

SARRAH 2012 Annual Review

1.0 Executive summary

Strengthening South Africa's Response to AIDS and Health (SARRAH) is a five year programme supported by the UK Government which aims to support the South African Government's commitment to achieving a long and healthy life for all South Africans - outlined in the National Service Delivery Agreement (NSDA) targets. SARRAH supports national reforms, programmes and institutions of the South African health sector through a range of strategic interventions identified jointly by DFID and the National Department of Health. The second Annual Review of the SARRAH programme took place in June 2012 and was carried out by Zoë Wildig, Governance Adviser, DFID London, and Prof John Seager, Public Health and Development Consultant contracted by Coffey International Development. The purpose of the annual review is to measure SARRAH's progress towards annual milestones set out in the programme log frame. The review found that SARRAH is delivering highly valued and high quality inputs to the Government's health transformation programme. The support has an exceptionally high level of ownership within the National Department of Health (especially by the Director General) and is clearly aligned behind and contributing to the NDoH 10-Point Health Plan.

SARRAH support has enabled the NDoH to respond rapidly to new energy behind South Africa's health sector transformation. In particular it has made technical inputs to building institutions such as National Health Insurance, and medicine and facility regulation and monitoring. It has supported organisational reform within the NDoH and laid the groundwork for the recruitment of appropriately skilled hospital CEOs. SARRAH's support in the past year has been focused on the National Health Insurance system. Interventions in support of NHI are laying the foundation for better quality healthcare across the country, regardless of the eventual outcome of the NHI policy debate. The Minister was quoted in February 2012 as saying, "When we launched the NHI Green Paper, we said a precondition for the NHI to survive and be successful is that the quality of healthcare in public institutions has to improve. It is non-negotiable that we overhaul and improve quality." SARRAH is providing critical support to this process.

An effective health system requires monitoring and accountability and SARRAH's core support to TAC and SANAC has been a key facilitator in enabling these two bodies to weather a period of loss of identity, purpose and in SANAC's case, leadership. Both are now well on the way to fulfilling their core role in monitoring the national strategic plan and holding government to account.

The responsive and flexible nature of SARRAH's support is praised by partners. However, the strong level of ownership brings with it challenges for programme management. In particular, SARRAH's full complement of work and progress is not always reflected in the logframe because it is constantly evolving. And where financial support for activities has ceased SARRAH reporting does not always continue to monitor progress.

2.0 Introduction

Strengthening South Africa's Revitalised Response to AIDS and Health (SARRAH) is a five year programme supported by the UK Government which aims to support delivery of the NSDA targets. The SARRAH programme 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 NDoH. 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 is aligned to the NDoH 10 Point Health Plan, the policy instrument through which the NSDA will be delivered. SARRAH contributes to nine of the 10 areas (the exception being research). While all SARRAH workstreams are working towards the same overarching goal, the diversity is such that each workstream could be considered as an intervention in itself.

SARRAH commenced in January 2012 and is due to end in December 2014. The total committed funds are £20,352,215.06. The second Annual Review of the SARRAH programme took place between 28 May and 1 June and was carried out by Zoë Wildig, Governance Adviser, DFID London, and Prof John Seager, Public Health and Development Consultant contracted by Coffey International Development. The purpose of the annual review is to measure SARRAH's progress towards annual milestones set out in the programme log frame.

3.0 Key successes in 2011/12

3.1 Strengthened leadership and accountability of the national response to HIV and AIDS

SARRAH aims to support strengthened leadership and accountability of the national response to HIV and AIDS. It does this by supporting three organisations which represent three pillars of the leadership and accountability framework for the HIV/AIDS response in South Africa: the National Department of Health, which is responsible for delivery of national health services; the South African National AIDS Council (SANAC), which is the body responsible for coordination of the national response to HIV and AIDS; and the Treatment Action Campaign (TAC), which is an NGO whose reputation for advocacy, primarily in terms of access to HIV treatment, was established during the period of the AIDS denialists. In addition, SARRAH provides support to relevant parliamentary oversight committees.

The 2011 Annual Review recommended that SARRAH reconsider support to both TAC and SANAC. TAC was struggling to redefine its *raison d'être* within a new context where space existed for policy dialogue with government (which had previously been almost completely absent) and this struggle was compounded by a negative external compliance review. SANAC was struggling to establish itself as the national coordinating mechanism. In the subsequent year both organisations have made remarkable progress. A new SANAC CEO was appointed in February and has already: secured Board approval (on 4th June) for a new organisational structure and a focus on provinces; reinvigorated and reorganised SANAC's governance structures – including getting buy-in up to the level of Deputy President; and is dealing with financial and HR management challenges. TAC has managed to meet all this year's milestones whilst going through a process of quite radical reorganisation. With support from SARRAH it has developed a new Business Plan (2012-15) which puts its membership base at the centre. It will provide district structures with the skills, tools and capacities to advocate at a local level and draw on the knowledge and activism of this

membership base to feed into national level policy formulation. As part of its strategy towards financial sustainability TAC is currently in the process of establishing an Activist Centre which will be a 'college for activist education' using TAC experience as a case study for how policy can be influenced by coordinated activist movements.

3.1.1 SANAC 2012 Milestone Achievement

2012 Milestone: SANAC secretariat lead formulation and publication of National Strategic Framework 2012/2016 including final review of 2007 – 11 National Strategic Plan.

2012 Actual: The National Strategic Plan on HIV, STIs and TB 2012 – 2016 (NSP) was published on 1st December 2011. The development of the NSP was led by the SANAC secretariat, the Programme Implementation Committee and staff of the Department of Health and contributions were made by SANAC sectors, task teams and individuals who contributed more than 100 written submissions. SARRAH provided technical assistance.

2012 Milestone: SANAC functions as an independent entity.

2012 Actual: The Milestone is no longer relevant as SANAC does not need to be an independent entity, which was seen as necessary in the 'HIV denialist era', but will continue to operate under the purview of NDoH. Since the appointment of the new SANAC CEO in February 2012, the SANAC Plenary, Chaired by the Deputy President, has approved new SANAC organisational and governance structures including four new Technical Task Teams aligned to the NSP plus a Research Task Team and an NSP Financing Committee, the latter comprising, among others, six Deputy Ministers. The Board of Trustees has signed off on SANAC banking arrangements to operate the South African National AIDS Trust Account, a Chief Financial Officer has been recruited and an Executive Manager for NSP Implementation has been appointed. The Board has also approved a SANAC budget for the next three years and 13 of 21 positions within the organisational structure are funded. Provinces will be front and centre of the newly refocused SANAC. The Deputy President, Minister of Health and nine Premiers reviewed the SANAC structure prior to submission to the SANAC plenary on 1 June to ensure buy-in.

2012 Milestone: Revised NAC (CCM) structure defined and established to support GFATM applications and grants.

2012 Actual: The SANAC Remunerations Committee has been restructured with a subcommittee specifically looking at GFATM issues. The committee will be able to meet all the requirements of GFATM in July 2012.

2012 Milestone: Costed new NSP in place published after consultative process.

2012 Actual: The NSP costing summary covers all known key cost drivers – some interventions and strategies are uncoded as apparently no costing was possible.

3.1.2 TAC 2012 Milestone Achievement

2012 Milestone: M&E system developed and aligned to NSP and Quarterly Reviews informed by TAC data.

2012 Actual: TAC's M&E system was developed and in place in 2011, however, subsequently TAC has gone through a process of restructuring. A new business plan is in place and an

M&E roadmap developed to support alignment of the M&E system to the new business plan – which is linked to monitoring of the NSP. Appropriate targets have been set, with the support of HLSP, but the M&E system is not yet fully operational.

2012 Milestone: External DFID audit complete.

2012 Actual: The audit was completed during the second quarter of 2011 and substantial improvements were noted. SARRAH support of TAC continued as a result.

2012 Milestone: 81,000 citizens supported by TAC to hold government to account for commitments made in the NSP.

2012 Actual: As of the end of September 2011, TAC had supported 54,033 citizens to hold government to account for NSP commitments. At the time of the review (May 2012) the latest quarterly report was incomplete but the TAC Chief Operations Officer estimated the number of people mobilised in TAC activities as greater than 81,000. Active membership, which utilises a mobile phone subscription system, was estimated at 6,000 in 6 Provinces.

2012 Milestone: two submissions to government on key issues in relation to HIV and health.

2012 Actual: In collaboration with Section 27, TAC produced an NSP review document. TAC has also produced: an NHI review document; a paper on the functioning of AIDS Councils; and, as part of a national campaign of against abuse of women and children, women's health/gender-based violence maps which provide details of services in model districts.

2012 Milestone: 50% of TAC-linked PHC facilities providing comprehensive post-exposure prophylaxis (PEP) services.

2012 Actual: Currently 59% of facilities where TAC has a presence (70 out of 120) are providing comprehensive PEP services and programmes.

3.1.3 Parliamentary Oversight 2012 Milestone Achievement

In order to support Parliamentary oversight of HIV and AIDS within the broader framework of the health sector SARRAH prepared a report (in February 2012) proposing that future SARRAH support is focused on the three main parliamentary oversight committees for health – the Portfolio Committee on Health, the Select Committee on Social Services and the Joint Committee on HIV and AIDS.

2012 Milestone: Mechanism for engaging Parliament agreed and two public hearings supported.

2012 Actual: Members of the Joint Committee on HIV and AIDS were elected in March with members including representatives from the National Assembly and the Council of Provinces. About 60% of the members of this committee are also members of the Health Portfolio Committee. The Joint Committee held its first meeting on 24th May 2012.

3.1.4 Recommendations:

SANAC, TAC and Parliament provide critical oversight and accountability functions with respect to Government's implementation of the NSP and strategic support to help them fulfil this mandate is essential for ensuring long term sustainability of SARRAH's interventions in support of the NSP.

Continued SARRAH support for TAC, SANAC and Parliament is recommended. If new funding is committed, SARRAH's logframe should be amended to reflect the new strategic direction of SANAC and TAC and new support to three Parliamentary committees.

The indicator related to gender under the support to TAC (Provision of Post-exposure Prophylaxis) is not directly related to TAC activities. TAC's gender specific work could be better reflected in an indicator related to advocacy on gender-based violence.

3.2 Support of national interventions to improve access and equity to HIV and health services

To support improved access and equity to health care, SARRAH is assisting preparation for National Health Insurance (NHI). By supporting the establishment of the regulatory bodies for medicines and clinical standards SARRAH will assist the improvement national health care standards.

The Minister of Health publicly stated that improving quality in public health is a precondition for NHI. SARRAH interventions support the foundations for improved health care at district level. SARRAH has provided technical papers to inform the NHI Ministerial Advisory Committee deliberations on the institutional set up of NHI. SARRAH has enabled broad consultation on NHI both with South African technical experts and local stakeholders.

Delays in the legislative processes which will establish the NHI, South African Health Products Regulatory Authority (SAHPRA) and Office of Health Standards Compliance (OHSC) mean that SARRAH's inputs have not yet realised their ambition. However, high quality technical inputs have laid foundations for strong institutions when legislation is passed.

This support to root and branch strengthening of the South African health system will be invaluable for improving health outcomes no matter what the eventual outcome of the NHI debate. That said, all interviewees shared the view that the ruling ANC party is firmly committed to NHI and concur that it will be implemented. International delegates at the Johannesburg conference on NHI, supported by SARRAH, contributed evidence in support of a more realistic time frame to achieve universal access, namely 14 years.

SARRAH's rapid logistical and technical support has enabled consultation through the ongoing ministerial road-show with representatives of large numbers of stakeholder groups at district level. The level of commitment shown by the minister (spending 30 days in the 10 pilot districts) is comparable to the number of days candidates spend campaigning in UK parliamentary elections. This demonstrates an exceptional level of commitment to the initiative and SARRAH's support has been vital to facilitating this process.

3.2.1 NHI (National Health Insurance) 2012 Milestones

2012 Milestone: Draft bill for NHI published for public comment.

2012 Actual: The Green Paper was gazetted for public comment in August 2011. The target for the White Paper is September 2012.

SARRAH provided logistical support to the NHI Ministerial Advisory Committee (MAC) and a series of technical papers to inform MAC deliberations. These covered benefit package design; purchasing provider payment mechanisms and price determinations; and an investigation of capitation payments.

2012 Milestone: NHI started in pilot districts.

2012 Actual: 10 Pilot Districts were announced in March 2012.

SARRAH assisted with the selection of pilot districts for the NHI by providing a briefing paper proposing criteria for their selection and a paper on options for District Health Authorities. SARRAH prepared terms of reference (ToR) for secretariat support to the NHI Pilot Advisory Committee designed to enable pilot districts to draw on national expertise.

HLSP seconds a Technical Lead, Dr Gugu Ngubane, full time to the office of the Director General. A facility audit of 4,300 facilities to assess performance against six core quality standards in seven domains of health care was carried out. Dr Ngubane assisted through preparation of ToR for Health Facility Improvement Teams (FIT) and overall coordination of the project, including coordination of four new Facility Improvement Teams that will prepare an improvement plan for each district.

In order to secure buy-in to the NHI from key stakeholders, the Minister of Health has embarked on a road show where he spends three days in each district introducing NHI to groups including GPs, mayors, traditional leaders, religious groups, school principals, health workers, teachers' unions, facility managers, NGOs and media. In each district closed meetings are held with each group and the Minister presents the NHI and takes questions. SARRAH is providing logistical support to this process.

SARRAH drafted guidance on the Ministerial District Clinical Specialist Teams, which aim to reduce maternal and child mortality (a key target of Millennium Development Goal 6 which is the primary Goal of SARRAH). The purpose of the team is to improve clinical governance at a higher level by preparing clinical guidelines and training doctors. The teams should comprise of an obstetrician, gynaecologist, paediatrician, physiotherapist, nurse etc., who look at options for improving health outcomes at a district level. Incentives will be paid to attract the necessary health professionals although it seems unlikely that a full complement will be available in each district due to work force constraints. SARRAH is providing technical inputs as well as support to the Ministerial Task Team (MTT) leading the initiative, for example a six month costed work plan for the MTT.

3.2.2 Improved performance of key programmes for PHC (Primary Health Care) 2012 Milestones

2012 Milestone: Basic package for NHI agreed.

2012 Actual: A technical report on a basic package of services was submitted to the NHI Technical Specialist in NDoH in June 2011.

SARRAH played a leading role (financing, logistics, rapporteuring) in an international conference on NHI in late 2011 for 500 delegates which contributed to the ongoing deliberations on the basic package of services (among other aspects of NHI). The current status of deliberations on the basic package is unknown as the department is taking this forward internally.

3.2.3 South African Health Products Regulatory Authority (SAHPRA) 2012 Milestones

2012 Milestone: Staff trained on on-line registration and tracking system (EDMS and CTD).

2012 Actual: 120 staff were trained in the on-line system but relocation to the Civitas building revealed limitations in the NDoH servers and IT system which prevented implementation of the new software. Since staff are unable to use the new system they will almost certainly need to be re-trained once the IT challenges have been resolved. The Minister reiterated his commitment to establishing SAHPRA by April 2013 in his budget speech and it seems likely therefore that these challenges will be addressed. Ultimately, the proposed system will allow on-line tracking and management of applications in a secure yet transparent way which is essential for improved throughput.

2012 Milestone: No further growth of evaluation back-log

2012 Actual: The evaluation back-log was considered by interviewees to be as bad, if not worse than before the 2010-2011 intervention by SARRAH. A recent Daily News article (30 May 2012) quoted Dr Nicholas Crisp, the SARRAH-supported Project Manager,, as saying that the current backlog would take up to five years to clear at the present rate of progress. Pharmaceutical company executives were quoted in the same article saying that they had up to 600 applications at the MCC with some of them having been filed almost four years ago. However, the AR was informed by the NDoH lead that she was currently in the process of hiring consultants (for six months) to work on clearing the back log.

As was noted in the previous annual review, releasing critical drugs from this log jam can have enormous economic benefits – a saving of R4.7 billion was achieved partly as a result of the previous backlog project, which helped make cheaper antiretroviral drugs available. However, part of the problem relates to hundreds of applications for relatively unimportant drugs in terms of health outcomes and a system for prioritising applications is needed. Resolving the IT issues and operationalizing the online system, whilst outside the immediate control of SARRAH, is central to improving the throughput of applications and needs to be prioritised. A suite of options for getting the IT system up and running has been provided by SARRAH, but the costing is still to be done.

2012 Milestone: On-line registration and tracking system (EDMS and CTD) in place.

2012 Actual: Implementation has stalled owing to limitations of the Civitas/NDoH IT system.

2012 Milestone: Enabling legislation for SAHPRA in Parliament.

2012 Actual: A Cabinet Memo was drafted by HLSP consultants and the proposed legislation has been gazetted for public comment which closed on 12th June. SARRAH supported the drafting of a business plan for SAHPRA which was a requirement of Treasury.

2012 Milestone: Draft regulations prepared and consulted with industry.

2012 Actual: SARRAH inputs speeded up drafting regulations and the consultants assisted in the engagements with industry which produced positive responses.

2012 Milestone: Revised fees operational.

2012 Actual: The revised fee structure has been discussed with industry and re-submitted to the Minister for approval and were expected to be published by the end of June 2012. However, it seems unlikely that increased fees will be acceptable until the necessary improvement of service is achieved.

Beyond the specific milestones listed above, there are critical negotiations still required between NDoH and Treasury which will draw on the technical assistance provided by SARRAH. Likewise the establishment of SAHPRA has implications for existing NDoH staff which apparently have to be addressed at Ministerial level. This entailed job descriptions prepared by NDoH being approved by the Ministry of Public Service and Administration before agreements with organised labour could be finalised. While all these aspects draw on SARRAH contributions, the speed of progress is largely beyond SARRAH's control.

3.2.4 Office of Health Standards Compliance 2012 Milestones

2012 Milestones: OHSC established and operational.

2012 Actual: Legislation has been drafted with assistance of HLSP consultants and published for comment which is currently being analysed. SARRAH assisted with collating comments.

Four teams of Inspectors have been trained and are currently refining the audit tools. The more senior inspectors were sent for training with the UK Care Quality Commission. Another four teams are to be established with HLSP support.

The Cluster Manager at NDoH said that without SARRAH support the OHSC could not have made the progress that it has. There were no staff initially but the initial SARRAH inputs allowed a Director's position to be filled in February 2011 and there has been a subsequent increase in budget allocation from NDoH in response to the groundwork completed. SARRAH was described as playing an "invaluable" catalytic role.

2012 Milestone: 25% of facilities certified.

2012 Actual: Until the legislation is finalised the inspectorate has no legal authority but voluntary evaluations are being carried out.

3.2.5 Recommendations:

SARRAH has undertaken a broader scope of work than originally anticipated under NHI, which should be captured in the logframe to accurately measure performance.

Several activities under this Output have been adversely affected by delays to the legislative process which were not anticipated. Regular internal assessment (for example aligned with quarterly reporting) of legislative progress may enable HLSP to better sequence programme inputs (e.g. to delay staff training until legislative mandates are received). Milestones relating to legislative processes could also be updated to reflect more realistic timeframes.

Any future SARRAH support to medicine regulation or supply chain management may benefit from a political economy analysis to identify champions and vested interests which can speed up or slow down reform processes.

The current contract with the SAPHRA consultant (Benguela Health) finishes in July but the Deputy Director General: Health Product Regulations expressed concern that further support may be required to implement SAHPRA, particularly in the area of labour law. Given that SARRAH currently supports a labour law consultant for SANAC it may be possible to use the same person for this task.

As SARRAH support begins to wind down, the OHSC work faces similar challenges and there will be a need for ongoing support during the implementation phase. There is also further work required on evaluation of the standards.

3.3 Strengthen performance management & strategic planning for HIV and health services at national and provincial level

Most of the work supported by SARRAH under this Output has been carried out by sub-contractors, several of whom were not selected by the implementing agency and much of the work was not carried out within the current reporting period. In addition, the sensitive nature of some of the findings and programmes meant that quality assurance and subsequent interventions were largely led by the NDoH. Consequently SARRAH's internal reporting against this Output is not as current as other Outputs.

A Staff Circular in November 2011 informed all staff that the new organisational structure, developed in the previous year with the assistance of SARRAH consultants, had been approved by the Department of Public Service and Administration.

In addition to the work above, some inputs during this reporting period were not specifically reflected by the logframe indicators. These included providing three consultants seconded to a Technical Support Unit in the NDoH, two of whom were subsequently absorbed by the NDoH. The support included assistance with provincial financial management, asset management, conditional grant management and supply chain management. All provinces submitted 2012/13 business plans in March 2012 which were approved in time for the beginning of the new financial year (April).

3.3.1 Public sector district and hospital managers competency 2012 Milestones

2012 Milestone: Ministerial Task Team established to implement recommendations of the competency review.

2012 Actual: SARRAH support to this work stream was completed in Quarter 1, 2011 with the completion of competency assessment of all public sector hospital and district managers carried out by DBSA. Informed by the analysis in this report the Government gazetted a Green Paper in August 2011, *The National Policy on Regulating Management of Hospitals*. The aims outlined in the policy are to: ensure implementation of applicable legislation and policies to improve functionality of hospitals; ensure appointment of competent and skilled hospital managers; provide for the development of accountability frameworks; and to ensure training of managers in leadership, management and governance. The paper provides a framework for the classification of hospitals and the job description and competencies of CEOs. Positions of hospital CEOs were re-advertised in February 2012, at which time the Minister was quoted as saying: "We want to ensure that we have the right people with the right skills and experience in our hospitals." Interviewees reported that a team within NDoH is currently reviewing applications and the Minister is taking a personal interest in hospital CEO appointments.

3.3.2 National Department of Health restructuring 2012 milestones

2012 Milestone: Recruitment of top structure completed.

2012 Actual: The new NDoH structure has been adopted and approved, including by the Department of Public Administration (November 2011). All Deputy Director General (DDG)

positions have been advertised and five of the six filled. All Chief Directors (CD) have been placed in the new structure and of the eight vacant CD positions two have been filled so far.

2012 Milestone: Lower structures designed and agreed

2012 Actual: The restructuring of lower levels is being taken forward internally by DDGs as they are appointed. The Annual Review was informed that the process of fully populating the organogram should be concluded by August 2012.

2012 Milestone: Performance management system in place.

2012 Actual: An evidence-based e-appraisal system was developed and launched in April 2012. Two templates are used, one for staff below Director and another for Director and above. The manual appraisal system is operating in parallel owing to IT limitations. All appraisals should be on-line by 2013. A new Performance Management Directorate is taking this forward. The new Directorate includes sub-directorates for: Performance Management; Training, Capacity Building and Special Programmes; and Skills Development.

3.3.3 Service Transformation Plan (STP) 2012 Milestones

2012 Milestone: 9 STPs agreed and approved by provincial heads of department and National Health Council.

2012 Actual: 9 STPs were developed and approved.

3.3.4 National and provincial Department of Health Audit Milestones

2012 Milestone: 3 of 10 Provinces receive unqualified audits.

2012 Actual: 2 of 10 Provinces received unqualified audits; the NDoH audit was also qualified. SARRAH support has focussed on improving Asset Management as poor performance in asset management had been the primary contributor to qualified audits. To date, asset management systems have been completed for all NDoH sites around the country and development of systems for Mpumalanga, Kwazulu-Natal and Eastern Cape provinces are under way. The new asset management system currently being implemented is expected to improve the audit situation and the results will be known once the next Auditor-General's report becomes available (June/July 2012).

3.3.5 Recommendations

Indicators 3.3.1, 3.3.2 and 3.3.3 refer to areas of work in which SARRAH no longer has a direct input; if these indicators continue to be reported on a mechanism needs to be developed to enable SARRAH/HLSP to report against progress – for example, updates could be provided by NDoH at SARRAH Steering Committee Meetings.

3.4 Monitoring and evaluating the national and strategic plans for HIV & AIDS and health

While good progress has been made in producing the new National Strategic Plan for HIV & AIDS, STIs and TB, and this includes proposed indicators which were developed with SARRAH technical assistance, the M&E framework has not yet been developed. The new National Health Information Centre is able to collate information from the District Health Information

System, StatsSA (socioeconomic data) and financial data from the NDoH but it remains to be seen how effective this will be for M&E of the various health programmes.

A National M&E Framework for monitoring the NSDA has been developed and SARRAH is represented on the Health Data Advisory and Coordination Committee (HDACC).

3.4.1 SANAC (South African National Aids Council) M&E systems 2012 milestones

2012 Milestone: National M&E framework developed and disseminated to Provincial AIDS Councils, National AIDS Council and the private sector.

2012 Actual: The SANAC M&E framework is not yet developed but the reviewers were told that this will be given priority by SANAC once immediate actions related to restructuring are accomplished. However, HLSP has provided technical assistance for the development of M&E indicators which were incorporated in the new NSP.

3.4.2 Joint national monitoring of the NSDA (Negotiated Service Delivery Agreement)

2012 Milestone: Joint monitoring (Presidency and NDoH) in place.

2012 Actual: HLSP contracted the Health Information Systems Program South Africa (HISP) from April 2011 to March 2012 to develop the National Health Information Centre (NHIC) in collaboration with the Strategic Planning Cluster of the NDoH. The NHIC (recently renamed the National Health Information Repository and Data Warehouse), has been established and demonstrations given to the NDoH, other departments and the Presidency. The Centre provides up to date information not only on routine National Indicator/Data Sets (NIDS) but also, among others, District Health Expenditure Review data, Ante-natal Survey data and HIV Counselling and Testing Campaign data. Thus the Centre is well placed to undertake monitoring of the NSDA.

Following the production of a National M&E Framework funded by SARRAH, which details how the NSDA should be monitored, the Director General set up a Health Data Advisory and Coordinating Committee (HDACC) which reviewed the framework document and is responsible for taking the work forward. The DFID Senior Health Advisor sits on this committee and the Minister of Health launched the first HDACC report in November 2011.

There is good buy-in from the Presidency into the ongoing SARRAH Impact Evaluation which will include evaluation of NSDA indicators. The Presidency will host the next Impact Evaluation Steering Committee in the Presidency and the Deputy President's office will also participate. The involvement of the Presidency provides a potentially important link between SARRAH and national monitoring and evaluation efforts.

2012 Milestone: First review produced

2012 Actual: First HDACC report was launched November 2011 and published in February 2012

3.4.3 Recommendations

Given the critical importance of effective M&E for managing the health system, SARRAH should continue its support of SANAC and HDACC to help ensure that the necessary data is made available and effectively used.

3.5 Improvements in quality of and access to HIV & AIDS and health services in selected districts

SARRAH's contribution to efforts to prevent mother-to-child transmission of HIV (PMTCT) concluded in June 2011. At that time the MTCT rate had already reached the 2012 Milestone according to an MRC study (3.6%) and since then has further improved to 2.89% by February 2012, according to the National Health Laboratory Services (NHLS).

3.5.1 Transmission rate of MTCT

2012 Milestone: 4%

2012 Actual: This work was completed in June 2011 at which time the national MTCT rate was 3.6%. By February 2012, the national average was 2.89% (NHLS, Feb 2012).

3.5.2 Utilisation Primary Health Care facilities

2012 Milestone: 3.1 visits per capita

2012 Actual: Although the PHC revitalisation agenda is moving forward, implementation of improvement interventions in the pilot districts has not yet started, although some pilot districts have started the recruitment process for the implementation teams. The 2010/11 District Health Information System (DHIS) reports a utilisation rate of 2.4 visits per capita.

3.5.3 Antenatal visits before 20 weeks rate

2012 Milestone: 38.5%

2012 Actual: The 2011/12 DHIS reports a rate of 40.2% indicating that this milestone was exceeded, despite the PHC revitalisation interventions not having started yet.

3.5.4 PHC visits of children under 5 years (annualised)

2012 Actual: Not available

3.5.5 Recommendations

Specific activities in terms of prevention of mother-to-child HIV transmission ended in June 2011. Further roll-out of the PMTCT A-plan is dependent on the NDoH and does not currently involve SARRAH. Although future milestones for this indicator will reflect sustainability of the SARRAH intervention, the relationship becomes more tenuous over time. It may be appropriate to drop the PMTCT-specific milestone (3.5.1) and revisit the more general PHC ones (3.5.2 – 3.5.4) only when the Quality Improvement of PHC facilities and/or NHI is started in the selected districts.

4.0 Challenges

SARRAH financial support

Due to frontloading of programme activities, SARRAH financial resources will be fully utilised at the end of this year. It is considered that continued SARRAH support (due to a level of flexibility not provided by other donors) is critical to enabling TAC to fully implement change processes which are underway. Similarly, continued support to SANAC would facilitate the

dynamic change underway at this organisation (although SANAC has a core operating budget and should be able to secure funding from other donors more easily). With regard to SAHPRA and OHSC, SARRAH support has laid strong institutional foundations; however, once legislative delays are overcome additional technical assistance could help ensure that these institutions get off to a strong start.

Organisational and human capacity

South Africa is implementing an incredibly ambitious reform of the health sector, the goal of which is for all South Africans to realise a long and healthy life. SARRAH support has in large part contributed to the institutional framework which will govern South Africa's revitalised response to HIV and AIDS and the health system more broadly. Ensuring that South Africa has the human and organisational capacity to implement these institutional frameworks is critical to realising the vision for long and healthy lives. SARRAH's approach to capacity building is therefore critical. At Ministry level SARRAH currently fills a gap in terms of the supply of technical knowledge, both in terms of supplying evidence and advice and in commissioning it through the drafting of Terms of Reference and identification of consultants. There is a hypothetical risk that filling gaps may allow weaknesses to be sustained which might otherwise be addressed using local resources.

Political will

The vision and energy which Minister Motsoaledi is bringing to the health sector transformation process was considered by interviewees to be unique. There is such a broad base of support for health sector reform that a change in Minister (ANC National Conference at the end of 2012) would not throw the reform process off track, however, appointment of a new Minister could result in a significant change of pace.

5.0 Recommendations

SARRAH is delivering highly valued and high quality inputs to the Government's health transformation programme. The support has an exceptionally high level of ownership within the National Department of Health (especially by the Director General) and is clearly aligned behind and contributing to the NDoH 10-Point Health Plan.

SARRAH support has enabled the NDoH to respond rapidly to new energy behind South Africa's health sector transformation since the appointment of Minister Motsoaledi in 2010. In particular it has made technical inputs to building institutions such as National Health Insurance, and medicine and facility regulation and monitoring. It has supported organisational reform within the NDoH and laid the groundwork for the recruitment of appropriately skilled hospital CEOs. SARRAH's support in the past year has been focused on the National Health Insurance system. Interventions in support of NHI are laying the foundation for better quality healthcare across the country, regardless of the eventual outcome of the NHI policy debate. The Minister was quoted in February 2012 as saying, "When we launched the NHI Green Paper, we said a precondition for the NHI to survive and be successful is that the quality of healthcare in public institutions has to improve. It is non-negotiable that we overhaul and improve quality." SARRAH is providing critical support to this process.

An effective health system requires monitoring and accountability and SARRAH's core support to TAC and SANAC has been a key facilitator in enabling these two bodies to weather a period of loss of identity, purpose and in SANAC's case, leadership. Both are now

well on the way to fulfilling their core role in monitoring the national strategic plan and holding government to account.

The responsive and flexible nature of SARRAH's support is praised by partners. However, the strong level of ownership brings with it challenges for programme management. In particular, SARRAH's full complement of work and progress is not always reflected in the logframe because it seems to be constantly evolving. And where financial support for activities has ceased SARRAH reporting does not always continue to monitor progress.

Recommendations for remaining 6 months

- Milestones relating to legislative processes should be revised so that future Annual Reports / Programme Completion Reports are able to score against a more realistic timeframe (see recommendations below for further possible amendments to the logframe).
- SARRAH addresses significant gender related aspects of healthcare, however, gender aspects of the programme need to be better reflected in project reporting.
- Mechanisms for reporting on progress of interventions for which SARRAH is no longer providing financial support should be identified. These could include updates from NDoH at SARRAH steering committee meetings and inclusion in quarterly reports of media reporting against these interventions.
- Increase the number of case studies on SARRAH's website.
- SARRAH's approach to capacity building should be reflected in all new ToRs and appropriate skills for capacity building should be a prerequisite in recruiting consultants.
- The new DFID Development Policy Committee paper on Capacity Development should be shared with HLSP.
- DFID should consider supporting systematic documentation of South Africa's response to the HIV and AIDS crisis in order to capture lessons learned to inform both South Africa's health sector transformation and development of other health systems in the region. Support through the second window of the DELPHE programme (support to Higher Education Institutions, currently under tender) would enable a South African Higher Education Institution to lead this process. The Emerging Powers Team also have a source of finance (*Global Partnerships Programme*) which supports projects in emerging powers which have regional benefit.

Recommendations for further financing

- Further support to TAC is critical to supporting organisational restructuring and implementation of their new business plan.
- Further support to SANAC and Parliamentary Oversight Committees would support establishment of necessary oversight of the process of health reform.
- Additional support to SAHPRA and OHSC, when legislation is passed, could enhance effective functioning of these institutions.
- SARRAH is providing high quality technical inputs to the NHI policy debate and enabling broad stakeholder consultation; continuing this support would capitalise upon the current momentum behind health service reform.

Recommendations if further funds are committed

- The logframe should be revised to tighten up outputs and outcome level indicators:
 - Legislative indicators should be removed as these are outside the control of the project;

- Small amendments to Output language would increase clarity;
- New gender indicators should be included – TAC indicators are not reflective of TAC’s core work;
- Milestones should reflect more realistic timeframes;
- Indicators and milestones could better reflect the totality of SARRAH’s interventions, in some cases fewer indicators may assist this;
- Some Output 1 indicators are more appropriate Outcome level indicators.
- DFID should consider whether the nature of partnership with the NDoH should be incorporated into the theory of change model to capture benefits of this approach.
- Any future support to medicines regulation or supply chain management would benefit from political economy analysis (DFID has experience in Mozambique and Burundi).
- Quarterly management assessments of the progress of legislative or policy processes may assist in sequencing of future interventions.
- Capacity Building and Organisational Capacity of NDoH: Strategies to strengthen the approach to capacity building could consider more use of secondments (in and out), twinning and mentoring. A recent multi-donor evaluation of Public Sector Reform identifies good experience with organisational capacity building (Ugandan Ministry of Finance or Indonesia’s External Audit Board); review of this may identify lessons for SARRAH.
- Request support from the Results Hub in DFID’s Politics State and Society Team in measuring governance results and measures of value for money.
- Where NDoH is the lead in identifying consultants, national systems of procurement should be utilised.