the assumptions underpinning the work-stream?	*Too little information on assumptions to assess effects on outcomes*	*Assumptions are questionable and insufficiently detailed*	*Realistic and credible assumptions about externalities, good coverage and depth*	*Realistic and credible assumptions, analysing externalities in sufficient depth*
	2.2 What is the likelihood and risk that the work-stream will or will not deliver their intended purpose?	*Little or no likelihood outputs will deliver purpose*	*Risk of not achieving purpose high*	*Low risk of underachieving; likely will achieve purpose*	*Probable will achieve or exceed purpose*

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[45] Adapted from Source: Barnett, C; Barr, J; Christie, A; Duff, B; Hext, S (2011), *Measuring the Impact and Value for Money of Governance and Conflict Programmes*, DFID (Quest doc: 3120325)

Finally, a **weighting system** was used to reflect proportionality of financial resources: work-streams were weighted proportionally to the share of SARRAH's resources for which they accounted for.

3.4 Assessment of SARRAH's Value for Money

3.4.1 Economy and Efficiency

The VFM Review completed for DFID in March 2012 concluded that SARRAH 'has to date provided a satisfactory level of Value for Money in the production of deliverables and milestones.' The review found that there was reasonably strong evidence that SARRAH as a programme had achieved its deliverables at the right price (i.e. economically) and that it had delivered services against its milestones in the right ways (i.e. efficiently).

This MTE assessment corroborates the VFM Review's conclusion that SARRAH performed reasonably well in terms of efficiency. On average across the different work-streams, SARRAH achieved an Efficiency score of 2.8 (see **Table 7**) which feeds into the overall VFM Score for SARRAH presented in **Table 10** below. The lead evaluators assessed and scored the available evidence for each work-stream against the VFM effectiveness criteria. Moderation of the Value for Money assessment was undertaken by the evaluation team in collaboration with the lead evaluators.

3.4.2 Leverage

At this stage of implementation, there is some evidence to suggest that SARRAH has leveraged additional resources to date, particularly in the form of a € 5m, EU-funded extension to SARRAH in order to support NDOH on a programme to contract private sector General Practitioners to work in public sector clinics[46]. On average however SARRAH has achieved a relatively low score of 2.3 (see **Table 10** below) for the amount of additional resources it has levered. This is perhaps to be expected at the mid-term stage of SARRAH's lifecycle. However, it is likely that the amount of additional financial and in-kind resources levered by SARRAH has been under-reported to date. Consequently, the amount and type of additional resources levered by SARRAH will be captured between now and the final evaluation as a key value for money indicator of the programme's effectiveness. Furthermore, by the time of the final evaluation in 2015, it is likely that evidence of leverage by the programme will be more prevalent as stakeholders build on the different types of structures, systems and processes that SARRAH has developed to date. The additional resources that SARRAH has successfully leveraged would typically take the form of human resources and commitments by donors and the NDOH to continue funding work-steams such as SAHPRA. However, the extent to which the leveraged resources will enable the delivery of the additional benefits that are required to catalyse significant improvements in South Africa's health system remains unclear at this stage – for example, additional financial commitments have been made in principle to some of the work-streams, but these have yet to be realised pending budget allocation approval processes.

The likelihood that SARRAH will have a significant scale of effect is equally inconclusive, with the relevant average score achieving only 2.2 (see **Table 10** below). Work-streams such as SAHPRA have the *potential* to have a significant scale of effect, but evidence beyond its immediate effects has yet to emerge. It remains to be seen how well new structures, such as those introduced through the NDOH or the NHIRD work-streams, will be engaged or used by stakeholders at the national and regional level. Similarly, SARRAH has enabled improvements to TAC's M&E capacity, which may eventually help it to improve its organisational effectiveness and attract additional donor funding.

3.4.3 Theory of Change

A Theory of Change evaluation requires that the assumptions underlying SARRAH's causal linkages should be tested. With regards to the effectiveness of the implementation of the work-streams, many of these assumptions are neither proven nor disproven. On-going large work-streams, such as SAPHRA and SANAC, are highly dependent on political processes and the allocation of resources to

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[46] This is a new work-stream, which will be evaluated as part of the final evaluation

enable these activities to fulfil their objectives, which has proved challenging to date. However, although these resources have not yet been provided, this does not necessarily mean that they will not be provided in the future. By contrast, assumptions behind some of the completed work-streams are beginning to be corroborated by their results. PMTCT, for example, was tested in a few districts before being scaled up, which enabled its assumptions to be validated empirically.

There remains a risk that the larger work-streams in particular, will not deliver their intended purpose within the remaining lifetime of SARRAH. This is reflected in the rather low average score of 2.0 (see **Table 10** below) that SARRAH achieved against the risk aspect of the Theory of Change criterion. The success of many of SARRAH's work-streams relies on the sustained efforts and investment by NDOH, other funders and the political drive to empower those engaged in the activities that have been delivered. Much of this core support has yet to be provided. For example although effective reorganisation of NDOH in the context of its restructuring has the potential to influence national health service delivery, there remain questions as to whether the reforms can be fully implemented in the short term given the critical shortage of suitably qualified health managers in South Africa. Similarly for the Quality Assurance work-stream, while the international evidence for the benefits of effective Quality Assurance systems is strong, capacity constraints are likely to limit its future implementation.

Table 10 -- Overall Summary of SARRAH VFM Scores

	VFM Criteria	Key VFM Question	Average Score	Overall VFM Score
SARRAH Programme	VFM Review Score (Economy & Efficiency)	N/A	2.8	**2.4**
	Leverage (additional resources)	Q1.1	2.3	
	Leverage (scale)	Q1.2	2.2	
	Theory of Change (assumptions)	Q2.1	2.6	
	Theory of Change (risk)	Q2.2	2.0	

3.5   MTE Value for Money conclusion

Overall, the activities that SARRAH has delivered to date represent satisfactory VFM, as shown by the summary of the VFM assessment scores presented in **Table 10** above. SARRAH achieves an overall VFM Score of 2.4 which is a non-weighted average of the five VFM criteria scores across work-streams (the individual VFM assessment results for each SARRAH work-stream are summarised in **Table 11** below). SARRAH has developed and delivered activities that are reasonably economic and efficient. Its activities are relevant to the needs and priorities of NDOH and its key partners and stakeholders and the assumptions that underpin SARRAH's Theory of Change currently hold true. SARRAH's ability to generate, or precipitate systemic change as measured by additional resources invested in the supported policy, is unclear thus far, and there is no consistent evidence of a significant resource commitment that would enable the programme to affect change at the scale required to have a substantial (and evident) impact on South Africa's health systems. Some notable exceptions should be noted however. For instance, SARRAH's work on supporting the PMTCT A-Plan pilots was so evidently successful that the A-Plan was immediately rolled-out nationally, with support from the South African Government and a range of donors. Given that the majority of work-streams have been completed or are nearing completion, the successful achievement of the programme's objectives and outcomes is largely dependent on the influence and support of SARRAH's immediate beneficiaries and stakeholders. Based on the evidence currently available the extent to which SARRAH is likely to fulfil its intended purpose is unclear. This intermediate assessment of the extent to which the programme has levered support to enable it achieve its desired effects provides a set of benchmarks that will be further assessed in the final evaluation.

Table 11 – Summary Assessment of VFM of SARRAH by work-stream

Work-stream	Spend to date (£)	Estimated % overall spend to date	Estimated % activities complete	VFM criteria	VFM effectiveness questions	VFM score	Overall VFM score
SANAC	1,568,636	12%	50%	Efficiency		2	1.8
				Leverage	Q1.1	1	
					Q1.2	1	
				Theory of Change	Q2.1	3	
					Q 2.2	2	
NHI	1,539,513	11%	50%	Efficiency		2	2.6
				Leverage	Q1.1	2	
					Q1.2	3	
				Theory of Change	Q2.1	3	
					Q2.2	3	
SAHPRA	£2,958,838	22%	50%	Efficiency		3	2.0
				Leverage	Q1.1	2	
					Q1.2	2	
				Theory of Change	Q2.1	2	
					Q2.2	1	
Quality Assurance	£820,500	6%	80%	Efficiency		3	3.0
				Leverage	Q1.1	4	
					Q1.2	3	
				Theory of Change	Q2.1	3	
					Q2.2	2	
NDOH	£633,000	5%	100%	Efficiency		4	3.0
				Leverage	Q1.1	3	
					Q1.2	3	
				Theory of Change	Q2.1	2	
					Q2.2	3	
NHIRD	£271,000	2%	100%	Efficiency		2	2.2
				Leverage	Q1.1	2	
					Q1.2	3	
				Theory of Change	Q2.1	2	
					Q2.2	2	
PMTCT	£280,000	2%	100%	Efficiency		3	3.8
				Leverage	Q1.1	4	
					Q1.2	4	
				Theory of Change	Q2.1	4	
					Q2.2	4	
TAC	1,511,000	11%	TBC	Efficiency		3	2.2
				Leverage	Q1.1	1	
					Q1.2	2	
				Theory of Change	Q2.1	3	
					Q2.2	2	
Assessment of CEOs	£1,149,437	8%	TBC	Efficiency		3	2.0
				Leverage	Q1.1	2	
					Q1.2	1	
				Theory of Change	Q2.1	2	
					Q2.2	2	
Provincial Financial Management	£215,000	2%	100%	Efficiency		2	1.6
				Leverage	Q1.1	1	
					Q1.2	1	
				Theory of Change	Q2.1	2	
					Q2.2	2	
Conditional Grant Management	£72,200	1%	100%	Efficiency		3	2.8
				Leverage	Q1.1	2	
					Q1.2	3	
				Theory of Change	Q2.1	3	
					Q2.2	3	
STPs	£249,800	2%	100%	Efficiency		3	2.4
				Leverage	Q1.1	2	

					Q1.2	2	
				Theory of Change	Q2.1	3	
					Q2.2	2	
Human Resources	£198,000	1%	100%	Efficiency		2	**1.4**
				Leverage	Q1.1	1	
					Q1.2	1	
				Theory of Change	Q2.1	2	
					Q2.2	1	
Asset Management	£2,168,523	16%	100%	Efficiency		3	**3.0**
				Leverage	Q1.1	4	
					Q1.2	3	
				Theory of Change	Q2.1	3	
					Q2.2	2	

4   CONCLUSIONS

SARRAH has been able to apply development aid in a facilitatory way and has played a role in delivery on nine of the ten areas of the NDOH Ten Point Plan, but with varying levels of success to date. This section summarises SARRAH's performance against the OECD DAC criteria, based on cross-cutting findings from the evaluation of individual work-streams presented in Section 2.

4.1   Relevance: Full alignment with the NSDA and the Ten Point Plan

The programme's **relevance** is probably the most consistently praised aspect of SARRAH's performance. **The average weighted relevance score of SARRAH work-streams is 3.7** on a scale of 1 to 4. All work-streams have scored 3 or 4 against the relevance criterion.

All of the SARRAH supported initiatives were jointly selected by the Department of Health and DFID to address high priority areas requiring immediate attention and support. These initiatives all followed a sound process of evidence gathering and analysis, and/or the adaptation of international best practice to the South African context. Furthermore, the vast majority all of the stakeholders interviewed during the mid-term evaluation acknowledged that the initiatives addressed pressing needs identified beyond reasonable doubt. Moreover, all SARRAH work-streams are aligned with one or more of the priorities identified in the Ten Point Plan and the NSDA.

For instance, there is little doubt that South Africa's MCC, the regulatory body previously in charge of approving and licencing new medical products into the South African market, was too small and insufficiently staffed and empowered to fulfil this role to a high standard of quality in a country of 52 million people, and that it needed to be replaced[47]. It was also clear when SARRAH was being designed that SANAC was struggling to establish itself as the "the highest body that serves to advise, provide strategic and political guidance as well as support and monitoring for sector programmes for HIV and AIDS and STIs in South Africa"[48], which is the role that had been assigned to it by the NSP. Equally, the on-going consultation process to design the NHI, the government's flagship health project towards which most NDOH initiatives are designed to contribute, has uncovered immense needs for organisational, financial management, human resource, regulatory and digital data reforms across the whole health sector to pave the way for its successful implementation[49].

The highly complex nature of these national initiatives was always going to involve tapering into national and international pools of technical expertise to support the design, establishment and implementation

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[47] See section 2.2.1 and Annex 16

[48] Consequent. Management Consulting (2010), *Developing a Workable Delivery Model for SANAC and the SANAC Secretariat*

[49] NDOH (2011), *National Health Insurance in South Africa: Policy Paper (the Green Paper)*
http://www.sarrahsouthafrica.org/LinkClick.aspx?fileticket=GesHTP9Y7iw%3d&tabid=2311

of new entities and systems across the health sector. The consensus among the stakeholders consulted during the MTE research phase was that SARRAH was instrumental in enabling this to take place.

4.2 Efficiency

The efficiency with which these various technical assistance activities were delivered by the SARRAH implementing partners and associated sub-contractors was generally perceived to be high. **The average weighted efficiency score of SARRAH work-streams is 2.8**. In total, 9 out of 14 work-streams, representing 72% of SARRAH expenditure evaluated in the MTE, have scored 3 or 4 against the efficiency criterion.

The efficiency of SARRAH is most apparent in the speed with which consultants were contracted through the SARRAH facility to carry out the work, and to the capacity of SARRAH to identify and quickly deploy some of the leading South African and international experts in their respective technical fields. The competence, professional ethos and timeliness of the HLSP technical leads, as well as that of most of the consultants contracted through SARRAH since 2010 generally left the impression among NDOH technical leads and other associated stakeholders that the programme was capable of quickly allocating expert resources to solve short terms problems and complete discrete technical tasks to a high standard of quality.

The generally positive view of SARRAH's efficiency also stems from the perception that most of the work could not have been undertaken directly by NDOH within similarly tight timeframes and to a higher standard of quality, and that other, more traditional procurement routes would have led to the same outputs being delivered much later: **time-efficiency** is therefore a key feature of SARRAH's perceived efficiency.

4.3 Effectiveness and Impact of SARRAH to date

SARRAH's **effectiveness in strengthening the South African health systems** and making the national response to HIV & AIDS better coordinated and more accountable **has been variable to date**. The average weighted effectiveness and impact scores of SARRAH work-streams are 2.5 and 2.1 respectively. In total, 7 out of 14 work-streams, representing 57%% of SARRAH expenditure evaluated in the MTE, have scored at least 3 against the effectiveness criterion. For impact, the respective figures are 3 out of 14, and 23%. The relatively low scores achieved are partly due to the proportional weighting system introduced to reflect the relative size of different work-streams in terms of funds spent, and results from the relatively poor, or short-lived, results on some of the larger work-streams including SAHPRA and SANAC.

SARRAH's perceived contribution to key achievements was very clearly identifiable in some work-streams (e.g. PMTCT) but less apparent in others (e.g. SANAC), while in some cases the claims that SARRAH had made a critical contribution to key achievements were impossible to verify and the evidence base weak (e.g. TAC). However, we also find that the majority of SARRAH-supported initiatives will take a longer period to realise their full effect than the MTE timeframes allowed for, and that the final evaluation will be able to measure with greater certainty how effective SARRAH was in strengthening different parts of the health system.

Section 5.1 below explores the **key drivers of success** identified during the MTE.

The **impact** of SARRAH was not assessed in great depth in the MTE, although the potential of emerging outcomes to contribute to higher level impacts in the near future was assessed and scored. The impact criteria was allocated a small weight (10%) in the numerical tool developed by the evaluation team in order to reflect the process focus and preliminary nature of these findings and the fact that it was not a focus of the MTE.

4.4 Looking forward: sustainability of SARRAH

SARRAH's sustainability will be investigated in more detail during the final evaluation, although the preliminary assessment undertaken during the MTE suggests a mixed picture. **The average weighted sustainability score of SARRAH work-streams is 2.3.** In total, 5 out of 14 work-streams, representing 25% of SARRAH expenditure evaluated in the MTE, have scored at least 3 against the sustainability criterion.

- **Sustainability of the SARRAH "facility"**.

Little could be said at the mid-term stage with regards to the potential continuation of SARRAH in one form or another beyond 2015 when DFID (and EU) funding to the programme will come to an end. Interviews conducted suggest that the flexibility and versatility provided by SARRAH's resources is so valued by NDOH that there could be an appetite to maintain it. However, it is not clear how it would be funded (whether by other donors or by NDOH itself, or a combination of both) and the logistical and legal aspects of an NDOH-owned facility have not been fleshed out in any detail at this stage.

- **Sustainability of SARRAH supported initiatives**.

As discussed previously, those work-streams which have relied to a large extent on SARRAH's financial or technical assistance have generally scored relatively poorly on sustainability. This is particularly relevant to the **TAC** work-stream[50]. TAC had historically struggled to obtain funding for its core functions (finance, management and planning, human resource management, monitoring & evaluation, etc.) until DFID began core funding through SARRAH. It is not clear at this stage who will step in to fill this gap post-2015 and the risk that TAC will be unable to maintain the higher standards of internal governance, management and M&E without SARRAH support cannot be dismissed.

Health care management and delivery is an issue that tends to involve significant political stakes. In assessing the sustainability of SARRAH work-streams, it has therefore been critical to understand the specific political economy factors surrounding them. It is on the basis of this kind of analysis that, for instance, the **NHI** work-stream was awarded a high sustainability score given the generally supportive environment surrounding this ambitious reform, while the **SAHPRA** work-stream was rated lower given concerns about the authorities' ability to staff this new regulatory entity and empower it to fulfil its regulatory mandate effectively. Likewise, while the **Asset Management** work-stream has involved significant capacity building in training new staff to conduct asset audits on a large scale, it is not clear that provincial health departments will have either the willingness or capacity to incorporate these newly trained auditors into their respective Asset Management Units.

4.5 Strategic Added Value: SARRAH's catalytic effect

Another feature of SARRAH is its ability to link South Africa with experts in the UK. For example, the link to the UK Care Quality Commission identified similar problems in the UK and South Africa (with regards to infant deaths in hospitals), and this was a useful lesson learning experience. Similarly, when legislation for the OHSC needed support from parliament, sending MPs to see the UK system allowed properly informed decisions to be taken. SARRAH also provided comprehensive reviews of alternative health systems, for example models of Quality Assurance, and these ideas were then incorporated into local norms and standards. SARRAH's input led to better, evidence-based decision making and was advocated as a best practice example.

The sustained support from SARRAH has also played an important role. Policy development can be a long drawn out process and people tend to lose interest along the way but the NHI pilots, supported by SARRAH, have helped maintain interest. The initial reaction to the proposed NHI was "outrage about the cost" but the pilot sites offer a chance to do more accurate forecasting. The Minister of Health's roadshow, also supported by SARRAH, has allowed direct engagement with 15,600 stakeholders to date. SARRAH was seen as contributing to both policies and programmes in ways that other donors find difficult. For example, US government staff acknowledged that PEPFAR was better placed to deliver 'proof of concept' type projects and pilot new ideas, whereas SARRAH has been able to take ideas further in policy and legislative arenas. **Annex 2** provides a more detailed analysis of the strategic context in which SARRAH has operated and the perceived strategic added value of SARRAH among key stakeholders.

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[50] See section 2.2.1 and Annex 19

5   LESSONS LEARNT

5.1   SARRAH's key drivers of success

The mid-term evaluation results suggest there are several "key success factors".

- **Lesson 1 As for any large health delivery and health governance programme, political economy factors must be assiduously considered and accounted for in the design of initiatives.**

The political economy surrounding the various strands of work SARRAH is involved in or supporting seems to have had a significant impact on the programme's ability to reach its intended outcomes. For instance, the "high profile" status of NHI, its position at the very top of the government's agenda and the absence of any legislative constraints to the approval and implementation of the NHI pilots seem to have contributed to the provision of a favourable environment and framework for SARRAH to contribute positively. By contrast, the relative lack of progress achieved in the design and establishment of SAHPRA resulted partly from an unfavourable political economy surrounding the initiative, characterised by a slow and repeatedly delayed legislative process and inadequate buy-in from experts and industry representatives. This also applied to the SANAC work-stream, which suffered from the complex politics that revolve around this relatively newly established entity. Findings suggest that the support to SANAC, while important and valued as such by a number of stakeholders, was constrained in its effectiveness by the difficulties faced by the organisation in its quest for empowerment in holding HIV and AIDS actors to accountability.

- **Lesson 2: Ensuring that the purpose and mandate of SARRAH are clear to stakeholders will ensure that resources are used to greater effect.**

Clarity around the mandate of SARRAH helps set expectations among beneficiary stakeholders and helps it focus its finite resources and activities to greater effect. While SARRAH's flexibility is generally praised and its capacity to become the "ultimate gap-filler" appreciated, limiting its mandate to such ad-hoc support is insufficient to allow SARRAH to create a dynamic of positive change in the larger initiatives, such as SANAC. Structuring SARRAH's support around a key, significant output or outcome, which was the case for PMTCT, the Conditional Grant Management or the Asset Management work-streams, seems to have been an effective strategy for generating tangible outcomes in a short space of time. This was also evident in SARRAH's "QA" work to support the development of the NCS and the establishment of OHCS.

- **Lesson 3: The size of SARRAH support must be balanced to achieve outcomes while also promoting sustainability.**

The size and significance of the SARRAH support relative to the initiative seems to have increased its capacity to contribute more effectively to the intended outcomes. The more control over what the content of the final output will be and over the timings associated with their delivery, the more effective SARRAH's contribution. This was apparent in the Asset Management work-stream, one of the largest in terms of the proportion of SARRAH funding allocated. However, it should also be recognised that while the size of SARRAH's relative contribution is a success factor in terms of effectiveness in the short-term, it also appears to be negatively correlated with the sustainability of SARRAH post 2015. The evaluation team considers this a key driver of success.

5.2   A uniquely flexible facility for the South African NDOH

- **Lesson 4: SARRAH's flexible approach to providing technical support to strategically important initiatives compensated for the bureaucratic challenges of procuring technical assistance faced by government institutions.**

SARRAH differs significantly from other health programmes in South Africa in the way that it is managed by the service provider. External procurement and management of consultants and sub-contractors can often be an administratively and legally cumbersome process for NDOH, and was said to sometimes be a barrier to programmes running in the department. SARRAH is characterised by a very flexible funding mechanism and offers a facility through which relatively small, discrete but strategically important initiatives can be quickly commissioned and implemented. This flexibility was

praised by virtually all of the stakeholders interviewed who were able to clearly identify SARRAH and discuss its contribution to their portfolio of initiatives.

There was a sense that the flexibility of SARRAH funding and its attention to clearly identified priorities had been critical in making things happen. One senior government official felt that the Minister and DG would have struggled to get their work done without this flexible support and even acknowledged that frustration with lack of progress had often led to resignations of good people in the past. Although Treasury provides direct support for the sort of health reforms being undertaken by SARRAH, a well-managed donor-funded project often works better (and faster). This may imply that supervision of government funds is not tight enough but it is also probably because it is harder to ring fence government funds for targeted interventions.

- **Lesson 5: Flexible mechanisms for technical assistance are likely to be heterogeneous by nature and therefore will be difficult to evaluate in a rigorous manner.**

SARRAH's flexibility makes it more difficult to evaluate than a more conventional technical assistance programme normally would, which is not to be underestimated in a context of increasingly scarce resources and a global push for rigorously generated results on the outcomes and impacts of international development programmes.

- **Lesson 6: Close collaboration between SARRAH and the NDOH improved the responsiveness of SARRAH.**

The perception of SARRAH as being to some extent embedded in NDOH is another key characteristic of this programme. The process by which the department procures work through this facility is so seamless that some stakeholders said they "*sometimes forget that the SARRAH staff do not work for NDOH*". It is also clear that having a DFID Health Advisor seconded to the NDOH has facilitated closer cooperation than is usually the case.

6   OVERALL RECOMMENDATIONS

This section summarises some of the cross-cutting recommendations which can be made at this stage in the implementation of the SARRAH programme, beyond the work-stream specific recommendations presented throughout Section 2:

- **Maintain support to initiatives which have already absorbed a significant amount of SARRAH resources, provided that the political economy environment surrounding these initiatives is conducive to a positive contribution from SARRAH**. Activities carried out under some of the larger work-streams, especially SANAC and SAHPRA (including clearing the backlog of applications at the MCC) have, and are still facing daunting logistical, operational, legal and political challenges and have so far been struggling to achieve any really tangible outcomes, in spite of a lot of work conducted by apparently competent and committed professionals. However the evaluation team's assessment is that the Theories of Change which underpin these initiatives are still valid, and that their plausibility has not been affected by the slow progress shown to date. The potentially high impact that these initiatives could have on the South African health system justify maintaining technical and financial support until completion and attainment of intended outcomes. Not following through with these initiatives would present a high risks that this significant UK contribution would not achieve any tangible goals. For instance in the case of SAHPRA, once the legislation to empower SAHPRA is passed SARRAH will no longer face a legislative hurdle, and support will then be able to focus on the establishment of SAHPRA as a functional, empowered and effective regulatory authority. However recent developments suggest that the political-economic difficulties relating to SAHPRA remain critical, which makes any further immediate support from SARRAH inadvisable at this stage.

- **Enforce a much higher level of oversight from DFID and HLSP of activities commissioned and funded under SARRAH.** Neither the funding organisation (DFID), the implementing organisation (HLSP) nor the independent evaluators (HSRC & Coffey) have been allowed access to NHIRD, the McKinsey report on the organisational redesign of NDOH, the results of the assessment of DHMs and CEOs or central and provincial financial management data. We recognise that the delivery model, which consists of a very close partnership between DFID and NDOH, is highly desirable to ensure that SARRAH can contribute effectively to the national health policy agenda. However, this model seems to have morphed, in a number of instances, into an asymmetrical partnership where critical information is systematically undisclosed on the grounds of confidentiality. While it is understood that the information produced by some SARRAH-funded initiatives is of a highly sensitive nature, disclosure should be granted more freely through rigorous data protection systems and protocols. Otherwise, it is probable that a number of initiatives that together account for a significant share of the SARRAH budget, will not be traceable and evaluable. At the time of finalising this report, substantial headways had been made in this respect, which is particularly encouraging with respect to the preparation for the final evaluation.

- **Use SARRAH-funded M&E initiatives to monitor progress and evaluate outcomes of work-streams which have not yet produced observable impacts but which might do in the future**. An increased M&E capacity in SANAC and TAC and a fully functional and regularly updated NHIRD would constitute an immensely rich and useful source of monitoring and evaluation data and systems to track progress and longer-term impacts of other SARRAH work-streams including NHI, Quality Assurance or PMTCT. There is an obvious synergy which, depending on progress made against the M&E related work of SARRAH and on the accessibility of data by independent evaluators, should be exploited going forward. Full disclosure of SARRAH information and data to SANAC's and TAC's M&E units as well as full access to NHIRD would be highly desirable and would strengthen the sustainability of the M&E effort currently led by HLSP, Coffey and HSRC.

- **Ensure that data collection for the final evaluation of SARRAH takes into account the lessons learned from the mid-term evaluation in order to fully capture its effectiveness and impacts.** Preparation for SARRAH's final evaluation should commence following

completion of the MTE to ensure that the data collection strategy and analytical approach for the final evaluation is able to:

- ✓ Support more summative conclusions about SARRAH's performance with regards to the effectiveness and impact of individual work-streams;

- ✓ Capture more information and data about the amount and type of additional financial and in-kind resources SARRAH has been able to lever and the effect this has had on the sustainability of the work-streams that it funds;

- ✓ Systematically gather data that enables higher level analysis (at the output and outcome level of the programme logframe) of the effects of SARRAH's work-streams on the original programme logic, the linkages identified and the assumptions that underpin them. This will include a comprehensive assessment of the context in which SARRAH has been implemented that builds on the preliminary analysis conducted for the MTE as an integral part of assessing SARRAH's contribution to changes in HIV and health service delivery in South Africa;

- ✓ Capture effects between and across work-streams and output and outcomes identified in the logframe;

- ✓ Cover work-streams not evaluated in the MTE due to the early stage of their implementation such as the Parliamentary Oversight Committee work-stream; and

- ✓ Build on and improve stakeholder engagement (particularly NDOH) in the evaluation process to ensure that the final evaluation has the appropriate levels of support and as such is well-informed and has developed a sense of ownership among its key stakeholder audiences.

- **Effectively monitor and manage emerging needs and demand for SARRAH to address gaps through its current work-streams**. Stakeholders have consistently praised SARRAH's flexibility, its capacity to respond to needs jointly identified by NDOH and DFID and its ability to unlock resources quickly and efficiently. This characteristic is invaluable and should be maintained going forward, despite the methodological challenges it creates for evaluators. However, in order to build on the work completed and expertise acquired to date, the evaluation team recommends that SARRAH support be confined to the current streams of work to prevent SARRAH from spreading its resources to thinly in the future.

Annex 1

Twenty Year Historical Review of Health Systems in South Africa

1   INTRODUCTION

The period of this review not only covers a very important political transition period in South African history, when the first democratic elections took place, but also includes the time when the Department for International Development (DFID) was set up. Prior to 1997 the UK aid programme was managed by the Overseas Development Administration (ODA), a wing of the Foreign and Commonwealth Office. Under ODA, Britain's aid had largely focused on economic development. In 1997 the renewed focus became fighting world poverty and as a sign of its commitment the government set up the new DFID headed by a cabinet minister. One of the first challenges was to put development higher on the agenda both within the UK and overseas. The core concept in DFID's activities is 'poverty reduction' and because health is intrinsic to economic development, health intervention programmes became a significant part of DFID's work.

This review of DFID's engagement with the South African health sector was done during October and November 2011, and forms part of a longer term Evaluation of South Africa's Revitalised Response to AIDS and Health programme (SARRAH). Even though SARRAH is a broad initiative involving the National Department of Health (NDoH), the South African National AIDS Council (SANAC) and the Treatment Action Campaign (TAC), and the Parliamentary Oversight Committee (POC), it is nonetheless a small input to a very large system. Changes are inevitably occurring all the time, both inside and outside the health sector, which affect the health system and health outcomes. These wider changes and how they were/are sequenced will have a major influence on whether interventions supported by the SARRAH programme will be successful. Key to understanding 'causal chains' is to know the various events and trends within South Africa that led up to the 10 point plan of the NDoH,[51] and also how DFID has evolved to its current programme of support. This assignment summarises the major developments in the South African health system between 1948 and 2010 and the role DFID has played in HIV and health from 1993 to the beginning of 2010.

The approach taken was to review published and 'grey' literature, including reports by DFID, NDoH and NGOs, correspondence and media releases. Key informant interviews were used to obtain first hand opinions regarding DFID's engagement with the South African health sector. Table 1.1 below, summarises the incumbents holding key health portfolios starting from the transition to democracy in 1993 to early 2010; these include South African government officials, DFID staff and managers of some pertinent NGOs. Twelve key informants were selected from this group and this proved sufficient to achieve acceptable data saturation with dominant themes arising repeatedly. Additional information was obtained from unstructured interviews and correspondence with current DFID and HLSP staff.

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[51] Development Bank of Southern Africa, 2008. Health Roadmap.
http://www.dbsa.org/Research/Documents/Health%20Roadmap.pdf

Annex 1

Table 1.1: Historical Perspective of Health Ministers, Directors General, DFID Staff and Selected NGO Partners 1993-2010

Year	President	Minister of Health	Director General	Key NDoH staff	DFID SA Health Advisors	Other (DFID SA and NGO staff)		
1993	F W de Klerk	Dr Rina Venter	Dr Coen Slabber				Allison Beattie, Regional Advisor (Soul City)	Dr David Harrison, Chief Executive Officer, Health Systems Trust
1994								
	Nelson Mandela	Dr Nkosasana Dlamini Zuma	Dr Olive Shisana					
1995					Jane Miller, DFID Associate Prof. Officer, Seconded to Health Systems Trust (HST)			Dr Peter Barron, Director HST (1995-2004) then TA to NDoH (2004-2011)
1996				Dr Yogan Pillay	Dr Julian Lambert			
1997				Deputy Director				
1998				General, Strategic				
1998			Dr Ayanda Ntsaluba	Health Programmes and later DDG: HIV/AIDS, TB and MCWH				
1999								
	Thabo Mbeki	Dr Manto Thsabalala-Msimang					Dr Kevin Bellis, TCO TB, M&OD NW Prov.	
2000					Dr Dennis Tracey	Ian Ralph		
2001						TCO Seconded to EU		
2002						Graham Coomber, TCO Gauteng Prov.		
2003					Dr Tim Martineau			
2004			Dr Kamy Chetty (Acting)					
2005			Thamsanqa Mseleku					
2006					Dr Kevin Bellis	Hilary Nkulu, Health		

Year	President	Minister of Health	Director General	Key NDoH staff	DFID SA Health Advisors	Other (DFID SA and NGO staff)	
2007					(Acting)	Team Programme Manager	
2008					Robin Gorna		
2009	Kgalema Motlanthe	Barbara Hogan					
2010	Jacob Zuma	Dr Aaron Motsoaledi	Dr Kamy Chetty (Acting)		Dr Bob Fryatt		
			Dr Yogan Pillay (Acting)				
			Malebona Precious Matsoso	Nelly Malefetse, Director Devt Cooperation in Health			Prof David Sanders, Regional Health Advisor, Save the Children

2 DFID AND THE SOUTH AFRICAN HEALTH SECTOR

2.1 Health Systems under Apartheid and the Transition to Democracy (1948-1993)

Apartheid (literally meaning "separateness" in Afrikaans) or the policy of separate development for different races was formalised by the National Party which came to power in 1948. Under this regime Black people were eventually deprived of their citizenship (in 1970) and forced to reside in Bantustans or homelands, some of which had quasi-independence. Health services in the Bantustans were systematically underfunded and by 1970 the doctor to population ratio there was estimated at 1:15 000 compared with 1:1 700 in the rest of the country. By 1980, 40% of doctors worked in the private sector and by 1990 this figure had reached 60%.[52] The 1977 Health Act further fragmented the health services with curative care being designated a provincial responsibility and preventive care to local government. This process went even further in 1983 when the Tricameral Parliament established separate health services under white, coloured and Indian "own affairs" departments. It was this extremely fragmented health system, comprising 14 different health administrations, which the first democratic government inherited in 1994.

The apartheid health system not only introduced unnecessary fragmentation but also dismantled some excellent early work on community-based primary health care begun in 1940. One of the most famous initiatives is what became known as the Pholela Experiment led by Dr Sidney Kark.[53] A characteristic of the Pholela model was that it involved community participation in health care and families were seen as the unit of intervention rather than individuals. Kark was later a member of the 1942 Gluckman Commission which recommended establishing a National Health System based on a network of primary health care facilities based on the Pholela model. Gluckman was appointed Minister of Health in the United Party and although he and others pushed hard to develop a National Health Service the system was never properly funded.[54] In 1948, when the National Party came to power, most of the champions of health system reform were removed from office and many left the country. The situation at the time was summed up by Kautzky and Tollman in the following terms:

"Ultimately, the progress South Africa had made over 20 years of innovative, community-based research, training and health systems development was lost. Health care and systems development in South Africa in the coming decades would focus on hospitals and an exclusivist private sector, with disastrous effects for the health of the country's citizenry."[55]

Despite this depressing situation there were numerous agencies outside government that sought to influence its health policy. Among these were the Centre for Health Policy (CHP) at the University of the Witwatersrand, the Centre for Epidemiological Research in Southern Africa at the Medical Research Council, the National Primary Health Care Network and the Health Systems Trust. Because they were primarily funded by overseas donors, or had a substantial degree of autonomy, such agencies were able to be openly critical of government. At the time (1995) Max Price, then Director of the Centre for Health Policy, wrote:

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[52] Coovadia, H, Jewkes, R, Barron, P, Sanders, D, McIntyre, D, 2009. The health and health system of South Africa: historical roots of current public health challenges. Lancet 374:817-34.

[53] Kark, S, 1951. Health centre service. In Cluver, EH (ed) Social Medicine. Johannesburg: Central News Agency

[54] Marks, S, 1997. South Africa's early experiment in social medicine: its pioneers and politics. American Journal of Public Health 87(3):455-7.

[55] Kautzky K, Tollman SM, 2008. A perspective on Primary Health Care in South Africa. In: Barron P, Roma-Reardon J, editors. South African Health Review 2008. Durban: Health Systems Trust. http://www.hst.org.za/publications/841 (Accessed 3 Nov 2011)

"…we had complete autonomy over our research agenda and little concern about publicity that would antagonise government officials or politicians. In turn, these officials had no interest in hearing anything we had to say, and we were never consulted on any policy developments." [56]

However, by the late 1980s government had realised the need for a changed health system and appeared more amenable to inputs from external organisations. Researchers now had to find a way to change from primarily critical opponents to potential partners in change. One of the beneficial consequences was that groups like CHP were commissioned to undertake community engagement - something which had been almost completely absent during the apartheid years. This process opened the door for other stakeholders, including the liberation movement, to be brought into policy development.

By 1993 the transition to a democratic government was well under way; the Constitution of South Africa Act of 1993 provided for a Government of National Unity and a five-year transition. It was under the terms of this constitution that Nelson Mandela became president in May 1994. The new constitution enabled international aid agencies that had been waiting to support the 'new South Africa' to move into high gear. The Overseas Development Administration (ODA) opened an office in Pretoria which became DFID Southern Africa in 1997. The ANC was working hard on its National Health Plan which was being developed with some of the best public health specialists in the world ready for release in 1994. [57]

2.2   Health System Developments in the Mandela Era (1994-1999)

An unexpected corollary of the transition phase was that a more open style of consultation between 1990 and 1994 was quickly replaced by a more centralised one. Naturally enough, donors now wanted to channel funds through the democratic government and suddenly only those projects approved by the Ministry of Health were likely to receive support. This was perhaps inevitable but it did place health policy decisions in the hands of a very few relatively inexperienced people. The policy analysts who opted to remain independent from government had to find new ways of engaging in constructive ways. Max Price wrote, somewhat prophetically, in 1995:

"Yet we need to recognise the rarity of this space – perhaps a few years during which there is sufficient openness in government to new ideas and a political imperative for change. …there is the political will to try something really different. Our task is to avoid being seduced by the immediate rewards of becoming government think tanks and consultants, and to secure a long-term relationship with government and the society which will promote critical policy analysis in the future." [56]

As will be shown below, there were times in the following years when open policy dialogue was encouraged and others when it was either suppressed or ignored.

Informants said that this period was characterised by a great sense of urgency and a desire to get the recovery from apartheid under way. Dr Nkosasana Dlamini-Zuma was the first Minister of Health with Dr Olive Shisana as Director General; two people who have maintained a reputation for getting things done throughout their various positions during the past 20 years. However, this period was not without its controversy and two events stand out as potential scandals, namely the Sarafina II health promotional stage production in 1996 and the abortive attempt to rush through an untried antiviral agent 'Virodene' in 1998. Sarafina II appeared to have used substantial public funds - £2.1 million (R14.3 million at 1996 rates) - to little or no measurable effect. Virodene was blocked by the

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[56] Price, M, 1995. Some reflections on the changing role of progressive policy groups in South Africa: experiences from the Centre for Health Policy. Transformation 27: 24-34.
[57] African National Congress, 1994. A national health plan for South Africa. Johannesburg: African National Congress.

Medicines Control Council (MCC) owing to inadequate testing and later found to contain a toxic industrial solvent. Government response at the time was to replace the MCC.

Events leading up to these two 'scandals' suggest that things may have been moving rather too fast and without sufficient control. One respondent suggested that these mistakes were perhaps a consequence of initial enthusiasm and naiveté; there were few properly tested, large scale HIV interventions available and anyone who appeared to have a viable idea was likely to receive an audience. There were concerns at the time about whether the donor's funds (European Union in this case) had been approved for this type of intervention. The intention seems to have been to develop community-based interventions with potentially large application despite little certainty of what was appropriate. The negative publicity caused by such 'failed' efforts would take some time to fade. Several years later, mass media interventions such as Soul City and LoveLife became popular and were more successful. Although to this day, such interventions are hard to evaluate and remain a challenge for funders who require quantifiable results in the short to medium term. However, the durability of these particular programmes may be because scientific evaluation was given appropriate emphasis from the outset.

2.3   Health System Developments in the Mbeki Era (1999-2008)

After the heady enthusiasm of Nelson Mandela's Presidency, a more cautious approach characterised the Thabo Mbeki era. Mbeki apparently took time to investigate the aetiology of AIDS and began to question how much of a role poverty and inequity played in the epidemic. Sadly, while realising that poverty and inequity are contributory factors in many public health problems, Mbeki appears to have been unduly influenced by a group of researchers who challenged the basic aetiology of AIDS – the so-called 'AIDS dissidents'. What began as a healthy circumspection for unproven interventions and a concern for the social determinants of health quickly became an extraordinary chapter of 'denialism' in the South African government's AIDS programme. The appointment of a new Minister of Health, Dr Manto Tshabala-Msimang, should have brought clarity to the situation, but actually led to further confusion and delay. One of the early events of this period was a Presidential Enquiry into AIDS in 2000-2001,[58] to which prominent scientists from around the world were invited. For many of the scientists who participated in the process, the recognition given to the dissident views was a substantial challenge to their engagement. One of the participants at the time was heard to say "it's like going to a meeting of the flat earth society", meaning presumably, that the participants sometimes had no foundation of agreement from which to start discussions. In the uncertain days of early HIV research there may have been some plausible explanation for the critics' views but by the time of the Presidential Enquiry the vast majority of scientists were long convinced that HIV causes AIDS and felt that the enquiry was a fruitless exercise. The report acknowledges that the internet discussion (part of the enquiry process) was poorly supported by delegates from the "faction that supported the notion that HIV causes AIDS" whereas those who did not support this view used the medium as a platform for their views; which is perhaps not surprising, because they found few other outlets for their increasingly unsubstantiated ideas.

One consequence of the era of denialism was to create very difficult conditions for donors who wished to engage with the NDoH. While conventional approaches to treating patients with HIV infection continued, the slowness of the response to the epidemic was seen by many as irresponsible. Several informants spoke of this period being characterised by an almost complete inability to get programmes approved within the Department of Health. Those responsible for the HIV & AIDS

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[58] NDoH, 2001. Presidential AIDS Advisory Panel Report: A synthesis report of the deliberations by the panel of experts invited by the President of the Republic of South Africa, the honourable Mr Thabo Mbeki. http://www.doh.gov.za/show.php?id=625 (Accessed 17 Oct 2011)

programme often apparently agreed with proposed initiatives tabled by DFID, but were unwilling or unable to obtain authorisation from higher levels. This problem affected health personnel right up to the most senior levels, including the then Deputy Minister Nozizwe Madlala-Routledge, who was widely applauded for her efforts to get the National Strategic Plan on HIV & AIDS 2007-2011 accepted. The outspoken Deputy Minister was eventually fired, but her departure was lamented by many who saw her as having done much to restore some sanity to South Africa's controversial AIDS policy.

A more positive factor in the mix at this time was the important challenge made by the South African government and others, to ensure that antiretroviral drugs (ARVs) were made more affordable to countries where HIV was hyper-endemic.[59] After initial resistance and protectionism by pharmaceutical companies over intellectual property rights, the prices of ARVs fell sharply, and in some countries, local manufacture was authorised. This opened the way for ARV treatment on a wider scale, since cost was no longer such an issue, but the readiness of the health services to manage complex treatment regimens was still used as a reason for not providing ARVs everywhere. Cabinet approved a comprehensive AIDS treatment plan, including free ARVs in November 2003, but it was to be a long time before ARVs became widely available. Initially, there were only two clinics per province approved for ARV treatment. According to the Actuarial Society of Southern Africa 2003 model there were 521,000 people deemed eligible for treatment who were not receiving it in 2005.[60]

During this period, many donors, including DFID, and local researchers, found that the NDoH's slow response to the AIDS crisis forced them to look elsewhere for partners. Officials in the NDoH suggested that they were still open to working with DFID and its partners at this time, but the DFID Health Advisors reported an effective impasse; they then diverted efforts towards NGOs. However, many of the health-related NGOs that had fought for equitable health services under an apartheid government had suffered severe funding cuts when their raison d'être appeared to fall away with the advent of democracy. Thus the partners who would have been available to assist in providing equitable health services, especially at community level, were severely depleted. Provincial programmes did expand rapidly though, with the assistance of international aid agencies and these began providing appropriate care for people living with HIV. One of these projects, run by Médecins Sans Frontières, the World Health Organisation, the University of Cape Town and the Provincial Government of the Western Cape, demonstrated the feasibility and potential preventive benefits of providing HIV testing and ARVs, even in a resource-poor setting.[61]

At about the same time, one of SARRAH's current partners, the Treatment Action Campaign, won a constitutional court case which required the South African government to make antiretrovirals available to HIV-infected pregnant women to prevent infection of their unborn children[62]. Meanwhile, the NDoH was still arguing that the health services were not yet ready to provide ARVs on a large scale even though the cost argument had been nullified by Nevirapine being offered to the government at no charge for three to five years.[63]

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[59] UNAIDS (2010), defines hyper-endemic areas as those where HIV prevalence exceeds 15% among pregnant women attending antenatal clinics.
[60] Actuarial Society of South Africa, 2005. ASSA2003 AIDS and Demographic model. http://aids.actuarialsociety.org.za/404.asp?pageid=3165 (Accessed 4 Nov 2011)
[61] World Health Organisation, 2003. Antiretroviral therapy in primary health care: experience of the Khayelitsha programme in South Africa. WHO: Geneva
[62] Minister of Health v Treatment Action Campaign (TAC) (2002) 5 SA 721 (CC). http://www.escr-net.org/caselaw/caselaw_show.htm?doc_id=403050 (Accessed 28 Nov 2011)
[63] Chigwedere P, Seage GR, Gruskin S, Lee T-H, Essex M, 2008. Estimating the lost benefits of Antiretroviral Drug Use in South Africa, J Acquir Immune Defic Syndr 49(4): 410-415.

Even after the research evidence on the feasibility of wider scale ARV treatment was published in 2003, it took another five or six years before government ARV programmes got going. These delays were in no small part due to 'HIV denialists' such as the Minister of Health, Manto Tshabalala-Msimang, and her Director General (DG) Thamsanqa Mseleku. An indication of the antagonism felt towards the NDoH denialists can be seen in a quote from Dr Francois Venter, President of the Southern African HIV Clinicians Society, who commented on Mseleku's eventual departure in the following terms:

"He, along with Tshabalala-Msimang, grossly mismanaged our health system and cost hundreds of thousands of South African lives. In a just world, they would both go to jail. The HIV world is just pleased to see the back of him."[64]

Such comments were by no means exceptional at the time. The 2008 study by the Harvard School of Public Health, cited earlier,[63] calculated that the failure to provide antiretrovirals for prevention of mother-to-child transmission of HIV and to treat those infected, cost more than 333,000 lives.

Whilst it is not the intention of this review to re-hash an infamous era in South African health policy, we must not underestimate the difficulties experienced by anyone trying to work with the National Department of Health on HIV & AIDS at the time, or how much time was lost in responding to the HIV epidemic and how this forced the hand of various donors. The net result was that with the best will in the world, people were unable to work through conventional channels and spent an inordinate amount of time trying to find ways around them. The Multisectoral Support Programme described below was one of the larger responses which led to diversification of the DFID portfolio to many NGOs and partnering with other government departments.

2.4 Health System Developments in the Motlanthe Era (2008-2009)

When President Mbeki was recalled by the ruling party in 2008, the situation with regard to HIV & AIDS seemed set to change for the better. President Kgalema Motlanthe immediately replaced the Minister of Health, Dr Manto Tshabalala Msimang, with Ms Barbara Hogan. In her first media briefing, Hogan identified her two main priorities as "the co-existence of the TB and HIV epidemics, and improving the quality of our services".[65] She endorsed the adoption of the National Strategic Plan for HIV & AIDS and TB (2007-2011),[66] and the initial plans for making antiretrovirals more readily available. The health system seemed poised for recovery and larger scale treatment at last.

When Barbara Hogan was appointed in September 2008, the British Prime Minister had already committed long term support for AIDS relief in the form of a £1 million donation to the Nelson Mandela Foundation in June 2008, and followed this with an additional £15 million for a 5-year initiative called the *Rapid Response Health Fund*. The British government pledged support to the South African Government and civil society to deliver the National AIDS strategy. Assistance was also offered to help design the programme and to support long-term capacity building. The Fund was designed to provide flexible resources to assist with revising policies and programmes to deliver the most effective

The UK funds were designated for:

1. **More protection for mothers and babies:** better availability of free tests for mothers during pregnancy, and anti-HIV drugs for pregnant mothers and children.

2. **National HIV awareness campaign:** information on safe-sex and HIV health issues to be sent out via radio, newspaper, text messages and street posters.

3. **Better nurses, doctors and clinics:** medical staff and managers helped to improve the quality of advice and service to patients, and staff morale improved through stronger incentives for quality care.

4. **HIV and AIDS watchdog:** SA National AIDS Council strengthened and given a clearer remit to hold all parts of government to account.

responses to AIDS, TB and the other major health challenges of South Africa.

Despite these major commitments of support it must be recognised that this was effectively an interim government, pending the national elections which were to take place the following year (2009), which inevitably limited the changes that Barbara Hogan was able to make or carry through. The British government clearly recognised this window of opportunity and made special efforts to provide substantial "unencumbered" funds to encourage a rapid response. An excellent start was made and AIDS stakeholders with few exceptions welcomed the positive directions being taken.

2.5   Health System Developments under the Presidency of Jacob Zuma (2009-2010)

After the 2009 election, President Jacob Zuma came to power and he replaced Hogan with Dr Aaron Motsoaledi. It was to be another five months before DG Mseleku left the Department of Health, thereby clearing away what was seen as the last of the really obstructive old guard from the Tshabalala-Msimang era. The post of Director General was held briefly by Dr Kamy Chetty (in an Acting capacity), pending the arrival of Ms Precious Matsoso in mid-2010. Finally it seemed that there were people going to be in charge of the national health agenda with whom engagement was possible and real change a probability.

From the NDoH perspective, informants appeared pleased with the relationship with DFID. Despite being one of the smaller donors, DFID has established a strong relationship with the department and provides funding and expertise that allow them to deliver programmes "better and quicker". DFID was not seen as delivering new or additional programmes but helps the department to refine its programme delivery. The additional expertise, including experience gained in other countries, was seen as particularly useful. However, donors should be cautious about introducing new programmes which are not integrated into national plans because these are unlikely to be sustainable.

3   HEALTH SYSTEM FINANCING

According to a review done by McIntyre & van den Heever in 2007,[67] per capita public sector health expenditure remained relatively constant between 1997/98 and 2008/09. This amounted to an average of 11% of government funding and does not appear to reflect any response to the increasing burden of disease resulting from HIV over this period. Moreover, Heads of States of the African Union made a commitment in 2001 to make 15% of annual government budgets available for the health sector to address the then identified needs. In contrast, private sector health expenditure increased fairly steadily between 1996 and 2003 at rates exceeding the inflation rate until levelling off from 2003 (Figure 3.1). Within this expenditure scenario there are concerns that despite having relatively high healthcare spending per capita, the country's health indicators are worse than many middle-income countries.[51] Some of this can be ascribed to the HIV epidemic, affecting maternal mortality, life expectancy and infant mortality, but inequitable access to healthcare remains a serious problem and leads to unacceptably high mortality and morbidity from preventable conditions. The expanding private sector caters for a small minority of the population. In 1992, 17% of the population belonged to a medical scheme but by 2005 this had dropped to 14.8%.[68] Space does not permit a full discussion of the private health system in South Africa during this period but costs of private health care

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[67] McIntyre, D, van den Heever, A, 2007. Social or National Health Insurance. In: Harrison S, Bhana R, Ntuli A editors. South African Health Review 2007. Durban: Health Systems Trust. http://www.hst.org.za/uploads/files/sahr2007.pdf (Accessed 15 Nov 2011)
[68] McIntyre D, Bloom G, Doherty J, Brijlal P, 1995. Health Expenditure and Finance in South Africa. Durban: Health Systems Trust and the World Bank.

appeared to be spiralling out of control. In the late 1980s and early 1990s contribution rates were increasing 25 to 30% per annum and although legislation helped to bring these increases down (e.g. statutory requirements to offer generic medicines), between 2000 and 2005 annual increases of 7% continued to be a cause for concern. Recently, the public and private sector have begun to cooperate around the proposed National Health Insurance initiative which seeks to: provide improved access to quality health services for all South Africans, irrespective of whether they are employed; pool risks and funds so that equity and social solidarity can be achieved; secure services on behalf of the entire population and efficiently mobilise and control financial resources; and strengthen the under-resourced public sector and improve health systems performance.[69]

Another aspect of health care expenditure is that the public sector was unable to compete with the private sector in terms of salaries which resulted in a gradual decline in public sector health personnel employment between 1997/98 and 2002/2003 (from 250,000 to about 220,000). There has been a slight recovery since then but if employment of health personnel had kept up with population growth there should have been an additional 64,087 health workers by 2007/08, costing around R9.7 billion.[51] If one considers the growing burden of disease, this figure increases to 79,791 and R12 billion. In short, there is a chronic shortage of health personnel in the public sector and although recent incentives such as occupation-specific-dispensation should help, its implementation has been slow.[70]

Figure 3.1: Healthcare expenditure per head in South Africa's public and private sectors, 1996-2006. Data adjusted for inflation, expressed in 2000 prices. (Source: Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009)[52]
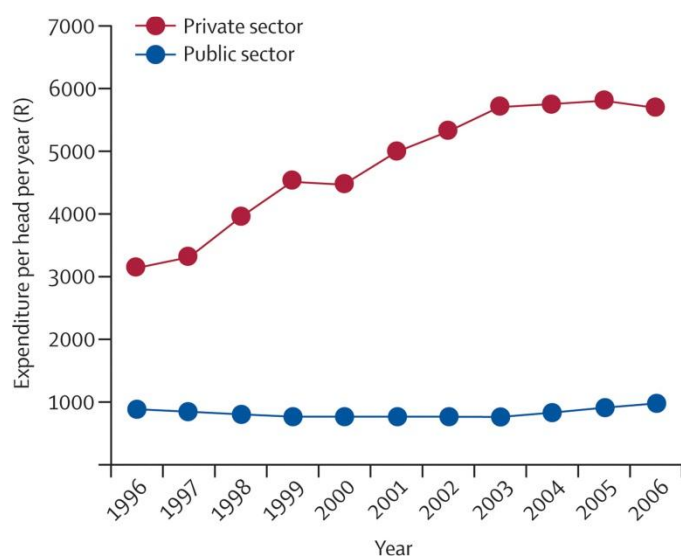
4   CURRENT HEALTH SYSTEM PRIORITIES

In terms of DFID's engagement with the South African health sector, this review has observed a shift over the years in terms of how much of the programmes are determined by DFID, and how much by the national or provincial stakeholders. To some extent, this is inevitable because donors had to

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[69] South Africa, 2011. National Health Insurance in South Africa. Government Notice 657 of 12 August 2011, Gazette No. 34523 http://www.doh.gov.za/docs/notices/2011/not34523.pdf
[70] Van Niekerk, JP, 2009. Occupation-specific dispensation — partial solution (Editorial). South African Medical Journal 99(9): 616.

operate differently depending on the prevailing political situation. In the early days of democracy, there was an eagerness to try almost anything, later this was replaced by an approach that was at best cautious, and sometimes obstructive when tried and tested interventions were refused. In recent years, a much more positive situation prevails but not without its challenges as different priorities compete.

The role of donors and recipients has been influenced to some extent by OECD-led initiatives such as the *Paris Declaration on Aid Effectiveness* of 2005. Part of the Paris Declaration sought to promote ownership by developing countries of their development policies and to coordinate development efforts. A key feature of the Paris Declaration was that partner countries committed "to exercise leadership in developing and implementing their national development strategies" and donors committed to "respect partner country leadership and help strengthen their capacity to exercise it."[71] Thus donors face the challenge of listening carefully to recipients' intentions and helping them achieve their goals. When the aims are too ambitious, plans have to be tailored to available resources and capacity strengthening has to take place.

The manager responsible for coordinating national and provincial overseas development assistance in the NDoH commented on the relationship between the department and donors such as DFID saying that a concern had arisen previously that some Technical Cooperating Officers (TCO) either failed to deliver or had been unable to develop a sustainable model and exit strategy. This situation apparently did not contribute sufficiently to capacity building and therefore the current approach is to monitor these activities more closely. The highly consultative model currently in place means that the donor-funded activities are closely aligned to NDoH strategic priorities and the Aid Effectiveness Framework.[72] This is in line with the Paris declaration and promotes donor coordination.

5   EXAMPLES OF DFID FUNDED PROJECTS

5.1   The Early Projects (1993-2002)

Table 5.1 below, lists health projects supported by ODA/DFID in South Africa over the period of this review. Since this review covers a period before there was wide use of electronic databases, project information is quite hard to obtain and resides in various places. The information is derived from DFID UK, DFID SA and AidData, part of the International Aid Transparency Initiative. Regrettably, these databases do not provide links to project documents or evaluations and efforts to obtain these from both DFID UK and DFID SA were largely unsuccessful. The listing is not intended to be exhaustive, but does provide an indication of the type and scale of interventions that have been supported.

During 1993 and 1994, the projects were geared towards supporting the new democratic government in making rapid adjustments so that the health system could provide equitable access for all. Health policy and management issues were given priority. At the same time, there were some projects which can perhaps best be described as 'emergency relief', such as the support for Operation Hunger and the Alexandra Health Centre. The former addressed malnutrition, and the latter was an independent urban health centre with an excellent reputation for community-centred primary health care, which found itself in a funding crisis when the provincial health services were undergoing restructuring. This was a common problem for many NGO service providers who had prospered under an anti-apartheid banner, but found themselves severely underfunded immediately post 1994.

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[71] Organisation for Economic Cooperation and Development, 2005. *The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.* http://www.oecd.org/dataoecd/11/41/34428351.pdf
[72] Smith, MJ, Browne, P, Dube, N, 2006. High level forum on the harmonization for Aid Effectiveness in South Africa: Final report April 2006. http://www.u4.no/pdf/?file=/themes/coordination/final_report_sa (Accessed 5 Nov 2011)

In the second half of the 1990s, DFID's efforts were directed at both national and provincial health departments. At national level, there was substantial investment in human resource capacity development (£1.2 million) and in the provinces efforts were beginning to be directed at strengthening the district health system.

Some important keywords emerge in the titles of these projects which indicate that the programmes were not just about developing systems but recognised the need to "enhance the capacity of health care workers" and "to operationalise this system". Despite these good intentions, a recurrent theme in the key informant interviews has been the tendency for aid to focus on policies and systems which fail to be fully implemented. This problem persists and the challenge is to provide the necessary support to convert policies into *implementable* plans and then to *operationalise* them. Informants suggested that too little emphasis is given to the transition from excellent policies to practical interventions. Often the policies are designed around international standards which require adaptation for use in South Africa, and this step may be overlooked or receive too little attention. In part, this may be because the South African government is expected to take ownership of the initiatives, and therefore, has to take responsibility for implementation. However, this final and critical step is often the most difficult and may need more support. There was and still is an acute shortage of human capacity at all levels of the South African health sector[73,74] and this makes the need for skilled planners and managers all the more important. Personnel with clinical skills can be imported but it is harder to do this for public health managers who need to be familiar with the prevailing South African conditions. One criticism regarding DFID's, and other donors' strategy for health investments, was that donors frequently overestimate local capacity. While South Africa has far more resources than many developing countries, limited capacity at national, provincial and district levels remains a serious impediment to development initiatives.

In the early 2000s, new challenges arose for the South African health system, particularly regarding HIV & AIDS under the controversial leadership of President Mbeki, Minister Manto Tshabalala-Misimang and others. By 2002, HIV prevalence in 25-29 year old females had reached 32% and demand for treatment was increasing.[75] There had been significant breakthroughs regarding availability of generic antiretroviral drugs, but treatment was not yet widely available for the thousands of people now living with AIDS who were eligible for antiretroviral therapy. Working with the department of health was becoming increasingly difficult at this time, and donors began to broaden their approach. In recognition of the urgent need for more efforts to 'stem the tide', behavioural interventions began to receive more support. Many localised behavioural intervention programmes were underway, mostly run by small NGOs, but the Soul City television series was recognised as an intervention with broader potential. The Soul City project, which had pioneered education-via-entertainment or 'edutainment' since 1992, was allocated a substantial grant of £6.6 million in 2002. Since then, Soul City and its affiliates have expanded evidence-based health promotion using TV, radio and other media in eight countries.

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[73] USAID, 2003. *The health sector human resource crisis in Africa: An issues paper.* Washington: Support for Analysis and Research in Africa and Academy for Educational Development.
www.**health**gap.org/camp/hcw_docs/USAID_**healthsector_africa**.pdf *(Accessed 8/11/11)*
[74] Dept of Health, 2011. Human resources for health South Africa: HRH strategy for the Health Sector 2012/13-2016/17. Pretoria: National Dept of Health. http://www.rhap.org.za/wp-content/uploads/2011/11/Abridged_Final_HRH_Strategy-2011.pdf *(Accessed 8/11/11)*
[75] Shisana, O, Simbayi, L, et al., 2002. Nelson Mandela/HSRC Study of HIV/AIDS: South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey 2002. Cape Town: Human Sciences Research Council.

Table 5.1: Examples of DFID-Funded Health Projects in South Africa: 1993-2010[76]

Project Title	Start	End	Project Purpose	Project Lifetime Budget	Sector(s)
Assistance to the Health Policy Unit	1993		To develop viable health policy options to provide a quality, effective, efficient, equitable and affordable health service to all South Africans, especially previously disadvantaged groups.	£426,293	Health, General
Basic nutrition	1993		To develop with Operation Hunger guidelines for the planning administration and monitoring of emergency feeding programmes in South Africa	£879,481	Basic Health
Health service management and training	1993		Pilot course in primary health care management	£480,756	Health, General
Assistance to Alexandra Health Centre	1994		Bridging finance for Alexandra centre to meet the funding gap during the restructuring of health services in the PWV province.	£510,611	Basic Health
Assistance to National Dept of Health	1994		Health Economics to assist National Department of Health establish Committee for reform of Health Service Finances	£140,195	Health, General
Health policy and Admin Management	1994		To make cost-effective primary mental health care available to children and adolescents in Khayelitsha by developing capacity of key community members to deal with psycho-social problems.	£83,155	Health, General
Community based rehabilitation and self-help (Action on Disability and Development)	1995		To enable resources within the community to be harnessed to help disabled individuals improve their social interaction, so as to acquire improved medical care, educational opportunities and equipment	£140,420	Health, General

[76] Table 5.1 Notes: (1) Projects showing only start year are derived from http://www.AidData.org (International Aid Transparency Initiative); those with start and end dates are derived from http://dfid.projects.gov.uk; (2) AidData budgets are converted from US dollar amounts using exchange rates on 31 March for the relevant year (http://www.oanda.com); (3) Actual spending may be less than initial lifetime budgets for operational reasons; (4) This list is not exhaustive since it relies on secondary data from numerous sources and databases which are still under development; (5) Interventions appearing several times in discontinuous years reflect multiple funding tranches.

Project Title	Start	End	Project Purpose	Project Lifetime Budget	Sector(s)
M and OD Health Care Services Northern Cape	1995		To develop management and organisational capacity of the Provincial Health Service in Northern Cape to enable the Provincial Health Dept. to develop an efficient, integrated primary and secondary health care system within a district framework.	£347,915	Health, General
Strengthening Management Capacity in the Health Service	1995		To develop management and organisational capacity of the Provincial Department of Health Service in the Northern Province to enable the PHD to develop an efficient, integrated primary and secondary health that are within a district framework.	£322,840	Health, General
Assistance to National Dept of Health	1996		Health Economics to assist National Department of Health establish Committee for reform of Health Service Finances	£44,714	Health, General
Health management and human resource development	1996		To develop Human Resource systems and skills capacity within the Chief Directorate of Health Resources Planning and formulate and implement HR policies which will lead to the development of equitable, efficient and effective integrated tertiary, secondary and primary health services.	£1,207,271	Health, General
Health service management and organisational development (North West)	1996		To develop systems and skills capacity within the Provincial Health Service of the North West Province to develop equitable, efficient and effective integrated secondary and primary care within a district framework.	£396,417	Health, General
Strengthening of women's reproductive health	1996		To assist the dept. of Health to develop a comprehensive reproductive health care system and to enhance the capacity of health care workers to operationalise this system	£146,821	Health, General
Dept of Health Know How Fund	1997			£489,151	Health, General
Health programme South Africa British Red Cross JFS 1197	1997		To improve the capacity to provide longer-term health assistance to vulnerable communities. By the provision of appropriate training and technical support to Red Cross Personnel and volunteers.	£184,043	Health, General
Community based Primary Health Care programme	1998		To improve access to and utilisation of cost effective primary Health care Services in targeted communities in four provinces: Northern, North Western, Kwa-Zulu Natal and Northern Cape	£426,215	Basic Health

Project Title	Start	End	Project Purpose	Project Lifetime Budget	Sector(s)
Health policy and Admin Management	1998		To make cost-effective primary mental health care available to children and adolescents in Khayelitsha by developing capacity of key community members to deal with psycho-social problems.	£219,196	Health, General
Provincial Primary Health Care	1998		Effective reproductive health services for adolescents and youth in the poorest communities in the Northern Cape, North-West and Northern provinces	£1,339,533	Basic Health
Support to National TB Control Programme (NTCP)	1998		To support the strengthening of South Africa's National Tuberculosis Control Programme	£365,327	Basic Health
Assistance to National Dept of Health	2000		Health Economics to assist National Department of Health establish Committee for reform of Health Service Finances	£16,946	Health, General
Basic nutrition	2000		To develop with Operation Hunger guidelines for the planning administration and monitoring of emergency feeding programmes in South Africa	£705,890	Basic Health
Health management and human resource development	2000		To develop Human Resource systems and skills capacity within the Chief Directorate of Health Resources Planning and formulate and implement HR policies which will lead to the development of equitable, efficient and effective integrated tertiary, secondary and primary health services.	£1,027,846	Health, General
Health service management training	2000		Pilot course in primary health care management	£25,711	Health, General
M and OD health care services Northern Cape	2000		To develop management and organisational capacity of the Provincial Health Service in Northern Cape to enable the PHD to develop an efficient, integrated primary and secondary health care system within a district framework.	£22,541	Health, General
Primary Health Care	2000		Delivery of a comprehensive health services to a deprived low income urban area.	£ 250,100	Health, General

Project Title	Start	End	Project Purpose	Project Lifetime Budget	Sector(s)
Provincial Primary Health Care	2000		Effective reproductive health services for adolescents and youth in the poorest communities in the Northern Cape, North-West and Northern provinces	£1,270,953	Basic Health
Hospital revitalisation programme emergency medical services	2001		To provide provision of primary health care in rural areas by developing and improving the emergency Medical Services	£21,557	Health, General
South Africa cholera control operation	2001			£19,454	Basic Health
Health policy and Admin Management	2002		To make cost-effective primary mental health care available to children and adolescents in Khayelitsha by developing capacity of key community members to deal with psycho-social problems.	£1,469	Health, General
Health systems support programme	2002		Accelerated Implementation of improved health services in support of Department of Health Strategic Plan	£55,075	Health, General
Provincial Primary Health Care	2002	2004	Effective reproductive health services for adolescents and youth in the poorest communities in the Northern Cape, North-West and Northern provinces	£ 245,780	Basic Health
Soul City	2002		To impact positively on the HIV/AIDS epidemic, health and lifestyle among the populations of South Africa	£6,608,989	Basic Health
Hospital revitalisation programme emergency medical services	2003		To provide provision of primary health care in rural areas by developing and improving the emergency medical services	£935,268	Health, General
Hospital revitalisation programme emergency medical services	2004		To provide provision of primary health care in rural areas by developing and improving the emergency medical services	£ 764,305	Health, General
SA Institute for Health Care Managers	2004		To enhance high standards of professional health care management in the public and private health sectors of SA through appropriate professional development and training.	£46,302	Basic Health

Project Title	Start	End	Project Purpose	Project Lifetime Budget	Sector(s)
HIV and AIDS Multi-sectoral Support Programme (MSP)	01/04/ 2003	31/03/ 2010	To contribute to a strengthened South African response to HIV/AIDS with stronger coordinated support from the international community	£44,781,324	STD control including HIV/Aids
Addressing Gender Based Violence and HIV/AIDS (Civil Society Challenge Fund)	01/04/ 2007	31/03/ 2011	To empower women men and youth to demand and protect women's rights reducing the vulnerability of women and girls to Gender Based Violence and HIV/AIDS.	£ 317,076	Human rights (60%), Health Education (40%)
MOU With WHO for Clinical Associates Programme (Training of Midlevel Health Care Workers)	01/09/ 2008	31/12/ 2009	Establish a new mid-level cadre of health workers in South Africa.	£400,000	Health personnel development
Strengthening South Africa's Revitalised Response to AIDS and Health (SARRAH)	01/01/ 2009	31/12/ 2014	Improved governance of an integrated effective response to HIV & AIDS and health in South Africa.	£26,973,838	STD control including HIV/Aids
Core Support to Nelson Mandela Foundation	05/08/ 2009	31/12/ 2012	The global objective in respect of dialogue is to develop and sustain a dialogue platform promoting the founders legacy	£1,000,000	STD control including HIV/Aids (50%), Basic health care (25%), Health Education (25%)

5.2 The National Health Service Management Education System through Open Learning (MESOL) in South Africa (1994-2002)[77]

MESOL was one of the first DFID assistance initiatives offered to the South African health system, post 1994. The MESOL course was originally developed for the British National Health Service (NHS) by the Open University (OU) to train managers required for all aspects of the NHS, from Practice Managers to Managers required in Hospitals and Trusts. In the UK model the British Department of Health and the NHS had input into the content and structure of the course, the OU set the academic standard of the study material, and a variety of tertiary institutions delivered instruction and certified graduates.

In South Africa, MESOL was first offered in the ODA/DFID aid package to the NDoH. Mr Tony Mapplebeck, a DFID-supported Advisor to the NDoH, was the early champion of the programme. He and teams of tutors from the UK provided all the national level courses described below. Mapplebeck also acted as advisor to the Provincial Departments who used the materials, and to the rewriting team later assembled by the South African Institute for Distance Education.

After MESOL had been proven to have merit, it was offered to the Northern Cape Province, the Northern Province (later Limpopo) and the North-West Province. Each of these Provinces used MESOL slightly differently. The differences will be described below. Further NDoH courses were offered after the first one was concluded. Finally, DFID, the OU and the NDoH agreed to adapt the material to reflect Southern African realities with the intention of making the material available to a wider SADC/Sub-Saharan Africa audience.

5.2.1 The first NDoH MESOL offering

Initially, about 75 health managers, two from each of the nine provinces and the rest from the Pretoria NDoH, were exposed to the British NHS/OU materials. Instruction was delivered by experienced UK-based trainers and British institutions certified the SA learners. During this process it became apparent that MESOL would be a valuable tool in the hands of Provincial Health Managers, and ways of bringing this about were explored.

5.2.2 Provincial level MESOL offerings

DFID made a grant of about £650,000 to each of the three pilot provinces (Northern Cape, Limpopo and North-West Province) to build capacity in their newly created Health Departments.

The Northern Cape acquired, with financial aid from DFID, 250 packages of the MESOL material from the OU, set up a relationship with the University of the Free State who trained eight dedicated tutors, and put over 240 of its staff through the course in 18 months. Eventually, 193 of these staff graduated with a University of the Free State post-graduate diploma, rated at Level 7 by the South African Qualifications Authority.

The North-West Department of Health used its grant to hire Management and Organisational Development Technical Assistants and made no more use of MESOL than has been described above.

The Northern Province employed the services of a Johannesburg based Technical College (as they then were), copied OU materials and presented MESOL material to their Managers.

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[77] This section is based on a report on the MESOL programme kindly prepared for this review by Stan Kahn, DFID Health Management Unit TCO, Northern Cape, 1995-2001.

5.2.3   Further NDoH MESOL offerings

By the late 1990s Provinces that had not been part of the DFID Provincial support programme described above also wanted MESOL training for their staff. Through the NDoH a further four cohorts were assembled and MESOL instruction was delivered by a combination of British and South African tutors. Eventually, about 180 Health Managers, from Mpumalanga, Kwa-Zulu Natal and the Eastern-Cape, graduated through this channel, with a University of Sheffield Hallam certificate.

The Free State undertook training on their own, with the tutors they had trained for the Northern Cape project, while the Western Cape and Gauteng did not formally avail themselves of MESOL material.

5.2.4   The production of a Southern African MESOL course

By the end of the 1990s there was widespread and sustained interest in MESOL and the variety of modalities by which it had been delivered, and there was a groundswell of interest in 'indigenising' the materials for SA use. Consequently, further effort was put into establishing relationships with South African tertiary institutions who might take such an indigenisation process forward. There was interest expressed by all parties involved – DFID, the NDoH, a variety of South African tertiary institutions and the OU. The OU agreed that up to 25% of their material could be modified in the SA version of the programme.

This led to a contract being awarded by DFID to the Health Systems Trust (HST) to undertake this 'rewrite' of MESOL. The HST in turn contracted with the South African Institute for Distance Education, an NGO specialising in the production of distance educational materials, to undertake the actual production of the course.

At this point there was a change in DFID policy, as well as changes in DFID Pretoria personnel which resulted in the project stalling after production of the first (pilot) volume. It took another 18 months before funding for Phase 2 came through, at which point work on the rewrite was resumed.

The rewrite task encompassed almost 1 600 pages of material. The project was finalised in 2001, with the final, OU approved, course materials being delivered. The total cost, all borne by DFID, was in excess of R 3.5 million. By this time the *dramatis personae* in the NDoH had changed and 'political cover' for the project had diminished. At the same time other EU donors expressed interest and new staff in the NDoH bought into these new offerings. Eventually the Agreement between the OU and the NDoH lapsed, and despite numerous attempts to revive implementation of the project, nothing further came of it. The entire course as it existed in early 2001, typeset in the programme Quark, is still available but new licence agreements would have to be negotiated with the OU and the partners in the process before it could be used.

5.3   The Multi-Sectoral Support Programme (2003-2009)

By 2003, DFID support for HIV & AIDS began to expand beyond the health sector alone. The Multi-sectoral Support Programme, which was allocated a budget of £44.8 million for the period 2003 to 2010, provided technical assistance to the departments of Health, Social Development (DoSD) and Defence, specifically for reducing the impacts of the HIV epidemic. This initiative recognised the multifaceted nature of the AIDS epidemic and the need for it to be addressed more broadly than in the health sector alone and also recognised that the scale of the problem required donor coordination. This programme was established at the time when 'AIDS denialism' dominated thinking in the NDoH and as such the project is a good example of how DFID diversified its programme under difficult circumstances. The MSP worked with DoSD to promote important community and home-based care initiatives and programmes for orphans and vulnerable children. Another positive spin off from the hiatus in NDoH was that efforts were directed at provincial authorities, particularly the Eastern Cape, KwaZuluNatal, Limpopo and Mpumalanga – provinces with a history of neglect and high HIV prevalence.

Despite its positive impacts, the MSP was not without its critics, and there were some serious management problems by the end of its term. There was no satisfactory monitoring and evaluation framework or measurable indicators for many of the individual projects, which by the end of 2008 amounted to 170 projects.[78]

5.4   The Rapid Response Health Fund (2008-2009)

With the change of South African government towards the end of 2008, the British government made a renewed commitment to supporting HIV & AIDS interventions through the health department. The Prime Minister committed £1 million to the Nelson Mandela Foundation to support the National AIDS strategy and followed this with a further £15 million when the new minister of health (Barbara Hogan) was appointed. The *Rapid Response Health Fund* (RRHF) was designed to provide the new Minister with "immediate and flexible resources to … re-orient policies and programmes and deliver the most effective responses to AIDS, TB and the other major health challenges." This was a bold step and the key points in this offer were that the funds were to be "immediate and flexible" – something which is not typical of overseas development assistance. Bold measures needed to be taken to release the log jam of the previous administration and get things moving again. The RRHF provided such a vehicle and ran through to the end of 2009.

The project completion report for the MSP[79] concluded that the transition from the end of the MSP in December 2008 to the RRHF enabled DFID to take advantage of the new national health leadership to further the technical assistance ends of the MSP. The outcomes of previous components of the MSP were regarded as "mixed in their levels of success", but Output 5 or the RRHF, changed the programme's total impact. All of the indicators for Output 5 (the RRHF) met and exceeded their required targets, and contributed substantially to the programme purpose of strengthening the response to HIV & AIDS. The report reached the following conclusion: "The level of influence and goodwill achieved as a result of RRHF outputs means that this programme should be regarded as having a high level of success."

5.5   MOU with WHO for Clinical Associates Programme (Training of Midlevel Health Care Workers) (2008-2009)

A small initiative which is worth mentioning is support for the Clinical Associates Programme in collaboration with the World Health Organisation. This programme was established to provide support to the National Department of Health's Strategy on Human Resources for Health which had identified shortages of mid-level health professionals as an impediment to the expansion of Primary Health Care services and the District Health System. The Clinical Associates training programme was specifically geared towards the needs of secondary hospitals, and as such, contributes to strengthening District Health Services. The first 23 graduates completed their three year Bachelor of Clinical Medical Practice (B CMP) at Walter Sisulu University in the Eastern Cape, in December 2010. Another 79 graduates are expected from the universities of Witwatersrand, Limpopo and Pretoria at the end of 2011. The NDoH provided bursaries for trainees using funding from DFID, the European Union (EU), the World Health Organisation (WHO) and others.

At the first graduation ceremony the National Minister of Health, Dr Aaron Motsoaledi, congratulated the first 23 Clinical Associates. Motsoaledi, said:

"They will be competent, professional members of the health care team with the necessary knowledge, skills and attitudes to function effectively in the district health system, primarily working

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[78] DFID, 2008. HIV & AIDS Multisectoral Support Programme (MSP) - South Africa. Annual Review – Aide-Memoire.
[79] DFID, 2009. Project completion report: Multisectoral Support Programme South Africa.

with and under the supervision of qualified medical practitioners, to assist them with emergency care, procedures and in-patient care." [80]

A slightly less optimistic tone was taken by the Member of the Executive Council for Health in the Eastern Cape, Mr Sicelo Gqobana, who acknowledged the challenge faced by many human resources initiatives when graduates are head-hunted by overseas recruitment offers. He appealed to the clinical graduates to:

"…not abdicate their responsibilities by allowing themselves to be poached by overseas offers [and to] embody the principles of Batho Pele[81] by caring for the South African people, serving them with a smile and knowing that they belong to those communities they will serve."[80]

6   LESSONS LEARNT

As mentioned above, it has been difficult to obtain information on previous DFID projects and with regular turnover of staff institutional memory is fragmented. According to the DFID Web site (www.dfid.gov.uk), the project database only contains current or recently completed DFID-funded programmes. It includes project descriptions, dates, purposes, countries, sectors and financial data but does not yet include documents with more detailed information. Annual reviews, project completion reports and log frames will be published in the future but this is unlikely to be retrospective and will therefore be of limited use for a review such as the current one. Clearly there is a case to be made for a more systematic review of the successes and failures over the years but this would require more time and some dedicated support to assist with access to DFID archives.

In the absence of detailed project documentation, key informant interviews can provide an interesting perspective on progress and processes within DFID projects in South Africa over the past 20 years. The section that follows draws on specific issues that arose during key informant interviews and general discussions with other stakeholders. The information is inevitably subjective but is derived from carefully considered opinions of senior health professionals. The qualitative method used relies on a relatively small number of interviews but there was clear data saturation with dominant themes arising repeatedly. These opinions provide some useful insights into what worked well and some potential pitfalls to be avoided in future.

5. A concern raised by informants was that even excellent policies need a lot of work before they can be translated into implementable plans, and these plans then need to be operationalised. These processes depend on sufficient senior and operations staff which may be in short supply. Despite its economic strength, compared to many African states, South Africa still has a critical shortage of skilled people. While measures are in place to address this, effective capacity building must receive priority so that recipients of aid are not perpetually dependent on technical assistance. Training programmes such as those for Clinical Associates will help alleviate the shortage of clinical skills but other forms of training are needed for the mid-level managers who have to implement the new policies. In-service training is offered by several Schools of Public Health and these programmes are sufficiently varied to meet many of the needs of the National and Provincial Health Departments but the locally adapted MESOL initiative would appear to be a missed opportunity to complement these programmes. A further step proposed by one informant was to include a mentoring programme for graduates of such training (both short courses and degree programmes), so that support continues

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[80] Ngalika, O, 2011. First South African Clinical Associates take their pledge at Walter Sisulu University. WSU Newsletter, Feb 2011.
[81] Batho Pele is Sotho for "People First". It is a South African political initiative which aims to facilitate better delivery of goods and services to the public.

when students return to their normal work environment; without such support, training may go to waste.

6. Changes to DFID policy in the early 2000s, which resulted in a decreasing administration budget and Health Advisors no longer having their own budget, meant that alternative strategies were required. This led to projects being assigned to management agents and carried out by the NDoH with little input from DFID. In the period of 'denialism', short term technical advisors worked with the department, but other resources were widely distributed through civil society organisations in the provinces. According to informants, these activities (MSP and others) became so diverse that "DFID lost its way", and was unable to adequately monitor impacts. The current management appears to be acutely aware of these problems, and is implementing revised monitoring and evaluation mechanisms. However, it is vital that these evaluations remain practical and that suitable indicators are used, even though this may require modifications to the agreed logframe because workstreams may change over time.

7. Informants were asked whether there was disagreement or mismatch between DFID and local priorities and whether donor engagement sometimes took resources away from planned work. In most cases, informants felt that DFID programmes were well aligned with local needs, but there were instances when good local programmes were side-lined by donor driven activities, and high transaction costs were a potential drain on local resources. One informant felt this was more of a problem with other (perhaps larger) donors that came with pre-conceived programmes which recipients had to adopt in order to receive funding. Where this entails mere endorsement and all resources are external, there is little harm, but when existing resources are diverted from routine duties this is a problem.

8. The consensus among informants was that DFID support resulted in more being achieved in the health sector than would have been possible otherwise; in part because DFID technical officers had skills that are often unavailable locally. Part of the activity was capacity building which, as indicated above may need more mentoring for lasting impact. However, impact is hard to measure within a large system, especially when training tends to make people more likely to move. One informant pointed out that the evaluation of capacity building should include "benefits to the health system overall" which may not be apparent if evaluation is limited to a specific project. Another informant observed that even small amounts of funding can be effective in leveraging funds from elsewhere.

9. A feature of DFID's approach appears to have been what informants described as "flexible financing" which worked well when developing innovative systems. This flexibility brings with it challenges for monitoring and evaluation, but several informants cited this flexibility as a significant strength. Efforts should be made to ensure that the essential accountability mechanisms do not inhibit innovative programmes more than absolutely necessary.

10. DFID's activities in the health sector have contributed to developing new policies and programmes, and a strength of its engagement has been to bring stakeholders together to discuss policy. Where specific expertise was lacking, DFID provided technical officers and consultants that allowed the South African government to develop programmes, which it would not have been able to implement as quickly without this additional capacity. Sometimes this was done in partnership with other donors (e.g. EU), in line with efforts to improve donor coordination, and should continue.

11. Over the years, DFID has supported numerous policy initiatives which are too many to list here, but the on-going role in strategic planning with the NDoH, and work with the Medicines Control Council (the backlog project), were cited as particularly important ones. The latter reportedly contributed to a saving on national drug expenditure of about £440 million (R4.7 billion) in 2010, by facilitating registration of new antiretroviral drugs.**Error! Bookmark not defined.** owever, a pertinent comment from one of the informants, was that DFID may be contributing to the phenomenon of "reinventing the wheel". In much the same way as mentoring is needed to ensure that improved skills are optimally utilised, policies are only useful if they are fully implemented. It is of little value to keep on developing new policies, if the previous ones have not been fully implemented or evaluated.

12. A simple but telling comment from one informant and this reviewer's experience is that the nature of appointments in DFID SA appears to result in a loss of institutional memory. More effective handover from one incumbent to the next would help prevent the sense of isolation expressed by some previous health advisors and TCOs. One informant felt that although TCOs were usually recruited for a specific task, their skills could be better used if they were more integrated into the larger DFID structure. When compounded by understaffing in NDoH with similar lack of continuity in some key positions, it is inevitable that a fragmented programme will result. There is a sense that each administration comes with its own priorities and pursues these with vigour, sometimes to the detriment of valid on-going or developing programmes. Clearly there is no simple solution to this problem, but continued local capacity development and efforts to avoid high staff turnover remain essential. There must also be adequate records of strategic decisions and the rationale for particular programmes so that we do not continue to 'reinvent the wheel'.

13. Overall, the attitude of all informants to DFID's role in South Africa was very positive. The NDoH sees DFID as a reliable ally for getting its work done, and the senior public health specialists consulted confirmed that DFID is playing a substantially beneficial role. There are aspects of the delivery process that need to be carefully monitored, but there seems little doubt that DFID's aid is making a positive contribution to health systems development in South Africa.

Annex 2

Strategic Context of SARRAH

1 Strategic context of SARRAH

1.1 Introduction

In order to better understand the context in which the Strengthening South Africa's Revitalised Response to AIDS and Health (SARRAH) programme operates, it is useful to understand the conditions under which the programme began, and how the South African health system has evolved since its inception in 2010. SARRAH was initiated at a time when South Africa was emerging from a period of controversial health system management, particularly with regard to HIV and AIDS. During President Mbeki's tenure, the Ministry and National Department of Health (NDoH) were adversely influenced by the 'AIDS denialists' and HIV and AIDS services were severely compromised as a result.

One consequence of the era of denialism was to create very difficult conditions for donors who wished to engage with the NDoH. While conventional approaches to treating patients with HIV infection continued, the slowness of the response to the epidemic was seen by many as irresponsible. This period was characterised by an almost complete inability to get new HIV-related programmes approved within NDoH. Those responsible for the HIV and AIDS programme, apparently, often agreed with proposed initiatives tabled by DFID, but were unwilling or unable to obtain authorisation from higher levels. This problem affected health personnel right up to the most senior levels, including the then Deputy Minister Nozizwe Madlala-Routledge, who was widely applauded for her efforts to get the National Strategic Plan on HIV and AIDS 2007-2011 accepted. The outspoken Deputy Minister was eventually fired, but her departure was lamented by many who saw her as having done much to restore some sanity to South Africa's controversial AIDS policy.

At this time, despite successful efforts to make anti-retrovirals (ARV) more readily available, and some being offered free of charge, the roll-out of this life-saving treatment was painfully slow. However, despite these problems, other evidence-based HIV programmes continued to be implemented by resolute policy makers. Moreover, civil society activism culminated in successful challenges to the government in the courts, led by among others the Treatment Action Campaign (TAC), one of the current SARRAH partners. The TAC intervention gained international acclaim for its part in causing government to make ARVs more widely available. It also led to the piloting of a prevention of mother-to-child transmission (PMTCT) programme (the PMTCT A-plan) which was supported by SARRAH.

Many donors, including the UK Department for International Development (DFID), found that the NDoH's slow response to the AIDS crisis forced them to look elsewhere for partners. Officials in the NDoH suggested that they were still open to working with DFID and its partners at this time, but previous DFID Health Advisors reported an effective impasse to which they responded by diverting much of their attention to NGOs. However, many of the health-related NGOs that had fought for equitable health services under an apartheid government had suffered severe funding cuts when their raison d'être appeared to fall away with the advent of democracy. Thus the partners who would have been available to assist in providing equitable health services, especially at community level, were severely depleted.

It was thus from a very low base that SARRAH began its work to revitalise the response to AIDS and health. The changes of leadership which followed the recall of president Mbeki in 2008 created an opportunity for donors to work with renewed vigour on health matters with the South African government. The SARRAH programme was designed to make the most of this opportunity.

1.2 Historical efforts to identify and address current public health challenges

1.2.1 The Health Roadmap 2008

When President Mbeki was recalled in 2008, President Kgalema Motlanthe immediately replaced the Minister of Health, Dr Mantombazana Tshabalala-Msimang, with Barbara Hogan. Tshabalala-Msimang is infamous for her extraordinary AIDS policies which, according to an authoritative team from the Harvard School of Public Health, led to the unnecessary deaths of over 333,000 people[82]. Hogan lost little time in addressing the AIDS crisis and in her first media briefing identified her two main priorities as: "the co-existence of the TB and HIV epidemics, and improving the quality of our services"[83]. One of the first initiatives was to formalise the so-called *Health Roadmap* which was based on preparatory work done by NDOH staff. The *Health Roadmap* comprised a diagnostic process that was commissioned by the African National Congress' National Executive Committee Sub-Committee on Health and Education, in 2008, to identify the key challenges facing the health sector. The commission was jointly chaired by Barbara Hogan, National Minister of Health, Zweli Mkhize, MEC Finance and Education, and Jay Naidoo, Chairperson of the Board, Development Bank of Southern Africa.

The *Roadmap* identified some achievements since the dismantling of the apartheid health system in 1994. These included improvements in developing the District Health System, better access to health services through the provision of comprehensive Primary Health Care, the introduction of a strategic programme to address HIV, AIDS, TB and other important diseases, and health sector reforms to, inter alia, reduce the costs of drugs and increase access to care. However, Millennium Development Goals health outcomes were bad, and in some cases, e.g. maternal mortality, getting worse. South Africa was described as having "war-like death statistics" because so many young adults were dying - as a result of AIDS[84]. Overall, South Africa was achieving poor results relative to cost.

The Roadmap report, with its various background papers, allowed priorities to be set and the initial focus was: prevention and treatment of HIV and TB infection; efforts to strengthen effectiveness at all levels of the health system, both public and private, including better information systems and decision-making; and addressing human resource and budget constraints. This prioritisation process eventually led to what is known as the *10-Point Plan,* a document intended "to guide government health policy and identify opportunities for coordinated public and private health sector efforts, in order to improve access to affordable, quality health care in South Africa"[85]. The proposed Ten Point Plan (Box 1) paved the way for the development of the *National Department of Health Strategic Plan 2010/11–2012/13,* which took on board many of the Roadmap's recommendations.

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[82] Chigwedere P, Seage GR, Gruskin S, Lee T-H, Essex M, 2008. Estimating the lost benefits of Antiretroviral Drug Use in South Africa, J Acquir Immune Defic Syndr 49(4): 410-415

[83] Minister of Health Ms. Barbara Hogan, Address to the media 2 October 2008. http://www.bhfglobal.com/address-media-minister-health-ms-barbara-hogan-press-conference Accessed 17/7/2013

[84] DBSA. Health Roadmap. Summary presentation on the Health Roadmap process, November 2008. www.dbsa.org/Research/Documents/Health%20Roadmap.pdf Accessed 16/7/2013; and DBSA. A Roadmap for the reform of the South African Health System: A process convened and facilitated by the Development Bank of Southern Africa. http://tinyurl.com/pp4q8h7 (Accessed 18/7/2013)

[85] Rispel, L, Moorman, J, 2010. Health Legislation and Policy: Context, Process and Progress. Chapter 14 in: S. Fonn & A. Padarath. (eds). *South African Health Review 2010*. Durban: Health Systems Trust: 127–142.

Box 1: Health Sector Strategic Framework: the 10-Point Plan

- Provision of Strategic leadership and creation of Social compact for better health outcomes.

- Implementation of National Health Insurance.

- Improving the Quality of Health Services.

- Overhauling the health care system and improving its management.

- Improved Human Resources Planning, Development and Management.

- Revitalisation of physical infrastructure.

- Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.

- Mass mobilisation for the better health for the population.

- Review of drug policy.

- Strengthen Research and Development.

1.2.2 The work of the Integrated Support Team (DFID)

Not long after the *Health Roadmap* had been prepared, DFID carried out a *Review of Health Overspending and Macro-assessment of the Public Health System in South Africa*[86]. This work was carried out by the Integrated Support Team (IST) which consisted of teams of three consultants for each province and a national team. The rationale for the review, which was supported by the DFID Rapid Response Health Fund, was that projected overspending in some provinces was thought likely to compromise the health system and particularly likely to adversely affect the HIV epidemic. The review found many shortcomings in the health sector including: strategic planning and leadership; financial management; and monitoring and evaluation. The Team concluded that the weaknesses needed urgent intervention without which the health system would come under increasing pressure.

Leadership, governance and service delivery were found to be lacking and there was strong criticism of the lack of a coordinated national service transformation plan. The NDoH was failing to ensure that the necessary resources were available for the service targets called for by a range of national policies. Recommendations included developing an annual national health plan which would be closely monitored. An Office of Standards and Compliance was also proposed which would develop norms, standards and guidelines, and help to improve service delivery. The way that senior managers at national level operated was also called into question and it was pointed out that they should focus on strategic issues, such as achieving health outcomes and quality service delivery to improve health system performance.

Financial recommendations concentrated on quantifying the financial backlogs and addressing the numerous unfunded mandates such as the Occupational Specific Dispensation; dual therapy for prevention of mother-to-child transmission of HIV (PMTCT); new vaccines; and the takeover of local government functions and staff as part of the district health system. The initial model for scale up of antiretroviral therapy was also considered unsustainable. Conditional grants were also being poorly managed and there was insufficient accountability or consequences for overspending. A specific recommendation was for funds for HIV to be ring-fenced and measures taken to prevent over-spending.

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[86] DFID. Consolidated report of the Integrated Support Team: Review of health overspending and macro-assessment of the public health system in South Africa. May 2009. http://section27.org.za.dedi47.cpt1.host-h.net/wp-content/uploads/2010/09/Consolidated-IST-Report.pdf Accessed 15/7/2013

In terms of human resources the review found several weaknesses. These included a need to review organisational structures at both national and provincial levels. Another issue was the problem created by insufficient delegation of authority which, although provided for in legislation, had frequently been withdrawn. This process had the potential to make matters worse by creating feelings of disempowerment and a lack of accountability.

The next issue raised was the lack of adequate monitoring and evaluation, and specifically the lack of objective information being used for decision making. The review called for an overhaul of the District Health Information System and a reduced and rationalised National Indicator Data Set. There was a strong motivation made for pooling M&E resources, including costly electronic health information systems, in a National Health Information System.

Lastly, prioritising drug budgets appeared to be important, particularly for ensuring continuation of treatment for patients on ARVs, but also with regard to essential vaccines. The costs of laboratory tests were noted as a major cost driver and a call was made for a national working group to develop essential laboratory test lists for the different levels of health care. Technology and infrastructure was found to be inadequate and maintenance was having a negative impact on service delivery and contributed to poor retention of staff.

The review identified the main role-players responsible for implementation of its various recommendations, and highlighted the need for a consolidated response, whereby the various components of the national health system would work together to improve population health.

1.2.3   Analysis by renowned academics: the *Lancet* series *Health in South Africa*

Yet another analysis of the situation in South Africa in 2009 was undertaken in collaboration between the *Lancet* and a group of South African academics. A series of six papers was prepared of which one, providing an overview of the health system[87] by Coovadia et al, and another covering the likelihood of attaining the Millennium Development Goals[88], are perhaps the most relevant to a discussion of the antecedents of the SARRAH programme. While HIV and AIDS dominated South Africa's health environment, this Series helped to highlight many other under-recognised underlying health determinants. It too, made the point that this was a time when the administration had "a unique opportunity to implement key health policies to shape South Africa's future"[89]. Coovadia et al summarised the situation for human and financial healthcare resources being characterised by stagnation in government funding: six times greater expenditure per head on private medical care compared to the public sector (in 2006); and three quarters of general practitioners working in the private sector. They concluded that despite progressive pro-poor policies during the Mandela era (1994-1998), the health system failed to be transformed during the subsequent Mbeki years (1999-2008).

There were some encouraging signs reported, such as increased spending on Primary Health Care to over 22% of the total public sector healthcare expenditure in 2005. However, confusion arose with changing geographical boundaries and governance responsibilities within the district health system. Power was concentrated within the provinces and many local authorities lost control of their preventive and promotive health functions, and these activities became further marginalised. These

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[87] Coovadia, H. Jewkes, R, Barron, P, Sanders, D, McIntyre, D. 2009. The health and health system of South Africa: historical roots of current public health challenges. *Lancet* 200910.1016/S0140-6736(09)60951-X. published online August 25.

[88] Chopra, M, Lawn, JE, Sanders, D, Barron, P, Abdool Karim, S, Bradshaw, D, Jewkes, R, Abdool Karim, Q, Flisher, AJ, Mayosi, BM, Tollman, SM, Churchyard, GJ, Coovadia, H. 2009. Achieving the health Millennium Development Goals for South Africa: challenges and priorities. *Lancet* 200910.1016/S0140-6736(09)61122-3. published online August 25.

[89] The Lancet. Health in South Africa. Launched in Johannesburg, South Africa, August 24, 2009 http://www.thelancet.com/series/health-in-south-africa Accessed 22/07/13

papers highlighted similar challenges to those identified by the other reports including: inadequate human resource capacity and planning; poor stewardship, leadership, and management; and the increased stress on the public health system caused by the AIDS epidemic and restricted spending in the public health sector[90].

The *Lancet* series was particularly critical of the poor stewardship, leadership and management in the health system and there are numerous articles which refer to these problems both at different levels of the system and between similar facilities[91]. These problems appeared to manifest in the form of dramatically different health outcomes across the country. For example, tuberculosis (TB) cure rates in the Western Cape, a province with historically one of the highest TB rates in the world, were close to 80%, whereas in KwaZulu Natal cure rates were between 40% and 60% in 2007. Higher HIV prevalence in KwaZulu Natal may have played a role, but both provinces theoretically had similar resources. As part of the effort to address the HIV epidemic, the City of Cape Town distributed over five times more condoms per sexually active male than the national average[92].

1.3 Development of SARRAH

The Health Roadmap, the IST and the *Lancet* series effectively identified what needed to be done but it was immediately apparent that there were gaps in resources which would make achieving the necessary turn around very difficult. It was as a result of this situation that DFID, in discussion with the NDoH, began to develop the SARRAH programme. Initially the work plan involved a substantial amount of work aimed directly at health service delivery, such as a focus on PMTCT in clinics, but with the appointment of the new Director General (DG) in 2010 a more strategic orientation, as suggested by the IST, was taken. The DG invited Cluster Managers in NDoH to identify strategic initiatives for SARRAH support but made it clear that funding should only be used for initiatives which could not be achieved using routine mechanisms. Eventually, many of the priorities identified by the earlier policy initiatives were to be incorporated into the SARRAH programme.

SARRAH is not a single large-scale intervention, but supports national reforms, programmes and institutions of the South African health sector through a range of strategic interventions identified jointly by DFID and the SARRAH partners, namely: the National Department of Health (NDoH); Treatment Action Campaign (TAC); two parliamentary oversight committees - the Joint Committee on HIV (JCH) and the Portfolio Committee on Health (PCH); and the South African National AIDS Council (SANAC). This has led SARRAH to diversify into a range of activities, each supporting different parts of the policy landscape and each intervening at different levels in the line of management. SARRAH's work streams are closely aligned with the NDoH 10-Point Plan, the policy instrument through which the Negotiated Service Delivery Agreement is to be achieved (Figure 1).

[90] Coovadia, H. Jewkes, R, Barron, P, Sanders, D, McIntyre, D. 2009. The health and health system of South Africa: historical roots of current public health challenges. *Lancet* 200910.1016/S0140-6736(09)60951-X. published online August 25.

[91] Sanders D, Chopra M. 2006. Key challenges in attaining health in an inequitable society: the case of South Africa. *Am J Public Health*; **96**: 73-78; and Schneider H, Barron P, Fonn S. 2007. The promise and the practice of transformation in South Africa's health system. In: Buhlungu S, Daniel J, Southall R, Lutchman J, eds. State of the Nation: South Africa 2007. Pretoria: HSRC Press; and Rispel L, Setswe G. 2007. Stewardship: protecting the Public's Health. In: Harrison S, Bhana R, Ntuli A, eds. South African Health review 2007. Durban: Health Systems Trust; and Lehmann U. 2008. Strengthening human resources for primary health care. In: Barron P, Roma-Reardon J, eds. South African Health Review 2008. Durban: Health Systems Trust.

[92] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60951-X/fulltext - back-bib101 Day, C, Barron, P, Monticelli, F, eds. 2009. District Health Barometer 2007/08. Durban: Health Systems Trust.

Annex 2

Figure 1: SARRAH's technical work streams (boxes) in support of the 10-Point Health Plan[93]

In the last 18 months (2012-2013), the SARRAH theory of change model has been reorganised to more explicitly emphasise preparatory work for National Health Insurance (NHI) implementation. Many of the activities in the earlier stages were geared to strengthening the health system in general, an essential precursor to NHI, but they are now becoming more directly aligned to the NHI building blocks as illustrated in Figure 2 and Figure 3.

93 SARRAH. 2012. SARRAH Quarterly Report January to March 2012.
http://www.sarrahsouthafrica.org/ABOUTSARRAH/SARRAHProgressReports.aspx Accessed 12/06/2013

Annex 2

Figure 2: Summary of SARRAH's Work Streams in support of NHI preparation[94]
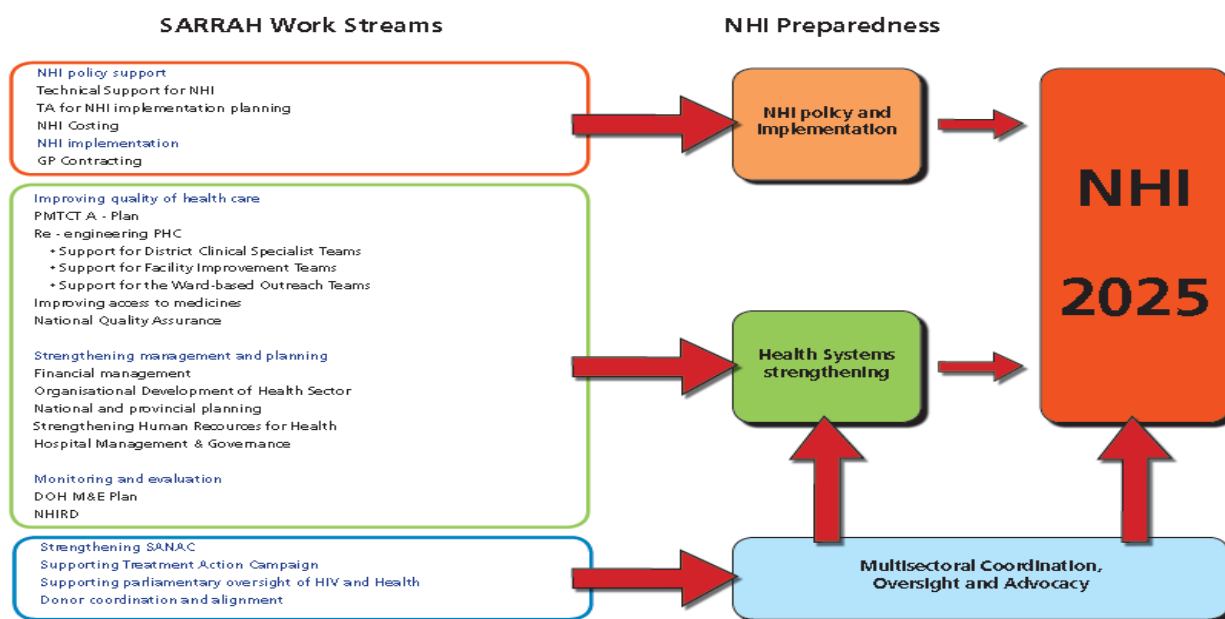
Figure 3: SARRAH's Technical Work Streams (boxes) in support of the NHI Building Blocks[95]
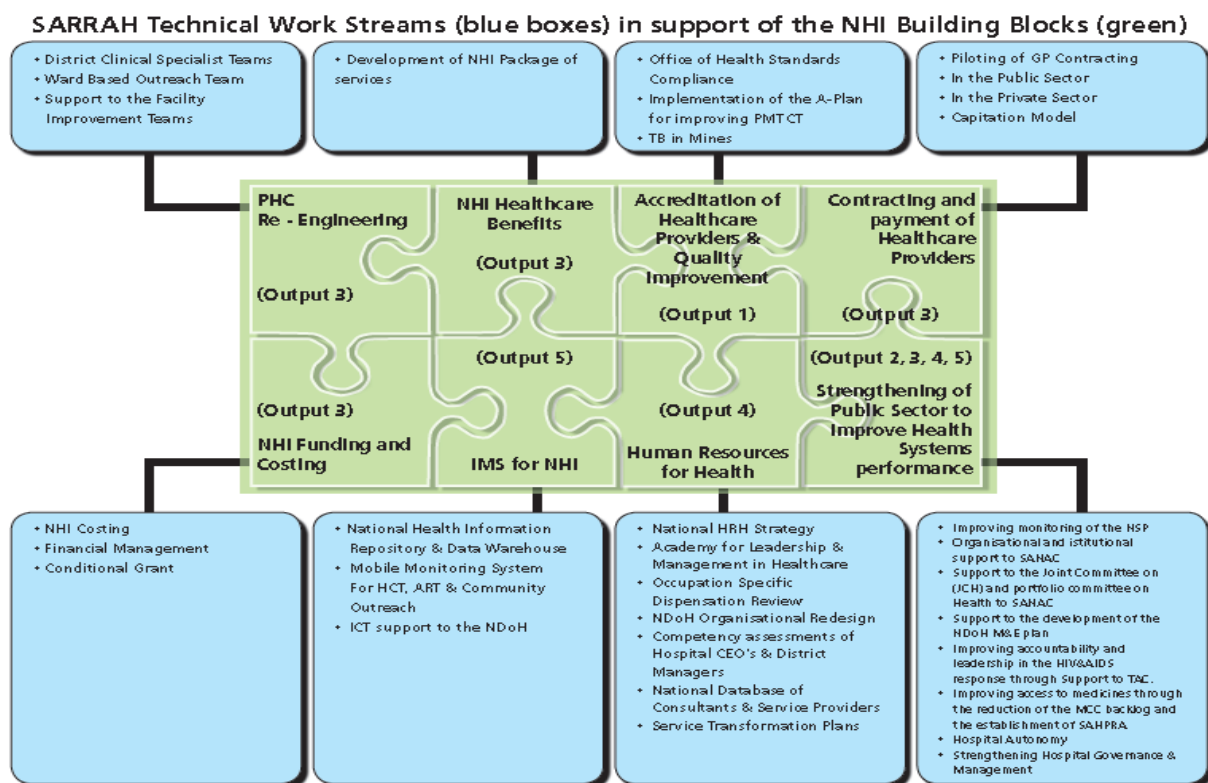
[94] SARRAH. 2012. SARRAH Quarterly Report October to December 2012.
http://www.sarrahsouthafrica.org/ABOUTSARRAH/SARRAHProgressReports.aspx Accessed 22/07/2013
[95] Ibid

1.4   Progress since the inception of SARRAH in 2010

As explained in more detail elsewhere (i.e. SARRAH Impact Evaluation[96]), many changes have occurred in the South African health system since 2010 and it is difficult to attribute changes to SARRAH directly, but the programme's annual reviews are generally very positive about its contributions. It is notable that the Minister of Health, Director General and several Deputy Director Generals (DDGs) were personally involved in projects supported by SARRAH, such as the Leadership Academy and the Facility Improvement Teams, which suggests that these initiatives are seen as worthwhile in the eyes of the beneficiaries.

A follow-up to the 2009 Lancet Series was published by Mayosi et al[97] in the Lancet in December 2012. This identified four important changes that had occurred since 2009: (a) improved leadership, (b) a changing morbidity and mortality profile, (c) steps towards universal coverage with national health insurance (NHI), and (d) consensus about health research.

Leadership changes included the new Minister, Dr Aaron Motsoaledi and Director General, Precious Matsoso, who were regarded as key to implementing changes, many of which were supported by SARRAH. Mayosi et al. did, however, point out that the bureaucracy of the health system was such that there is considerable inertia, and despite recommendations for greater delegation of authority, change had been slow to reach the facility level.

Changes to address the morbidity and mortality arising from what has become known as 'the four colliding disease epidemics', namely: HIV and TB; chronic illness and mental health; injury and violence; and maternal, neonatal and child health; were substantial. HIV prevention and treatment has improved dramatically and South Africa has moved from having almost no ARV treatment to having the largest treatment programme in the world within the space of a few years. SARRAH was directly involved in the PMTCT A-plan which contributed to a marked reduction in mother to child transmission of HIV infection and some of the gains in under-five child mortality. SARRAH and its partners have also played a part in addressing drug supplies through the work of facility improvement teams and lobbying for better procurement strategies. However, gender-based violence (GBV) has shown little sign of improvement even though the Department for Women, Children and Persons with Disability established a National Council Against Gender-Based Violence in 2012. One of SARRAH's partners, the Treatment Action Campaign, is addressing GBV through its branches.

Progress towards universal coverage with NHI is being made and, as indicated above, SARRAH has recently aligned all its activities with NHI (see Figures 2 and 3 above). Another key element of NHI is establishing quality norms and standards though an Office of Health Standards Compliance. SARRAH has played a pivotal role in helping to develop National Core Standards, in partnership with the NDoH, and worked extensively on the policy and legislation leading to amendments to the Health Act which allow for the establishment of the Office of Health Standards Compliance (OHSC).

The final priority, namely consensus about the importance of health research, particularly for informing policy, represented something of a landmark achievement when it was included as the tenth point in the NDoH 10-Point Plan. Various recommendations were made by the National Health Research Committee, the Academy of Science of South Africa and others, and there was a call for the NDoH to honour its commitment under the Bamako Declaration (to which it is a signatory), which called for an increase in research funding from 0.37% to 2.0% of the national health budget[98].

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[96] DFID. 2011. Impact Assessment on Strengthening South Africa's Revitalised Response to AIDS and HIV (SARRAH). http://www.sarrahsouthafrica.org/ABOUTSARRAH/SARRAHEvaluation.aspx Accessed 26/07/2013

[97] Mayosi, B, Lawn, JE, Van Niekerk, A, Bradshaw, D, Abdool Karim, SS, Coovadia, HM. 2012. Health in South Africa: changes and challenges since 2009. *Lancet;* 380:2029-43.

[98] The Lancet. 2008. The Bamako call to action: research for health. *Lancet*; 372:1855.

The follow-up Review concluded: "much remains to be done to improve the health and living conditions of large sections of the population. However, for the first time in two decades, this progress instils basis for hope".[99]

1.5   The political and economic environment

The DFID Rapid Response Health Fund (RRHF), which ran from 2008 to 2009, laid the foundations for SARRAH. The RRHF was designed to provide "immediate and flexible resources to … re-orient policies and programmes and deliver the most effective responses to AIDS, TB and the other major health challenges"[100]. This was a bold step and the key points in this offer were that the funds were to be "immediate and flexible" – something which is not typical of overseas development assistance. But bold measures were needed to release the log jam of the previous administration and get things moving again.

Despite the dramatic changes that were enabled by this new fund there were other changes taking place around the world that would have a profound influence on the development sector, not least of which was the worst global recession since the 1930s. In order to get a better understanding of how development programmes such as SARRAH have been affected by global events between 2010 and 2013 we interviewed a range of stakeholders including representatives of bilateral funding agencies from Europe and the United States and discussed local perceptions of the political and economic environment with South African government officials. These interviews were designed to get a better understanding of how global political and economic events may have affected SARRAH and, equally importantly, whether SARRAH had responded appropriately to the changing political and economic scenario.

Most stakeholders commented on the fundamental change in commitment to health reforms in general and HIV programmes in particular that occurred after the change in leadership of 2009/10. This was seen as a critical opportunity by several donors for renewed engagement in South Africa. One of the early initiatives of the new Minister of Health was to call a meeting to discuss donor coordination; this led to the production of the Aid Effectiveness Framework[101]. It was a refreshing change to see policy being directed by scientific evidence and the relationship between NDoH and donors became stronger as they became known as 'development partners' rather than mere sources of funds.

The interviews deliberately did not dwell on the mistakes made during Minister Tshabalala Msimang's term of office but it was obvious from respondents' comments that by 2009 the South African health system was regarded as failing the majority of the population and the AIDS-related mortality had become a crisis of "war-like" proportions[102]. However, encouraged by the new administration, donors were eager to seize this opportunity, and a period of strong collaboration appears to have begun. A notable feature of DFID's funding through SARRAH was that it could be front-loaded and was driven by NDoH priorities. The SARRAH funding was agreed to by the DFID Minister in discussion with the South African Minister of Health and DFID then worked closely with the Minister of Health and the Deputy Minister to agree on the priorities. Shortly after this the new Director General was appointed and there was sufficient flexibility to allow the programme to evolve as new health interventions and priorities were identified.

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[99] Mayosi, B, Lawn, JE, Van Niekerk, A, Bradshaw, D, Abdool Karim, SS, Coovadia, HM. 2012. Health in South Africa: changes and challenges since 2009. *Lancet;* 380:2029-43.
[100] DFID, 2009. Project completion report: Multisectoral Support Programme South Africa. London: DFID
[101] NDoH, 2011. The Aid Effectiveness Framework for Health in South Africa. Pretoria: NDoH. http://www.doh.gov.za/docs/stratdocs/2012/aideffect.pdf Accessed 23/07/2013
[102] DBSA. Health Roadmap. Summary presentation on the Health Roadmap process, November 2008. www.dbsa.org/Research/Documents/Health%20Roadmap.pdf Accessed 16/7/2013

Before 1994, DFID funding was mostly directed at NGOs but these were fragmented and there were limitations. Post 1994 there was a shift in funding to government, but this was not without its challenges, especially when some government policies flew in the face of international best practice. Partly because of this history, and also because of recent austerity measures related to the global recession, there has been an increased focus on accountability and advocacy, which tests and challenges government delivery.

Despite a change in the UK government from Labour (under Gordon Brown) to a Conservative and Liberal Democrat Coalition (under David Cameron) in 2010, funding for the SARRAH programme was not adversely affected. There were cross-party concerns, but the commitment for funding continued. The debates between parties are more about *how* to effect change rather than *what* to change. There is a stronger focus now on results and particularly on the Millennium Development Goals – a priority for many development agencies as we approach 2015 – and this has led to a greater emphasis on evaluation. The latter is valuable for understanding what has worked and what has not, and helps SARRAH to respond to potential critics.

The continuation and indeed increases in SARRAH funding between 2010 and 2013, despite the change of government, suggests strong commitment by the UK government to the programme, but the ramifications of the Global Economic Crisis and subsequent changes in development aid policies are still going to be felt. DFID is shifting its emphasis to fragile states, and will not be funding South Africa beyond 2015. Similarly, the US government, the largest development funder by far, will reduce its PEPFAR allocation to 50% of current values by 2017 down to US$250m. The EU is also revising its funding, and many EU Member States are withdrawing support for the health sector in Middle Income Countries. There is no guarantee that the next EU Framework Programme (2014-20) will include health.

These potential funding cuts have implications for programmes like SARRAH and make it all the more important to align activities with government priorities so that they will continue if, or when, donor support is withdrawn. Interestingly, one respondent pointed out that the declining funding environment had focused efforts and potentially rendered programmes more efficient. The EU provides considerably more money, but was said to achieve a lot less. Recently, the EU has recognised the efficiency of some of the SARRAH initiatives and has agreed to partner with SARRAH for some of the NHI-related initiatives such as the GP contracting model.

On the local level, there is strong praise for SARRAH's efficient use of funds. One respondent felt that the funds were better targeted than other programmes, such as those that offer general budget support. SARRAH was said to exercise better judgement about which projects to support, and which consultants to use, and this was more effective than some government programmes. Projects were said to be well selected, as were the consultants and "they delivered"; other initiatives were said to frequently fail on both counts. One official said that he placed the SARRAH activities among the top ten things achieved by the NDoH in the past few years.

1.6   What would have been different without SARRAH?

The DG has a very positive opinion of SARRAH, and described it as one of the "most rewarding programmes" and spoke about important projects being those that changed the world or changed lives. The stakeholders' opinion was that SARRAH is improving lives and has the potential to change the way the world goes about health development initiatives.

SARRAH differs from other programmes in the way that it is managed by the service provider. External management was said to sometimes be a barrier to programmes running in NDoH, but in SARRAH's case the process is so seamless that the DG "sometimes forgets that the SARRAH staff don't work for the NDoH". It is also clear that having a DFID Health Advisor seconded to the NDoH has facilitated closer cooperation than is usually the case.

SARRAH has been able to apply development aid in a facilitatory way and has played a substantial role in delivery on nine of the ten areas of the NDoH 10-Point plan (see Figure 1). The area that lags behind is HIV and AIDS, but more than one stakeholder pointed out that if SARRAH only addressed AIDS, its impact would be less. These comments were also endorsed by the Treasury.

Another feature of SARRAH was its ability to link South Africa with experts in the UK. For example, the link to the UK Care Quality Commission identified similar problems in the UK and South Africa (viz. infant deaths in hospitals), and this was a useful lesson learning experience. Similarly, when legislation for the OHSC needed support from parliament, sending MPs to see the UK system allowed properly informed decisions to be taken. SARRAH also provided comprehensive reviews of alternative health systems, for example models of Quality Assurance, and these ideas were then incorporated into local norms and standards. SARRAH input led to better, evidence-based decision making and was advocated as a best practice example.

The sustained support from SARRAH has also played an important role. Policy development can be a long drawn out process and people tend to lose interest along the way but the NHI pilots, supported by SARRAH, have helped maintain interest. The initial reaction to the proposed NHI was "outrage about the cost" but the pilot sites offer a chance to do more accurate forecasting. The Minister of Health's roadshow, also supported by SARRAH, has allowed direct engagement with 15,600 stakeholders to date.

Deficiencies in the hospital system had been highlighted in the media, and SARRAH was able to assist with the CEO competency assessment. This was a very sensitive issue and had to be handled discretely. The process included categorising the different hospitals and the requirements for CEOs at different levels were then specified. Many had formal qualifications such as MBA, MPH or M Public Admin, but these qualifications did not necessarily mean people had the required skills. Consequently, once the posts had been re-advertised and filled the Academy for Leadership and Management was set up to address shortcomings.

There was a sense that the flexibility of SARRAH funding and its attention to clearly identified priorities had been critical in making things happen. One senior government official felt that the Minister and DG would have struggled to get their work done without this flexible support and even acknowledged that frustration with lack of progress had often led to resignations of good people in the past. Although Treasury provides direct support for the sort of health reforms being undertaken by SARRAH, a well-managed donor-funded project often works better (and faster). This may imply that supervision of government funds is not tight enough but it is also probably because it is harder to ring fence government funds for targeted interventions.

SARRAH was seen as contributing to both policies and programmes in ways that other donors find difficult. For example, US government staff acknowledged that PEPFAR was better placed to do 'proof of concept' and pilot new ideas whereas SARRAH has been able to take ideas further in the policy and legislative arena.

1.7 Conclusion

SARRAH began at a time when the South African health system was in serious disarray, yet managed to take advantage of a new era of optimism and appetite for policy based on scientific evidence. The programme is closely aligned with some important priority setting exercises, namely the *Health Roadmap* (2008), the work of the DFID *Integrated Support Team* (2009) and extensive analysis of public health in South Africa by a team of academics commissioned by the *Lancet* (2009). Having initially developed a wide range of activities in support of the NDoH 10-Point Plan, it has become increasingly oriented towards supporting implementation of NHI. Throughout the process, there have been political and economic changes to contend with, and thus far SARRAH appears to have weathered these changes well.

The three Annual Reviews completed to date have given positive ratings to the majority of activities, and there is evidence of improvements over time. However, the on-going full impact evaluation which

runs until 2014[103] will determine more specific impacts, and should answer important questions regarding sustainability.

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[103] DFID. 2011. Impact Assessment on Strengthening South Africa's Revitalised Response to AIDS and HIV (SARRAH). http://www.sarrahsouthafrica.org/ABOUTSARRAH/SARRAHEvaluation.aspx Accessed 26/07/2013

Annex 3

Terms of Reference for the Evaluation of SARRAH

1 Terms of Reference for the Evaluation of SARRAH

1.1 Background

The goal of the SARRAH programme is ambitious with indicators representing achievement of MDG 4, 5, 6 some of which are thought possible but many are unlikely[104]. South Africa is undergoing a major revitalization of the health system with the aim of tackling the main causes of ill health – HIV and TB, maternal and child mortality, non-communicable diseases and injuries and violence. It has set targets that would see it returning to the health outcomes associated with middle income countries such as Brazil. The purpose of SARRAH program is to improve governance of the national response to HIV and health work[105] by supporting reforms in the public health sector, in the National AIDS Council, and through improving accountability through Parliament and Civil Society. The support is programmed to support implementation of the Presidents Negotiated Service Delivery Agreement (NSDA) for Health (see below) which provides a unified strategy on health and HIV with clear targets and indicators related to impact.

Negotiated Service Delivery Agreement for Health: *"A long and Healthy Life for All South Africans"*:

- Output 1: Increasing life expectancy
- Output 2: Decreasing maternal and Child Mortality
- Output 3: Combating HIV & AIDS and decreasing the burden of disease from Tuberculosis
- Output 4: Strengthening Health System Effectiveness

The programme has five outputs that contribute to the achievement of the purpose:

- Enable the improvement in quality of and access to HIV & AIDS and health services in selected districts
- Strengthened leadership and accountability of the national response to HIV and Aids
- Support National interventions to improve access and equity to HIV and health services
- Strengthen performance management & strategic planning for HIV and health services at national and provincial level.
- Strengthen systems to effectively monitor and evaluate national strategic plans for HIV & AIDS and health

1.2 Objectives of the evaluation

DFID's emphasis on improving evaluation and impact analysis[106] and more clearly linking investments to improvements in the wellbeing of women and children provides a helpful challenge for the SARRAH work. Linking improvements in systems and governance with improvements in service delivery can be difficult. The evaluation will:

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[104] http://www.statssa.gov.za/news_archive/Docs/MDGR_2010.pdf
[105] SARRAH Purpose statement is *"Improved governance of an integrated, effective response to HIV & AIDS and Health in South Africa".*
[106] http://dfidinsight/Other/Departments/EvaluationDepartment/PUB_024258

- Briefly summarize the past 20 year history behind the initiatives supported under SARRAH and describe how DFID support to health and HIV has evolved.

- Clarify the degree to the SARRAH program is achieving its objectives and is impacting on health and HIV in South Africa, as part of a government led, joint assessment of the Negotiated Service Delivery Agreement.

- Use evaluation methodologies to assess how well specific initiatives supported by the SARRAH programme are being successfully implemented, and assess the cost to ascertain the 'value for money' of the DFID contribution;

- Use the knowledge gained from the work to inform annual reviews of progress in collaboration with principal partners.

1.3 Approach

1.3.1 Use the Negotiated Service Delivery Agreement as the focus

The first step will be to gain agreement with principal partners that a joint approach to monitoring the NSDA is required. This has started under an NDOH lead, with development partners being asked to sign up to an AID Effectiveness Framework based on the Paris Declaration and good practice established elsewhere[107]. Indicators from the NSDA will be used, with appropriate disaggregation (gender, socio-economic etc.). Rigorous evaluations of specific aspects will need to be commissioned; this will include those parts of the NSDA and 10 point plan supported by the SARRAH programme. The entire SARRAH programme cannot undergo an impact analysis, but major initiatives can be included, and ten of these are suggested here.

1.3.2 Understanding context and history

The SARRAH program only supports some interventions within a much broader set of changes, inside and outside the health sector, aimed at strengthening the health system and improving health outcomes. These wider changes and how they are sequenced will have a major influence on whether interventions supported by the SARRAH program will be successful. Work has already started to understand those other factors; this will be completed by end of 2010. Key to understanding 'causal chains' is to know the various events and trends within South Africa that led up to the 10 point plan, much of which is already documented[108], and also how DFID has evolved to its current program of support.

1.3.3 Build on global experience

As well as the experience in South Africa, there is growing experience of rigorous evaluations of scaling up services in low and middle income countries[109] including evaluation of complex, country wide reforms such as in Brazil[110] and Mexico[111].

1.3.4 Clarifying the causal chains (or theories of change) for SARRAH support

Quasi-experimental approaches will be used where possible and the 'causal chain' between inputs and eventual outcomes will be made clear so as to guide collection of data, and assess how well inputs and activities from the SARRAH program are leading to outputs and outcomes in the NSDA (an

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[107] For example through the International health partnership plus
[108] http://www.dbsa.org/Research/Documents/Health%20Roadmap.pdf
[109] Measuring impact in the Millennium Development Goal era and beyond: a new approach to large-scale effectiveness evaluations. Cesar G Victora et al. The Lancet, 9 July 2010 doi:10.1016/S0140-6736(10)60810-0
[110] Impact of the family health program on infant mortality in Brazilian municipalities. Aquino R Am J Public Health. 2009 Jan; 99 (1): 87-93.
[111] Assessing the effect of the 2001–06 Mexican health reform: an interim report card. Emmanuela Gakidou et al. Lancet 2006; 368: 1920–35

example based on drug regulation is quoted below). Examples of basic 'story-lines' for key interventions are provided below, including the focus on services in a few districts to assess overall impact. The five areas shown here are based on the SARRAH logframe. Not all interventions will have to be included as some may be more of a priority than others, and some may be combined.

- Enable the improvement in quality of and access to HIV & AIDS and health services in selected districts:

  - Improvement in access to services: a sample of poorer SA districts will allow an assessment of the service impact of national reforms in general (e.g. quality of services, increase access to drugs) focusing on areas of specific interest to DFID such as gender and poverty impact and engagement of women and children.

  - Quality Improvement Projects (QIPs): PHC based services (e.g. MCH/HIV/TB) will be directly affected by projects focusing on data driven quality improvement interventions (e.g. clinical audits).

- Strengthened leadership and accountability of the national response to HIV and Aids:

  - **SANAC:** establishing the SANAC trust and its secretariat will provide more efficient coordination and reporting on the national response to HIV & AIDS.

  - **Parliament:** establishing the oversight committee on HIV & AIDs will lead to faster uptake of national HIV initiatives (eg HCT) and more consistent communications and hold national and provincial government to account.

  - **Civil Society:** The support to TAC will strengthen local accountability, empower citizen's engagement, and hold government to account and bring about change to ensure services reach those most in need.

- Support National interventions to improve access and equity to HIV and health services

  - South African Health Products Regulatory Agency: Together with the "MCC backlogs" project, will speed up registration and community access to new essential drugs.

  - Office of Standards and Compliance: Together with work on establishing standards, the accreditation of providers will provide a quality assurance mechanism for expanding public and private services in poor districts.

  - National Health Insurance: Subject to a national consultation and government approval, mandatory contributions and public sector finance will be pooled to purchase an expansion of accredited services to increase access and quality, starting in poorer districts.

- Strengthen performance management and strategic planning for HIV and health services at national and provincial level:

  - Competency improvement of public sector district and hospital managers. A competency assessment project across the country will lead to the appropriate placement, support and re-training of managers, and improved systems for performance management.

  - NDOH Organizational Development. A re-structured, more efficient and better motivated NDOH with clear national functions will improve interaction with Provinces and Districts and improve overall public sector efficiency.

  - Service Transformation Plans: Long term plans for the public health sector will enable the development of appropriate service delivery platforms in provinces.

  - Public Financial Management: PFM improvement plans and a review of procurement will lead to unqualified audits, cost savings, reduction of debt and more resources to expand service delivery.

- Strengthen systems to effectively monitor and evaluate national strategic plans for HIV & AIDS and health:

- Monitoring and evaluation: Joint monitoring of the NSDA and national response to HIV & AIDS by government, SANAC, civil society and development partners, will identify gaps in current monitoring arrangements, improve quality and use of data, and provide annual reports on progress that feed into national reviews.

1.4   Deliverables of the assessment and reporting requirements

DFID will set up a steering group with its principal partners: NDOH, SANAC and TAC and with external groups/individuals to oversee selection of the agency to perform the work, and to ensure alignment with the 'joined up' approach to the wider M&E of the South African Governments Negotiated Service Delivery Agreement.

- Initial proposal to be submitted for pre-qualification (PQQ) to internal DFID technical selection panel (February 2011) clarifying for assessment against PQQ criteria and to prepare a short-list of agencies to be issued with an 'Invitation to Tender'.

- Following the guidance in the DFID Invitation to Tender, preparation of a detailed evaluation proposal (March 2011) with details of:

  - The suggested overall evaluation framework for the SARRAH programme

  - Using information provided[112] and that available in public domain, propose causal chains ('theory of change') for the initiatives being assessed to monitor progress and identify any unintended consequences.

  - Provide methodological details & proposed sources of data with reference to relevant literature and showing triangulation using multiple approaches.

  - Indicative timetable and budget.

- Following selection of preferred agency by ITT Selection Panel, and issuance of a contract:

  - Baselines to be presented post the first annual review in the latter part of 2011.

  - The background to the current initiatives being supported by the SARRAH program, and description of how DFID support has evolved over time;

  - Detailed scope and plan for the evaluation agreed and prioritized with main stakeholders and costed with key milestones included.

- Continual learning, engagement and dissemination events including:

  - Annual reports to inform joint, government led reviews of progress, with lessons and suggestions for strengthening implementation.

  - Dissemination events, action research and other innovations to improve engagement of beneficiaries and to strengthen implementation.

- Final evaluation report(s) (Dec 2012 & 2014) to be made available:

  - 3 & 5 yrs after the start.

  - Possibly later (if requested by partners) given that many impacts may not be realized for many years.

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[112] Including: South Africa's Negotiated Service Delivery for Health, SARRAH logframe and project memorandum.

1.5   DFID co-ordination

Within DFID the consultants will report to the Senior Health Adviser: Dr Bob Fryatt and the Programme manager: Hilary Nkulu (*N.B now the Governance Advisor Joel Harding, and Programme Manager, Beaulah Muchira*), with oversight provided by a steering committee consisting of same representation as the selection panel.

1.6   Timeframe

This assignment will commence in the beginning of August 2011, which is in line with the South African Government's own planning and monitoring processes. The end date is December 2014 with a possible extension of another two years.

Annex 4

SARRAH Evaluation Strategy

Coffey International Development
April 2014

Annex 4

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Annex 4

LIST OF ACRONYMS

A-Plan	PMTCT Accelerated Plan
ART	Antiretroviral Therapy
CEO	Chief Executive Officer
CFO	Chief Financial Officer
DG	Director General
DFID	Department for International Development (UK)
DFID - SA	Department for International Development (UK) – South Africa
HR	Human Resources
HSRC	Human Sciences research Council
ICT	Information & Communication Technology
IE	Impact Evaluation
MDG	Millennium Development Goal
M&E	Monitoring & Evaluation
M&OD	Management & Organisational Development
NDOH	National Development of Health (South Africa)
NHIC	National Health Information Centre
NSDA	Negotiated Service Delivery Agreement
NHI	National Health Insurance
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
POC	Parliamentary Oversight Committee
QA	Quality Assurance
SAHPRA	South African Health Products Regulatory Authority
SANAC	South African National AIDS Council
SARRAH	Strengthening South Africa's Revitalised Response to HIV and Health
TAC	Treatment Action Campaign
TOC	Theory of Change
TOR	Terms of Reference
VFM	Value for Money

1   INTRODUCTION

In April 2011 the Department for International Development (DFID) commissioned Coffey International Development and the Human Sciences Research Council (HSRC) to undertake an Impact Evaluation (IE) of the SARRAH programme. This Inception Report aims to provide DFID with a clear understanding of the progress made under contract during the inception phase, documents the plans and systems which have been put in place to date and details the work programme for the remainder of the contract period.

1.1   Overview of SARRAH

SARRAH is a five-year programme funded by the UK's Department for International Development (DFID). Technical support and financial management are provided by HLSP, an international professional services firm specialising in the health sector. SARRAH commenced in January 2010 and is expected to finish in December 2014.

1.1.1   Overview

Strengthening South Africa's Revitalised Response to HIV and Health (SARRAH) provides technical advice, funding and support to strategic national initiatives to strengthen South Africa's response to HIV and health. Its main focus is support for the Ministry and National Department of Health in renewed efforts to increase life expectancy, decrease maternal and child mortality, combat HIV and AIDS and TB, and strengthen the health system. SARRAH is designed to support the achievement of the targets in the government's Negotiated Service Delivery Agreement (NSDA) for health.

SARRAH is a five-year programme funded by the UK's Department for International Development (DFID). Technical support and financial management are provided by HLSP, an international professional services firm specialising in the health sector. SARRAH is based on partnerships with leading national players in HIV and health. Key partners are:

- The Ministry of Health and the National Department of Health.
- The South African National AIDS Council (SANAC).

The programme also supports civil society through the Treatment Action Campaign (TAC) and, when established, the work of a parliamentary oversight committee on HIV and AIDS.

1.1.2   SARRAH activities

The SARRAH programme has five main objectives:

- Improving the quality of health services and access to healthcare.
- Strengthening the management and oversight of the HIV response.
- Supporting national reforms aimed at providing universal access to HIV and health services.
- Strengthening management and planning for health.
- Improving monitoring and evaluation of HIV and health programmes.

SARRAH is structured around a combination of work-streams, each of which is managed by a Technical Lead within HLSP. The work-streams feed into two key thematic areas: support to equal access to healthcare, and support to the national HIV response.

Support to equal access to healthcare

In 2010 the Minister of Health signed a Negotiated Service Delivery Agreement with the President, in which he pledged to dramatically improve the nation's health and health services. To this end he has outlined an ambitious ten-point plan to provide universal, quality health care that is free of charge at the point of delivery.

SARRAH is assisting the Minister of Health to realise this vision by support to projects that increase access to medicines, improve the health information system and strengthen planning and financial management in the health sector. SARRAH also seeks to support strategies to improve the quality of and access to services in poorer parts of the country, establish independent regulatory bodies to oversee the quality of services, and preparations for the establishment of a new National Health Insurance scheme.

Strengthening the national HIV response

The South African National AIDS Council (SANAC) is the national body that is mandated to coordinate all partners working in HIV and AIDS. SARRAH is supporting the SANAC secretariat, in strengthening IT, Human Resources and governance systems. It is also supporting the establishment of a monitoring and evaluation unit in SANAC.

SARRAH also provides support for agencies and organisations that monitor the national HIV response and advocate for expanded access to HIV services, such as the Treatment Action Campaign (TAC). The programme will support the development of a cross-party parliamentary committee on HIV and AIDS, which, when established, will strengthen oversight of the national HIV response.

HLSP was selected by DFID to implement the SARRAH programme. SARRAH is structured around work-streams, each of which is managed by an HLSP Technical Lead (TL). The SARRAH programme commenced in January 2010 and is expected to finish in December 2014.

1.2   Impact Evaluation of SARRAH

As per the Terms of Reference, the IE will:

14. Briefly summarise the past 20 year history behind the initiatives supported under SARRAH and describe how DFID support to health & HIV has evolved. **This deliverable was submitted to DFID and approved at the end of the inception phase**.

15. Clarify the degree to which the SARRAH program is achieving its objectives and is impacting on health and HIV in South Africa, as part of a government led, joint assessment of the Negotiated Service Delivery Agreement;

16. Use IE methodologies to assess how well specific initiatives supported by the SARRAH programme are being successfully implemented, and assess the 'value for money' of the DFID contribution;

17. Use the knowledge gained from the work to inform annual reviews of progress in collaboration with principal partners.

While various levels of impact can be evaluated, attribution of outcomes directly to SARRAH is difficult. The SARRAH Programme Memorandum itself states "*attribution in such a programme is complex if not impossible to accurately calculate*" because "*SARRAH is a relatively small contribution compared with government and other major donor funds.*" **Recognising this challenge means that the IE will have to apply state of the art evaluation methods and carefully selected indicators**.

The complete Terms of Reference are attached in Annex 1.

2   PURPOSE OF THE EVALUATION STRATEGY

SARRAH is a large, complex and strategically important intervention, operating at the forefront of the fight against HIV/AIDS and of potentially game-changing, high profile health policy reforms in South Africa. The purpose of the Evaluation Strategy is therefore dual:

- To ensure that the best possible methodology to measure the effectiveness, impact and Value for Money (VFM) of SARRAH is used bearing in mind the methodological challenges identified during the Inception Phase;

- To ensure that the IE responds to the needs of the various stakeholders involved and that the IE results provide useful evidence to support decision making.

2.1   Methodological challenges and solutions identified during the Inception Phase

This preliminary phase of the impact evaluation has led the IE team to infer the following conclusions:

- **The complex nature of the SARRAH programme**: the programme was evidently never conceived as a single, targeted, large scale intervention, but rather as a fund designed to support national reforms, programmes and institutions of the South African health sector through a range of strategic interventions identified jointly by DFID and NDOH. This has led SARRAH to diversify into a range of different activities, loosely connected with one another, each supporting different parts of the policy landscape (horizontal) and each intervening at different levels in the line of management (vertical). While all activities, or work-streams, are working towards the same overarching goal, which is the achievement of the NSDA's targets, this diversity is such that each work-stream could be considered as an intervention in itself. The IE will need to recognise this diversity and consider the work-streams individually in the first instance, before making an attempt to aggregate their impacts: each has a different causal chain from the activities it conducts to the impact it seeks to achieve, and each will therefore have to be assessed through a different range of relevant and tailored indicators of success.

- **The challenges of attributing outcomes and impacts to SARRAH**: SARRAH is thinly spread across a range of small, strategic activities each absorbing between circa £80,000 and £2,000,000 of the total programme budget. Moreover, most of the activities undertaken as part of the SARRAH programme can be categorised as either capacity building (e.g. SANAC) or as "Strategic Added Value" (SAV) activities, i.e. that involve (1) taking on a catalyst role in encouraging the key stakeholders to contribute to national targets, (2) contributing to broader policy intelligence and (3) coordinating national and international efforts. While such activities can have a very significant impact (evidence collected to date would already seem to suggest that this is the case for SARRAH), the latter is often difficult to measure, for several reasons:

  - ✓ It tends to be diluted into a vast and complex system of decision making mechanisms, which makes the attribution of benefits to one particular action very challenging;

  - ✓ It is subject to a significant level of risk as the success of these actions relies upon stakeholders being responsive, willing to modify their behaviours as a result of the support and sufficiently skilled to do so, all of which fall largely outside of the programme's control.

  - ✓ Its success also relies upon the success of other international, national and provincial programmes, reforms and policies, all of which also fall outside of the programme's control.

  Based on this, and after having thoroughly assessed each work-stream's intervention logic, the IE team came to the conclusion that some of the causal linkages underpinning the programme, and in particular those linking SARRAH activities to high level outcomes and impacts (e.g. greater and more equitable access to health services) are in some instances too

weak to warrant investigating in a significant amount of detail, and are unlikely to do justice to a programme whose overall budget represents circa 0.2% of South Africa's health budget. This may imply the need to shift the focus of the IE down from the overarching impact or goal, to lower level outcomes which are more likely to be attributable to activities undertaken as part of the SARRAH programme.

- **A "pyramid" approach to evaluating SARRAH**: in spite of the diversity of activities undertaken as part of the SARRAH programme, a common overall purpose seemed to emerge through the inception phase (see figure page 5), as it became evident that all activities sought to make the South African health system more effective, more equitable, more accountable and more transparent, all of which should ultimately lead to a healthier, less HIV/AIDS stricken and more productive society. This vision is captured in the NSDA, which SARRAH was designed to support, and in the overarching Theory of Change (TOC) developed during the inception Phase. For the above mentioned reasons, the IE team believes that while a common, overarching framework is crucial to carrying out an IE mindful of the overall context that underpins the programme, the work-streams should be first considered individually before an attempt is made to aggregate their overall impact on the South Africa health sector.

- **The log-frame in itself is not a sufficiently detailed framework for the IE**: on completion of a three-month period during which the IE team undertook a consultative exercise with HLSP Technical Leads to understand in detail what the activities conducted as part of the SARRAH programme consist of, what they seek to achieve and through which means, it has become clear that the log-frame in its current form is not a sufficiently comprehensive conceptual framework within which the IE could be undertaken: it does not capture systematically and logically the causal relationship between outputs, outcomes and impacts which will constitute the backbone of the IE implementation phase. However the log-frame will remain a useful monitoring tool through which valuable outcome and impact indicator data can be collected at regular intervals, and which will inform key parts of the IE.

2.2   Responding to stakeholder needs

The purpose of the Evaluation Strategy is to establish a clear assessment framework for SARRAH, enabling stakeholders to learn, improve and plan for the future. The information needs vary according to each stakeholder, as does the way in which the information will be used. An overview of the key stakeholders and the nature of their interest and involvement with the SARRAH IE are provided in Table 1 below:

Table 1 – Stakeholders analysis

Stakeholder	Key information requirement	How the information will be used
DFID / DFID-SA	DFID is the funding organisation of SARRAH as well as SARRAH's IE, and is the primary recipient of the IE deliverables. DFID's priority is to get insights into the effectiveness, impact and VFM of the various SARRAH initiatives as well as of SARRAH overall. Specifically, the IE will: • Summarise the past 20 year history of South Africa's response to HIV/AIDS and Health, and how DFIDs' approach to its support has evolved over time • Assess SARRAH's effectiveness in achieving its objectives and in supporting	The IE's findings will be used to • determine what the most effective ways are to move forward and inform the remainder of the SARRAH implementation phase • inform potential future health and HIV/AIDS programmes in South Africa and elsewhere • justify aid expenditure to the public and in parliament • illustrate how DFID funding is changing lives and promoting human development

Stakeholder	Key information requirement	How the information will be used
	the NSDA • Compare the effectiveness of specific initiatives supported by SARRAH • Assess the Value for Money of DFID's contribution • Inform annual reviews of progress in collaboration with principal partners	
DFID Evaluation Department (EvD)	SARRAH IE Steering Committee Member. Primarily interested in the impact evaluation methodologies used, and in any innovative IE solutions used.	EvD will: • scrutinise the robustness of the IE process and findings, based on the methodologies used • disseminate knowledge of the methodology used across the Department
HLSP	SARRAH programme Managers - will want to get insights into the effectiveness, impact and VFM of the various SARRAH initiatives as well as of SARRAH overall.	The evaluation and analysis provided can help the SARRAH Manager to manage the programme more effectively and achieve greater value for money.
NDOH	NDOH is a SARRAH Programme partner and member of the IE Steering Committee. The Department is committed to: increased life expectancy; decreased maternal and child mortality; combat ting HIV and AIDS and decreasing the burden of disease from TB; and strengthening health system effectiveness. They will be interested in (TBC).	The evaluation and analysis provided can help the NDOH to (TBC)
SANAC	SANAC is a SARRAH Programme partner and member of the IE Steering Committee. It is the coordinating body for HIV/AIDS and STIs, and facilitates civil society participation in the national response.	The evaluation and analysis provided can help SANAC to (TBC)
TAC	TAC is a SARRAH Programme partner and member of the IE Steering Committee. It advocates for increased access to treatment, care and support for people with HIV and campaigns to reduce new infections. Will be interested in (TBC).	The evaluation and analysis provided can help TAC to (TBC).
M&E Department of the Presidency	A SARRAH Programme partner and member of the IE Steering Committee. Will be interested in (TBC).	The evaluation and analysis provided can help the Presidency to (TBC).
General public	Will be interested in (TBC).	The evaluation and analysis provided can provide the public with (TBC).

3   APPROACH & METHODOLOGY

The Evaluation Strategy of SARRAH is based on the evaluation questions set out in the TOR for the IE, and sets out the IE team's strategy for answering these questions in the most methodologically robust fashion and in a way that is most useful to the range of stakeholders involved, considering the time and budget constraints the study is subject to.

The Evaluation Strategy will assess the performance, additionality and Value for Money (VFM) achieved by SARRAH against its stated objectives and the theories of change. The overarching approach is provided in the main body of the text while the work-stream specific evaluation methodologies are provided in the annexes. This section will cover:

- The key principles of the Evaluation Strategy (3.1)
- The team's overall approach to measuring the effectiveness and impact of SARRAH (3.2)
- The evaluation designs and methods envisaged for the SARRAH IE (3.3)
- The IE team's step by step methodology for measuring the effectiveness and impact of SARRAH (3.4) including:
  - ✓ Its approach to evaluating each work-stream, or group of work-stream individually;
  - ✓ Its approach to reviewing the evidence collected through the individual IEs;
  - ✓ Its approach to aggregating the finding of the various individual IEs through a meta-evaluation, and;
- The IE team's approach to measuring SARRAH's VFM. (3.5)

The following section (Section 4) will detail the IE process, in particular with regards to consultations with stakeholders, the communication and the dissemination of the IE's findings.

3.1   Key principles

This section details the key principles which will guide the Evaluation Strategy and its implementation throughout the contract period 2011-2014. These cover the evaluation criteria (including OECD-DAC) as well as the design criteria of utility, proportionality and evaluability which will guide the IE team's recommendations on what to evaluate, how and when.

3.1.1   Evaluation Criteria

The Evaluation Strategy should support the provision of robust and verifiable information for the relevant stakeholders that enables an assessment that is aligned with OECD-DAC[113] evaluation criteria of project. These criteria have informed the research questions set out in the analytical framework (p.17, Section 3.3).

- **Relevance** - *The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor*. In this case "relevance" should be defined as the extent to which SARRAH has met the needs and priorities of NDOH and the South African public. This will involve testing the rationale for intervention and its "fitness for purpose". Research questions relating to SARRAH's relevance are set out in the analytical framework, Section 3.3.

- **Effectiveness** – *The extent to which the project has achieved its objectives*. This will form an essential part of the 2012 evaluation report. Effectiveness should be defined in this case as the extent to which SARRAH's intended outputs and outcomes and impacts were achieved (results) and how well they were achieved (process). The objectives of SARRAH were not

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[113] DAC Principles for the Evaluation of Assistance, OECD (1991), Glossary of Terms

sufficiently clearly defined at the outset due to the ever changing nature of the intervention, however the TOC process conducted during the Inception Phase has significantly informed the intervention logics underpinning the various work-streams and helped the IE team conceptualise the pathway to change anticipated as a result of the intervention. Research questions relating to SARRAH's effectiveness are set out in the analytical framework, Section 3.3.

- **Efficiency** – *a measure of the outputs -- qualitative and quantitative -- in relation to the inputs.* This should be defined as the extent to which the project has delivered its outputs at the least cost and is able to demonstrate **complementarity** with other modes of support in doing so. This is essentially a measure of VFM and will be mainly informed by the external and independent SARRAH VFM audit recently carried out. The research methodology for assessing SARRAH's value for money is set out in Section 3.6.

- **Sustainability** – *extent to which the qualitative and quantitative benefits arising from the project's activities are likely to continue and progress once project funding has ceased*. The SARRAH programme was designed to achieve systemic and sustainable change throughout the South Africa health sector through strengthening governance systems and institutions and making the sector more equitable, accessible, accountable and effective. Sustainability is therefore at the heart of SARRAH and will be thoroughly assessed throughout the contract period. SARRAH's sustainability will be treated as a cross-cutting theme, and will be systematically assessed at the work-stream as well as at the programme level.

- **Impact** – *extent to which the project has positively or negatively affected change, either directly or indirectly, intended or unintended, in high level outcome and impact indicators*. The nature and complexity of the environments suggest that it will be very difficult to attribute the direct effects of the project to changes in the South African health sector and the national prevalence of HIV/AIDS given the multitude of prevalent intangible effects and influences. However, the IE team's approach, which entails a participatory approach to developing the project's TOC and subsequently its contribution to the observed effects, ensures that even though attributing causality will be difficult, findings and conclusions concerning the project's effectiveness are plausible and credible because they have been informed by extensive feedback from national counterparts and key stakeholders. In some instances, more robust and empirical methods will be used to measure impact. Research questions relating to SARRAH's impact are set out in the analytical framework, Section 3.3.

- **Gender & Equity** – the extent to which SARRAH is supporting gender equality and equity will be assessed as a cross-cutting theme whenever appropriate throughout the evaluation.

3.1.2 Additionality

Impact is defined here as the 'net' impact that SARRAH has in terms of the additional benefits realised that are directly attributable to its activities. The additionality of SARRAH is of key importance for DFID as it is crucial to understanding the net impact of its interventions. Additionality is defined as 'an impact arising from an intervention is additional if it would not have occurred in the absence of the intervention'[114]. Typically, this requires a comparison between what actually happened (i.e. factually) and what would have happened in the absence of the intervention, otherwise called the counterfactual. The fundamental evaluation problem that all impact assessment faces is that we cannot observe what would have happened if the intervention had not happened to those already affected by the intervention.

Impact evaluation requires a rigorous approach to establishing a counterfactual. The most robust way to do this is to compare the outcomes achieved by those who benefited from an intervention with the outcomes achieved by a group of people who are similar in every way to the beneficiaries, except that they were not subject to the intervention i.e. a control group (refer to Figure 1 below). An impact

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[114] HMT Green Book

evaluation is designed to overcome selection bias, contamination and externalities / spillovers by isolating the treatment from the counterfactual. The nature of the SARRAH intervention, as well as the timing of the impact evaluation, does not lend itself well to such an impact evaluation design.

Figure 1 – Measuring Additionality
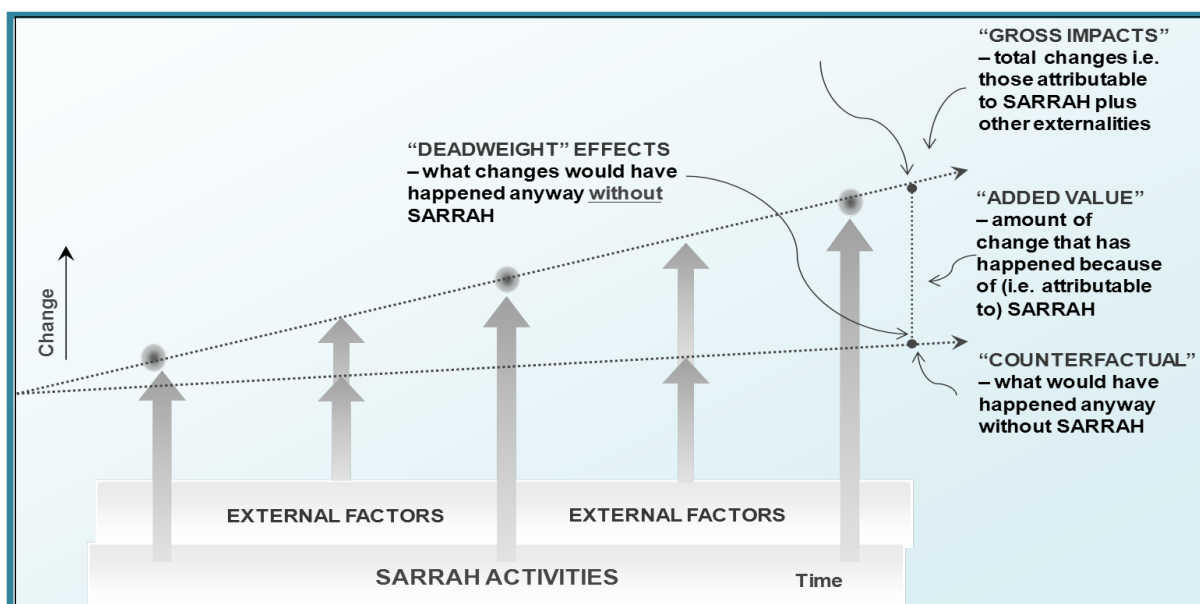
Source: Coffey

SARRAH is first and foremost concerned with influencing and catalysing change that indirectly results in sustainable improvements at outcome and impact levels in making the South African health system more effective, equitable and affordable. Apart from SARRAH initiatives undertaken in pilot districts with a view to inform further rollout, most work-streams are by definition designed to generate systemic changes across the national health system and therefore "contaminate" the environment as thoroughly as possible through strategic, far reaching interventions that influence a wide range of different groups in different ways across different timescales.

Moreover, the environment was already "contaminated" at the point of implementation of SARRAH, due to the multiplicity of South Africa led, donor led and NGO led interventions and programmes pursuing similar objectives.

Last but not least, the timing of the impact evaluation implies that except for a couple of work-streams under which activities have not yet started, the window of opportunity for setting up a baseline has passed.

Combined, these characteristics of SARRAH will make robust and definitive impact attribution particularly challenging. While the concept of additionality will remain one of the guiding principles of the IE throughout and will be measured wherever possible, it should be recognised at the outset that a theory-based approach using a **contribution analysis** to evaluation will either be the best, or the only possible approach to evaluating most work-streams or groups of work-streams.

The TOC process led by the IE team during the Inception Phase will be instrumental in successfully carrying out theory-based approaches.

3.1.3   Prioritisation criteria

The Evaluation Strategy will culminate in a set of recommendations (Section 4) setting out what the IE team believes should be evaluated, how and when. These recommendations will be based on three core criteria:

- **Utility**. Operating with budget constraints imposes that resources and research activities are allocated in priority to the work-streams considered by the IE team, DFID and NDOH as strategically important. The strategic priorities were identified by the IE team, DFID and NDOH and will inform the recommendations formulated in Section 4.

- **Proportionality**. The Evaluation Strategy will be sensitive to each work-stream's level of funding, strategic importance and impact potential to formulate recommendations as to the level of resources that should be allocated to evaluate it. The investment in evaluation activity should itself represent value for money and methodologies applied at the work-stream level should be justified by the level of expenditure involved, and the extent to which the evaluation is able to produce useful and meaningful results.

- **Evaluability**. The familiarisation and TOC work carried out during the inception phase shed light on the evaluability of the various SARRAH work-streams, i.e. the extent to which they can be evaluated, and if so, when and how. It was apparent that the **time lag** between the completion of activities and the potential realisation of impacts as a result of these activities would impose that careful consideration is given to the research timeframes and the appropriateness of dedicating resources to assess impacts at various points during the contract period. Moreover, the TOC process enabled an assessment of the **strength of the causal linkages** between inputs, activities and anticipated outcomes and impacts, and of the extent to which these linkages can be thoroughly assessed within the research budget and timeframes.

3.2 Approach

This section will detail the proposed approach to evaluating the impact of SARRAH and of its various work-streams. The nature of the intervention has led the IE team to believe that a theory-based approach, coupled with the use of contribution analysis where necessary and quasi-experimental techniques where possible, and feeding into an overarching meta-evaluation of SARRAH, is the best possible approach for delivering meaningful evaluation results and aggregating the outcomes and impacts of the various initiatives undertaken as part of the programme.

3.2.1 The Theory of Change approach

A significant part of the inception phase was dedicated to understand and depict what the Theory of Change (TOC) underpinning the SARRAH programme is, in order for the IE team to understand the intervention and how it fits in the health policy environment in South Africa, and crucially, to develop an analytical framework from which the IE can be carried out.

What is a Theory of Change

A TOC outlines what should happen if the theory supporting an intervention is correct. It is a systematic and well-thought out study of the complex links between processes, activities, outcomes and context and the changes that occur in the short, medium and long term.

Building the TOC from the bottom up through extensive stakeholder engagement is a core strand of the approach. Such an approach is usually required to build a sense of ownership and consensus on what changes should happen in the short, medium and long term. The TOC should be evidence-based and be able to distinguish change at all levels culminating in a clear set of outcomes. It should also be plausible, achievable, testable and meaningful to provide an effective means of framing the IA research.

The TOC key purpose is to clearly establish what the causal linkages between the different levels of the intervention logic are believed to be, for the IE to measure the intervention's success in achieving its intended outcomes. It revolves around the concept of contribution (or attribution) as it seeks to measure the impact that can be directly or indirectly attributed to the intervention. For example: how much of the observed improvement in healthcare standards between 2010 and 2014 can be attributed to SARRAH?

To do so, the assumptions and risks each causal link is subject to need to be explicitly mentioned in the TOC. A TOC culminates in the development of a range of indictors designed to measure the success of the intervention.

Why We Use It

The SARRAH programme is a complex intervention, structured around a range of work-streams, each operating at various levels within the South African health policy mechanisms and health delivery systems. While the overall objective of SARRAH is to support the South African response to HIV and AIDS, it seeks to do so in various different ways and is thinly spread across a range of activities each

supporting a strategic policy or delivery area. Therefore there is not a single mechanism through which SARRAH will achieve an impact, but several.

- In order to develop a framework through which SARRAH's impact can be assessed, the IE team led a collective reflection around the intervention's TOC to:

- Map the programme's intended outcomes and impacts through a range of individual work-stream intervention logics;

- Develop an overarching TOC as a general framework against which the intervention can be evaluated and its impact assessed.

Method Used

The IE team adopted an inclusive approach and HLSP Technical Leads were significantly involved in helping the IE team understand the logic behind their respective work-streams, the content of their daily work and the objectives they hope to achieve through this work.

A first TOC workshop was held during the inception field visit at DFID offices with DFID as well as HLSP representatives, for the IE team to introduce the concept of TOC and its usefulness in assessing SARRAH's impact. Subsequently, a series of TOC workshops were held at HLSP offices with each Technical Lead and run by Coffey and HSRC, during which the logic was visually unpicked and a range of indicators were developed.

Outputs

Upon completion of these TOC workshops, the IE team depicted each work-stream's intervention logic diagrammatically, and also developed an overarching TOC for the SARRAH programme as a whole, of which a snapshot is presented overleaf.

The intervention TOC developed has been used to inform the Strategy Phase with regards to defining a clear set of hypotheses that the impact evaluation will test. This has resulted in a set of key research and evaluation questions for each intervention, enabling us to review and refine sets of indicators for each intervention that in turn define what data we need to collect, when and how. The overarching TOC is presented in Figure 2 overleaf, and has been subject to a number of changes since the Inception Phase as the IE team has developed, throughout the Strategy Phase, a better understanding of the synergies and complementarities across work-streams.

3.2.2   The SARRAH Theory of Change

What is the problem?

It is widely accepted that the South African Health Sector suffers from two distinct, yet related, and hugely complex problems.

The first one **(Problem 1)**, and probably the most commonly referred to in the international community, is the extraordinarily high prevalence of HIV/AIDS, which make South Africa the epicentre of the global HIV/AIDS epidemic. In 2009 UNAIDS estimated at nearly 6 million the number of people living with HIV in South Africa, corresponding to an 18% prevalence among South Africans aged 15 to 49. The sheer size of South Africa and its interconnectedness with Sub-Saharan Africa and the world make it the central battleground of the international fight against the epidemic.

The second one **(Problem 2)** is the vastly unequal access to healthcare in South Africa: a world class private health system catering for 15% of the South African population exists alongside a disturbing level of deprivation of even the most basic health services. Inequitable access to healthcare is a serious problem and leads to unacceptably high mortality and morbidity from preventable conditions.

What are the underlying causes of the problem?

The causes of the first problem are well known: the decade of flawed policies and active obstruction to treating the social and medical causes of the disease under the government of Thabo Mbeki, and which have led the epidemic to spread, affecting in particular the vulnerable communities and increasing the burden of HIV infection and AIDS with all the social and economic consequences this has.

The causes of the second problem are widely believed to be the legacy of the apartheid era during which the healthcare sector was racially segregated, only for it to mutate into a socially and economically segregated system over the 18 years following the fall of the apartheid regime. The absence of an integrated, public and universal national health insurance system has led to the development of a two-tier health system: a high quality system for the wealthy who can afford to purchase health insurance and a poor quality public system struggling to provide even the most basic services to the majority of South Africans.

What is the vision?

The vision of success underpinning the national health strategy and indeed the SARRAH programme is that of a "Long and Healthy Life for All South Africans", which is encapsulated in the Negotiated Service Delivery Agreement (NSDA), a charter which reflects the commitment of key partners to achieving the following goals: (i) an increasing life expectancy, (ii) a decreasing maternal and child mortality, (iii) a decreasing prevalence of HIV/AIDS and tuberculosis, and (iv) increasingly effective health systems.

How to get there?

A ten-point plan for the improvement of the health sector was developed in 2009 and lists the key policy priorities needed in order to achieve the goals set out above.

1. Provision of strategic leadership and creation of a social compact for better health outcomes.
2. Implementation of National Health Insurance (NHI).
3. Improving the quality of health services.
4. Overhauling the health care system and improving its management.
5. Improving human resources management, planning and development.
6. Revitalisation of health infrastructure.
7. Accelerated implementation of the National HIV&AIDS and STI National Strategic Plan (2007-2011) [115] and increased focus on TB and other communicable diseases.
8. Mass mobilisation for better health for the population.

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[115] Now superseded by the National Strategic Plan 2012-2016

9. Review of the drug policy.
10. Strengthening research and development

As can be seen, the policy priorities can be grouped in two categories: **Group 1** (addressing **Problem 1**) includes policies designed to address the problem of high prevalence of HIV/AIDS in South Africa (e.g. point 7) by supporting the national response to HIV/AIDS while **Group 2** (addressing **Problem 2**) includes policies designed to improve the quality of and access to South African healthcare through strengthening health systems (e.g. points 2 and 6). While both groups of policy priorities aim to make the South African people healthier, the first group is focusing on one of the major sources of mortality in order to generate short term measurable health impacts, while the second seeks to support longer term, systemic change in health systems to make them more effective, more inclusive and more equitable in a sustainable way.

The two are intrinsically intertwined, since stronger and more equitable and inclusive health systems will support the national response to HIV/AIDS, and equally a decrease in the prevalence of HIV/AIDS will facilitate a shift in the allocation of resources and efforts towards the achievement of more systemic, long term health objectives.

How is DFID contributing?

The fourth goal (iv: increasingly effective health systems) of the NSDA is seen as instrumental in achieving the former three goals in a way that is inclusive, equitable and sustainable. It is supported by a group of policy priorities (**Group 2**) designed to strengthen health systems and make healthcare more effective and accessible to all in the long run. Through the SARRAH programme, DFID's approach to supporting the NSDA is by providing technical assistance in several policy areas, falling under both **Group 1** and **Group 2** policy priorities.

The SARRAH programme is structured around a series of initiatives or "work-streams", different in scope, scale, timing and objectives. While attempting to group those work-streams rigidly and based on strict criteria is fraught with challenges, the following structure provides a reasonable overview of how SARRAH seeks to support the South African response to HIV and access to quality healthcare.

1. Interventions designed to **strengthen and coordinate the national response to HIV/AIDS**. These include for example technical assistance to the South African National AIDS Council (SANAC) whose mission is to monitor and coordinate the national response to HIV/AIDS, support to Treatment Action Campaign (TAC), a civil society organisation dedicated to advocating for stronger and more decisive response to HIV/AIDS, or technical support in setting up a Parliamentary Oversight Committee (POC) dedicated to overseeing progress made against national HIV/AIDS reduction objectives.

2. Interventions designed to **improve the effectiveness of health systems and their ability to provide quality healthcare to all**. These include in particular a range of technical assistance initiatives to support the establishment of the National Health Insurance (NHI), a universal health insurance system designed to provide free health coverage for all South Africans and to be funded entirely through taxes and national insurance contributions. They also include support in setting up SAHPRA, a health product regulatory authority capable of reviewing large numbers of new drug (and related product) applications in order to make the best treatments available to health facilities and patients rapidly, and the establishment of National Core Standards and the Office of Health Standards Compliance to improve the Quality Assurance.

What are the medium and long term anticipated outcomes?

3. Through a range of interventions such as SANAC and TAC designed to coordinate the national response to HIV/AIDS and making it more accountable, SARRAH will ensure that HIV/AIDS remains at the top of the policy agenda in South Africa, that progress against targets is rigorously monitored and gaps/needs are identified in "real-time" and that resources are efficiently allocated to address those needs. This should result in a **stronger national response to HIV/AIDS**, which in turn should lead to **measurable reductions in HIV/AIDS prevalence, transmission and mortality in South Africa**.

4. Interventions designed to strengthen South African health systems will also, by extension, benefit the national response to HIV/AIDS. However their scope is much larger as it encompasses all aspects of the South African health sector. Not all of these interventions will bear fruit according to the same timeframes.

5. For instance, SAHPRA will generate **benefits in the short/medium term** as it helps increase the number of certified drugs available in the market and potentially decrease the cost of purchasing drugs and other medical products as a wider range of alternative producers compete to serve facilities and patients.

Other interventions, such as the National Health Information Centre (NHIC) will **produce benefits in the medium term** as it improves access to critical medical, financial and operational information for a range of stakeholders including national and regional NDOH officials and health facilities, making the system better able to serve the people's needs with the resources available.

Finally, a range of interventions are designed to help South Africa prepare for implementation of the NHI, and pave the way for a successful rollout of the most significant health reform ever undertaken in South Africa. As the NHI is not forecast to be fully operational until 2026, the benefits generated by SARRAH work-streams such as NHI and the Human Resource Strategy for the South African health system **will be apparent in the long term**, and will materialise through a more effective and equitable health system for all. Such activities are most at risk of not bearing fruit since they rely on the continuity and the sustainability of the national effort for reforming the health sector over several legislatures, governments and presidencies.

### *What are the assumptions and risks?*

Political stability is seen as a key condition for SARRAH or any of the national interventions SARRAH is supporting to succeed. While there has been a momentum for reform of the health systems and a revitalised response to HIV/AIDS since 2008 and the transitional government of Motlanthe, sustained thereafter under the governments of the Jacob Zuma presidency, the nature of these initiatives requires a long term commitment to reform. The conditions for change also include the capacity and will of the South African health sector to undergo a large scale, sector wide upskilling of its labour force. The sustainability of SARRAH rests on a sustained capacity building effort across the health system. The analytical framework on page 17 also sets out a number of work-stream level assumptions which underpin their activities.

Who are the key players?

The operational model of the SARRAH programme is that of a partnership between **DFID** (the funding organisation), **NDOH**, and the implementing partner **HLSP**. Funding decisions are made jointly by DFID and NDOH to ensure the programme addresses government priorities. **Provincial governments** and their departments of health are an essential component of the South African health system and will interact significantly with the SARRAH programme, both as beneficiaries and as partners in its implementation. The **South African Parliament** will be involved in particular through the Parliamentary Oversight Committee for HIV & AIDS, which SARRAH will help establish. The **South African Presidency** is also involved, albeit to a lesser extent, with SARRAH. **SANAC**, itself a beneficiary of SARRAH, also sits on the programme's Steering Committee and will be a key player in ensuring that the national response to HIV/AIDS is closely monitored and effectively coordinated. A range of civil society organisations (**CSO**) will also play a role in ensuring the national response to HIV and health is accountable to the people of South Africa. One of them, **TAC**, is a direct beneficiary of SARRAH and sits on its Steering Committee. Finally, **health facilities** and their management and **medical personnel** will be instrumental in ensuring the success and sustainability of SARRAH.

Figure 2 below is an "**Outcome Mapping**" of the SARRAH programme, depicting diagrammatically the various causal linkages between SARRAH work-streams, logframe outputs, outcomes and impacts which the impact evaluation will be testing. The causal links are all numbered and corresponding research questions and indicators are presented in the analytical framework in Section 3.3. The Outcome Mapping also attempts to relate the programme activities and anticipated outcomes to the NSDA 10-point plan.

Annex 4

Figure 2 – Outcome Mapping
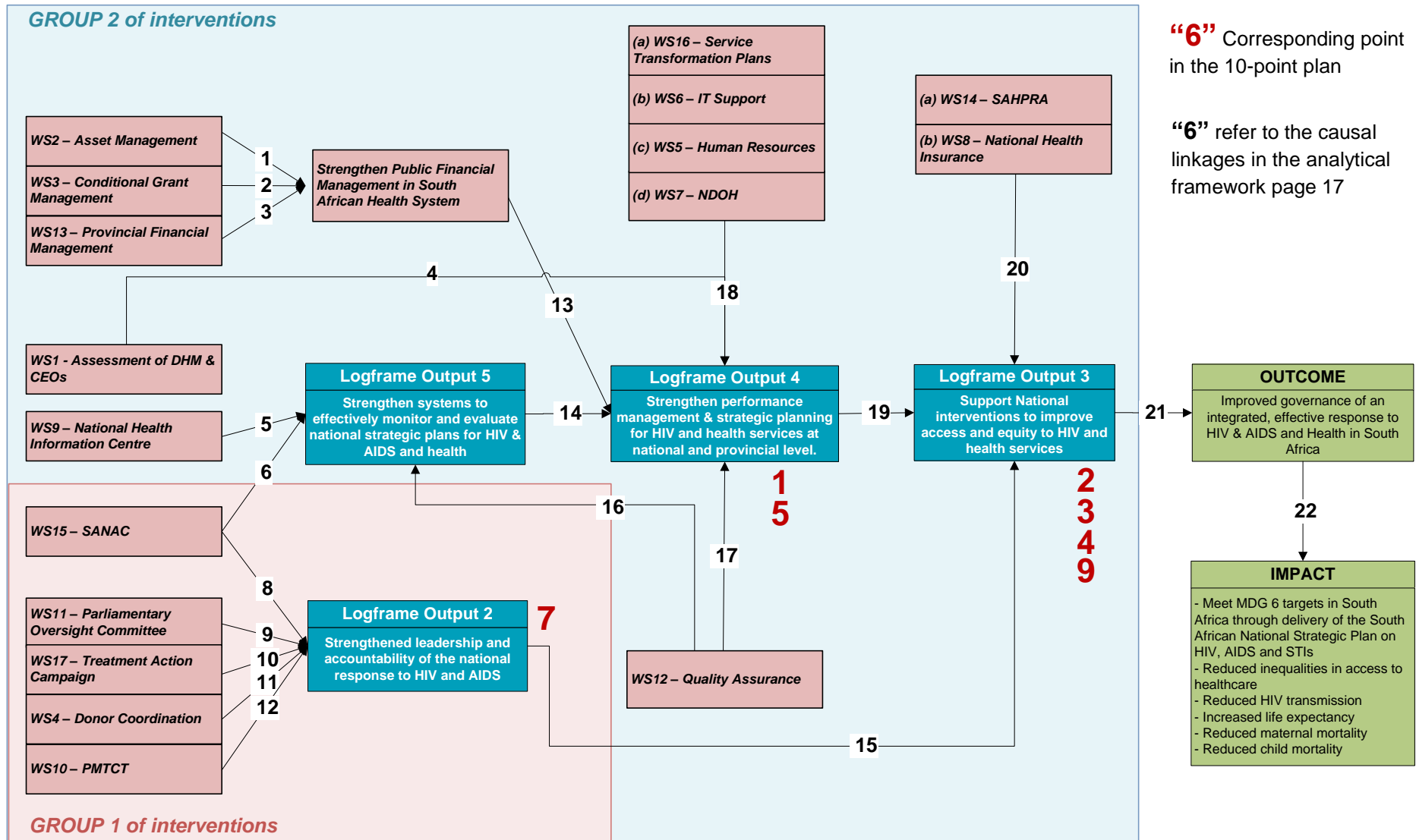
3.2.3 Contribution analysis

Contribution analysis explores causality by assessing the 'contribution' the project is making or has made to observed results through a TOC based approach. Essentially this requires an evidence-based approach to verifying the TOC that underpin the project as a whole and its component strands whilst, as far as possible, accounting for a wide range of contextual factors. The nature and scale of the impact attribution problem described above suggests that the use of contribution analysis is a highly appropriate evaluation approach in this instance. Contribution analysis involves more pragmatic, participatory and iterative evaluation processes than experimental or quasi- experimental methods that are not feasible or practical in this context. Most importantly this approach will enable us to:

- Collect evidence throughout the contract period to assess the likely contribution of the project to the changes that are or have been observed, after accounting for contextual influencing factors across the sector and other donor programmes and at local and national levels;

- Use tailored research methods to gather the evidence required to challenge the TOC, adjust it if necessary and re-assess the contribution of the project to the observed effects; and

- Ensure that the interpretation of findings, i.e. the formulation of conclusions through the findings in relation to a reasonable expectation, is informed by an iterative approach to evidence gathering and consensus building.

3.2.4 External validation of findings

Contribution analysis is by nature subjective, with multiple and conflicting views informing the analysis, each subject to different sorts of biases. These include among others:

- The "**courtesy bias**", when stakeholders are reluctant to tell the evaluator, out of courtesy, that the intervention didn't have the impacted aimed for;

- The "**personal perspective**" bias, which reflects the fact that someone's views depend strongly on where the person stands, and multiple perspectives are frequent;

- The "**self-importance bias**", which occurs when stakeholders have a natural tendency to see themselves as more important/influential than they actually are;

- The "**self-serving bias**", characterised by the belief that "when all goes well, it must be because of what stakeholders did, but when things go wrong, it was badly implemented, or the context is to blame."

- The "**exposure bias**" as evaluators we give more weight to the people they speak to/see, rather than those they don't (even though they might have been given insight into their opinion).

The multiple biases at play impose that an external validation of the findings by a range of key stakeholders be conducted and integrated to the evaluation and the reporting processes. The result of this external validation process should not be that more importance is given to the views of particular stakeholders rather than others, instead this process should **achieve consensus** around the key findings by sense checking the plausibility of findings across a range of credible stakeholders.

3.3   Analytical Framework

The analytical framework below seeks to unpick the key causal linkages depicted in the Outcome Mapping (p.15), the hypotheses underpinning those links, the assumptions made and the evaluation questions and indicators proposed to empirically test them. This framework will constitute a basis for the research activities to be undertaken during the evaluation, and will guide the meta-evaluation process by identifying the relationships and synergies between the various strands of activities, their outputs and their contribution to programme level outcomes and impacts.

The analytical framework below focuses on **effectiveness** and **impact** indicators, which will be the main focus of the 2014 impact evaluation. Individual work-stream evaluation specifications are available in the Annexes 3 to 18 and also include **process** indicators, which will be assessed during the 2012 evaluation. Process evaluation questions for all work-streams include:

- How effectively were the activities delivered?
- Were the outputs specified the in the TOR delivered in a timely fashion and to a satisfactory standard?
- How satisfied were the direct beneficiaries with the support received?
- Have they undertaken any activities or made any decisions as a result?

Process indicators for all work-streams include:

- % of direct beneficiaries stating they were at least "somewhat satisfied" with the quality of the support received
- % of direct beneficiaries stating they were "very satisfied" with the quality of the support received
- Outputs were delivered on time and fulfilled the TOR requirements

These will be complemented by work-stream specific process questions and indicators (see Annexes).

Table 2 – Analytical Framework

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
1	Asset Management	Strengthen Public Financial Management in South African Health System	Poor asset control negatively affects the day-to-day running of health facilities and can lead to unnecessary duplications of equipment and poor maintenance. By verifying, valuing and compiling a	☐ That the proposed asset management system was accepted and implemented by the NDOH;	☐ To what extent has the asset management verification undertaken by SARRAH improved NDOH's PFM? ☐ What effects has this had on the South African	☐ Decline in qualified audits related to improper asset management ☐ Proportion of facilities fully compliant with asset management processes *General PFM indicators*[116] ☐ A comprehensive and credible

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[116] World Bank and OECD (2011), "Indicator 2a: Reliable Public Financial Management (PFM) Systems"

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
			comprehensive database of over 40,000 NDOH assets (national & provincial) the Asset Management work-stream will optimise the management of health facilities and the allocation of capital resources, and thereby strengthen PFM in the South African Health System.	☐ That a strategy was developed to address obsolete equipment identified; ☐ That there are sufficient trained staff allocated to the ongoing asset management task.	Health sector? ☐ Where there any negative, or unintended, consequences?	budget, linked to policy priorities; ☐ Effective financial management systems to ensure that the budget is implemented as intended in a controlled and predictable way; and ☐ Timely and accurate accounting and fiscal reporting
2	Conditional Grant Management	Strengthen Public Financial Management in South African Health System	Poor grant management leads to grants being regularly under-spent or over-spent, with the consequence of an increasing divergence between planned expenditure and actual expenditure, making strategic planning more difficult. The Conditional Grant Management work-stream will help ensuring grants are spent when and where they are supposed to be, and maximise the grants' impact on healthcare delivery.	☐ That the inconsistency between planned grant expenditure and actual grant expenditure is due to lack of financial management capacity at the provincial level ☐ That corruption and excessive turnover of MECs are addressed	☐ To what extent has the Conditional Grant Management support provided by SARRAH reduced the discrepancies between planned and actual expenditure. ☐ To what extent has the Conditional Grant Management support provided by SARRAH improved NDOH's PFM at national and regional levels?	☐ Reduction in the gap between planned grant expenditure and actual grant expenditure in all regions ☐ Satisfaction rate of grant recipients (NGOs) in (a) amount received and (b) efficiency of the grant application process and timeliness of payments *General PFM indicators* ☐ A comprehensive and credible budget, linked to policy priorities; ☐ Effective financial management systems to ensure that the budget is implemented as intended in a controlled and predictable way; and ☐ Timely and accurate accounting and fiscal reporting
3	Provincial Financial Management	Strengthen Public Financial Management in South African Health System	Provinces in South Africa have a significant degree of autonomy in the area of health provision, and a significant part of the national health budget is spent by the provinces. A stronger Public Financial Management (PFM) at the provincial level would therefore help strengthen PFM in the South African health system.	☐ That recommendations formulated in reports are taken up by provincial DOH to improve PFM and capacity built	☐ To what extent has SARRAH strengthened PFM capacity in provincial departments of health?	*General PFM indicators* ☐ A comprehensive and credible budget, linked to policy priorities; ☐ Effective financial management systems to ensure that the budget is implemented as intended in a controlled and predictable way; and ☐ Timely and accurate accounting and fiscal reporting

Annex 4

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
4	Assessment of DHMs & CEOs	Log-frame O5 Strengthen systems to effectively monitor and evaluate NSP for HIV & AIDS and health	DHMs and hospital CEOs are at the forefront of the healthcare delivery. An assessment of DHMs and CEOs will help identify gaps in skills and competencies and strengthen existing performance monitoring and evaluation systems of health facilities, as these are directly related to the skills and competencies of their managers.	☐ That the culture of political patronage is addressed ☐ That there is no shortage of highly skilled people to take on hospital CEO and DHM positions ☐ Post evaluation and remedial action remains priority for NDoH and MoH	☐ To what extent did the assessment of DHMs and CEOs identify and offer solutions for inadequacies of senior district and facility managers? ☐ To what extent did the assessment of DHMs and CEOs carried out by SARRAH enhance performance management for HIV and health services?	☐ Proportion of District Management Teams with written delegations of authority. ☐ Proportion of DHM and hospital CEO posts filled. ☐ Number of staff trained/mentored. ☐ Proportion of facilities with performance management systems in place ☐ Proportion of facilities/districts conducting annual performance evaluation of top management. ☐ Proportion of DHM and hospital CEOs with required levels of qualification
5 & 7	National Health Information Centre	Log-frame O5 Strengthen systems to effectively monitor and evaluate NSP for HIV & AIDS and health	Through the establishment of a giant data warehouse integrating up-to-date information on all aspects of health and health systems in South Africa, NHIC will considerably strengthen HIV and Health M&E systems, performance management and strategic planning at national and provincial levels, by ensuring data can be accessed by any stakeholder from anywhere in South Africa.		☐ How accessible is the NHIC to the intended users? ☐ Is NHIC an effective tool to support planning for health services at national and provincial levels?	☐ Satisfaction rate of users ☐ # of planning decisions by NDOH, provinces and districts based on information provided by the NHIC.
6	SANAC	Log-frame O5 Strengthen systems to effectively monitor and evaluate NSP for HIV & AIDS and health	The establishment of SANAC as a legal entity, and the strengthening of SANAC's M&E unit, will support the systems in place to monitor and evaluate progress against HIV and Health plans.		☐ Has SARRAH increased the capacity of SANAC to monitor and evaluate the national response to HIV/AIDS ☐ Has SANAC made the national response to HIV/AIDS more accountable	**M&E** ☐ Number of HIV/AIDS policy decisions based on SANAC M&E evidence ☐ Formal requirement to use SANAC M&E above a certain expenditure threshold **Accountability** ☐ # of organisation/institution's

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
						plans/projects/budget with evidence of positive response to expressed community priorities ☐ Increased public provision of timely, accurate and useful public finance information at a national level ☐ # and description of requests for information made ☐ # and description of cases where requested information was not made available ☐ # and results of appeals against refusals or inability to provide information
8	SANAC	Log-frame O2 Strengthened leadership and accountability of the national response to HIV and AIDS.	SANAC's key function is to coordinate the national response to HIV and AIDS which will strengthen its leadership. SANAC will also improve the accountability of the national response through increased M&E capacity and through its independence as an organisation.		☐ Has SARRAH strengthened leadership of the national response to HIV and AIDS through support to SANAC?	**Leadership** ☐ Alliance and partnerships between actors are strong and operating effectively ☐ Various stakeholders are increasingly coordinated towards common goals
9	Parliamentary Oversight Committee	Log-frame O2 Strengthened leadership and accountability of the national response to HIV and AIDS	The HIV and Health Parliamentary Oversight Committees will enable democratically elected representatives of the people of South Africa to oversee the national response to HIV and support its accountability.		☐ Has POC been successful in maintaining HIV/AIDS high up on the political agenda? ☐ Has POC made the government's actions on HIV/AIDS more accountable?	☐ # of NDOH's plans/projects/budget with evidence of positive response to expressed community priorities ☐ Increased public provision of timely, accurate and useful public finance information at a national level ☐ # and description of requests for information made ☐ # and description of cases where requested information was not made available ☐ # and results of appeals against refusals to provide information

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
10	Treatment Action Campaign	Log-frame O2 Strengthened leadership and accountability of the national response to HIV and AIDS	As a civil society organisation dedicated to advocacy for stronger action against HIV/AIDS, SARRAH's support to TAC will improve the national response's accountability.		☐ Has TAC made the national response to HIV/AIDS more accountable? ☐ Has TAC influenced the national response to HIV/AIDS, and how did SARRAH contribute?	☐ Increase in access to and quality of healthcare in areas where TAC operates and identified needs ☐ # and % of communities / CSOs stating they benefit from constructive engagement with power holders ☐ # and % of power holders stating they benefit from constructive engagement with communities/CSOs ☐ Evidence of improved relationship between power holders and communities / CSOs ☐ # of NDOH's plans/projects/budget with evidence of positive response to expressed community priorities ☐ Increased public provision of timely, accurate and useful public finance information at a national level ☐ # and description of requests for information made ☐ # and description of cases where requested information was not made available ☐ # and results of appeals against refusals to provide information
11	Donor Coordination	Log-frame O2 Strengthened leadership and accountability of the national response to HIV and AIDS	By helping coordinate the efforts of various bilateral and multilateral donors in the area of HIV and AIDS, SARRAH will strengthen the leadership of the national response to HIV/AIDS by ensuring donor efforts are aligned with the national plan and minimise duplication of efforts.		☐ Has SARRAH's work on donor coordination strengthened leadership of the national response to HIV and AIDS through support to SANAC?	☐ Alliance and partnerships between actors are strong and operating effectively ☐ Various stakeholders are increasingly coordinated towards common goals
12	PMTCT	Log-frame O2	By coordinating PMTCT activities, advocating for the		☐ Has SARRAH's work on PMTCT facilitated a	☐ Alliance and partnerships between PMTCT actors are strong and operating

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
		Strengthened leadership and accountability of the national response to HIV and AIDS.	PMTCT plan to be implemented nationally and monitoring its implementation, SARRAH will strengthen leadership in this aspect of the national response to HIV/AIDS, and will make it more accountable.		smooth and effective implementation of the PMTCT Plan? ◻ Has SARRAH's work on PMTCT led to a decrease in mother-to-child transmission of HIV/AIDS?	effectively ◻ Various stakeholders are increasingly coordinated towards common goals in PMTCT ◻ Decrease in rate of MTCT ◻ increase in Utilisation rate of Primary Health Care facilities ◻ increase in Antenatal visits before 20 weeks rate ◻ increase in Utilisation rate (visits), children under 5 years (annualised)
13	Strengthen Public Financial Management in South African Health System	Log-frame O4 Strengthen performance management & strategic planning for HIV and health services at national and provincial level.	By improving PFM across the South African health sector, SARRAH will help building a clearer picture of how resources are spent and where the gaps are, which will enable NDOH to make strategic planning for health services more effective.	◻ The necessary financial information is made available in the public domain.	◻ To what extent has improved PFM led to more effective strategic planning of health services?	*General PFM indicators* ◻ A comprehensive and credible budget, linked to policy priorities; ◻ Effective financial management systems to ensure that the budget is implemented as intended in a controlled and predictable way; and ◻ Timely and accurate accounting and fiscal reporting
14	Log-frame O5 Strengthen systems to effectively monitor and evaluate NSP for HIV & AIDS and health	Log-frame O4 Strengthen performance management & strategic planning for HIV and health services at national and provincial level.	Effective M&E of the NSP will provide essential information for management and strategic planning regarding the HIV and health.	◻ Information provided by the M&E system is accepted and is in a form suitable for planning purposes.	◻ What is the best way to 'package' routine M&E information for decision-making?	◻ Routine HIV and health information is used as the basis for performance measurement and strategic planning.
15	Log-frame O2 Strengthened leadership and accountability of the national	Log-frame O4 Strengthen performance management & strategic	A coordinated and accountable national response to HIV and AIDS will allow better performance management and strategic planning of HIV and	◻ SANAC and its M&E Unit are adequately staffed and operational.	◻ To what extent does SANAC contribute to the management and planning of the national AIDS response?	◻ Frequency of routine and strategic reports produced by SANAC. ◻ Extent to which provincial AIDS plans follow SANAC guidelines.

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
	response to HIV and AIDS	planning for HIV and health services at national and provincial level.	health services.			
16	Quality Assurance	Log-frame O5 Strengthen systems to effectively monitor and evaluate NSP for HIV & AIDS and health	The establishment of National Core Standards and an Office for Health Standards Compliance will introduce an independent and transparent performance M&E system for health facilities based on internationally recognised and transparent standards.	☐ Adequate resources allocated for OHSC to become operational.	☐ To what extent has SARRAH assisted the development and implementation of the National Core Standards and the OHSC? ☐ What has been the result of the development process? ☐ What has been the result of the implementation?	☐ Recognition by key stakeholders of SARRAH's role in developing and implementing the core standards. ☐ Extent to which the NCS meet ISQua standards set up to assess the quality of healthcare establishments.
17	Quality Assurance	Log-frame O4 Strengthen performance management & strategic planning for HIV and health services at national and provincial level.	The establishment of National Core Standards and an Office for Health Standards Compliance will help NDOH manage performance of health facilities and plan resources strategically.	☐ Adequate resources allocated for OHSC to become operational.	☐ To what extent has the OHSC increased NDOH capacity for monitoring and improving health facilities?	☐ Proportion of selected facilities achieving compliance with NCS.
18a	Service Transformation Plans	Log-frame O4 Strengthen performance management & strategic planning for HIV and health services at national and provincial level.	Provinces were required to prepare Service Transformation Plans to address the 10 point plan; it is assumed that this transformation process will improve health services in the provinces.	☐ STPs developed and implemented.	☐ To what extent did the STPs developed with assistance from SARRAH consultants improve provincial health services?	☐ Number of initiatives guided by the STPs. ☐ Changes in budget allocation to align better with NSDA.
18b	IT Support	Log-frame O4	Accurate and timely information	☐ E-Health Strategy	☐ How useful was the E-	☐ Stakeholder opinions of the E-Health

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
		Strengthen performance management & strategic planning for HIV and health services at national and provincial level.	is essential for effective planning; IT support will improve information flow to and from the NDOH.	is implemented by NDOH	Health strategy and Gateway review provided to the NDOH by SARRAH? ☐ Is there improved access to and recording, reporting and quality of health data after e-Health strategy implementation? ☐ Is the available information being used for planning purposes?	strategy document. ☐ Measures of E-Health strategy implementation. ☐ Number of accurate and timely reports based on DHIS and other sources. ☐ Number of quotes of data generated by the E-health systems.
18c	Human Resources	Log-frame O4 Strengthen performance management & strategic planning for HIV and health services at national and provincial level.	Sufficient trained personnel are a prerequisite for effective health service delivery: the proposed HR strategy will promote appropriate training and retention of health personnel throughout the country.	☐ HR Strategy is adopted. Consistent political will to strengthen health services through training and retention incentives.	☐ To what extent has the National Human Resources for Health (HRH) strategy been implemented? ☐ What has been the result of that implementation? ☐ What, if any, are the unintended results? ☐ How have SARRAH and its agents contributed to that process and its results?	☐ Proportion of stakeholder organisations (e.g. NDOH, NHC, Provincial Health Depts., Universities) endorsing the HRH strategy. ☐ Changes in retention rates for health personnel (by region and discipline). ☐ Changes in enrolment rates for health science courses (doctors, nurses, allied health professionals). ☐ Measures of case management of HR-intensive chronic illness (e.g. TB, diabetes, HIV) such as treatment adherence rates. ☐ Number of adverse events reported in district health facilities.
18d	Organisational redesign of the NDOH	Log-frame O4 Strengthen performance management & strategic planning for HIV and health services at national and provincial level.	Organisational redesign of the NDOH is necessary to improve decision-making and service delivery. This is especially true for addressing the 10 Point Plan, NSDA, Annual Performance Plan and implementation of NHI.	☐ New structure approved by DPSA and Unions. ☐ Budget made available. ☐ Broader restructuring is implemented by those appointed.	☐ To what extent has the organisational redesign of the NDOH been achieved? ☐ What has been the result of that process and has it contributed to better leadership and accountability in the national response to HIV and health? ☐ How have SARRAH and	☐ Proportion of NDOH management job descriptions completed ☐ Proportion of NDOH management posts advertised. ☐ Proportion of NDOH management positions vacant. ☐ Performance management system in place and in use.

Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
					its agents contributed to that process and its identified results?	
19	Log-frame O4 Strengthen performance management & strategic planning for HIV and health services at national and provincial level.	Log-frame O3 Support national interventions to improve access and equity to HIV and health	Enhanced performance management and planning of health services will improve access and equity to HIV and health services.	☐ Planned interventions are fully implemented.	☐ To what extent has improved management and planning improved service delivery?	☐ Proportion of districts receiving basic package of PHC.
20a	SAHPRA	Log-frame O3 Support national interventions to improve access and equity to HIV and health	An efficient SAHPRA will make essential drugs more readily available and potentially reduce prices through increased competition and licensing of generics.	☐ Challenges to SAPHRA's registration as a legal entity successfully resolved.	☐ To what extent has SARRAH technical support facilitated the establishment of an efficient health and related products regulatory authority? ☐ Has SAHPRA improved availability and affordability of essential drugs?	☐ SAPHRA registered as a public entity. ☐ Approved business plan for SAHPRA in place. ☐ Proportion of SAHPRA posts filled. ☐ Electronic Document Management System operational. ☐ Proportion of evaluation backlog addressed. ☐ Time taken to evaluate new applications. ☐ Number of new products registered per month. ☐ Cost comparison of old and new essential drug list.
20b	National Health Insurance	Log-frame O3 Support national interventions to improve access and equity to HIV and health services	National Health Insurance will improve equitable access to HIV and health services.	☐ NHI enabling legislation is passed. ☐ Progress is made according to NHI implementation plan.	☐ To what extent have SARRAH's contributions to the establishment of NHI been implemented? ☐ Have these contributions contributed to planning more equitable and accessible health care?	☐ Draft NHI bill (Green Paper) published for comment. ☐ NHI Bill promulgated. ☐ NHI preparations completed in pilot districts. ☐ Phased roll out of NHI to other districts under way.

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Causal link	Cause	Effect	Hypothesis	Assumptions	Key research questions	Indicators of change
					☐ Were there any unintended results?	
21	Log-frame O3 Support national interventions to improve access and equity to HIV and health services	Log-frame Outcome Improved governance of an integrated, effective response to HIV & AIDS and Health in South Africa.	Improved access and equity are considered cornerstones of effective governance of the national response to HIV & AIDS.	☐ Accurate and reliable data available to monitor achievement of purpose/outcome.	☐ Has SARRAH contributed to improved governance of the national response to HIV & AIDS and health in South Africa?	☐ Selected UNGASS National Composite Policy Indicators.
22	Log-frame Outcome Improved governance of an integrated, effective response to HIV & AIDS and Health in South Africa.	Log-frame Impact	An appropriate, well-governed health system will help achieve MDG 6 targets, including a reduction in HIV infection and improved access to treatment.	☐ Political commitment to delivering on HIV and health policies remains strong. ☐ NSDA targets are feasible within SARRAH timeframes. ☐ Reliable data is available from routine surveillance systems (DHIS and NHIC).	☐ Has SARRAH contributed to reaching MDG6 targets?	☐ Age-specific HIV prevalence trends. ☐ Age-specific HIV incidence trends. ☐ All-cause mortality trends (25-49 and <5 years). Maternal mortality ratio trends.

3.4   Evaluation Design & Methods

The ways in which SARRAH delivers the outcomes and impacts articulated in the TOC are complex and are potentially different for each work-stream. For this reason the IE team has developed a range of evaluation designs and research methodologies that will enable to attribute effects from output to outcome to impact level. Figure 4 below provides an illustration of the range of evaluation designs which have been considered during this process.

3.4.1   Summary of the IE team's approach to design and methods

A range of evaluation designs were considered for each work-stream during the Strategy Phase, systematically beginning by envisaging the possibility of using counterfactual based approaches, deemed more robust, and then gradually moving towards contribution analysis based approaches when the former were considered unfavourably or were deemed unfeasible. Figure 3 below depicts the range of evaluation designs which were considered for each work-stream.

Figure 3 - Evaluation design approaches
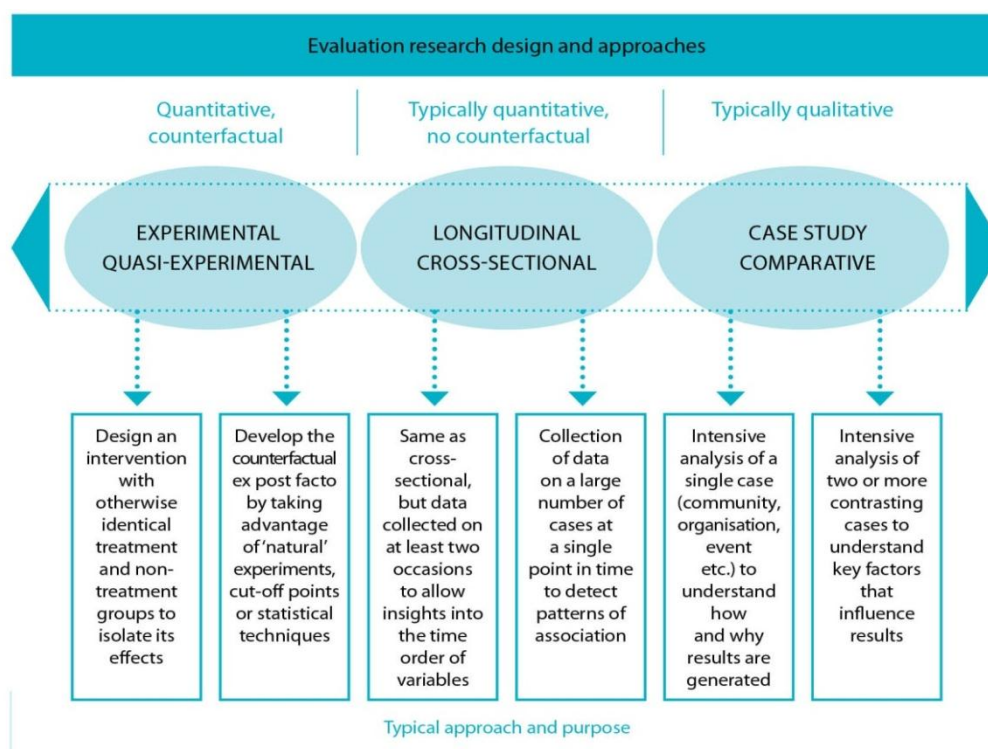
Source: Coffey

The range of different types of initiatives requires a range of different types of evaluation design. This is to ensure that the impact evaluation process is able to rigorously identify and assess the strength and the nature of the correlation between SARRAH and a variety of effects across the TOC.

Arguably, all programme impact evaluation requires a mixture of evaluation designs and research methods. While the timing of the IE excludes the use the use of experimental methods (e.g. Randomised Controlled Trials), as most of the activities conducted under SARRAH are completed or soon will be, we have provisionally kept the option for consideration until more information is released on the NHI pilots and how SARRAH will contribute to implementing those.

Similarly, a mixture of research methods is required in order to establish which activities are having what effects, on whom and at what time. Regardless of the complexity of the programme we would propose a mixed methods approach, which applies qualitative research to provide an explanation of 'why' and 'how' the programme is affecting the type and scale of changes that are evidenced through quantitative research.

3.4.2 Commitment to rigorous, high quality qualitative research

The nature of most activities undertaken as part of SARRAH imply that a qualitative approach to evaluation will adopted for some work-streams, and that qualitative methods for data collection and analysis will be used for all work-streams. The IE team includes highly experience qualitative researchers and will ensure that a rigorous approach to collecting and analysing qualitative data is adopted.

We are committed to ensuring that the research undertaken is as rigorous as possible and as such propose a peer review process involving:

- DFID Evaluation Department; and
- Leading research academics whom Coffey partners with on a regular basis.

3.4.3 Overview of the approaches, evaluation designs and research methods proposed

Tables 2 and 3 below summarise the evaluation designs and research methods proposed to evaluate individual work-streams.

Table 3 – Evaluation Approaches and Designs

	Approach		Designs					
	Counterfactual	Contribution Analysis	Experimental	Quasi-Experimental	Longitudinal	Cross-Sectional	Case Study	Comparative
PMTCT	✓			✓		✓		
Strengthening SANAC		✓				✓		
SANAC M&E		✓			✓	✓		
Treatment Action Campaign		✓				✓	✓	
Parliamentary Oversight Committee		✓			✓	✓		
NHI		✓				✓		
SAHPRA		✓					✓	
Quality Assurance		✓			✓	✓		✓
IT Support		✓					✓	
National Health Information Centre		✓					✓	
Financial Management		✓				✓		
Asset Management		✓				✓		
Conditional Grant Management		✓				✓		
NDOH 2		✓		✓				
Assessment of DHM & CEOs		✓				✓		
STP		✓					✓	
Human Resources		✓					✓	✓
Donor Coordination		✓				✓		

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Table 4 – Data Collection Methods

	Methods						
	Desk Review	**Quant. secondary data**	**Quantitative Survey**	**Qualitative Interviews**	**Focus Groups**	**Panel Discussion / Workshops**	**Field Visits**
PMTCT	☑			☑	☑		
Strengthening SANAC	☑			☑	☑		
SANAC M&E	☑			☑			
Treatment Action Campaign	☑	☑		☑			
Parliamentary Oversight Committee	☑		☑	☑			☑
NHI	☑	☑		☑	☑	☑	
SAHPRA	☑			☑			
Quality Assurance	☑	☑	☑	☑	☑	☑	☑
IT Support	☑			☑			☑
National Health Information Centre	☑	☑		☑			☑
Financial Management	☑			☑			
Asset Management	☑			☑	☑	☑	
Conditional Grant Management	☑			☑	☑		
NDOH 2	☑			☑	☑	☑	
Assessment of DHM & CEOs	☑		☑	☑			
STP	☑	☑		☑	☑		
Human Resources	☑			☑	☑	☑	
Donor Coordination	☑			☑			

3.5 Methodology

One of the critical issues around the Impact Evaluation of SARRAH is the diversity of the initiatives undertaken through the programme, and the consequent lack a consistent set of indicators of success that could be aggregated for the purpose of meta-analysis of their total effects and impacts. Furthermore, the significant differences in the way each work-stream operates, or has operated, means that a consistent approach to the evaluation of effectiveness and impacts (i.e. attributable additional effects) is also problematic. Despite attempts to standardise the approach to impact evaluation in this strategy, evidence will be gathered at the work-stream level at different times, by different evaluators, using different tools and techniques resulting in a wide array of sources of data and information. The challenge is to find a systematic approach to collating and organising the evidence base to enable an aggregate assessment of SARRAH that meets the quality criteria set out in the previous section – in other words ensuring that the evidence produced from various sources, is fit for the purpose of assessing the performance of SARRAH as a whole.

To enable the IE Team to conduct this assessment the proposed approach involves:

1. Individual work-stream, or groups of work-streams Impact Evaluations following appropriate methodologies, and exploiting potential synergies and complementarities between initiatives;

2. A systematic review of the evidence collected by the evaluation leads to ensure that the quality of the evidence is of a sufficient standard to be fit for assessing the overall performance SARRAH; and

3. A meta-evaluation of the sources of quality assured evidence base in order to draw summary conclusions from their findings that provide answers to the key evaluation questions.

3.5.1 STEP 1 - Work-stream level Impact Evaluations

The Strategy Phase has mainly consisted of developing individual IE methodologies for all of the SARRAH work-streams, based on the information gathered through desk research and the TOC process during the Inception Phase. These are available in full in the Annexes. These methodological pieces were structured around the following points:

- **Overview of the work-stream**: description of the context in which the work-stream was conceived and delivered, and of the activities undertaken by SARRAH under this work-stream;

- **Evaluation questions**: description of the objectives of the assignment and what the IE should seek to assess for each work-stream;

- **Assessment of the "impact evaluability" of the work-stream**: the extent to which quantitative vs. qualitative impacts can be measured, the strength of the causal linkages between activities undertaken and anticipated outcomes and impacts, and when should the research take place to ensure they are best captured;

- **Rationale for the proposed approach**: justification of the recommended approach based on the findings of the "impact evaluability assessment" carried out;

- **Indicators**: indicators of success at the outcome and impact levels of the work-stream's intervention logic;

- **Research Methodology**: detailed methodology for evaluation the work-stream, including (1) the research design and (2) the data collection methods envisaged;

- **Timeframes**: research timelines taking into consideration the overall contract timeframes (IE reports due in 2012 and 2014) and the impact realisation timeframes, i.e. the time at which outcomes and impacts can be anticipated to occur and be measured;

- **Costs**: indicative research costs across the whole contract period for each work-stream and including consultant fees and additional expenses;

- **Outline of data collection instruments**: where possible, an outline of the key themes which data collection instruments are expected to cover.

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These methodological pieces will be used as a starting point to carry out **impact evaluations of the various work-streams** selected for the research. Each work-stream, or group of work-streams, will be subject to specific data collection and reporting timeframes depending on a range of factors (see Section 5 "Work Plan").

3.5.2   STEP 2 - Systematic review

Systematic review is a key tool that will enable the IE team to systematically collect, collate and quality assure evidence collected through the various work-stream impact evaluations. In the first instance a systematic review approach requires the use of explicit criteria to ensure that the data and evidence submitted covers the areas required and are of a standard of quality that is consistent with the evaluation requirements.

In practice the approach to undertaking the systematic review involves the following steps:

Definition of the scope, focus and quality of analysis and evidence

The Evaluation Strategy and supporting appendices clearly set out the scope and focus of the evaluation activity that should be undertaken by the IE team. In the first instance, all evidence collected by the IE team will review compliance with the evaluation requirements.

Table 5 below, designed by Prof Liz Spencer for the UK Cabinet Office in 2003, provides a framework for appraising the quality of evaluation evidence submitted to the core IE team by evaluators.

Table 5 – Systematic review framework

Appraisal focus	Key appraisal questions	Key quality indicators
FINDINGS	1. How credible are the findings?	Findings /conclusions are supported by data /study evidence Findings /conclusions 'make sense' /have a coherent logic Findings /conclusions are resonant with other knowledge and experience Use of corroborating evidence to support or refine findings
	2. How well does the evaluation evidence address its original aims and purpose?	Clear statement of study aims and objectives (where relevant) Findings clearly linked to the purposes of the study – and to the initiative or policy being studied Summary of conclusions directed towards aims of study Discussions of limitations of study in meeting aims
	3. Scope for drawing wider inference – how well is this explained?	Discussion of what can be generalised to wider beneficiary population Detailed description of the contexts in which the study was conducted to allow applicability to other settings /contextual generalities to be assessed Discussion of how hypotheses /theories of change may relate to wider theories of change at the policy level Discussion of limitations on drawing wider inference
DESIGN	4. How defensible is the	Discussion of how overall evaluation /research

	research design?	strategy was designed to meet the aims of the study
		Discussion of the rationale of the study design
		Use of different features of design /data sources evident in findings presented
		Discussion of limitations of research design and their implications for the study evidence
	5. How well was the data collection carried out?	Discussion of: • Who conducted data collection • Procedures /documents used for collection /reporting • Checks on origin /status • Description of fieldwork methods and how these may have influenced data collected
ANALYSIS	6. How well has the approach to and formulation of the analysis been conveyed?	Description of form of original data
		Clear rationale for choice of data management method
		Discussion, with examples, of how any constructed analytic concepts have been devised and applied
REPORTING	7. How clear are the links between data, interpretation and conclusions – i.e. how well can the route to any conclusions be seen?	Clear conceptual links between analytic commentary and presentations of original data
		Discussion of how /why particular interpretation /significance is assigned to specific aspects of data
		Discussion of how explanations /theories /conclusions were derived
NEUTRALITY	8. How clear are the assumptions /theoretical perspectives /values that have shaped the form and output of the evaluation /evidence submitted?	Discussion /evidence of the main assumptions /hypotheses /theoretical ideas on which the evaluation was based and how these affected the form, coverage, or output of the evaluation
		Discussion /evidence of the ideological perspectives /values of the evaluation team and their impact on the methodological or substantive content of the evaluation
		Evidence of openness to new /alternative ways of viewing subject /theories /assumptions
		Discussion of how error or bias may have arisen in design /data collection /analysis and how addressed, if at all
		Reflections on the impact of the researcher on the evaluation process
AUDITABILITY	9. How adequately has the research process been documented?	Discussion of strengths and weaknesses
		Documentation and reasons for changes in coverage /data collection /analytic approach
		Reproduction of main study documents

Source: "Quality in Qualitative Evaluation", Cabinet Office, 2003

3.5.3   STEP 3 - Meta-evaluation

The next phase of the assessment takes a meta-evaluation approach to analysis, involving a synthesis of the evidence collected through the various work-stream impact evaluations using a range of both formal and informal approaches and analytical techniques to enable value-based judgements and conclusions to be drawn at the overall SARRAH level. The overarching meta-evaluation approach enables systematic qualitative research that is sufficiently representative of the portfolio as a whole and capable of producing meaningful and useful findings.

Figure 6 below depicts the relationship between the various individual impact evaluations and the 2012 and 2014 meta-evaluation reports.

3.5.3   STEP 3 - Meta-evaluation

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Figure 6: Meta-Evaluation Process
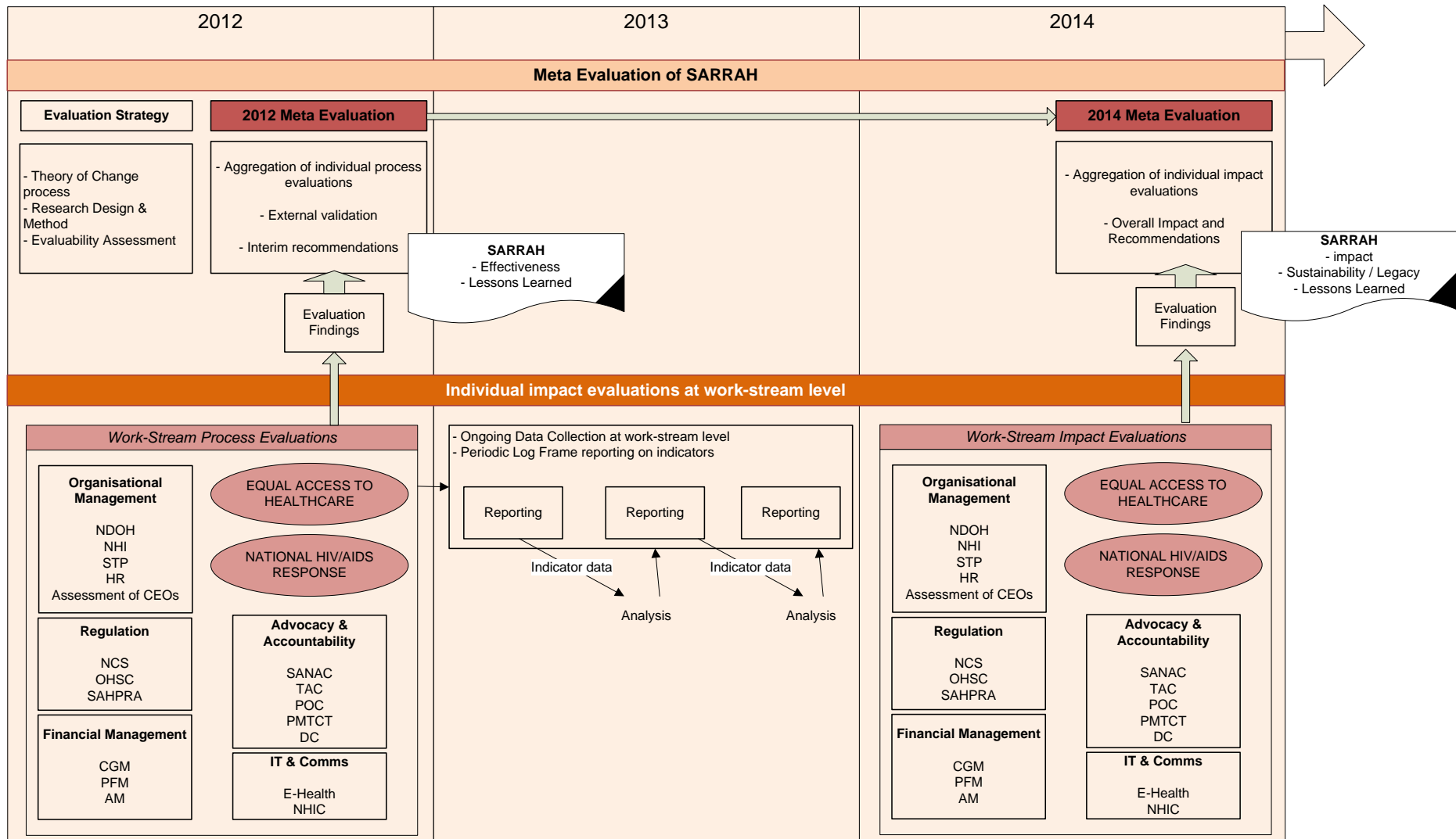
Source: Coffey

3.6   Assessing Value for Money

Given the range of different types of interventions within SARRAH it is essential that, as far as possible, the 'value' delivered by each initiative, or group of initiatives is clearly defined and evidenced in ways that captures both qualitative and quantitative benefits. Accordingly the assessment of VFM requires a range of potential tools and techniques to enable an appropriate but explicit assessment of the extent to which the value of the benefits achieved justify the costs incurred.

3.6.1   The '3Es' approach

Our approach to assessing VFM of SARRAH is framed by a '3E's approach that considers the key components of value for money as economy, efficiency and effectiveness.

Figure 7 below sets out the key components of value for money that represents an impact chain (or logic chain) linking the allocation of financial resources to outcomes. The diagram below relates the impact chain to the overall value for money i.e. the total outcomes achieved for the total costs incurred, broken down into the following components:

- **Economy** – the cost of the inputs; are the necessary inputs (e.g. human resource costs, travel costs, accommodation costs, IT costs etc.) being secured at the minimum necessary cost? In other words, are you doing things at the right price;

- **Efficiency** – the ratio of inputs to outputs; are outputs being produced efficiently? In other words, are you doing the right things at the right price; and

- **Effectiveness** – the link between outputs and outcomes / impacts; to what extent do the outputs translate into the anticipated outcomes? In other words, are you doing the right things at the right price, in the right ways?

Figure 7: Value for Money throughout the project lifecycle
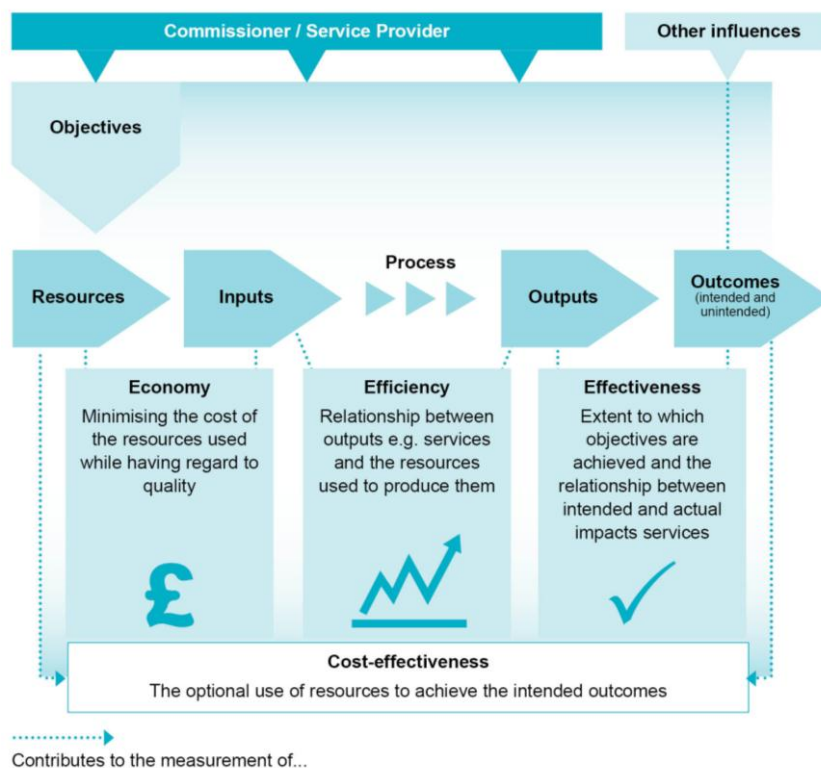
Source: adapted from ODPM (2004), Assessing the Impacts of Spatial Interventions

Value for money assessment at the work-stream level

There are two main approaches through which work-streams can assess and report on value for money in line with the '3E's approach described above:

- **A measurement approach** which focuses on cost optimization through measurement and comparative assessment to determine: whether work-streams have achieved the quantity and quality of the inputs, outputs and outcomes required at the 'least' cost; and a comparative assessment of all lifetime benefits and costs to provide a social and economic return on DFID's investment; and

- **A management approach** which focuses on an assessment of the extent to which key management processes and resource allocation decisions made at each stage of the implementation process results in the efficient delivery of higher value inputs, activities, outputs and ultimately outcomes and impacts. The independent VFM audit of SARRAH recently commissioned by DFID and undertaken by Charles Wright has followed this management approach and will be built upon for the VFM assessment to be undertaken as part of the SARRAH IE.

Value for money assessment at the fund level

The analysis and findings gathered at the work-stream level will be collated and analysed as part of the systematic review / meta-evaluation process. This part of the assessment considers how well DFID has allocated and managed the use of the resources at its disposal to deliver sustainable impacts.

3.6.2 Contributors to the VFM assessment

It is important to point out that while the IE will provide an overall VFM assessment incorporating all elements of the 3Es approach, SARRAH's VFM will be informed by several contributors, not all of which are part of the IE team:

- **VFM Audit**: DFID recently contracted consultants to carry out a VFM audit of SARRAH with a view to "*enable an understanding of the accounting and budgetary internal controls systems used in SARRAH's milestone payment plan and project progress reports to DFID, to establish whether proper accounting records have been maintained, and to assess value for money in relations to costs of achieving milestone outputs*". The report of this VFM audit was recently submitted to DFID, and as explicitly required in the TOR, focuses almost exclusively on the **Economy and Efficiency** aspects of the programme's VFM, as well as on the performance of SARRAH's **internal management and financial processes**. As this VFM audit was carried out at an advanced stage in the SARRAH project lifecycle, its findings will remain valid throughout the IE contract period of 2011-2014, and will be drawn upon substantially to avoid duplication of work and ensure the IE resources are used in the most cost-effective way.

- **SARRAH IE (Coffey and HSRC)**: the IE will concentrate its attention and resources on assessing SARRAH's **Effectiveness and Impact**, and by extension, its **cost-effectiveness**. The IE team will draw from the VFM audit and other sources to triangulate findings and provide DFID with an overall assessment of SARRAH's VFM.

- **Annual Reviews**: the VFM assessment will also be complemented by external and independent Annual Reviews of SARRAH. These are contracted on a yearly basis and are primarily designed to assess progress made against programme's goal, purpose and outputs set out in the log-frame and documentation. Annual Reviews involve substantial primary research with programme beneficiaries and if done concurrently with the IE and in a way that is complementary and mutually beneficial, will provide useful information on SARRAH's effectiveness, cost-effectiveness and VFM.

4   RECOMMENDATIONS FOR IMPLEMENTATION

During the Strategy Phase, the IE team has thoroughly assessed the appropriateness and the opportunity costs of spending significant resources in evaluating each individual work-stream as well as of the SARRAH programme as a whole, through the lens of three criteria: Utility, Proportionality and Evaluability (see Section 3.1.3 for more detail).

4.1   Impact Evaluation Priorities

The rationale for identifying evaluation priorities is based on the understanding that (1) the various initiatives undertaken as part of the SARRAH programme are not all equally strategic; (2) the budget constraints imply a need to prioritise and allocate research activities strategically and (3) a few high quality impact evaluations are worth more to policymakers than many poor quality ones.

Those three criteria have guided the IE team's recommendations as to where evaluation activities and resources should be allocated to maximise their benefit for decision makers in DFID and in the various partner organisations involved. Table 6 below uses a scorecard and traffic light system to rate the Utility, Proportionality and Evaluability of each work-stream as well as assign them an overall score. The result of this process is a three-tier prioritisation system:

- "Green" work-streams are considered to be priority activities that should be allocated the largest share of evaluation resources. These will involve significant amount of primary research and robust assessment of the counterfactual if appropriate;

- "Red" work-streams are not considered a strategic priority and should only be subject to minimal, essentially desk-based research to ensure that they are somewhat captured in the assessment. These may involve a limited number of stakeholder interviews;

- "Amber" work-streams are seen as strategic but are characterised by low levels of proportionality and evaluability, and should therefore be subject to more than "minimal" research activities, but less than full-scale and labour intensive impact evaluation activities.

Table 6 – Scorecard

	Criteria			OVERALL
	Utility	Proportionality	Evaluability	
PMTCT	High	Medium	High	Medium
SANAC and SANAC M&E	High	High	High	High
Treatment Action Campaign	High	Medium	Medium	Medium
POC	Medium	Low	Low	Low
NHI	High	High	High	High
SAHPRA	High	High	High	High
Quality Assurance	High	High	High	High
- IT Support	High	Medium	Medium	Medium
- NHIC	High	Medium	Medium	Medium
- Financial Management	High	Medium	Low	Low
- Asset Management	High	Medium	Low	Low
- Cond. Grant Management	High	Medium	Low	Low
NDOH 2	High	Medium	High	High
Assessment of DHM & CEOs	High	High	High	High
STP	High	Medium	Medium	Low
Human Resources	High	Medium	Medium	Medium
Donor Coordination	Medium	Low	Low	Low

Low	Medium	High

While this assessment provides a useful guide for deciding what work-streams to evaluate with a view to inform the overall effectiveness and impact of SARRAH, the above will be sense checked and discussed with key stakeholders to ensure that it reflects the policy priorities identified.

4.2   From Process to Impact

As explained previously, the nature of SARRAH as an intervention and of its various work-streams implies a significant time lag between completion of the activities and the realisation of tangible, measurable and sustainable impacts on the South African health system. Meanwhile, the IE is structured around two key IE report submissions in December 2012 and December 2014. It is therefore essential that the evaluation work feeds into those two reports in a way that is logical, that maximises the value of the findings presented, that makes the best use of the available resources and that minimises duplication across the reports. The IE team recommends structuring the research around the two reports with the understanding that **both a process and an impact** evaluation will be carried out: this is based on the belief that for SARRAH's impact to be properly understood, an assessment of how it proceeded to support the various organisations and institutions across the South African health system and how was this support perceived by the direct and indirect beneficiaries at the point of reception is necessary, and should form an integral part of the "**effectiveness**" assessment of SARRAH.

- **2012 Report**: most activities undertaken under SARRAH and its various work-streams have been recently completed, or are approaching completion later in the year (with the exception of support to the NHI pilots). The IE team believes that this makes a thorough **process evaluation** across the selected work-streams and of SARRAH highly desirable in the short term, while the information is still "fresh" and easy to collect and analyse. The IE team would therefore recommend that the process evaluation work primarily informs the 2012 report.

- **2014 Report**: while it is the IE's view that some of the work-streams may generate measurable impacts sooner than others (e.g. it is believed that the "Quality Assurance" work-stream could theoretically produce measurable impacts on the performance and rating of health care facilities as soon as 2012), the general perception is that the opportunity to observe the evolution of various parts of the South African health system over the next 2.5 years and to collect and monitor information and data at regular intervals throughout that period, would greatly enhance the capacity of the IE team to understand the role played by SARRAH in fostering this change with a good degree of perspective and confidence. The IE team would therefore recommend that while outcomes and impacts will be measured and presented in the 2012 report if possible and/or appropriate, most of the impact measurement will be undertaken throughout the remainder of the contract period with a view to conduct a **meta-impact evaluation** for the 2014 report.

4.3   Next steps

This Evaluation Strategy report is a **Draft Report**, which will be subject to amendments and additions after review by DFID and other members of the Steering Committee. Moreover, the IE is still awaiting additional information to be provided by HLSP on funding and expenditure data by work-stream, as well as a full list of stakeholders, both of which will inform the Evaluation Strategy once available.

The IE team will submit a Final Strategy report to DFID and the Steering Committee up to three weeks after the Steering Committee Meeting which will be held in Pretoria, SA on 25th April 2012. The final report will take into account the additional information made available as well as the comments made on the Draft Report by members of the Steering Committee.

5   WORK PLAN

		2012				2013				2014			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Implementation Phase		Steering group meetings											
		Conduct pilot study											
		Ongoing Project Management & Communication											
	Primary Research	PMTCT											
		Strengthening SANAC											
		SANAC M&E											
		Treatment Action Campaign											
		Parliamentary Oversight Committee											
		NHI											
		SAHPRA											
		Quality Assurance											
		National ICT Strategy											
		National Health Information Centre											
		Financial Management											
		Asset Management											
		Conditional Grant Management											
		NDOH											
		Assessment of DHM and CEOs											
		STP											
		Human Resources											
		Donor Coordination											
		Aggregate findings for 2012 Meta-Evaluation											
		Aggregate findings for 2014 Meta-Evaluation											
		Communication Baseline											
		Dissemination of evaluation findings											
		Submission of quarterly progress report											
		Submission of quarterly financial report											
		Submission of annual overview report											
		Impact Evaluation reports and recommendations for changes											
		Annual lesson learning, engagement and dissemination events											
Exit Phase		Prepare exit strategy											
		Submission of completion report											

Legend:

▲ SC Meeting

▢ Deliverable

▢ IE Report

▢ Presentation

Annex 5

Assessment of District Health Managers and Chief Executive Officers

Summary Report – Assessment of District Health Managers and Chief Executive Officers

1.1 Background

In 2006 the National Human Resources Plan for Health noted that a cadre of skilled managers was critical to the provision of quality and efficient health care in South Africa. Despite the efforts in tackling the challenges posed by the health sector, there was a growing recognition that South Africa's health system is steeped in crisis manifested by the growing burden of disease,weakness of the health system and poor health outcomes. In 2009, the then Minister of Health, Ms Barbara Hogan, commissioned a financial and health system review of all nine provinces and the National Department of Health (NDOH) to quantify the extent of, and investigate the reasons for, 'the projected overspending in some of the provinces during the 2008/09 financial year'. The projected overspend was seen to have the potential to undermine the capacity of the NDOH to improve health outcomes and in particular the health sector's response to the HIV epidemic. In 2010 the NDOH went further to formulate the ten-point plan aimed at ensuring that South Africa met its Millennium Development Goals (MDGs) and strengthening the health system to provide quality care. The Plan (2010) addresses the ten key priority areas which the NDOH would address by 2014.

1.2 Overview of Work-stream

The assessment of District Health Managers (DHM) and Chief Executive Officers (CEO) is one of the Ten Point Plan deliverables which forms part of the restructuring of the South African public healthcare system and improving its management. The rationale of the intervention was based on the belief that the skills and competencies of DHMs and CEOs, or the lack thereof, are partly responsible for hospitals' performance, and that assessing DHMs and CEOs through a standardized test would enable the identification of training or staffing needs and ultimately improve the hospitals' performance. There is ample evidence that poor hospital management can affect health outcomes negatively, which indicates that if it is not targeted or executed properly, the intervention could have an adverse impact on hospital performance.

1.3 Evaluation Method

The evaluation of the intervention was conducted in order to establish the process of assessing DHMs and CEOs. The key questions focused on what had been accomplished through the assessment, rather than the impacts of the assessment. The process evaluation was conducted using key informant interviews with key personnel from the NDOH as well as personnel from the Gauteng Department of health. A target was set of interviewing eight participants however the actual number interviewed was five. The evaluation explored issues of relevance, effectiveness, efficiency, sustainability and gender.

1.4 Findings

1.4.1 Relevance

The assessment of DHMs and CEOs in the public health sector in South Africa was conducted in 2010 with a view of enhancing efficiency and delivering quality care in the public health sector. A range of policies informed the assessment and the central purpose was to ensure that the managers in charge of the public healthcare system are competent enough to deliver quality of care and reduce

the burden of disease in the country. Furthermore, the assessment occurred at a time when the National Health Insurance programme was being discussed hence it too was a driving force behind the assessment of CEOs and DHMs. Participants contextualized the assessment within the national health policies and strategic frameworks and vision for health and were emphatic that the assessment was relevant.

1.4.2   Effectiveness

The study was reported to have been conducted within the existing policy framework although some policies, such as the classification of health facilities, were amended within the period of the assessment.

1.4.3   Efficiency

In the assessment of DHMs & CEOs, all the managers had to be assessed as the NDOH did not have an accurate number of the healthcare facility managers in the country. Thus a census rather than a survey was conducted. The competency assessment was authorised by the Minster of Health and implemented by the NDOH in collaboration with the provincial departments of health. The assessments were carried out by the Development Bank of Southern Africa (DBSA).

In preparation for the competency assessments, the tool for assessing the healthcare managers was discussed with the Department of Public Service and Administration (DPSA) to deal with the risk of it not being in line with the DPSA competency assessment model for top management. To ensure full participation, the DBSA contacted all managers to inform them of the assessment and when it was going to be conducted. As a result of prior engagement with the managers the DBSA had a 92% response rate and the completion of the assessment tools was also great. The lack of 100% response rate was due to the unavailability of some Western Cape managers to participate in the saudit. During the assessment, legal issues were taken care of and each of the managers had to sign informed consent forms agreeing to undergo the psychometric assessment.

It is notable that although a whole range of communication documents were developed in order to address the potential risks to the assessment of DHMs and CEOs, these documents were not available to the evaluation team. What was however useful was that the provincial reports are available on the internet[117]. A study participant noted that the provincial reports were made public after the Democratic Alliance (DA) demanded that the findings of the assessment to be made public. Although the provincial reports are available on the internet, neither the executive summary nor the complete report is available. The view is that the final report on the competency assessments is still embargoed and has not been released because it is sensitive and contains information that affects the careers of specific individuals. Healthcare managers were assured that those found not to be suitable for their positions would be redeployed rather than dismissed. Since the assessment, some managers have opted out, others have volunteered for redeployment and positions have been advertised in various provinces.

Commenting on efficiency, a participant noted that the competency assessments are among those exercises that cannot be repeated. The whole exercise cost approximately R25 million. If such an assessment were to be conducted among middle managers nation-wide, it is likely to cost much more. Yet another participant was of the view that should the impact of the assessment prove valuable in improving service delivery, spending funds on a similar exercise would be justifiable. The costs involved prohibit rolling-out the assessments to middle and lower management levels in the

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[117] http://www.health-e.org.za/news/article.php?uid=20033227

healthcare sector. Almost all the health facility managers were assessed but most study participants noted that the exercise was reported to be so expensive that it cannot be repeated.

1.4.4 Gender

The gender composition of the study participants involved in this evaluation comprised of mainly males because it was difficult to get officials at the provincial level. Thus the findings in this evaluation have a strong male bias. The provincial health officials that were not interviewed were all women.

1.5 Conclusions

The findings suggest that the assessment of DHMs and CEOs was a useful exercise. It was conducted in all the nine provinces and it resulted in the restructuring of the health system, changes in policies and the implementation of ideas that had been recommended years back. There was consensus that the assessment was relevant as there was need for skilled health managers; the restructuring happened in order to prepare for the NHI and to generally help reduce the inefficiencies associated with the health sector. What is however notable is that there was agreement that the exercise that could not be repeated due to expenses involved. Thus the assessment exercise appears to have been a once-off initiative which might not be repeated by government; it is not sustainable.

1.6 Recommendations

1   Getting access to key informants proved difficult in this evaluation and the NDOH should intervene to ensure that the next phase of the study proceeds smoothly.

2   Critical documentation from the NDOH also needs to be made available if the real impact of SARRAH funding is to be established.

3   Co-operation from key stakeholders in the NDOH is critical in ensuring effective evaluation of the SARRAH programme.

4   The findings of this study suggest that the process of the assessment of DHMs and CEOs occurred effectively. The replacement of such personnel occurred during the process evaluation. Once the new personnel take over, only then will it be possible to establish the impact of the assessment of DHMs and CEOs.

Annex 6

Asset Management

Coffey International Development
April 2014

Summary Report – Asset Management

1.1 Background

Poor asset control negatively affects the day-to-day running of health facilities and can lead to unnecessary duplications of equipment and poor maintenance. The Auditor General has repeatedly identified poor asset control as a cause for concern within NDOH and there were qualified audits in 60% of department of health facilities in 2012 and most of these were the result of a history of poor asset management. Unsatisfactory financial management is regarded as a priority for government and addressing the asset management problem was therefore selected as an indicator for the SARRAH programme.

Asset management in an organisation as large as the National Department of Health (NDOH), with hundreds of facilities and tens of thousands of assets, is a formidable challenge and solving the problems called for specialised support.

1.2 Overview of work-stream

The work began with physical asset verification for NDOH and then the Provincial departments in Kwa-Zulu Natal, Mpumalanga and the Eastern Cape. Most of the activities were contracted out to an independent service provider (i-Chain) using a proprietary software system for which i-Chain holds the South African licence. This system had been proven in a successful turnaround of asset management for the Gauteng province and therefore the system itself was not evaluated but rather its usefulness, on-going sustainability and impact in sites where it has been applied.

By verifying, valuing and compiling a comprehensive database of NDOH assets (national and provincial) the Asset Management workstream sought to optimise the management and the allocation of capital resources, and thereby strengthen public financial management (PFM) in the South African Health System.

1.3 Evaluation method

The overall questions guiding the evaluation included the extent to which improved asset management had contributed to better public financial management and the impacts this may have on the South African health sector. Specific impacts being measured were the number of qualified audits related to improper asset management, compliance with improved asset management processes, improved budgeting, and better fiscal reporting.

The mixed-method approach was used to distil information from numerous sources into formats suitable for decision-making. Qualitative and quantitative approaches were combined in the analysis as appropriate. Document reviews and analysis were used to determine the rationale for the work being undertaken, the proposed activities and intermediate and anticipated final outcomes. Key informant interviews were conducted with senior officials responsible for financial management at NDOH and Treasury and the consultants who developed the new system and helped to update the standard operating procedures.

1.4 Findings

Activities in the Asset Management workstream began with a pilot project to verify assets of the NDOH, which included physical verification, an assessment of condition, valuation, compiling a newly verified asset register and reconciliation of the newly verified register with the existing NDOH register. The work also included reviews of aspects of corporate governance, supply chain management and financial compliance policies. The final component was developing a database of all obsolete assets.

Once the pilot at the national office was completed similar exercises were undertaken in Mpumalanga, KwaZuluNatal and the Eastern Cape health departments. At the time of the evaluation (late 2012) the work in the national office was complete and the work in the provinces was on-going.

When the work is completed about 1.4 million assets at 2 800 sites will have been verified. The service provider also assisted in recruitment of staff for the provincial Asset Management Units (AMU) and a Policy and Procedure workshop was held to update provincial manuals. The capacity building programme engaged 85 asset management staff, covering areas such as scanning, assigning and cataloguing assets.

The i-Chain approach is to train local people to undertake asset management in terms of counts, condition assessment and valuation when paired with i-Chain staff. Once trained, these Interns are introduced to the Provincial Asset Management Unit as a potential resource for future audits.

Essential information was said to have been provided in a more accessible format (Excel spreadsheets or hard copy) and staff acknowledged that an accurate asset register helps them maintain equipment more effectively and motivate for more equipment when necessary.

1.4.1 Relevance

Poor asset management was recognised by senior management in the NDOH as a serious impediment to obtaining unqualified audits from the Auditor General and was consequently a priority for intervention. By verifying, valuing and compiling a comprehensive database of assets this work-stream will help optimise the allocation of capital resources and thereby strengthen public financial management in the South African Health System.

1.4.2 Effectiveness

NDOH achieved an unqualified audit in the first year of this project and Mpumalanga had four asset management- related audit findings reduced to two. Respondents indicated that the improved management of assets would contribute to 'the budget being implemented as intended in a controlled and predictable way'. This appeared to be particularly the case for equipment that was under-utilised or inadequately maintained.

1.4.3 Efficiency

By contracting an organisation with specialised asset management skills (i-Chain) which are in short supply within the national and provincial departments of health, improvements in asset management have been achieved reasonably quickly. It is unlikely that this could have been achieved using only internal resources because, according to the Auditor-General, repeatedly qualified audits were 'due to a shortage of personnel'.

1.4.4 Impact

The project has demonstrated considerable gains in the NDOH and is already having an impact in Mpumalanga. The national department achieved an unqualified audit opinion with findings for the first time in 2010/11, although it was qualified again in 2011/12. However, this was said to be partly due to moving to new buildings at the time of the audit and an unqualified audit was expected in 2012/13.

1.4.5 Sustainability

Sustainability of the asset management system depends on the ability of the various health departments to incorporate the newly trained staff into their Asset Management Units, some of which are not yet operational. Experience with other training initiatives for government departments suggests that budget allocations often lag behind immediate needs and resources may be lost if there is excessive delay in confirming appointments.

1.5 Conclusions

There is evidence that the new asset management systems are leading to better compliance with the Public Finance Management Act. If the systems put in place continue to be used the next Auditor-General's reports should show further reductions in qualified audits.

Respondents were generally positive about the potential impact of proper asset management on the South African health sector and there was a strong sense that the work was not merely about compliance with regulations but would lead to better equipped and maintained health facilities.

1.6 Recommendations

- Effective asset management systems have been demonstrated but the overall sustainability and impact depends on sufficient staff being assigned to the Asset Management Units. Resources should be prioritised by NDOH for this purpose.

- This workstream has resulted in the training of many unemployed matriculants, given them work experience and can potentially provide longer term employment. Efforts should be made to employ the best of this cohort of trained asset surveyors in the Provincial Asset Management Units.

- Further evaluations should be completed on an annual basis to track outcomes in terms of asset-related audit qualifications.

Annex 7

Conditional Grants Management

Summary Report – Conditional Grants Management

1.1 Background

Health Conditional Grants (CG) account for about 95% of the total National Department of Health (NDOH) budget. They are purpose specific grants intended to a) Enable the health sector to develop an effective response to HIV and AIDS, b) Support the implementation of the national operational plan for comprehensive HIV and AIDS treatment and care, and c) Subsidise in part funding for the antiretroviral therapy (ART) programme. CGs form one of the possible sources of healthcare funding, the other sources are Equitable Shares, and Provincial own revenue,

The National Treasury (NT) allocates funds to both Provinces and Municipalities under the Division of Revenue Act (DORA). DORA also contains clauses, which outline the process around funds transfers, management of reporting requirements, and various duties of transferring officers (national departments) and receiving officers (provinces and municipalities) with respect to conditional grants.

NDOH manages six Conditional Grants, which are: Comprehensive HIV and AIDS (which is the focus of this report), Forensic Pathology Services, Health Professions and Training and Development, Hospital Revitalisation, National Tertiary Services Grant, and Health Disaster Response.

The NDOH's management of CGs duties include:

- Determining the allocation criteria for the relevant grant

- Drafting the spending and management of conditions for each grant programme

- Managing the Business plans or Project plans for the relevant grant

- Certifying compliance with various requirements of the Division of Revenue Act

- Complying with the payment schedule

- Implementing a uniform performance monitoring system

- Monitoring implementation of the grant

- Reporting on performance and expenditure to National Treasury and Parliament in a manner consistent with the Public Financial Management Act (PFMA) and Municipal Financial Management Act (MFMA)

Whereas provincial departments and municipality duties include:

- Meeting the conditions stipulated in the relevant Government Gazette

- Proper management and ring-fencing of funds and spending

- Establishing payment schedules which corresponds to those of municipalities

- Reporting to national department on expenditure and performance

- Reporting on expenditure and projections to National Treasury via the Provincial Treasury, or national departments in the case of municipalities

- Reporting on CGs

NDOH submits collated expenditure and performance reports monthly and quarterly, respectively. After each quarter National Treasury meets with each national department to discuss quarterly and monthly reports, address challenges and propose solutions. At the end of the financial year, annual reports are submitted to the National Treasury and discussions are scheduled to discuss the outcomes. Where challenges are not addressed as recommended, drastic measures are taken, which are, withholding of funds; permanently stopping the transfer of funds; re-allocating unspent funds to

another province within the same programme; and informing the Auditor-General of instances of financial misconduct. During 2009/10, NDOH was affected by these conditions.

Source: Monitoring of Conditional Grants (2010) – presentation by National Treasury.

1.2 Overview of work-stream

Despite the yearly increase of allocated resources to the Comprehensive HIV and AIDS CG Management, concern has continued regarding the differences between planned and actual expenditure, poor grant management which had led to grants being regularly under-spent or over-spent and reporting poor.

South Africa's Revitalised Response to AIDS and Health (SARRAH) Programme support for the financial cluster of activities which included (1) Financial Management; (2) Conditional Grant Management; and (3) Asset Management was secured. SARRAH, through Human & Life Sciences Partnership (HLSP), provided technical support to turn around the situation and ensure that grants are spent timeously, and that they are spent for what they were allocated for with the aim of maximising the impact on healthcare delivery. The primary activity was to provide technical assistance to NDOH in provinces with regard to business planning, setting up systems for CGs spending, and for monitoring expenditure. Some of the activities were to provide capacity development support to provinces, by developing processes in line with NDOH priorities and Treasury timelines for the business plan and quarterly reports submission. Another activity identified was to increase understanding of how provincial planning, adherence to laws and policies with regard to spending on the CGs, and reporting on time affect the NDOH's financial audit outcomes. It was also seen as necessary to assist Non-Governmental Organisations (NGOs) with reviewing their applications for NDOH funding and capacity building of funded NGOs to comply with relevant government financial laws and policies relating to CG.

1.3 Evaluation method

The overall questions guiding the evaluation included the extent to which improved management of conditional grants at the provincial level had contributed to better public financial management and the impacts this may have on the South African health sector.

Qualitative data were gathered using document reviews and key informant interviews. The interviews were conducted in person for approximately one hour, and follow-up telephone interviews were conducted for clarity. An HLSP technical lead, who had been seconded to NDOH, was interviewed on 'key success indicators' from the SARRAH perspective.

1.4 Findings

1.4.1 Relevance

The Conditional Grant management work-stream implements activities that are related to Output 4: Strengthen public financial management in the South African health system. In order for HIV and AIDS programmes to be efficiently implemented in provinces, ring-fenced conditional grants are allocated by NDOH. Weaknesses were identified with regards to management of conditional grants. SARRAH supported NDOH through technical assistance which sought to strengthen performance management and strategic planning for HIV and health services at national and provincial levels. Evaluation findings therefore suggest the support provided through SARRAH was relevant to the provinces' needs.

1.4.2 Effectiveness

There is clear evidence that SARRAH was effective in providing the support, especially in capacitating provincial managers and NGOs in legal and financial management, regulations, timeous submission of business plans, and reports by provincial CG managers. SARRAH was also effective in setting up a functioning financial monitoring system, developing the understanding of CG management including

monitoring expenditure, compiling reports to National Treasury, developing indicators, allocating funds to programmes, disbursing funds to institutions, etc.

1.4.3 Efficiency

SARRAH's terms of reference were delivered with some efficiency through competent regional teams which made visits to provinces where CG managers were trained and offered on-going support. Evidence shows that concerns raised by the Auditor General in 2011/12 were taken seriously by being included in the 2012/13 strategic plans in order to address them.

1.4.4 Impact

It is too soon to evaluate medium and long-term impacts.

1.4.5 Sustainability

To build sustainability, NDOH hired the former SARRAH consultant at Director level to continue with this work. This also ensured continuity. In addition, a new unit that deals with the CG of HIV and AIDS was established. The unit was staffed with two Deputy Directors, two Assistant Directors and an Administrator. All financial managers' positions have been filled by managers whose Key Performance Areas (KPAs) are realigned with acceptable national standards. CG systems have been put in place, training has been conducted and the CFO established a forum of all CG managers within the department to deal with common experiences that they encounter.

1.5 Conclusions

The mid-term evaluation suggests the CG SARRAH mainly provided support to national and provincial departments of health on a number of financial management activities, especially for the purpose of aligning planning, practice and reporting to legislation and in preparation for the new National Strategic Plan (NSP). The idea was that correcting deviations, sharing information among provinces would increase accountability, channel funds where they are supposed to i.e. programmes such as Preventing Mother-to-Child Transmission (PMTCT), ARTs, Medical Male Circumcision (MMC), etc. SARRAH was able to achieve what was planned and more due to:

- Working closely with the office of the DG and Chief Financial Officer (CFO), therefore understanding the nature of challenges and gaps, understanding delinks between practice and legislation and adopting a remedial approach when supporting provinces;

- Working within teams constituting NDOH, National Treasury and provinces' representatives;

- Targeting managers of the Conditional Grants who are responsible for planning and reporting.

Impact form SARRAH support towards this workstream cannot be attributed to SARRAH alone given that both technical and financial support came not only from SARRAH but also from NDOH. However, SARRAH monthly reports compiled by the consultant provide some information on activities that were carried out and the achievements. Only the reports that were not deemed confidential were shared with the evaluators.

1.6 Recommendations

The following recommendations are made for this report:

- All reports submitted to NDOH should also be shared with HLSP for monitoring and evaluation purposes. The impact of this workstream should be conducted during 2013/14 to allow the programmes that were set up during 2011/12 to take root.

- Close monitoring of performance at provincial level must be on-going to detect areas that may require further support.

- Additional support should be provided through the office of the CFO and DG as before.

Annex 8

Financial Management

Summary Report – Financial Management

1.1 Background

In South Africa, all financial management is governed by the Public Financial Management Act (PFMA), 1999, which provides for the administration of state funds by functionaries, their responsibilities and incidental matters. The National Treasury (NT) disburse funds to meet South Africa's citizens' health needs and government commitments. The Chief Financial Officer in the National Department of Health (NDOH) oversees the Performance Financial Management, financial plans, allocations, disbursements, and the use and reporting of these finances at both national and provincial levels. The Standing Committee on Public Accounts (SCOPA) monitors and oversees the work and budgets of national government departments and holds them accountable.

The main goal of South Africa's Revitalised Response to AIDS and Health (SARRAH) Programme's support to Financial Management was to strengthen management and planning at national and provincial levels.

Provinces in South Africa have a significant degree of autonomy in the area of health provision and a significant part of the national health budget is spent by the provinces. Stronger Public Financial Management (PFM) at the provincial level would therefore help strengthen PFM in the national health system. Based on the assumption that recommendations formulated in reports are taken up by provincial departments of health to improve PFM and capacity, the process indicators identified to empirically test the effectiveness and efficiency of the SARRAH programme are:

- A comprehensive and credible budget, linked to policy priorities.
- Effective financial management systems to ensure that the budget is implemented as intended in a controlled and predictable way
- Timely and accurate fiscal reporting.

For NDOH therefore, it was crucial that financial management is strengthened at all levels and that corrective action be done systematically and uniformly.

1.2 Overview of work-stream

The reasons for SARRAH's focus on PFM include: poor health outcomes, despite a reasonable amount of expenditure; and, Cabinet's adoption of an outcome-based approach to service delivery.

There had been problems with unauthorised, fruitless and wasteful expenditure, usually commensurate with the size of the department's budget. Lack of capacity was also cited by NDOH as a reason for non-performance.

It was identified that strengthening systems in preparation for implementation of the National Health Insurance (NHI), and the national department's improved oversight role would both lead to strengthening the overall health systems performance.

SARRAH funding and technical support was harnessed with the aim of implementing a turnaround strategy for improving auditing outcomes and reducing the concerns raised by the auditor general. The funding was aimed at helping the development and implementation of the Management Improvement Plan (APPs) in all 9 provinces, improving the performance of the health system to provide services and respond to the burden of disease, which includes mobilising and channelling resources appropriately. Specifically, activities included identifying deficiencies and challenges within the system; providing an oversight role through the early identification of potential progress blockages and budget shortfalls; and initiating remedial action.

The PFM work-stream had various aspects to it including support to the office of the Chief Financial Officer (CFO) and the Director General (DG) in order to strengthen PFM at national and provincial levels. Other work was the management of Conditional Grant (CGs) and Assets which are presented in separate reports. Support for improving PFM was provided to only eight of the nine provincial support units through the provincial financial management improvement project.

1.3 Evaluation method

Three qualitative methods were used to collect the data. Firstly, archival research was conducted. This entailed undertaking a review of various documents on the work-stream obtained from HSLP. Secondly, two key informant interviews were conducted with both the Technical Lead from Human & Life Sciences Partnership (HLSP), and the Consultant who had been hired to assist with the PFM work-stream in the NDOH. Lastly, an analysis of the Auditor general of South Africa's (AGSA) audit opinions of PFM performance by the various provincial health departments in the country from 2004-05 to 2010-2011 was done to see if any improvements had occurred.

The impact and sustainability of the PFM work-stream was left out as it will be the focus for the final evaluation in 2014.

1.4 Findings

An audit of financial management practices in all nine provincial health departments was successfully completed. The audit findings show the financial profile of the health department and the analysis of the cost drivers and budget pressures of the health services.

Measures to improve financial management and budget control, in compliance with the PFMA of 1999, were developed. During roll out, the Western Cape refused to take part in the project as they had already started with their own assessments and had developed their own curriculum. KwaZulu-Natal also did not take up the programme as they had commenced with their assessment activities at the time when the project was commenced. They were however willing to see NDOH plans with regard to remedying the problems. This programme was then rolled out to the remaining 7 provinces.

Capacity development was undertaken and activity plans were aligned to the PFMA and the Negotiated Service Delivery Agreement (NSDA) to ensure continuous improvements in audit results, both at provincial and national levels. The proposed intervention curriculum was never implemented at all although all assessments were completed.

The consultant prepared and submitted Provincial and Consolidated reports to the Acting CFO, DG, and the Minister of Health. These were also shared with the National Health Council (NHC), provincial CFOs and Head of Departments (HoDs).

Although HLSP did not receive the reports, it released funds on the basis of approval by the NDOH. The contribution made by SARRAH was viewed as highly valuable; especially funds and technical assistance disbursed to the Asset Management and Conditional Grants Management work-streams.

It was found that only North West province has shown improvement by obtaining clean audits during both 2009-2010 and 2010-2011 financial years. The majority of other provinces including KwaZulu-Natal, which also had its own intervention developed alongside SARRAH's intervention at NDOH level, have shown little or no improvement in their PFM. More importantly, both the Northern Cape and Eastern Cape provinces continue to be the worst performers in their PFM practices during the entire period under review (i.e., from 2004-05 until 2010-2011).

High vacancy rates in provinces, especially posts that require financial skills was identified as one of the most worrying issues, since programmes that are put in place cannot be implemented without suitably qualified and skilled officials.

1.4.1 Relevance

PFM is a critical national issue. Therefore, there is no doubt about the significance of the successful implementation of the whole intervention as was originally planned.

1.4.2 Effectiveness

Despite the initial diagnosis of the PFM problems faced by the seven provinces where the programme was meant to be implemented, training of relevant staff using the proposed curriculum never occurred. Therefore, it is not surprising that in general there has been mainly little improvement in the performance on PFM by the seven provinces that were part of the project except for North West.

1.4.3 Efficiency

Efficiency could not be established. However, this may partly reflect the fact that the reports by the consultants were never shared with HSLP in order for them to push on with implementing the training phase of the project.

1.4.4 Sustainability

There is potential sustainability of the programme as the Minister of Health's budget speech in 2012 was partly based on diagnostic work that was done under this work-stream.

1.5 Conclusions

SARRAH was able to respond quickly to the DGs request for support towards assessing the provinces' PFM systems, putting in place a remedial programme to address challenges and gaps and also develop and implement the curriculum to upscale skills of financial managers in the provinces.

The strength and scale of the few improvements may be too early to evaluate as it would take a while for impact to be felt given the government processes and procedures for programme implementation.

1.6 Recommendations

It is unlikely that attribution on the successes can be made directly to SARRAH since SARRAH inputs may only be a small contribution to a more planned and sustainable effort to improve PFM by provincial health departments. Nevertheless, this project must be completed at all costs as PFM is very crucial if the implementation of the new national health insurance plan by 2025 will be successful. Similarly, support should continue towards the national and provincial levels, with the DG and CFO whose authority and influence cannot be underestimated.

The curriculum should be revived and implemented as planned. Mechanisms for monitoring progress should be put in place with the support of SARRAH, but implemented together with the NDOH, NT and provinces.

Technical assistance that was provided by SARRAH came to an end in 2012. New SARRAH support should consider providing technical assistance and support towards recruiting suitably qualified individuals to occupy vacant posts. However, employment of these individuals should remain NDOH's responsibility.

Issues of sustainability in NDOH must be addressed to ensure continuity of improvement of PFM if it has to be ready for full implementation of NHI.

Annex 9

Human Resources for Health Strategy

Coffey International Development
April 2014

Summary Report – Human Resources for Health Strategy

1.1 Background

South Africa like many other developing countries is facing a huge Human Resource for Health (HRH) crisis, mainly characterised by limited numbers in a poorly performing and de-motivated workforce. In response to this, the South Africa government decided to develop a Human Resources (HR) strategy that would guide response to the crisis. In this vein, this activity aimed to provide the National Department of Health (NDOH) with a draft national HR strategy for the health sector which will be used to align national health workforce interventions to the objectives of the NDOH annual performance plan and Medium Term Expenditure Framework (MTEF) priorities.

1.2 Overview of work-stream

The funding for this activity from DFID was for the provision of technical support to the NDOH to facilitate the development of the HR strategy. This support was offered by a consultant who was placed at the NDOH and had the sole responsibility of developing the HR strategy. The other key players with the development of the HR strategy were; the Director General (DG) of NDOH who was the main driver of the process, Cluster managers HRH at the NDOH usually transmitted the DG's requirement in relation to HRH, HLSP managed the deadlines and outputs.

Overall the 'South Africa's Revitalised Response to AIDS and Health' (SARRAH) Programme's support for human resource strengthening was mainly planned under four key activities;

5   Development of a draft HR strategy;

6   Development of an attraction and retention strategy;

7   Development of HR norms and standards for Primary Health care (PHC); and

8   Other Occupation Specific Dispensation (OSD) analysis and refinement.

According to SARRAH reports the main activities that were specifically under the HRH strategy were;

- Presentation of the draft audit of existing HR policies and research at NDOH;

- Submission of the draft HR strategy;

- Discussion document for consultation;

- Completion of the consultations; and

- Presentations and submission of the final draft HR strategy

1.3 Evaluation method

The evaluation plan for the HR strategy was based on the objectives and agreement of the set activities towards the development of the strategy. In order to ensure that a rigorous evaluation was conducted, the evaluation of the development of the HR strategy was guided by combining information from the; the logical framework developed by HLSP, the Theory of Change (TOC) and the evaluation methodology for SARRAH developed by Coffey. Areas of interest include; establishment of achievements against milestones, relevance, effectiveness and efficiency.

The research questions that guided the evaluation for the HR strategy work stream were mainly related to processes and impact.

Process questions were:

- To what extent has SARRAH contributed to the development of an HR Strategy

- How effective was this contribution?

Impact questions were:

- To what extent has the National HRH strategy been implemented?

- What impact has this had on the South African health system?

- How much did SARRAH contribute to this outcome?

- Where there any negative, or unintended, consequences?

Research methodology (and data collection strategy)

The study deployed a case study method using the "development of the HR Strategy" as the case. The specific methods were:

- Document review including the review of the strategy itself as well as other HRH related publications.

- Follow up In-depth interviews with key stakeholders (key informants) to gain an in-depth understanding of how the HR strategy was developed, ascertain any immediate outcomes and impact as a result of the strategy.

1.4 Findings

The findings were as follows:

1.4.1 Relevance

New service needs and accompanying initiatives in South Africa such as the National Health Insurance (NHI) and its accompanying reforms requires supportive and viable HRH. Evidence showed that existing HR policies fell behind the new initiatives such as NHI and PHC re-engineering. In order to support these initiatives it was necessary to update and develop a new HRH policy in line with the reforms.

1.4.2 Effectiveness

The development of the HRH strategy was accomplished in time and all its related objectives were met. These objectives included; presentation of the draft audit of existing HR policies and research at NDOH; submission of the draft HR strategy; discussion document for consultation; completion of the consultations; presentations and submission of the final Draft HR Strategy.

1.4.3 Efficiency

Using the SARRAH's Value for Money (VFM) approach coupled with evidence generated through the document review and interviews, it can be stated that the overall approach to development of the HR strategy was efficient. This judgement is based on the fact that the overall work-stream was delivered on time as per plans. It also addresses a key area of concern thus making the HR strategy a good investment that would benefit the NDOH in several years to come.

1.4.4 Impact

It is quite early to state if the HR strategy has had any impact with HR strengthening in South Africa. However evidence from the evaluation points several areas of immediate outcomes following the release of the HR strategy. These areas have mainly concentrated on increasing the outputs of health workers , improving recruitments and addressing nursing issues , a cadre desperately in need.

1.4.5 Sustainability

Sustainability in the case of the HR strategy is ensuring that it is translated into practical plans for implementation. This was not evident as there exist no operational plans nor budget and selection of activities from the plan have been on ad-hoc basis. The other threat is the lack of manpower to carry the HR strategy forward under the NDOH; currently the main driver is the minister himself.

1.5 Conclusions

This evaluation concludes that the development of the HR strategy work stream under SARRAH was successfully achieved. Despite a few criticisms in terms of its effectiveness and efficiency, the HR strategy is a very relevant document at the time when key policies such as NHI and PHC re-engineering are being implemented. There is also strong evidence that point out to immediate outcomes emanating from the HR strategy such as efforts towards expansion of the HRH, improved funding, improved employment and tackling of nursing shortages. However, it is evident that the implementation of the HR strategy is not guided by a clear implementation plan but rather an ad-hoc and spontaneous approach. The supporting activities that were set forth in the first place in connection with the development of the HR strategy have also lagged behind.

1.6 Recommendations

Moving forward in order to realise the input of the HR strategy there is a need for NDOH to develop a detailed and concrete human resource development plan. This needs, inter alia, the identification of capacity within the departments of health, training and research institutions and Non-Governmental Organisations (NGOs) to be drawn upon, and quantification of new resources in order to address the current and impending health human resource crisis, which, if unresolved, will render all the reforms meaningless.

Annex 10

Restructuring of the National Department of Health

Coffey International Development
April 2014

Summary Report – Restructuring of the National Department of Health

1.1 Background

The SARRAH programme was initiated at a time when the South African health system was emerging from a period of controversial management, particularly with regard to HIV and AIDS. Leadership changes which followed the recall of president Mbeki, in 2008, created an opportunity for donors to work on health matters with the South African government with renewed vigour and SARRAH was designed to make the most of this opportunity. At this time it became apparent that the organisational structure of the National Department of Health did not reflect the needs of the countries health priorities and therefore a programme of organisational redesign was undertaken. The restructuring aimed to improve decision-making for better service delivery. Importantly, several health sector initiatives depend on a revised and strengthened NDOH for their effective implementation. These include: the NDOH Ten Point Plan, the Negotiated Service Delivery Agreement (NSDA), the Annual Performance Plan and many aspects of National Health Insurance implementation.

1.2 Overview of work-stream

Most of the activities under this workstream were contracted out to McKinsey & Company, Johannesburg, a management consulting firm with a strong track record in organisational development, selected by the NDOH. The aim was to create a structure that is aligned with its functions, so as to achieve the outputs of the Negotiated Service Delivery Agreement (NSDA).

- Activities and key events under the NDOH restructuring comprise the following:
- Redesign of the organisational structure of the NDOH (from Deputy Director General to Director level);
- Approval of the new structure by the Department for Public Service and Administration;
- Acceptance of proposed changes by relevant unions;
- Recruitment of staff for new posts (or internal transfers to fill such posts); and
- Implementation of the broader restructuring all levels by those appointed.

1.3 Evaluation method

The hypothesis for this workstream is that organisational redesign of the NDOH was necessary to improve decision-making and service delivery. The mixed-method approach was used to distil information from numerous sources into formats suitable for analysis. Document review and analysis was used to determine the rationale for the work being undertaken, the proposed activities and intermediate and final outcomes. Because much of the documentation related to the restructuring of the NDOH is confidential, the evaluation relied on interviews with senior officials involved in its implementation. Key informants comprised those who are involved in the restructuring processes including senior staff in NDOH and the consulting firm providing support to the department.

The evaluation faced several research challenges. The restructuring in the NDOH is a long term project and most of the input by SARRAH took place early in the process. In addition, the work was contracted out to a consulting firm with little further involvement of the service provider (HLSP). By the end of 2012 not all of the new positions had been filled which meant that the restructuring was still incomplete and that the evaluation was therefore limited. However, the NDOH representatives pointed out that major restructuring inevitably takes time and the process is moving ahead steadily. It is anticipated that there will be greater opportunities for evaluation in the next phase, i.e. 2014/15.

1.4 Findings

Restructuring began from the top, with Deputy Directors General (DDG) and Chief Directors' positions being the first to undergo review. The rationale was for the NDOH structure 'to be aligned to the four priority outputs of the Negotiated Service Delivery Agreement and to improve its oversight function across the health system.' There was extensive consultation throughout with open forums, workshops and idea sharing. It was made clear to staff that a radical restructuring was under way, in order to meet the demands of the NSDA, and that nobody's job was guaranteed. Despite the inevitable anxiety that such initiatives create, the impression from talking to stakeholders was that staff felt change was long overdue and that it was 'a very broken system' in terms of organisational effectiveness and performance. Senior portfolios were not aligned with purpose and there were legacy issues resulting in the wrong skills being present.

10.4.1 Relevance

New service needs arose from NHI, PHC re-engineering, the School Health Programme and a ward-based PHC model. The NDOH redesign is extremely relevant in order to address the current shortcomings of human resources for health and their management.

10.4.2 Effectiveness

The NDOH appears to be satisfied with the project and the initial realignment of responsibilities has been achieved. However, there is much work still to be done and the decision-making structure remains 'quite opaque and centralised'.

10.4.3 Efficiency

There are concerns about providing support for the impact of the national organisational reconfiguration on provincial health departments and on health sector organisations at district and local level. Performance management has improved and become more objective and is now aligned with government handbooks and policies. There is a sense that organisational effectiveness has improved (albeit from a very low starting point) but this has not yet been objectively measured.

10.4.4 Impact

A Staff Circular in November 2011 confirmed that the new organisational structure, developed with the assistance of SARRAH consultants, had been approved by the Department of Public Service and Administration. The evaluation team was informed that the organogram should be fully populated down to Chief Director level by March 2013. Change management teams are in place and the Director level design has been completed although this has not yet been approved by the DPSA.

10.4.5 Sustainability

Overall, there appears to be little risk that the interventions will not be followed through since the changes have been approved by DPSA. Treasury has asked for budgets to be trimmed but given the government's commitment to implementing National Health Insurance it seems unlikely that NDOH will face major or unexpected cuts.

1.5 Conclusions

The NDOH restructuring appears to be progressing according to plan, although the process is a long one, and the new organogram appears to be well aligned to the requirements of the NSDA. There appears to be improved decision making within the department, according to stakeholders, and a sense of improved morale. Assuming the necessary human resources can be found and posts filled at all levels, the new structure should strengthen NSDA Output 4: Strengthening health system effectiveness.

1.6 Recommendations

- One of the main challenges with this workstream was the high level of confidentiality imposed on the material produced, which led to HLSP and the evaluation team being largely excluded from the process once the contractor was appointed. This phenomenon applies to several aspects of the SARRAH programme and the lack of access to information remains a challenge for both the service provider and evaluators. DFID should negotiate more access to information even if this requires confidentiality agreements to be signed. At the very least, NDOH should release 'desensitised summary reports', but it

would be preferable, and almost certainly beneficial to NDOH, if the service provider and evaluation team were taken into the confidence of NDOH.

- Further evaluation of this workstream will need to be undertaken during 2013 and again in 2014/15 to assess progress with the reorganisation and the impacts of the intervention.

Annex 11

National Health Insurance

Summary Report – National Health Insurance

1.1 Background

The South African government's planning for National Health Insurance (NHI) has been in progress for several years with inputs to its design from many local and international experts. A Green Paper on NHI was released for public comment in August 2011. The scheme aims to achieve equitable access to quality health care, free at the point of use, for all South Africans. NHI is a very ambitious undertaking which is estimated to need 14 years to be implemented.

Quality of healthcare under NHI depends on three mechanisms:

- Improving the quality of health services in the public sector through a massive investment in health infrastructure;
- Ensuring adherence to basic core standards in every health institution; and
- Overhauling the management of the healthcare system.

The SARRAH NHI workstream is primarily focused on the first of these activities, although the work it is closely related to the Quality Assurance workstream (Office of Health Standards Compliance) and the overall redesign of the National Department of Health.

In March 2012, the Minister of Health, announced the so-called Pilot Districts where the NHI concept would be developed and tested. The Pilot Districts were selected from some of the most deprived parts of the country and the Minister emphasised that they are intended "to lay the building blocks for NHI" and … "meant to strengthen the functioning of the district health system." The SARRAH NHI workstream has provided significant support to this piloting process.

1.2 Overview of work-stream

Direct support to the NHI process has included:

- Research into technical aspects of NHI including a wide range of international experiences in implementing national health schemes;
- Technical support for the development of district service packages ;
- Logistical support for the Minister's Advisory Committee on NHI;
- A communications strategy for the NHI process;
- Support for the Task Team working on the development of District Clinical Specialist Teams;
- Support for the Ward Based Outreach Teams;
- Support to the Programme Management Unit in the NDOH;
- Support for the selection of the NHI pilot districts; and
- Support for Facility Improvement Teams, which are preparing the districts for NHI.

1.3 Evaluation method

The evaluation so far has focused mainly on process evaluation. Specifically this included an assessment of what activities were undertaken by SARRAH to help prepare for the implementation of NHI and how effective this contribution has been.

The mixed-method approach was used to distil information from numerous sources into formats suitable for decision-making. Document reviews and analysis were used to determine the rationale for the work being undertaken, the proposed activities and intermediate and final outcomes. Initially the evaluation team mainly consulted those directly involved in implementation of NHI programme to identify relevant documents and

secondary data sources. As the implementation of NHI proceeds the evaluation team will draw on material produced by independent researchers at universities, research councils, etc.

A particular challenge with the evaluation has been the highly politicised nature of the NHI programme and access to information has been quite restricted. Detailed progress reports were not available at the time of the evaluation and much had to be derived from interviews or press releases and presentations at conferences and workshops. However, as NHI gains momentum, there is evidence of a commitment to providing progress reports as evidenced by the NDOH's report National Health Insurance: The first 18 months, which was released shortly after this evaluation.

1.4 Findings

SARRAH has played a significant role in helping to do the groundwork for implementation of NHI. This comprised high level technical assistance both in the form of consultants who have prepared background reports and specialists who have been seconded to work within the NDOH.

1.4.1 Relevance

The SARRAH NHI work is part of numerous activities in support of the National 10-point Plan. It has been suggested that having a specific NHI workstream may be inappropriate since NHI is a cross-cutting activity. However, because NHI is such a key programme in the government's agenda, maintaining a high profile for this activity is probably advisable and there is little doubt about the relevance of NHI support by SARRAH.

1.4.2 Effectiveness

SARRAH provided technical support at several levels and contributed important groundwork necessary for decisions to be taken by NDOH about the selection of NHI pilot sites and the activities to be undertaken there. They also provided the crucial stakeholder analysis and commissioned the communication strategy and web site necessary to secure buy-in from these stakeholders. SARRAH's 2010 Annual Report argues that this communication strategy was instrumental in producing a more balanced view of NHI in the mass media which, prior to this, had been largely negative.

1.4.3 Efficiency

SARRAH's contributions to NHI implementation are taking place at many levels and are laying the foundations for a complex system. Strengthening the public health sector is the first step and the Minister wants the private sector to help; so far buy-in by the private sector appears to be positive, although responses have varied between provinces. The groundwork being done by SARRAH and others is providing a substantial body of evidence that should contribute to more appropriate decisions.

1.4.4 Impact

It is difficult to judge conclusively whether South Africa is in a better position to implement NHI as a result of SARRAH but the work has filled some critical gaps. Top level consultants appear to have moved processes forward which otherwise were moving very slowly or might not have taken place at all. This catalytic nature of the SARRAH programme is likely to produce large impacts over time. There is a slightly haphazard sense about the diverse range of activities called for in this workstream but it is the responsiveness of the SARRAH programme to the changing requirements of the evolving NHI programme that is one of its strengths.

1.4.5 Sustainability

The NHI initiative has included consultation between national and provincial health departments, public and private health service providers, including General Practitioners, and Community-Based Organisations, which should potentially increase buy-in and sustainability. The majority of politicians are supportive of NHI and universal access to health care is widely accepted as a public good around the world.

In the opinion of one of the senior informants there are still not have enough people to run NHI. There are on-going 'turf wars' involving National and Provincial Departments of Health because health services are currently a provincial responsibility and NDOH is seen by some as taking over this function through NHI. Ultimately, NHI is still controlled by Treasury which funds NDOH, which in turn funds the provincial health departments. Thus a key component of successful implementation relies on 'convincing' Treasury of the economic merits and feasibility of the intervention.

1.5 Conclusions

At the beginning of the NHI initiative there were many unanswered questions but SARRAH has been able to undertake a diverse range of activities which appear to be filling critical gaps in knowledge. It is the responsiveness of the SARRAH programme to the changing requirements of the evolving NHI programme that is regarded as one of its strengths. Time will tell how many of the interventions are eventually incorporated into NHI but most, if not all of them, will contribute to improving the South African health system.

1.6 Recommendations

The on-going work in the pilot districts should be closely monitored and more in depth evaluation undertaken as the work proceeds. For example, interventions such as the work done by Facility Improvement Teams should be monitored to determine its sustainability once the teams withdraw.

As reforms cease to be novel and become routine there will be a need for careful change management to ensure sustainability.

Whilst the strong political commitment to NHI is a potential opportunity for exceptionally rapid change, systems should be put in place to ensure that suitable baseline information is collected so that thorough evaluation is possible.

Annex 12

National Health Information Repository and Data Warehouse

Summary Report – National Health Information Repository and Data Warehouse

1.1 Background

Output four of the Negotiated Service Delivery Agreement for Health (NSDA) addresses 'Strengthening Health System Effectiveness' and, within this, the inadequacy of current health information systems was highlighted. The existing systems were unable to satisfactorily produce data and information for management, monitoring and evaluation of the health system. The NSDA therefore identified the need for an overarching technology policy framework and supporting regulations to guide the processes of Information Communication Technology (ICT) procurement and management; track the health status of the population and produce data on disease profiles using reliable information management and systems. From this system would flow defined norms and roles for the provincial, district and local levels and which would culminate in a strengthened District Health Information System (DHIS).

1.2 Overview of work-stream

As a contribution to this health information system, SARRAH is supporting the development of the National Health Information Repository and Data Warehouse (NHIRD) which, according to the National Health Insurance (NHI) Green Paper, will contain 'up-to-date information on all aspects of health and health systems in South Africa'. NHIRD comprises a giant data warehouse and user interface containing not only health information but also social and economic data. SARRAH engaged HISP-SA, the developers of the current DHIS), to provide the necessary technical support for setting up NHIRD. SARRAH funded all of the technical support during the first phase, including two HISP-SA staff seconded to the department, while NDOH provided the hardware.

1.3 Evaluation method

Initial meetings with HSLP were used to identify relevant documents and secondary data sources and to develop a list of potential stakeholders to interview. Documents relating to information systems produced by the Government of South Africa, SARRAH, donors, and the service provider were reviewed. The main purpose of the desk review was to gain insight into the intended infrastructure, the process and outputs to date. The desktop review also further informed the semi-structured interviews that were conducted during the evaluation.

The data contained within NHIRD is regarded as highly sensitive and only limited information was made available to the evaluation team. This meant that interviews during the first round had to be restricted to head office staff. Clearly the users of NHIRD, both at national and provincial levels, are best placed to judge the usefulness of NHIRD, and we hope to include end-users in later stages of the evaluation.

1.4 Findings

By August 2011 the DHIS data, StatsSA socio-economic data and financial data from the NDOH, had been loaded on to the new system. The system was formally launched by the Minister of Health and its potential demonstrated to stakeholders from the national and provincial health departments as well as the media. Provincial roll-out of NHIRD commenced in February 2012.

Unlike the original concept, which identified a physical space within NDOH (Civitas) where users would access data, the system quickly evolved to a web-based system, which means that it can be accessed from any computer with internet access. The purpose of NHIRD was described as being to 'convert data into actionable knowledge to lead to better decision making'.

An important aspect of NHIRD's modus operandi is that the quality of data being supplied to the system remains the responsibility of other entities. Essentially, this means that data which has been 'signed off' by the relevant manager is accepted at face value with no further data checking or cleaning. Given the scale of the operation and the concerns about data availability and quality within the national and provincial departments of health, this has to be a cause for concern. However, in mitigation, the system apparently offers a user-friendly graphical interface

which allows those using the data to produce summary tables, graphs and reports which should allow data discrepancies and outliers to become more apparent.

A feature of the evolving NHIRD appears be responsiveness to user demands. Thus, whatever managers asked for was added to the system where possible. Users can also prepare a 'custom dashboard' for their specific requirements, i.e. National, Provincial, District or Facility level. Overall the system was said to be providing analysis within hours that previously took months.

1.4.1 Relevance

The activities supporting the development of NHIRD are in line with the information requirements prioritised as part of the Ten Point Plan and it will also facilitate monitoring and evaluation of the National Strategic Plan for HIV & AIDS and STIs, and the implementation of NHI.

1.4.2 Effectiveness

There were some problems in execution because the system differed substantially from what was originally envisaged (it is more comprehensive) and this has meant that the set milestones did not match up with what actually took place. Currently the system is only available to authorised (i.e. trained) department of health managers, heads of provincial health departments and their planners; there is no intention at this stage to allow direct access to the system by outside users.

1.4.3 Efficiency

The extent to which routine reports are being generated using data from NHIRD or how often users are able to access data was difficult to assess, given the sensitivity of the data. The challenge of integrating data from various sources is a notoriously difficult but NHIRD staff were confident that it was being successfully resolved.

1.4.4 Impact

In the absence of copies of any reports generated by NHIRD or using NHIRD data, impact could not be assessed.

1.4.5 Sustainability

The Minister has demonstrated an explicit interest in the functionality of NHIRD and there have been a number of successful demonstrations to other government departments and to the Presidency. This suggests high level support which is likely to help ensure sustainability. In the short term, NHIRD is dependent on seconded staff provided by SARRAH and their replacement by permanent NDOH staff will be necessary to ensure sustainability.

1.5 Conclusions

According to respondents, the scale and pace of NHIRD development exceeded expectations. However, the restricted access to information by the evaluation team has made formal verification almost impossible. Measures have been put in place to address this during the next round of the evaluation. Data quality is likely to remain challenging throughout the health system and if this is not adequately addressed the analysis provided by NHIRD will be compromised. It is to be hoped that as the system becomes better established there will be greater confidence in the data and more openness to evaluation.

1.6 Recommendations

The evaluation team recommends a more substantial evaluation of the NHIRD data management, utilisation and ICT systems in the 2014/15 evaluation cycle.

Annex 13

Preventing Mother-to-Child Transmission of HIV

Summary Report – Preventing Mother-to-Child Transmission of HIV

1.1 Background

Until recently 300,000 South African babies were being born exposed to HIV every year. An effective programme premised on multidrug therapy to unborn infants and their mothers has the capacity to prevent mother-to-child transmission of HIV (PMTCT) and to reduce transmission to less than 5%, thereby saving 37,200 new-born babies' lives each year. From May 2009 until June 2011, the National Department of Health (NDOH) implemented a pilot PMTCT Accelerated Plan ('A-Plan') through their existing partnerships with Development Partners, funded by and in collaboration with Department of International Development (DFID). The A-Plan was a "rapid health systems intervention to improve mother-to child transmission outcomes". The desired impact was to reduce vertical transmission to less than 5%.

The 'South Africa's Revitalised Response to AIDS and Health (SARRAH)' Programme PMTCT A-Plan project activities were to: assist with national coordination of partners in selected priority districts; advocating for the implementation of the National Accelerated Plan; mobilising additional partners and resources; monitoring and reporting on implementation and progress; and lastly ensuring sufficient capacity for scale up of the A-Plan. Eighteen priority districts were identified as beneficiaries of the A-Plan, which was rolled out in 161 facilities in the first 6 months, in six of the 18 priority districts as part of Phase 1. During Phase 2, the plan was implemented in all facilities in the 18 priority districts over 18 months. Thereafter, the lessons learnt and experience gathered through the A-Plan process was used to scale up PMTCT across the country.

1.2 Overview of work-stream

The A-Plan was aimed at increasing the demand for (through a social and community mobilisation strategy) and supply of quality PMTCT services within PMTCT and MCWH (Maternal, Child and Women's Health) services (by means of quality improvement of PMTCT services management). A steering committee/ project management team was assembled at the NDOH. It was made up of Provincial and District Health officials, DFID and other Development Partners, and SANAC representatives. It was led by the National Ministry of Health. Awareness was raised amongst steering committee members and all provincial partners about the abovementioned activities and the plans of the PMTCT A-Plan through workshops, meetings and quarterly reports. Provincial oversight of the priority districts developed provincial plans that were aligned to the A-Plan.

1.3 Evaluation method

The overall project was evaluated using an overarching Theory of Change (TOC) framework, developed during the SARRAH evaluation inception phase. Part of the process of the evaluation involved mapping outcomes of the SARRAH programme with "the various causal linkages between the work streams, logframe outputs, outcomes and impacts". The evaluation of the PMTCT work-stream was located under Logframe Output 2 (Strengthened leadership and accountability by the national response to HIV and AIDS). The main assumption guiding the evaluation activities of the PMTCT work-stream is that by: coordinating PMTCT activities; advocating for the PMTCT plan to be implemented nationally and monitoring its implementation, SARRAH would strengthen leadership in this aspect of the national response to HIV/AIDS, and make it more accountable. During this phase of the evaluation only intermediate outcome indicators have been reported on.

Indicators of change in the PMTCT work-stream:

- Alliance and partnerships between PMTCT actors are strong and operating effectively
- Various stakeholders are increasingly coordinated towards common goals in PMTCT
- Decreased in rate of Mother-to-Child Transmission (MTCT)
- Increased utilisation rate of primary health care facilities
- Increase in rate of antenatal visits made before 20 weeks

- Increase in utilisation rate (visits) by children under 5 years (annualised)

Research methods involving both qualitative and quantitative techniques were triangulated. This involved conducting key informant interviews with various PMTCT actors in national and provincial departments of health and non-governmental organisations (NGOs), as well as conducting archival research based on technical reports and research reports. To evaluate the effect of SARRAH a comparative analysis was also used. NDOH data on the PMTCT programme from the District Health Information System (DHIS), other technical reports and research reports based on the 2008 Human Sciences Research Council's (HSRC's) population-based HIV household survey were employed for this purpose.

1.4 Findings

1.4.1 Effectiveness

Overall, there was a very favourable perception by national, provincial and district officials as well as other PMTCT partners concerning the SARRAH programme and its perceived intermediate outcomes. Although the programme was only scaled up nationally from July 2011, there was already overwhelming evidence of the PMTCT's impact as MTCT nationally has already decreased to less than 5% according to District Health Information Service information.

1.4.2 Efficiency

Partners felt that HLSP provided significant support to the Department of Health in the leadership, management and coordination of the A-Plan, to the extent that alliances and partnerships between PMTCT actors are still strong, operating effectively and increasingly coordinated (even though the pilot study was completed nearly 2 years ago). As a result of this coordination, most of the strategic objectives of the A-Plan were achieved.

1.4.3 Impact

This aspect of the evaluation will only be undertaken in 2014/15 to allow for more time for the intervention to be implemented.

1.4.4 Sustainability

A few respondents expressed concern about the sustainability of the A-Plan, however, the NDOH in partnership with HLSP secured funding to continue with the work that the A-Plan has begun, namely to implement the Action Framework.

1.5 Conclusions

The SARRAH PMTCT initiatives were timeous in the preparation of the national Department of Health's Plan to roll out PMTCT services across the country. There is consensus from this review process that this work-stream played a key role in the coordination of various players (both developmental and state) in the PMTCT space, not only within the priority districts, but across the country. As a result of this intervention there have been important lessons learnt through the quality improvement process. Also the approach adopted by SARRAH has had far reaching benefits to the entrenchment of a coordinated approach to on-going PMTCT programme implementation. The results of these efforts can be seen clearly in the dramatic reduction of mother-to-child transmission across the country which makes zero vertical transmission an imminent possibility.

1.6 Recommendations

Part of the initial mandate of the SARRAH PMTCT work-stream was to mobilise additional resources towards achieving the objectives of the Accelerated Plan. While Global Fund funding has been secured to continue the work begun by the A-Plan, it is only recently that lifelong Antiretroviral Therapy (ART) to mothers was offered. As such integration of services for infants, mothers and their families remains a challenge that creates barriers to care. It is recommended that DFID continue to support the work of the NDOH in implementing best practices towards the

realisation of quality, integrated Maternal, Child and Women's Health services. South Africa has provided both PMTCT Options A and B. This has enabled women with a CD4[118] count <350 cells/ mm^3 to access antiretroviral therapy to prevent vertical transmission and enjoy the consequent benefits to their health. Option B+ would mean offering triple antiretroviral therapy to all mothers diagnosed HIV positive irrespective of their CD4 count. This would be a lifelong antiretroviral regimen to which the mother would need to adhere, however, infants would continue on AZT or NVP (nevirapine) until 4-6 weeks regardless of the infant feeding method. Option B+ offers a number of advantages, namely: simpler treatment algorithms which are more in sync with ART programmes; protection against vertical transmission in future pregnancies; protection against sexual transmission to serodiscordant couples and on-going treatment as opposed to the cycle of treatment initiation and termination post-partum. WHO notes that options A and B are "equally efficacious" if implemented appropriately, although they are programmatically different. The key to implementation of Option B+ is at the service delivery interface. DFID should consider supporting opportunities to investigate the feasibility and impact of this intervention. This will entail understanding the operational (e.g. drug safety monitoring, drug supply chain, organisation of services), patient centred (adherence and patient retention) and costing issues in various settings (e.g. urban and rural) around the implementation of Option B+ with a focus on integration of care and streamlined service delivery.

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[118] i.e. Cluster of Differentiation (CD4) count used to track progress of HIV infection

Annex 14

National Quality Assurance and Assisting the Establishment of the Office of Health Standards Compliance

Summary Report – National Quality Assurance and Assisting the Establishment of the Office of Health Standards Compliance

1.1 Background

In preparation for the implementation of National Health Insurance, the National Department of Health (NDOH) has developed a set of National Core Standards (NCS) for health establishments. The aim of the standards is to set 'the benchmark of quality care against which delivery of services can be monitored.' The standards will be used to identify deficiencies in facilities that do not comply and to use quality improvement methods to assist facilities to meet the standards. A national process of certification, managed by the Office of Health Standards Compliance (OHSC), will formally assess each health facility for compliance against these standards and compliance will be a prerequisite for facilities wishing to participate in the National Health Insurance system.

The development process of the National Core Standards was started in 2008 through a participative consultation process. A number of drafts have been produced and the development process is on-going. SARRAH has made various contributions during this process. The standards have been approved by Cabinet and are being implemented nationally in both the public and private sector. Training programmes to assist provinces in implementing the standards have been developed, with SARRAH support. Chapter 10 of the National Health Act, which refers to the establishment of an independent OHSC, was amended and is now called the National Health Amendment Act, No 12 of 2013 and signed into law on 24 July 2013. The OHSC will be an organ of state funded by appropriations from Parliament and fees for services rendered. It will manage complaints and facilitate compliance by healthcare providers, health establishments, facilities and health workers, with the NCS. This office will then certify health establishments that comply.

1.2 Overview of work-stream

Based on international evidence, health standards and compliance requirements, coupled with an independent and powerful oversight authority can have significant impacts on the quality of healthcare. Direct support by the Quality Assurance workstream has included technical support to designing the NCS and developing the OHSC.

The evaluation is based on the hypothesis that the establishment of NCS and an OHSC will:

- introduce an independent and transparent performance monitoring and evaluation system for health facilities based on internationally comparable and transparent standards; and

- Create an independent regulator which will assess compliance with the NCS and provide information that will contribute to NDOH management of compliance by health facilities and strategic planning of resources.

1.3 Evaluation method

The mixed-method approach was used to distil information from various sources into formats suitable for decision-making. Document reviews and analysis were used to determine the rationale for the work being undertaken, the proposed activities and intermediate and anticipated final outcomes. Key informant interviews were conducted with people involved in the quality assurance workstream, the OHSC and independent QA specialists. The interviews were used to assess the nature of the programme's design and implementation.

For the initial evaluation of the NCS, internationally accredited tools developed by the International Society for Quality in Health Care (ISQua) were used. It was understood that there was no intention, at the time of the evaluation, to seek international accreditation for the locally developed standards but the ISQua tools have been widely tested in many countries and offered a means for 'benchmarking' the NCS against agreed international norms and standards.

1.4 Findings

1.4.1 National Core Standards

By providing high calibre technical assistance to the NDOH SARRAH was instrumental in helping to finalise the standards drafted in 2008. SARRAH's support provided an 'enabling environment' and assisted with developing, refining and piloting the NCS and tools for compliance, and progressive development of the policy framework of the independent quality regulator. SARRAH helped to take forward the products of a Working Group set up in 2009, involving seven different organisations, and the revised standards were piloted in early 2010. Subsequently, further work entailed developing and refining questionnaires, measures and a database which could produce preliminary reports for facilities conducting assessments.

There are 93 standards in the NCS grouped into seven different categories: patient rights; patient safety, clinical governance and clinical care; clinical support services; public health; leadership and corporate governance; operational management; and facilities and infrastructure. After the pilot the National Health Council expressed concern about the complexity of the standards and asked for an abridged version. This request led to what became known as the six 'fast-track priorities' which were considered critical areas for quality care, namely, cleanliness, reduced waiting times, improved patient safety, infection prevention and control, medicine availability and improved staff values and attitudes.

1.4.2 Office of Health Standards Compliance

SARRAH completed a scoping exercise of QA Regulators in other parts of the world to assess what has worked elsewhere and then assisted with drafting a concept document for the regulatory structure of a South African national standards and accreditation body. The consultant also assisted in drafting the amendments to the National Health Act to make provision for the OHSC.

When the National Health Amendment Act was released for public comment SARRAH assisted with reviewing and collating comments from 11 public hearings for the Parliamentary Portfolio Committee on Health and tabling the legislation at the National Council of Provinces. SARRAH also helped with training inspectors and facilitated a study tour to the UK Care Quality Commission.

The National Health Council receives regular reports on OHSC progress and Heads of Health and MECs agree to the programme of inspections, which are voluntary at this stage. Facility Improvement Teams, using technical assistance from SARRAH, work with staff from some of the worst performing sub-districts.

1.4.3 Relevance

Quality assurance is considered a cornerstone for health service delivery and is regarded as an essential component of the National Health Insurance system in both the public and private sectors. When the current Cluster Manager for the Office of Standards Compliance joined NDOH in 2008 there was no single set of standards but many different sets were in use; there was a critical need for a uniform set of quality standards.

1.4.4 Effectiveness

The budget and proposed organisational structure for the OHSC, prepared with SARRAH support, received a letter of endorsement to prioritise funding and support for the OHSC from the Office of the Minister of Finance.

The NCS cover the majority of areas where poor quality of care carries a high risk of patient harm but several areas addressed within the National Core Standards lack the required detail to ensure adequate implementation of the intended processes. The measurable elements of a certification programme should be reliable, understandable, measurable, beneficial and achievable but the wording of some measures does not provide a clear indication of how the measurement will be achieved or what is considered to be an adequate score.

1.4.5 Efficiency

Some of the NCS measurements are ambiguous and compliance is open to potentially wide interpretation. While the NCS represent a reasonable start (as a 'work in progress'), it appears that more use could have been made of pre-existing tools which been validated in other settings. Other instruments, such as those accredited by the International Society for Quality Assurance (ISQua), may be better at identifying deficiencies in a way that highlights where action is needed and could provide direction for improving the NCS.

1.4.6 Impact

Given that inspections to date have only been voluntary and on invitation, it is too early to assess formal compliance with NCS or certification. According to a senior representative of the Free State Department of Health, 'quick wins should not distract the focus of the Health Facility Improvement Teams from the major tasks that remain to be done.' Many of these initial quick wins appeared to focus on very basic standards such as cleanliness, maintenance and stock control and while these issues are part of the fabric of a health service, they are largely cosmetic and further evidence is required to demonstrate real improvements in more serious issues such as infection prevention and control.

1.4.7 Sustainability

There are capacity constraints affecting implementation of the NCS and OHSC and a lack of dedicated administrative or human resources support within NDOH is one of the most pressing. The business case is being taken forward by the Treasury Assistance Unit and the final version was projected to be ready by mid February 2013 but it will inevitably take some time before the initiative is fully funded. By 2014, the Public Entity should exist and some staff will be in place, but the full complement will not be in place owing to a phased approach in line with budget allocations.

1.5 Conclusions

SARRAH has played a significant role in the development and implementation of the NCS and the preparatory processes for the OHSC. Five years ago QA was only being dealt with at sub-assistant director level in NDOH but now it is now a priority and a key component of NHI. Despite initial concerns about QA creating further work, staff at facilities were said to be finding the process useful because 'it tells them what to do'. However, this positive assessment, by those in the national office, was not always endorsed by those who are grappling with the application of the standards at facility level. Other informants stated that some facilities were battling to come to terms with the NCS, lacked the necessary documentation and, if they succeeded in conducting the audits were not always sure how to go about addressing deficiencies, either financially or practically.

Despite some ambiguity identified in the NCS, a solid start appears to have been made and the standards and tools have the potential to be refined and become a suitable means for improving the quality of the South African health system.

1.6 Recommendations

- NDOH should continue to refine the NCS, particularly with regard to correcting ambiguities in the wording of indicators.

- While the 'fast track priorities' provide a focus for initial quality improvements, NDOH should not allow these quick wins to take attention away from the more difficult and systemic challenges which the comprehensive QA system seeks to address.

- Further SARRAH technical assistance may be required to help resolve the more complex and systemic problems with QA at health facilities, i.e. the 'slow wins', and for regulatory policy development.

- The evaluation team proposes further investigation of the practical application of the NCS at facilities in 2013/14 and the operation of the OHSC, once this becomes fully operational.

Annex 15

South African Health Products Regulatory Authority

Summary Report – South African Health Products Regulatory Authority

1.1 Background

South African Health Products Regulatory Authority's (SAHPRA) mandate is to manage the registration, regulation and control of all medicines and related health products such as foodstuffs, cosmetics, disinfectants, medical devices, including in vitro diagnostic tests, and African Traditional Medicine. SAHPRA is an organ of state but outside the public service. Among others, SAHPRA will address the challenge of access to quality, safe and affordable medicines by addressing the inefficiencies of the Medicines Control Council (MCC) by fast-tracking registration of medicines and reducing backlogs.

Key policies which guide the implementation of this work-stream through 'South Africa's Revitalised Response to AIDS and Health's (SARRAH)' programme are the Negotiated Service Delivery Agreement (NSDA) (Output 3) for the Health Sector, 2010-2014 and the 10-point plan. In addition, the Annual Performance Plan (APP) 2011/2012 prescribes six critical areas for patient-centred care, one of which is ensuring that basic medicines and supplies are available to patients.

The main aims for establishing SAHPRA as stated by the National Department of Health (NDOH) are:

- To bring the South African health products regulation body to par with similar bodies elsewhere, such as the United States Government's Food and Drug Administration (FDA);

- To provide stewardship, regulatory, research, advisory and service delivery functions

- To promote public confidence in the objectivity of the decision-making on medicines by the MCC

- To keep the evaluation of applications processes independent of political interference

- To decisively deal with peddlers of complementary medicines

- To regulate all products for animals and humans under one regulatory authority

The hypothesis is that an efficient SAHPRA will make essential drugs more readily available, and potentially reduce prices through increased competition and licensing of generic drugs. For SAHPRA to improve the effectiveness of health systems and their ability to provide quality health care to all it must achieve two short and medium term outcomes: increase access to critical drugs; and, decrease the cost of purchasing drugs to ensure availability of affordable drugs.

1.2 Overview of work-stream

SARRAH funding, through the Human & Life Science's Partnership (HLSP) of approximately R30 million was injected into this project in agreement with NDOH leadership and National Treasury by providing Technical Assistance (TA) in the form of a team of experts in the field of health products, regulations and legislation, placed within the NDOH in the form of advice to the Director General (DG), the Deputy Minister of Health, and the Minister of Health. In some cases, TA interacted with the Medicines Control Council (MCC) and through the MCC secretariat.

This project was intended to be implemented in 2 phases: addressing MCC backlogs (audit of backlog of MCC); and the creation and establishment of the South African Health Products Regulatory Authority. A third phase replaced phase 2 and was used to design the South African Health Products Regulatory Authority.

Expected indicators of change included:

- SAPHRA registered as a public entity

- An approved business plan for SAHPRA in place

- A proportion of SAHPRA posts filled

- Electronic Document Management System (EDMS) operational

- A proportion of the evaluation backlog addressed and momentum sustained
- Current inefficiencies reduced
- A number of new products registered per month
- A cost comparison made of old and new essential drug list
- Working relationship and effective communication between Pharmaceutical industry / SAHPRA maintained

1.3   Evaluation method

The design for the process evaluation of this work-stream took a qualitative, case study approach. Key informant interviews were conducted with HLSP, the SARRAH supported SAHPRA project manager (in this context refers to EOH Abantu (Pty) Ltd, Benguela Health Solutions consultancy team and in some cases to the technical lead, interchangeably), NDOH, Pharmaceutical Industry, and a Clinical Research Association. Relevant documents were also reviewed. Email correspondence managed to source important information from potential interviewees who could not be met physically. A major limitation was the research team not being able to interview a more senior NDOH manager at Deputy Director General (DDG) or DG level.

1.4   Findings

All phase 1 SAHPRA activities were achieved: the EDMS was implemented and training of staff was done, compliancy testing on the system was completed, licences and yearly user fees were paid. The registration backlog was reported to have been reduced by more than half after six months. Policies were updated. NDOH and HLSP were pleased with the delivery of milestones.

Phase 2 started successfully with Devices Regulations discussed with the Pharmaceutical Industry and Cabinet memo and draft "Transitional Provisions" for coming into law of Act 72 were handed to DG and Minister of Health. Due to parallel discussions between the NDOH and Labour, and the delays in putting the amendments in the Medicines and Related Substances Act of 2008 into law, the project was suspended for 4 months. Therefore, milestones relating to change management, finance, labour, human resources and IT were halted.

Phase 3 milestones achieved: work completed on the proposed new grading system according to the job evaluations and a remuneration survey already conducted to determine the appropriate remuneration levels in the proposed grading system; a package for the Minister of Health to consult with the Minister of Public service and Administration was produced; a comprehensive set of Human Resources (HR) policies and procedures was packaged into a manual for the Minister of Health to consult with the Minister of Public Service and Administration, Performance Management to facilitate the designs of different systems for the Executives, technical staff and general staff. A comprehensive business plan and report on this phase was submitted to NDOH in 2012.

Monthly reports: all monthly reports as per requirement of the contract for the TA were submitted. These included reports on Information Technology (IT), Human Resources, Labour, Statutory and Finance reports were submitted to NDOH.

1.4.1   Relevance

Time had come for a new health products regulatory authority to be established according to the Medicines and Regulatory Act of 2008 to replace the 1965 established Medicines Control Council. The new entity, SAHPRA, would continue to process registration of health products in a broader scale. Besides providing accessible, affordable and quality medicines, the government's National Health Insurance, whose success depends heavily on availability of medicines, is being piloted and planned to be fully rolled out shortly. Establishment of SAHPRA is therefore relevant, so is SARRAH's technical assistance and funding support.

1.4.2   Effectiveness

As part of the establishment of SAHPRA, a back-log under the MCC had to be fast-tracked by setting up relevant systems to allow smooth transition from MCC to SAHPRA. New chemical entities (NCEs) and generics back-logs were successfully reduced as reported by the Minister of Health and MCC secretariat. This evaluation cannot conclusively report that SARRAH was effective in the area of establishing SAPHRA, since as yet, SAHPRA as a body is still to be established.

1.4.3 Efficiency

Phases were efficiently implemented. However, SARRAH TA did not have control of legislation processes that lead to legalising a body such as SAHPRA, and therefore delays would be expected.

1.4.4 Sustainability

SAHPRA is being established in accordance with approved legislation by the South African government. It should therefore be sustainable. However, this conclusion should be considered within the context of the following factors. Firstly, two thirds of funds are expected to be generated by SAHPRA from registration fees. The rest would be expected to come from the National Treasury and NDOH. Secondly, due to inadequate expertise in South Africa, there is doubt that SAHPRA will be able to recruit full-time protocol reviewers, which may lead to inefficiencies.

1.5 Conclusions

The evaluation of milestones found that planned activities were achieved, except those that were changed with NDOH. Phase 1 therefore was a success according to NDOH, even though pharmaceutical representatives do not fully agree that backlogs have been successfully updated.

NDOH announced that SAHPRA would begin to operate in 2012, but due to delays in legislation being approved by Parliament, it was later announced that it would commence work in 2013. NDOH will be implementing the business plan submitted by the TA, once it is adopted by the Technical Task Team set up in 2012 to review it.

1.6 Recommendations

SARRAH should continue supporting NDOH both by funding the activities of SAHPRA since substantial money has already been used for other sections of work under this work-stream, and therefore completing the work of setting up the body would achieve the outcomes that were set at the beginning of this project. Recommendations include:

- Monitoring of timelines, budget and quality of work should be done by HLSP. This should also be articulated in the contracts entered into with NDOH.

- NDOH to establish an effective communication tool to provide updates on the progress of applications.

- Separate protocol reviewers and a project manager (specifically for this work) should be appointed to fast-track the backlog. The backlog was fast-tracked early on, but has slipped - now 'worse' than before.

- NDOH (relevant task team) must widely consult and engage with all stakeholders before resuming with the establishment of SAHPRA: a communication strategy through the stakeholder forum should be effectively used to update stakeholders about the progress made in addressing backlogs, and invite and openly receive input and provide feedback to enquiries and questions from NDOH. The industry and other health professionals, including other bodies and government departments are major players in supporting NDOH to achieve outcomes and propel progress towards NDOH goals. Therefore, transparent and full engagement in a systemic way is paramount to maintaining trust between government and stakeholders to encourage collaboration and foster commitment to one vision in the sector.

- NDOH (relevant task team) must review related legislation guiding the work of the Medicines Research Affairs (MRA) e.g. applications for known compounds or compounds already approved by other medicines regulatory bodies such as the FDA

- Funding from NDOH for sustaining the work of SARRAH as additional funding to the registration fees that are being recommended for SAHPRA should be committed and ring-fenced before the new regulating authority commences. Sustainability should be made one of the key criteria for SAHPRA. Particularly as SAHPRA is planned to have 400 full time personnel, almost three times more than the MCC.

- SAHPRA should start operating to address all the issues stated and intended by the legislation and regulations.

- NDOH (relevant task team) must consider and plan the implication of establishing an entity such as SAHPRA under constrained human resources environment: suitably qualified and skilled experts should be recruited. Although there are scarce skills in South Africa, training programmes such as that the SARRAH supported project manager had started to implement for application evaluators, should be put in place.

- Suitable (efficient and effective) registrars and secretariats to support SAHPRA committees should be appointed, preferably individuals with industry experience. Appointing such individuals will have positive effects on both government and the industry.

Annex 16

South African National AIDS Council

Summary Report – South African National AIDS Council

1.1 Background

Strengthening South Africa's Response to AIDS and Health (SARRAH) is a five-year programme supported by the UK Government's Department for International Development (DFID) and implemented by Human & Life Sciences Partnership (HLSP). This intervention aims to support the South African Government's commitment to health. As part of this, SARRAH has provided support to the South African National AIDS Council (SANAC), which is the body responsible for coordination of the national response to HIV and AIDS. This evaluation focuses on SARRAH's support to strengthen leadership and accountability of the national response to HIV and AIDS in South Africa.

In the past, SANAC has struggled to establish itself as the national coordinating mechanism for HIV and AIDS. Its challenges appeared to exist for multiple reasons, as identified in national documents (e.g. reviews of NSP[119]s), internal reviews and through interviews. These challenges mainly included organisational, human resources and political barriers, and have left the organisation tainted with a challenged history. While several small milestones supported by the SARRAH intervention appear to have been achieved in SANAC between 2009 and 2011, major change did not take place until 2012.

1.2 Overview of work-stream

DFID commissioned Coffey International Development (Coffey) and the Human Sciences Research Council (HSRC) to evaluate how, and if, the SARRAH funding has contributed to strengthening SANAC. This evaluation sought to identify any gaps and challenges in the implementation of this support, the result(s) of that support, and then provide actionable recommendations for the SARRAH intervention. The evaluation describes SANAC's history, its present day role in the response to HIV and how HLSP has played a part in that transformation.

1.3 Evaluation method

Three research questions guided the evaluation:

- Has SARRAH strengthened leadership of the national response to HIV and AIDS through support to SANAC?
- Has SARRAH increased the capacity of SANAC to monitor and evaluate the national response to HIV/AIDS?
- Has SANAC made the national response to HIV/AIDS more accountable?

An utilisation focus guided the overall development and implementation of the evaluation. Systems thinking approaches and the General Elimination Model were used to explore attribution. A guided technical expert review was used for the IT (Information Technology) component. Organisational development theory was used to guide the research to explain the organisational structure. Finally a human rights approach guided the ethical decisions that are part of any evaluation. In order to apply this methodology, we used several methods:

- Document analysis, which also focussed the study
- Key informant interviews
- A heuristic design - IT component only.

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[119] National Strategic Plan's

1.4   Findings

Data suggest several significant changes in SANAC in 2012. For example, SANAC's role clarification in the 2012-2016 National Strategic Plan (NSP), the appointment of people in leadership positions, a new organisational structure with a focus on provinces and districts, an approved three-year budget, and access to a bank account were all deemed to be indicators of positive change. Despite these achievements, most documents and interview data suggested that the SANAC Secretariat appeared to be "lost in its own narrative", meaning that while there has been a focus on SANAC itself, there has been little observable achievement in terms of SANAC's interaction with, and influence on, the HIV response.

For instance, the changes to the SANAC structure have left some stakeholders confused, a few frustrated at the lack of transparency about how those decisions were made, and most hopeful and supportive that SANAC is moving forward with an intent to fulfil its intended mandate. Most interview data with civil society members suggested a certain level of mistrust, uncertainty, and to some degree frustration with SANAC. Thus, while the new SANAC structure and its leadership was viewed by most as positive, SANAC's history weighs heavily on an organisation that is taking the necessary initial steps to create positive change, and at the same time has not yet shown impact on the ground.

SANAC is the official structure that is meant to coordinate civil society, government and the private sector, and ensure a multi-sectoral response to HIV. Evaluation data suggest SANAC is influenced from various sources. Some data suggest that SANAC is strongly tied to government through finance and politics (e.g. the Deputy President serves on the Trust's Board). While it is intended to advise it, many civil society interviews and a few documents further suggest that SANAC is heavily influenced by government. Other interviews suggested that SANAC is heavily influenced by the most powerful and often internationally funded Non-governmental Organisations (NGOs), and therefore it is influenced by international donors. Yet others describe SANAC as a vehicle for, and influenced by, civil society. There is probably some element of truth to each of these perspectives, firmly indicating that politics weighs heavily on SANAC and influences how all sectors perceive, interact, and respond to it. The politics of SANAC are complex. This suggests that, in order to strengthen SANAC, an intervention needs to address both the basic infrastructure of SANAC and the more complicated and complex aspects. Data indicate that the SARRAH intervention focused at the more basic, output level, and that this was a role valued for its ability to sustain the organisation and prepare it to move forward with its intended role.

Nearly all interviews, and several documents, suggested that SANAC does not bring any "bark to its bite." It is viewed by some as a body that does not have buy-in from all sectors. Nearly all respondents stated that SANAC does not, and presently is unable, to hold sectors or groups accountable for achieving results. The intricacies of addressing the coordination of both monitoring and evaluation are significant; as the health system's current system appears challenged.

It is within this context that the evaluation attempted to understand how the SARRAH intervention interacted with SANAC and the result of that interaction.

1.5   Conclusions

Most data indicated that the SARRAH programme did not support SANAC to take great leaps forward. However, SARRAH's approach resulted in flexible and responsive support to maintain SANAC in a "holding pattern", a position that interview data suggested was critical for the achievements identified in this report. Two challenges emerged when attempting to identify how SARRAH contributed to changes in SANAC. First, SARRAH appeared to play a quieter role compared to other funding partners, and many respondents found it difficult to identify SARRAH's specific contributions. A second distinct challenge to this evaluation was that many of the criticisms and experiences identified through interviews and secondary data are mostly based on the 'old' NSP, and the 'old' SANAC, prior to the 2012 changes and new leadership.

The role of SANAC, to coordinate a multi-sector task in a politically complex environment, is a challenging one. Data suggests that this context, their mandate, and the history of their organisation, places them in a position of not being fully trusted or sometimes even understood by government or civil society, a critical deterring factor for a coordinating body. With this challenge easily identified, an appropriate intervention may have been to invest heavily in relationship building activities, an area that the SARRAH project did not support.

It is within this context, and with these research challenges, that the key findings answering the three key evaluation questions emerged. First, SARRAH did contribute to SANAC so that the organisation could strengthen its leadership of the national response to HIV and AIDS, a critical role. Second, and at the same time, SARRAH does not appear to have directly increased the capacity of SANAC to monitor and evaluate the national response to HIV/AIDS, or contributed to SANAC being more accountable to the national response to HIV/AIDS. Third, it is important to recognise that there were significant achievements within SANAC, and that SARRAH is recognised as playing a quiet and useful role in that. Finally, it is too early to tell how, and if, the 'new' SANAC will be more efficient, effective, sustainable, or ultimately more accountable.

1.6   Recommendations

The evaluation makes the following recommendations for future SARRAH support to SANAC:

- Clear, measurable indicators must be developed to monitor SANAC internally and externally. Consider qualitative data collection to measure the more complex areas (e.g. relationship strengthening), and build in mandated time for reflection, reaction and redesign, led by an internal and external team. To develop measurements, consider drawing from and augmenting the information (baseline and intended results) identified both in empirical research that has already been conducted, and identified 'hot spot' areas in SANAC's civil society workshop reports and the NSP Review website.

- Specifically focus on and clarify the mandate of the Secretariat. Further, develop a strategy to support that mandate, and create measurable criteria to monitor achievement drawing on the already established baseline as described in this evaluation and the March 2009 Consequent report, and Colvin's 2011 review of the NSP.

- Invest significant resources in understanding how SANAC can support the achievement of health results through effective Monitoring & Evaluation (M&E) that works within the current systems. Also consider providing support to address the challenges within that system, and develop a strategy that acknowledges a multi-sectoral approach in a complex and dynamic context.

- Continue to draw from existing, recent, empirical data to inform decisions on how to move forward. In particular, the Colvin Review of the 2007-2011 NSP, the 2010 Consequent Report, and the Proposal for Revised Governance and Secretariat Arrangements for SANAC, Draft 24th April, 2012, and Treatment Action Campaign (TAC) reports. These documents concur in many of their recommendations and are from informed sources.

- Focus on communication and supporting infrastructure.

- Focus on continuing to build relationships. This will ensure a multi-sectoral approach to HIV and AIDS.

Annex 17

Service Transformation Plans

Summary Report – Service Transformation Plans

1.1 Background

In 2006, the National Department of Health (NDOH) asked provincial departments of health to develop Service Transformation Plans (STPs). These are long-term plans (10 years), designed to help provinces to improve service delivery by assessing provincial health needs against existing health services and budgets.

Eight provinces produced draft STPs, and the Western Cape produced a long-term plan known as a Comprehensive Service Plan (CSP). After remaining in draft form for several years, in 2009, the National Health Council asked provincial health departments to finalise their STPS, and to revise them to bring them into line with the new administration's ten-point plan for health and the National Service Delivery Agreement (NSDA).

These plans were intended to provide the necessary detail on the envisaged service delivery plan and platform, and the related components of human resources, quality improvement, drug supply and management, information and communication technologies and health information system, communication and research, and development and financing (DFID, 2011).

Department for International Development (DFID) commissioned Coffey International Development (Coffey), and the Human Sciences Research Council (HSRC) to identify any gaps and challenges in the process of finalising the STPs[120], and to evaluate how the 'South Africa's Revitalised Response to AIDS and Health' (SARRAH) Programme support has contributed to strengthening the STPs in the provinces.

1.2 Overview of work-stream

The SARRAH programme aimed to address the fact that most STPs had inadequate draft plans, and had not been finalised for several years. Provinces were required to prepare STPs to address the ten-point plan for the improvement of the health sector (2010-2014). Approved STPs are expected to improve provincial health services through (1) reviewing the nature and extent of health services in each province (2) developing optional scenarios for future improvement of health services (3) estimating budgetary needs over a ten-year planning period and (4) providing information needed to develop short and long-term health plans.

1.3 Evaluation method

The evaluation of this work-stream used qualitative methods to explore what activities contributed to strengthening STPs in terms of its effectiveness, relevance, efficiency, sustainability, and how and if gender was addressed. To a lesser extent the evaluation examined the intervention's outcomes and the potential sustainability of those outcomes.

The evaluation time frame and budget limited the approach to a desk review. The evaluation team gathered data through a structured desk review focused around the key evaluation areas. The evaluation team identified most documents through the SARRAH website, provincial department of health websites and general internet searches. We drew information mainly from three sets of documents: SARRAH annual and quarterly progress reports and project brief, the reports of the Integrated Support Team, and NDOH and provincial Department of Health (DoH) strategic plans and reports. The data were analysed through a content analysis in order to identify core themes and patterns. Data were examined to identify if they led to achieving the key milestones. Specifically the evaluation sought to identify evidence that demonstrated achievement of the first two milestones by seeking to identify if the

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[120] It should be noted that two key words: "plan", and "STP", were often referred to interchangeably in the documents, and as such it was assumed by the researchers that "plan" referred to STP.

initiatives implemented by the SARRAH project resulted in changes in budget allocation, and led to better alignment with the NSDA.

1.4   Findings

In 2010, SARRAH procured Technical Assistance Teams (TAT) to engage with the provinces. SARRAH's 2010 progress report indicates that four activities were completed. These included: a desk-based review of 9 current draft STPs; acceptance of Gauteng recommendations on the STPs; completion of the remaining 7 provincial reports; and the convening of a national review panel (SARRAH Annual Progress Report, 2010). The SARRAH progress report further indicated that after all nine provincial STPs were completed; a national review panel would be established to assess the STPs. It is unclear whether this has taken place to date. By the end of 2011, 8 of the 9 STPs had been approved by the Departments of Health, with the exception of the costing component of the Kwazulu-Natal STP.

There are no data that describe the extent to which the STPs addressed the changes recommended by the Integrated Service Teams or their alignment to the ten-point plan and ministerial Primary Health Care (PHC) priorities. Further, there is no data available that confirm implementation of the STPs. Thus it is not possible to assess how the STPs contributed to, or are in the process of contributing to, an improvement in health services at the provincial level.

SARRAH's close-out report for this work-stream (see second and third quarterly SARRAH progress reports of 2011), was delayed while waiting for action by the Kwazulu-Natal Department of Health on the finalisation of their STP. It is unclear whether the final close-out report was written, as it has not been made publicly available, and could not be assessed by the evaluation team.

1.5 Conclusions

The SARRAH programme achieved its two milestones for this work-stream; Milestone 1 set for January 2011 (7 plans completed and approved) and Milestone 2 (provincial Heads of Department (HODs) and National Health Council (NHC) agreed on and approved 9 plans) set for January 2012, have both been achieved. However, in terms of assessing the process to support the STPs development and refinement, lack of data prevents determining the effectiveness, efficiency, sustainability or how gender was addressed by SARRAH funds.

While SARRAH has completed and closed this work stream, it is unclear from SARRAH reports the extent to which STPs was implemented. The data do suggest that the involvement of SARRAH has provided the catalyst and support needed for the completion of the STPs by provinces that did not have the capacity to address the gaps in their draft STPs.

1.6 Recommendations

As the project is already completed, and there are no identified plans to continue work in this area, no project recommendations have been made.

Annex 18

The Treatment Action Campaign

Summary Report – The Treatment Action Campaign

1.1 Background

The Treatment Action Campaign (TAC) is a civil society organisation which was founded on 10 December 1998, in Cape Town, South Africa. TAC's primary role is to hold the government accountable through monitoring the implementation of policies and other strategic plans including the National Strategic Plan on HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) 2012-2016 (NSP). Issues that TAC continues to fight against include: insufficient spending on healthcare; trends toward decreased international funding for HIV and AIDS; gender-based violence; infant and maternal mortality; and other threats to human rights. TAC works closer to the communities by opening offices at district level where they are able to respond quickly to the needs of individuals, families and communities. TAC has six district offices (Khayelitsha, Lusikisiki, Mgungundlovu, Ekurhuleni, Mopani, Gert Sibande) which are based in six provinces (Western Cape, Eastern Cape, KwaZulu-Natal (KZN), Gauteng, Limpopo, Mpumalanga). TAC is well placed to track the extent to which government responds to civil society advocacy, and acts upon identified constraints to scaling up the national HIV response.

Strengthening South Africa's Response to AIDS and Health (SARRAH) is a five year programme supported by the UK Government and implemented by the Human & Life Sciences Partnership (HLSP). It aims to support the South African Government's commitment to health and includes support to TAC. For example, SARRAH supported TAC's role of holding the government accountable for delivery of an effective response to HIV/AIDS and health. SARRAH's contribution to TAC was designed to strengthen organisational capacity and included the provision of two grants to fund salaries, operations costs, meetings and newsletters. SARRAH support was also aimed at TAC's advocacy for increased access to treatment of HIV, AIDS and TB, and to prevent HIV infection and Gender Based Violence (GBV). Department for International Development (DFID) commissioned Coffey International Development and the Human Sciences Research Council (HSRC) to evaluate how the SARRAH funding has influenced TAC's functioning. This report summarises the process/mid-term evaluation which was completed in 2013. The evaluation focused on SARRAH's support to strengthen leadership and accountability of the national response to HIV and AIDS in South Africa.

1.2 Overview of work-stream

As mentioned above, monitoring and supporting the implementation of HIV guidelines and policies, and advocacy around gaps were identified as amongst TAC's main priorities. To achieve TAC's goals, unconventional approaches such as community mobilisation, highly publicised campaigns, court actions against government and individuals who contributed to stalling the provision of Antiretrovirals (ARVs) to people living with HIV are used. For example, 81,000 citizens were mobilised by TAC (through i.e. door to door campaigns, group health talks) to hold government accountable for commitments made in the NSP. Frequent publicised campaigns forced government to engage non-government bodies such as academics, media commentaries, etc. on HIV and AIDS treatment issues. TAC also engages through different platforms such as legal actions, following up on issues reported by community members and escalating them, distributing magazines and pamphlets, etc. TAC is also represented in the National and Provincial AIDS councils where important issues are discussed and then raised to either the national or provincial government. TAC also undertakes joint NSP reviews for publication and dissemination.

1.3 Evaluation method

The study design used to evaluate the TAC work-stream was qualitative in nature. Primary data were collected through semi-structured interviews with key informants who represented TAC, as well as prominent stakeholders of TAC. These included TAC partners (n=2), TAC staff from the Khayelitsha district and head office (n=5), and South African Police Services (SAPS) (n=1), and a beneficiary (n=1) to demonstrate one of TAC's case studies. A focus group discussion (FGD) was also held with six members of TAC leadership from Khayelitsha township in Cape Town. A document review including TAC quarterly and annual reports, Department of Health (DoH) and South Africa National AIDs Council (SANAC) reviews and media reports was also done.

1.4 Findings

1.4.1 Relevance

TAC is a civil society organisation with many members and large coverage across South Africa that seeks to address the needs of communities who are infected or affected by HIV and related aspects such as stigma and violence. As such, it is well placed to monitor the South African government's renewed commitment to improving health and HIV and AIDS services and in conducting district reviews to monitor progress. To bolster TAC's capacity to monitor the NSP and respond to the needs of communities, SARRAH provided funding for its basic operational costs, such as salaries, and also contributed towards its ability to launch more effective advocacy campaigns by enhancing its policy, research and communications capacity. It was also provided with management support and guidance to improve its Monitoring & Evaluation (M&E) capacity.

1.4.2 Efficiency

SARRAH's contribution to TAC helped it to streamline its monitoring and reporting functions to donors. As recently as 2010, TAC reported on 25 separate grants, each of which required substantial attention to reporting at competing times - in different formats for various funders. By 2012, SARRAH assisted TAC to consolidate funding amongst 12 donors (with three new funding contracts awaiting signature). This improved reporting efficiency allowed TAC staff to be more involved and focused on their core business of monitoring and advocacy.

TAC as an organisation is able to demonstrate efficiency through its approach to forming strategic partnerships that complement and support its activities. Interviews with partner organisations confirmed that TAC is able to deliver campaigns and share its costs with its partners, while also transferring skills. It should be noted however, that specific outcomes cannot be directly attributed to SARRAH, since the majority of the support provided was in the form of core funding.

1.4.3 Effectiveness and Sustainability

SARRAH support to TAC was strategic; particularly in the way it enabled TAC to execute ad-hoc events which required media coverage, travelling to areas that required speedy attention, as well as awareness-raising of pertinent and current issues. Although about 75% of SARRAH funding to TAC covered salaries, the remainder allowed TAC to commit to short-term support to communities that would otherwise not have achieved the attention required to address their needs. For example, TAC is often required to respond quickly to issues requiring media releases, which frequently need to be developed and submitted within 24 hours. This is a core TAC function that is difficult to perform when formal authorisation processes need to be followed to use funds. By contrast, TAC does not have to check with DFID before using SARRAH funds, as this function falls within the original purpose of the DFID agreement.

TAC as an organisation is also showing signs of increased influence. At the national level, interview data and reports indicate that TAC has played an important role in the development of South Africa's new NSP. There are also examples of various campaigns organised by TAC which targeted national government shortcomings, such as the lack of new initiatives for patients requiring treatment, and further interruptions to the treatment supplies of patients already on ARVs (South African HIV Clinician Society, November 2012). Evidence of TAC effectively applying pressure at the local level was also found, as demonstrated by several high profile grassroots campaigns including: advocating for better health conditions in prison; supporting a protracted legal case involving a GBV victim; and improving access to hospital for people affected by HIV.

1.5 Conclusions

The report concludes that TAC conducted activities that have contributed towards the outcomes outlined in the SARRAH grant agreement. Attempts to understand how SARRAH contributed to these achievements were not always clear from the data. This is due to the fact that SARRAH funded salaries of TAC staff who were involved in all TAC's activities which are also funded by other donors. However, there are achievements that are attributed or partially attributed to SARRAH. For example, findings indicated that SARRAH funding contributed towards improving the effectiveness of TAC's communication effectiveness by assisting with the development and implementation of a communication strategy. SARRAH has enabled improvements to TAC's M&E capacity, which may eventually help it to improve its organisational effectiveness and attract donor funding. SARRAH has further helped significantly with restructuring and financially supporting TAC's human resources. Key Performance Areas (KPAs) of all remaining staff were realigned with acceptable national standards, and salaries adjusted accordingly.

1.6   Recommendations

SARRAH support to TAC is critical to supporting the new NSP. It is therefore recommended that SARRAH continues to support TAC financially and technically in the following ways:

- SARRAH-funded M&E should continue to monitor progress and evaluate the outcomes of TAC funding as it has not yet produced observable impacts but might do so in future. An increased M&E capacity in TAC would add an immensely rich and useful source of monitoring and evaluation data and systems to track progress and longer term impacts.

- Because TAC is a Community Based Organisation (CBO) whose work includes a fair amount of unplanned responses to emerging events, and therefore depends strongly on flexible funding such as that of SARRAH, SARRAH should continue to allow this flexibility, whilst ensuring that checks and balances on how funds are utilised are strengthened.

- Strategic partnerships should continue to be supported. Government, legal organisations, unions, human rights organisations, HIV and AIDS advocacy organisations and many others should be encouraged to work closely with TAC, which has proven to have a noticeable voice and capacity to lift local issues to international levels, where they can be highlighted and subsequently addressed.

- Audit and reporting requirements that are expected from TAC should be spaced in such a way that they do not hinder TAC's work. These should be agreed in advance.

Annex 19

Organisations Interviewed

List of Organisations That Provided Information

	Work Stream	Organisation	Type of Session (No.)	Session Details and Objective
1	**All**	HLSP	Interview	Status report and contact information for all workstreams
2	**All**	HLSP	Interview	Financial info on all workstreams and milestone matrix
3	**Assessment of DHM & CEOs**	Department of Health	Interviews (2)	Assessment of DHMs & CEOs
4	**Assessment of DHM & CEOs**	GP _DOH	Interview	Assessment of DHMs & CEOs
5	**Assessment of DHM & CEOs**	HLSP	Interviews (2)	Assessment of DHMs & CEOs
6	**Assessment of DHM & CEOs**	KZN _DOH	Interview	Assessment of DHMs & CEOs
7	**Assessment of DHM & CEOs**	MRC	Interview	Assessment of DHMs & CEOs
8	**Asset Management**	i-Chain	Interviews (2)	Asset management system, successes and risks
9	**Asset Management**	NDOH	Interview	Information on Asset management system and status of NDOH restructuring
10	**Asset Management**	HLSP	Interview	Information on work-stream TOR and outputs
11	**Conditional Grant Management**	HLSP	Interview	Background information on Conditional Grants
12	**Conditional Grant Management**	NDOH	Interview	1st hand information as a consultant and the NDOH employee
13	**Financial Management**	HLSP	Interview	Background information on Financial Management
14	**HRH**	NDOHNDOH	Interview s (2)	HR strategy and status quo
15	**NDOH**	NDOH	Interview	Information on Asset management system and status of NDOH

	Work Stream	Organisation	Type of Session (No.)	Session Details and Objective
				restructuring
16	**NDOH**	HLSP	Interview	Status report
17	**NDOH**	McKinsey	Interview	Review of NDOH restructuring and info on on-going work
18	**NHI**	HLSP	Interview	Overview of NHI workstream and current activities
19	**NHI**	NDOH	Interview	Status of NHI implementation and the Programme Management Unit.
20	**NHIRD**	HLSP	Interview	Status report
21	**NHIRD**	NDOH/HISP	Interview	Technical efficacy of NHIRD
22	**NHIRD**	NDOH	Interview	Status of NHIRD and role of SARRAH support
23	**NHIRD**	HISP	Interview	Technical efficacy of NHIRD
24	**PMTCT**	Centre for Rural Health	Interview	To assess PMTCT partners' perspectives on SARRAH's work on PMTCT and the implementation of the PMTCT A-Plan
25	**PMTCT**	Health Systems Trust	Telephonic interview	To assess PMTCT partners' perspectives on SARRAH's work on PMTCT and the implementation of the PMTCT A-Plan
26	**PMTCT**	20000+	Telephonic interview	To assess PMTCT partners' perspectives on SARRAH's work on PMTCT and the implementation of the PMTCT A-Plan
27	**PMTCT**	MRC, Health Systems Research Unit	Interview	To assess PMTCT partners' perspectives on SARRAH's work on PMTCT and the implementation of the PMTCT A-Plan
28	**PMTCT**	HLSP	Interview	To assess SARRAH's work on PMTCT and the implementation of the PMTCT A-A-Plan
29	**PMTCT**	UNICEF	Interview	To assess PMTCT partners' perspectives on SARRAH's work on

	Work Stream	Organisation	Type of Session (No.)	Session Details and Objective
				PMTCT and the implementation of the PMTCT A-Plan
30	**PMTCT**	CDC	Interview	To assess PMTCT partners' perspectives on SARRAH's work on PMTCT and the implementation of the PMTCT A-Plan
31	**PMTCT**	NDOH/HLSP	Interview	To assess SARRAH's work on PMTCT and the implementation of the PMTCT A-Plan
32	**PMTCT**	KZN DoH	Interview	To assess SARRAH's work on PMTCT and the implementation of the PMTCT A-Plan
33	**POC**	Parliament	Interview	To understand the process from committee member's perspective
34	**POC**	HLSP	Interview	Background information on POC
35	**Quality Assurance**	HLSP	Interview	Background information on QA
36	**Quality Assurance**	NDOH	Interviews (3)	Interviews on QA workstream including NCS and OHSC
37	**SAHPRA**	SACRA	Interviews (3)	Discussion of Clinicians view of SAHPRA
38	**SAHPRA**	Johnson & Johnson	Interview	Pharmaceutical industry perspective
39	**SAHPRA**	IMSA	Interview	Pharmaceutical industry perspective
40	**SAHPRA**	EOH Benguela	Interview	Technical lead's assessment
41	**SAHPRA**	NDOHNDOH	Interviews (2)	Overview of SAHPRA progress
42	**SANAC**	BOT SANET	Interview	BOT Member perspective
43	**SANAC**	SARRAH HLSP	Interview	SARRAH's role
44	**SANAC**	SANAC	Interviews (6)	SANAC members' perspective including finances
45	**SANAC**	Civil Society - Religious Sector	Interview	Civil Society perspective

	Work Stream	Organisation	Type of Session (No.)	Session Details and Objective
46	**SANAC**	Civil Society - Human Rights	Interview	Civil Society perspective
47	**SANAC**	DPSA	Interview	Civil Society and Government
48	**SANAC**	GIZ, and others	Interview	Stakeholder's perspective and partners; TA
49	**SANAC**	UNAIDS	Interview	Stakeholder's perspective and partners
50	**SANAC**	Civil Society Children's Sector	Interview	Civil Society and active member of SANAC
51	**SANAC**	Clinton Foundation	Interview	Clinton Foundation (Partner)
52	**SANAC**	Section27	Interview	Civil Society perspective
53	**SANAC**	NDOHNDOH	Interview	Government and SANAC
54	**SANAC**	DPSA	Interview	Government and Technical Task Team
55	**SANAC**	Monash University South Africa	Interview	Civil Society perspective
56	**SANAC**	TAC	Interview	Partner perspective
57	**SANAC**	RHRU	Interview	SANAC perspective and Civil Society
58	**SANAC**	SARRAH consultant	Interview	SARRAH's contribution
59	**TAC**	Section 27	Interview	TAC contribution as a partner
60	**TAC**	TAC Head Office	Interviews (2)	To understand TAC process and funding
61	**TAC**	TAC K'hayelithsha	Interviews (4) & Focus Group Discussions (4)	1st hand data from actual implementers of TAC programmes
62	**TAC**	Social Justice Coalition	Interview	TAC contribution as a partner
63	**TAC**	TAC K'hayelithsha	Interview	Perspective from a beneficiary

	Work Stream	Organisation	Type of Session (No.)	Session Details and Objective
64	**TAC**	SAPS	Interview	Government perspective on TAC's role
65	**TAC**	HLSP	Interview	Background information on TAC

A detailed list of everyone interviewed has been provided by the evaluators to DFID but this is not being included in the report on confidentiality grounds.

Annex 20

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