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Impact Evaluation of SARRAH:
Mid-Term Evaluation

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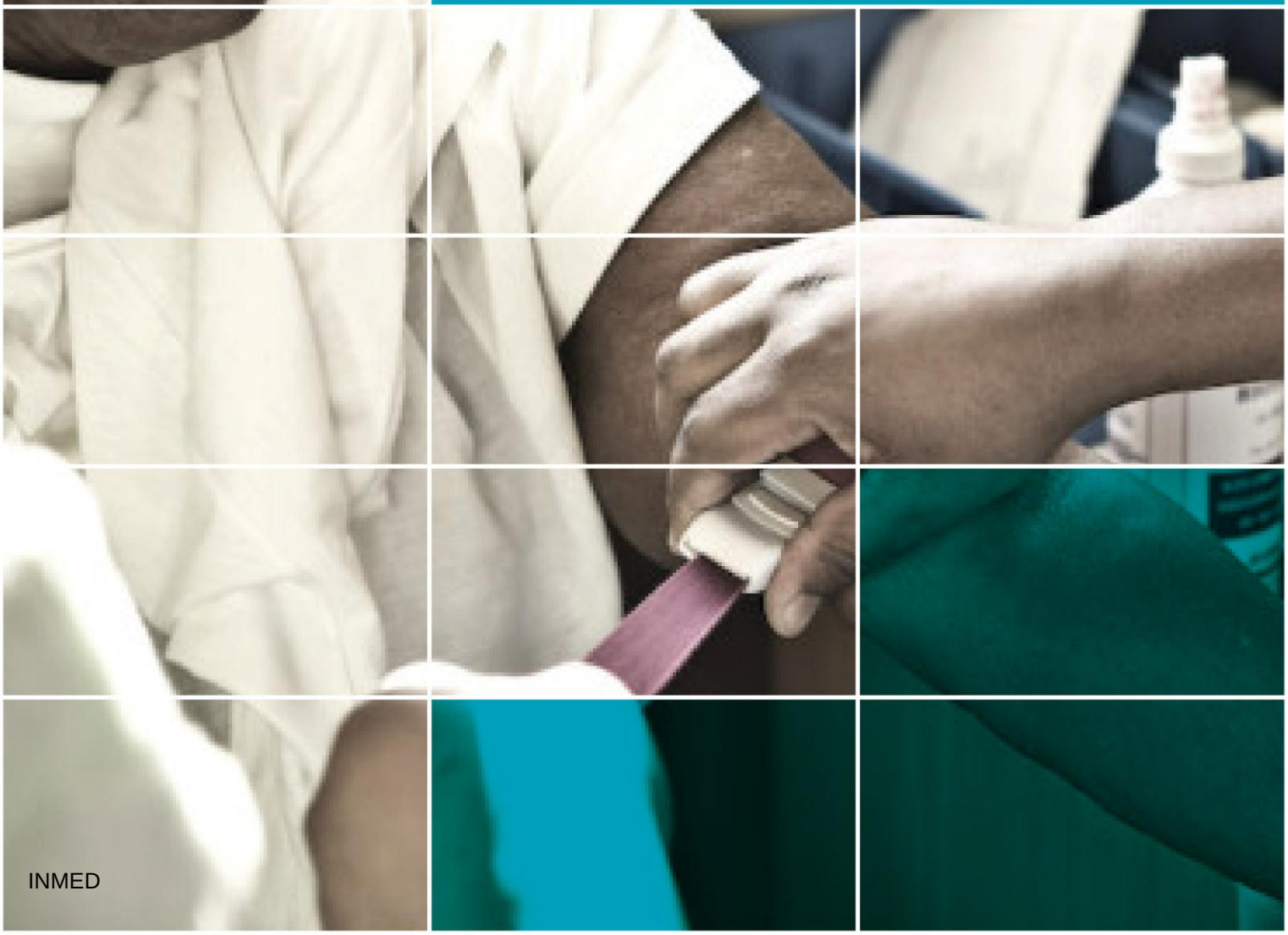

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LIST OF ACRONYMS

A-Plan	PMTCT Accelerated Plan
ART	Antiretroviral Therapy
CBO	Community Based Organisation
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CSO	Civil Society Organisation
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
MTCT	Mother-to-Child Transmission
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
NSP	National Strategic Plan
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 EXECUTIVE SUMMARY

2 INTRODUCTION

2.1 Purpose of the Evaluation

This report presents the findings of the Mid-Term Evaluation of SARRAH for the period up to December 2012, and of some of the most strategically important work-streams, with a particular focus on **process**. 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. It was therefore agreed during the strategy development phase that the mid-term evaluation would consist of a Process Evaluation of SARRAH, combined with an attempt to look beyond and measure the programme's outcomes and impacts wherever possible and appropriate.

This purpose of this evaluation report is therefore to:

- Assess the relevance of SARRAH as an intervention to support the South African health sector and its response to HIV and AIDS
- Assess how effectively and how efficiently SARRAH was delivered
- Measure the programme's emerging outcomes and impacts wherever possible
- Provide a base against which to fully evaluate the programme's impacts in 2014-2015

2.2 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.

2.2.1 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.

2.2.2 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.

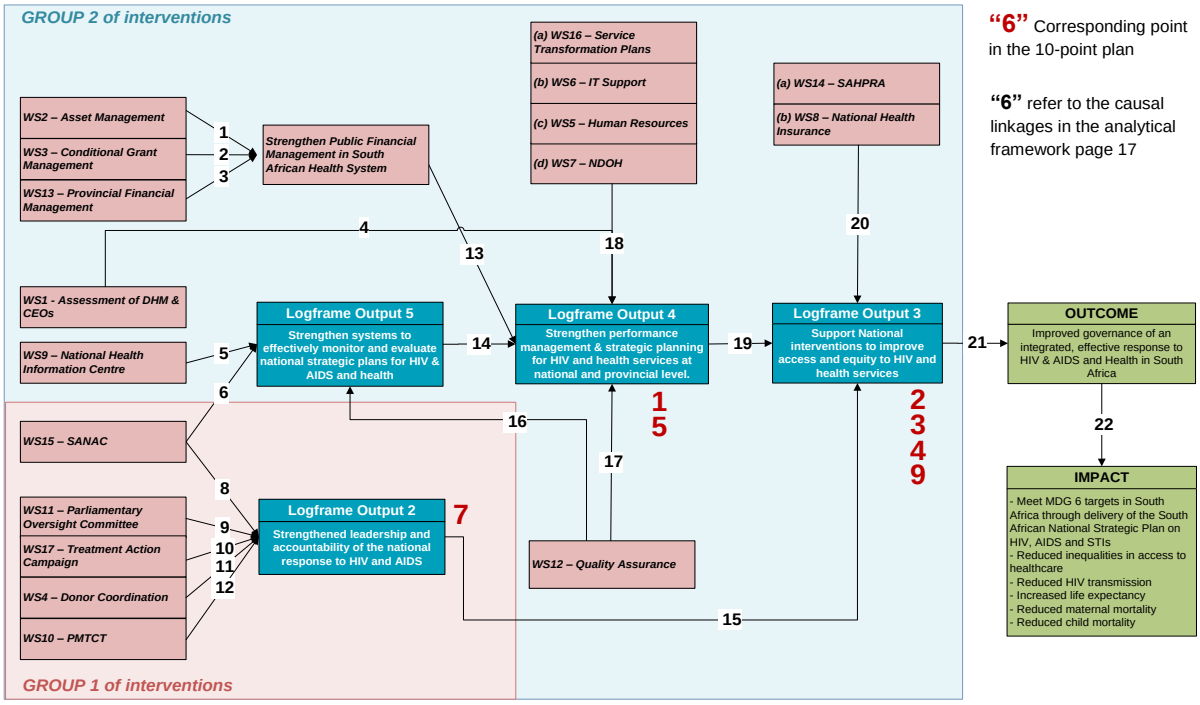
2.3 Methodology & Analytical Framework

2.3.1 Analytical Framework

Figure 1 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.

This Outcome Mapping underpins the analytical framework within which the individual work-stream evaluations were conducted and through which the SARRAH meta-evaluation was undertaken. The full analytical framework is available in Annex 1. It is important to note that the latter should be considered a working document subject to modifications and adaptations as the programme matures and the scope of some of some individual interventions is better defined.

Figure 1 – Outcome Mapping



Source: Coffey

2.3.2 Research Methodology

One of the main challenges with the Impact Evaluation of SARRAH is the diversity of the initiatives undertaken as part of the programme, and the consequent lack of a consistent set of indicators of success that could be aggregated for the purpose of meta-analysis of their total effects and impacts. Despite attempts to standardise the approach to impact evaluation, evidence had to be collected for each intervention or "work-stream", by different evaluators and 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 programme level evaluation that meets the quality criteria which the evaluation had defined at the outset – 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 involved:

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.

STEP 1 - Work-stream level Impact Evaluations

The starting point was to consider each of the programme's interventions, or "work-streams", individually and to carry out intervention level evaluations following the prioritisation schedule which had been agreed with the Steering Group during the Strategy phase, and which identified evaluation priorities 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.

Appropriate, mixed-method evaluation approaches were then developed by members of the evaluation team for each work-stream, usually involving a combination of desk research, secondary data collation and analysis, key informant interviews, focus groups, and in some cases site visits and surveys. Work-stream level evaluation findings were then structured around the OECD DAC criteria of Relevance, Effectiveness, Efficiency, Impact and Sustainability, to which was added the cross-cutting Gender thematic.

STEP 2 - Systematic review

Systematic review was then used to systematically collect, collate and quality assure the 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.

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.

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.

2.4 Meta-Evaluation process

A scoring system was developed to assess each work-stream, and the SARRAH programme, against the key evaluation criteria.

Each of the work-streams under scrutiny is coloured as per the colour scheme which had been established during the evaluation strategy phase as a way to prioritise evaluation activities and resources towards those work-streams which were deemed to be the most evaluable, the most strategic and those which had absorbed a sufficiently large proportion of the SARRAH budget to justify more in-depth research activities. A score of 1 to 4 was awarded to each work-stream and against each evaluation criterion within each work-stream, where:

Table 1 – 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 criteria

This scoring system is consistent with that used by the UK Independent Commission on Aid Impact's (ICAI[1]) traffic light rating system, and was adapted to the needs of the SARRAH evaluation.

Two weighting systems were then applied in the process of synthesising the evaluation findings. The criteria were weighted to reflect the key objectives of this evaluation, which are to provide DFID with an assessment of SARRAH's Effectiveness (30%), its Relevance (20%) and the extent to which it was delivered Efficiently (20%). The potential Impact and Sustainability criteria were given a 15% weighting each, reflecting the fact that the mid-term evaluation intentionally focuses on process rather than

[1] Independent Commission for Aid Impact (2011), *ICAI's Approach to Effectiveness & Value for Money* http://icai.independent.gov.uk/wp-content/uploads/2010/11/ICAIs-Approach-to-Effectiveness-and-VFM.pdf

outcome and impact measurement, which will be assessed more thoroughly, and weighted more heavily, at the final evaluation stage.

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

Table 2 – 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.

Table 3 below is a simplified example of the Meta-Evaluation process, which describes using made-up figures how the scoring system was applied in practice.

Table 3 - Meta-Evaluation Template

Work-stream	Criteria	Data Source 1		Funding	Weight	Total	Overall score
		Finding	Quality of Evidence				
1	Relevance	3	Strong	£1,000,000	17%	**3**	**2.50**
	Effectiveness	2	Weak			**2**	
	Efficiency	…	…			…	
	Impact	…	…			…	
	Sustainability	…	…			…	
2	Relevance	4	Strong	£2,000,000	33%	**4**	**2.85**
	Effectiveness	4	Weak			**3**	
	Efficiency	…	…			…	
	Impact	…	…			…	
	Sustainability	…	…			…	
3	Relevance	3	Strong	£3,000,000	50%	**3**	**2.30**
	Effectiveness	1	Medium			**1**	
	Efficiency	…	…			…	
	Impact	…	…			…	
	Sustainability	…	…			…	
					100%		
SARRAH	*Relevance*				*0.2*	**3.33**	**2.50**
	Effectiveness				*0.3*	**1.83**	
	Efficiency				*0.2*	…	
	Impact				*0.15*	…	
	Sustainability				*0.15*	…	

2.5 Research Challenges

One of the main challenges for any impact evaluation is the need to convince those being evaluated of the impartial nature of the evaluation and its potential for benefit rather than harm. Despite the best efforts of the evaluation team there was a tendency for bureaucracy to delay or even prevent access to information, especially when that information is regarded as politically sensitive or confidential. Despite health being a common good, the health system in South Africa is highly politicised and access to detailed information has been quite restricted. Progress reports were not available from the department

of health and information often had to be gleaned from press releases, presentations at conferences and workshops. Information derived from these sources is inevitably in a summarised form and precluded the depth of analysis we would have preferred. Once the first round of evaluation is complete, gaps in information will become apparent and we hope that a more participatory engagement will be acceptable to National Department of Health (NDoH) in phase two. The more comprehensive the evaluation, the more likely it is that the information provided will help direct appropriate action. Some examples follow to demonstrate the challenges faced in the evaluation of particular work-streams.

The restructuring in the NDoH is a long term project and most of the input by SARRAH took place right at the beginning of the process. In addition, the work was contracted out to the international consulting firm McKinsey & Company with little further involvement of the HLSP team. From the outside it appears that progress has been quite slow, since the revised structure was submitted to the Department of Public Service and Administration (DPSA) in late 2010 and approved by DPSA in November 2011 but by the end of 2012 not all of the new positions had been filled. This means that restructuring remains incomplete and that evaluation is therefore limited. This is one of several examples of SARRAH activities which had a promising start but then slowed down due to factors beyond the control of SARRAH. However, the NDoH representatives pointed out that major restructuring inevitably takes time and there were many factors such as approval by DPSA, the unions and treasury, all of which had to be achieved before the work could proceed. In other work-streams, such as SAHPRA, NHI and SANAC, lengthy legislative processes contributed to slow progress. The majority of these initiatives are now gaining momentum and it is anticipated that there will be greater opportunities for evaluation in the next phase, i.e. 2014/15.

There was extreme sensitivity about information relating to NHIRD and no direct evidence or documentation of any kind was made available. In the words of one of the SARRAH Impact Evaluation Steering Committee members, it appears that much of the information we seek is “classified”. Whilst the system inevitably contains some potentially sensitive data, if it is being used for routine monitoring and evaluation in the department of health, it would seem reasonable to expect that some of the reports, or at least examples, could be made available. One of the concerns expressed by HLSP was that the terms of reference for the technical assistance often changed as the project progressed. Whilst the client (NDoH) was apparently well pleased with the results, such changes have made the monitoring of deliverables difficult. Several deliverables were still outstanding at the time of the 2012 evaluation although others, which may have become necessary or were more relevant, had been substituted.

The Quality Assurance work-stream also involves politically sensitive information about the quality of South African public health services in an environment where government is acutely aware that there are serious shortcomings in many health facilities and criticism is common in the media. Setting standards is a complex process and there are some differences of opinion regarding how best to evaluate compliance with standards and identify priorities for intervention. The Health Systems Trust was commissioned by NDoH to assess quality of care in facilities across the country and they elected to do this using a simplified set of six indicators identified by NDoH as priorities. These indicators are referred to in the NCS preamble and became a target for the new Facility Improvement Teams and were the so-called ‘low hanging fruit’ that could produce some quick success stories. It was probably a reasonable starting point, given the complexity of applying the full set of standards, but critics argue that some of this ‘low hanging fruit’ is merely cosmetic and insufficient for real transformation of the health system.

The National Core Standards (NCS) and associated questionnaires provide the means for a more comprehensive assessment but there have apparently been difficulties in applying the standards and interpreting the results. The NCS remains a work in progress but there were reports of frustration at facility level in applying the standards and knowing what to do about the deficiencies they identified. In some areas, consultants were called in by provincial health authorities or facilities to assist with applying the NCS and interpreting the results. Regrettably, efforts by the research team to integrate NCS and alternative quality methodologies such as those used by ISQua, were rejected and consequently the evaluation of the standards as applied in facilities has been limited. During phase two further efforts will be made to evaluate the NCS in practice.

3 EVALUATION FINDINGS

This section summarizes the key findings of the Mid-Term Evaluation. It is structured around the four broad outcome categories identified in the logframe and in blue in the outcome mapping (section 2.3.1). Under each category of outcomes, the relevant work-streams were evaluated and the against each OECD-DAC evaluation criterion. An attempt was then made to assess SARRAH's performance in tackling each outcome category through a systematic synthesis of the combined relevant work-streams, using the meta-analysis system presented in section 2.4.

3.1 What has been SARRAH's role in strengthening leadership and accountability of the national response to HIV and AIDS

3.1.1 What support has SARRAH provided

SARRAH provided funding to five separate work-streams (SANAC, POC, TAC, PMTCT, Donor Coordination) in its effort to strengthen the leadership and accountability of the national response to HIV and AIDS (logframe Output 2), three of which (SANAC, TAC and PMTCT) were assessed as part of the midterm evaluation. Together these work-streams are designed to address a need that was jointly identified by NDoH and DFID as requiring additional support.

The largest recipient of SARRAH support under this output (circa £1,570,000) was the South African National AIDS Council (SANAC), the body responsible for the coordination of the national response to HIV and AIDS. As an independent organisation, SANAC is expected to improve accountability through increased M&E capacity to evaluate progress against HIV and Health plans. The most extensive evaluation undertaken under this output focused on SANAC and how SARRAH funds were used to support the SANAC secretariat to strengthen its IT, human resource and governance systems. It also supported the establishment of a monitoring and evaluation (M&E) unit in SANAC.

SARRAH also provided circa £1,500,000 to the Treatment Action Campaign (TAC), a civil society organisation which seeks to hold government accountable through monitoring the implementation of HIV and AIDS policies and other strategic plans. TAC was provided two grants to fund salaries, operations costs, meetings and newsletters. SARRAH's contributions to both SANAC and TAC were designed to strengthen organisational capacity; however, SARRAH also provided £280,000 of direct service delivery assistance to NDoH's work in Prevention of Mother-to-Child Transmission (PMTCT), an initiative that was sanctioned by SANAC. Specifically SARRAH funded strategic activities to support the implementation of the PMTCT A-Plan, a strategy that was initiated in 2008 that would act as a catalyst towards the achievement of the NSP 2007-2011 target to reduce MTCT of HIV to less than 5% by 2011. SARRAH funding supported a team of project managers to pilot initiatives, mainstream reporting indicators and share best practice.

3.1.2 Relevance

The SANAC, TAC and PMTCT work-streams evaluated under this output were all found to be relevant towards strengthening leadership and accountability of the national response to HIV and AIDS. Each work-stream evolved in response to the perceived organisational weaknesses and gaps required to implement effectively the National Strategic Plan (2007-2011) on HIV and AIDS and Sexually Transmitted Infections (NSP).

SANAC established in recognition, by the South African Government and civil society, of the need to guide policy and strategy, as well as monitor the overall implementation and review of the NSP. However, multiple reviews found SANAC unable to provide the required guidance and monitoring for sector programmes for HIV and AIDS. It was on this basis that SARRAH provided support to the organisation as it underwent structural reform.

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 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 for improving its M&E capacity.

The South African NDoH and SANAC, through their existing partnerships with development partners, wanted to pilot the PMTCT A-Plan. This plan aimed at increasing the demand for and supply of better quality PMTCT services in 18 priority health districts. Improving the health outcomes of women and children through improving the reach and quality of services is a key priority for the NSP given the high rates of MTCT infection in South Africa. SARRAH's support towards this particular pilot was relevant given the financial and technical needs of conducting such a programme. SARRAH support enabled the recruitment of key project staff including a full time team (project manager, coordinator and administrator), coordination of the pilot and the development of a quality improvement model aimed at improving 11 PMTCT indicators.

3.1.3 Efficiency

Both the TAC and PMTCT work-steams are able to demonstrate efficiency at the mid-term evaluation stage but demonstrating efficiency for the SANAC work-stream at this stage is more difficult.

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 at competing times. By 2012, HLSP through 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 so much of their time writing progress reports in different formats for various funders.

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 GBV pushed TAC, the Justice Coalition and other partners to pool resources and picket at constitutional houses 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 these outcomes cannot be directly attributed to SARRAH, since TAC was supported through unconditional grants.

Evidence of efficiency in the PMTCT work-stream is less clear. SARRAH's function was a coordination role. Interviews suggest that the strong leadership role that was demonstrated by the SARRAH funded project manager enabled a better operational effectiveness of the PMTCT A-Plan and its activities as development partners were able to complement each other to better address identified gaps. The A-Plan further created a forum for the harmonisation of key indicators that ultimately led to a reduced set of dashboard indicators. Previously there had not been a single, standardised set of PMTCT indicators that were collected for the country reporting. It is likely, therefore, that fewer indicators will lead to more efficient monitoring and reporting, however there is no reporting benchmark available to support this hypothesis.

Assessing the efficiency of SARRAH's support to SANAC is difficult since interviewees were rarely able to identify SARRAH's specific inputs and its relative contribution to SANAC. However, SARRAH appears to have been efficient in its ability to quickly respond to SANAC's needs in particular thematic areas (e.g. Human Resources). Timely access to resources can enable organisational efficiencies. For example, one interviewee noted how "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."

Assessing the overall efficiency of SANAC as an organisation has also proved difficult. SANAC at this stage in its reorganisation can claim few results which can be examined for efficiency.

3.1.4 Effectiveness & Sustainable Impact

SARRAH's contributions towards strengthening the leadership and accountability of the national response to HIV and AIDS are generally effective, especially in terms of filling strategic funding gaps. SARRAH's support to PMTCT in particular provides strong evidence of improved effectiveness. Although SARRAH provided support to SANAC that was viewed by many interviewees as helpful, evidence of SANAC's overall effectiveness is weak at this stage.

SARRAH support to TAC was strategic, particularly in the way it enabled TAC to execute ad-hoc events which require media coverage, travelling to areas that require speedy attention, as well as awareness-raising of pertinent and current issues. Although about 75% of SARRAH funding covered salaries, the remainder allowed TAC to commit to short-term support to communities that would otherwise not have gained desired attention for their needs. For example, TAC is often required to respond quickly to 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. 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 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). Evidence of TAC effectively applying pressure at the local level was also found, 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 with people affected by HIV.

While SARRAH's PMTCT work-stream was one of the smallest and shortest-lived work-streams, the evaluation found that 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 contribution. The pilot study overall was implemented successfully in 15 of the 18 original pilot sites including all six that were funded for by the SARRAH programme. According to all stakeholders interviewed the role that the SARRAH's PMTCT work-stream played was significant as it improved and expedited the progress of the programme. As one interviewee noted, "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." This view was validated by another interviewee who explained, "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."

The PMTCT programme as a whole is showing evidence of achieving significant intermediate outcomes. Following PMTCT's successful completion of its pilot phase, the lessons learned were scaled up and used to strengthen PMTCT in all 52 districts nationally from July 2011. Data from the DHIS PMTCT programme and HSRC shows a sizable decrease in the rate of MTCT, increase in utilisation rate of primary health care facilities, increase in antenatal visits and increase in utilisation visits by children under five.

Evidence of SARRAH's contributions to SANAC is not as clear, as the effects of the funding appears limited to supporting on-going organisational costs. Some interviewees viewed SARRAH's funding to SANAC as valuable in sustaining SANAC during its restructuring process, with one interviewee stating that "without this [SARRAH] money, the Secretariat would have been paralysed", while others noted that SARRAH funding "from the SANAC perspective has positively contributed. You may not be able to see it; it has contributed to getting it moving in the right direction." Most of the stakeholders interviewed maintained that SARRAH's contribution was not sustainable, and that SARRAH funding was used "as a gap filler". The widely help opinion by interviewees is that SARRAH funds permitted SANAC to remain in a "holding pattern" as structural changes continued.

Assessing how the structural changes to SANAC are improving its effectiveness is difficult to assess at this stage of the evaluation. Interviewees alluded to entrenched institutional culture in SANAC that is difficult to change, especially what is perceived as a secretariat that is mired in a politicised environment. Concerns over SANAC's inability to recruit and retain core staff was also felt by some interviewees as compromising its possible long term effectiveness. Nearly all respondents stated that SANAC does not and presently is unable to hold sectors or groups accountable for achieving results.

Despite these challenges, the organisational changes in SANAC suggest a fundamental shift in thinking. The previous structure encouraged broad participation yet it lacked a specific process to focus those

discussions or to prioritise issues. The new structure is designed to focus discussions and bring together experts to identify and use evidence to inform prioritisation while at the same time reaching the local level through provincial, district and local AIDS committees. It appears as though the new structure places the CEO in a more central position with more streamlined access to information. As one interviewee noted, "the new leadership in SANAC has achieved a lot in particular in bringing SANAC back in the arena of key players in the response to HIV&AIDS and in establishing the organisation. Processes, policies and guidelines are set up and allowing the organisation to function more smoothly and less as hoc". Evidence of organisation effectiveness may become more apparent in the final evaluation.

3.1.5 Conclusion

Below is an overall assessment of SARRAH's success in strengthening leadership and accountability of the national response to HIV and AIDS through its work on SANAC, PMTCT and TAC. SARRAH's overall score against that outcome is 2.21.

Table 4 - Meta-Evaluation Summary Table

Work-stream	Criteria	Data Source 1		Funding[2]	Weight	Total	Overall score
		Finding	Quality of Evidence				
SANAC	Relevance	3	Strong	£1,568,636	47%	**3**	**2.05**
	Effectiveness	2	Medium			**2**	
	Efficiency	2	Strong			**2**	
	Impact	1	Weak			**1**	
	Sustainability	3	Weak			**2**	
PMTCT	Relevance	4	Strong	£280,000	8%	**4**	**3.20**
	Effectiveness	3	Medium			**3**	
	Efficiency	3	Medium			**3**	
	Impact	3	Medium			**3**	
	Sustainability	3	Strong			**3**	
TAC	Relevance	3	Weak	£1,511,000	45%	**2**	**2.20**
	Effectiveness	2	Weak			**2**	
	Efficiency	4	Weak			**3**	
	Impact	3	Weak			**2**	
	Sustainability	2	Weak			**2**	
					100%		
SARRAH	*Relevance*				*0.2*	**2.63**	**2.21**
	Effectiveness				*0.3*	**2.08**	
	Efficiency				*0.2*	**2.53**	
	Impact				*0.15*	**1.62**	
	Sustainability				*0.15*	**2.08**	

The evaluation team's key recommendations all relate to the SANAC work-stream, considering that the PMTCT related work is long completed, and that SARRAH's support to TAC is in the form of unaccountable grant. Changing this support away from budgetary support and towards a more traceable

[2] 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

and therefore accountable form of support, such as the funding of specific projects or technical assistance, would be highly advisable. Recommendations are as follows:

- **Develop clear, measurable indicators 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 identified in SANAC's civil society workshop reports and the NSP Review website.
- **Mandate of the SANAC Secretariat.** Specifically focus on and clarify the mandate of the Secretariat, 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.
- **Accountability and M&E of SANAC**. Invest significant resources in understanding how SANAC can support the achievement of health results through effective M&E (accountability) that works within the current systems, potentially support addressing the challenges within that system, and develop a strategy that acknowledges a multi-sectoral approach in a complex and dynamic context. This should be done with an aim to promote accountability and responsibility for achievement of intended health results, and encourage buy-in from all sectors.
- **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 the Treatment Action Campaign reports. These documents concur in many of their recommendations and are from informed sources.
- **Focus on communication and supporting infrastructure, in particular a useful and accessible website**.
- **Focus on continuing to build relationships that will ensure a multi-sectoral approach to HIV and AIDS**.

3.2 What has been SARRAH's role in strengthening systems to effectively monitor and evaluate national strategic plans for HIV & AIDS and health

3.2.1 What support has SARRAH provided

SARRAH provided funding to three separate work-streams (SANAC, Quality Assurance and NHIRD) in its effort to strengthen systems to effectively monitor and evaluate national strategic plans for HIV & AIDS and health (logframe Output 5), all three of which were assessed as part of the midterm evaluation. Together these work-streams are designed to address a need that was jointly identified by NDoH and DFID as requiring additional support.

SARRAH provided £820,500 funding to National Quality Assurance (QA) and assisting the establishment of the Office of Health Standards Compliance (OHSC). The National Department of Health (NDoH) was in the process of developing a set of National Core Standards (NCS) for health establishments. The aim of the standards was 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. SARRAH is supporting the training programmes to assist provinces in implementing the standards that have been developed and has contributed to the development process of the National Core Standards which started in 2008.

As seen in section 3.1, SARRAH provided extensive support to SANAC, the body responsible for the coordination of the national response to HIV and AIDS. As an independent organisation, SANAC is expected to improve accountability through increased M&E capacity to evaluate progress against HIV and Health plans. The most extensive evaluation undertaken under this output focused on SANAC and how SARRAH funds were used to support the SANAC Secretariat in strengthening its IT, human resources and governance systems. It also supported the establishment of a monitoring and evaluation (M&E) unit in SANAC.

Finally, SARRAH provided £271,000 worth of support for the development of the National Health Information Repository and Data warehouse (NHIRD) that will contain up-to-date information on all aspects of health and health systems in South Africa according to the National Health Insurance (NHI) Green Paper. The purpose of NHIRD is "to convert data into actionable knowledge to lead to better decision making." NHIRD will house a monitoring and evaluation system from which the Health Management Information System would emanate.

3.2.2 Relevance

The QA, SANAC and NHIRD work-streams evaluated under this output were all found to be relevant towards strengthen systems to effectively monitor and evaluate national strategic plans for HIV & AIDS and health. Each work-stream evolved in response to the perceived organisational weaknesses and gaps believed to threaten the successful implementation of the NSP.

The QA work-stream is highly relevant as 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 a critical need for a uniform set of quality standards.

The establishment of SANAC is relevant to Output 5, especially its role in monitoring the overall implementation and review of the NSP. Multiple reviews previously found SANAC unable to provide the required guidance and monitoring for sector programmes for HIV and AIDS, and so it was on this basis that SARRAH provided support to the organisation as it underwent structural reform.

The activities of SARRAH in supporting the development of NHIRD are relevant in that they align with the priorities of the National Service Delivery Agreement for Health (NSDA).[3] The NSDA identifies the need to design an overarching technology policy framework and supporting regulations that will 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. Previously, NDoH did not have the health information system required to provide reliable data and to accurately monitor and evaluate the performance of healthcare services across the country.

3.2.3 Efficiency

The efficiency of activities conducted under the QA work-stream shows mixed results while SANAC's efficiency appears more limited to SARRAH's ability to quickly respond to funding gaps. Currently, the efficiency of NHIRD is difficult to determine without information on how reports are generated and used, which is currently categorised as classified information.

Evaluating the efficiency of the QA work-steam and the development of health measurements and indicators can be assessed by the extent to which information is produced on which users can act. Some of the NCS measurements are ambiguous and compliance is open to potentially wide interpretation. Other instruments, such as those accredited by the International Society for Quality Assurance (ISQua), appear to be better at identifying deficiencies in a way that highlights where action is needed. They also have the advantage that they recognise 'partial compliance' and encourage remediation incrementally over time.

However, it needs to be recognised that as the NCS have been sanctioned by NDoH as the standards to be applied and rolled out nationally, SARRAH's efficiency should also be measured against the support provided to NDoH in the process of developing these standards. Based on the feedback collected from the primary beneficiaries and a range of stakeholders, the support provided seems to have been delivered efficiently, i.e. in a responsive and utility-focused manner to the needs expressed by the department.

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

The same can be said about SARRAH's support in establishing OHSC: evidence suggests that the programme's role in making this initiative a reality has been significant, and that OHSC would not have been established as quickly, and to the same standard of quality, without the support provided by SARRAH.

"SARRAH played a major role in preparing the Business Case (including budget and HR plan) for DPSA and then Treasury." ***Stakeholder Interviews***

The overall efficiency of the NHIRD work-stream has proved more difficult to assess. It is unclear at this stage of the extent to which routine reports are being generated using data from NHIRD or how often users are able to access data. Another outstanding question relates to the extent of the integration of databases from various sources, which is a notoriously challenging problem, although NHIRD staff were confident that it was being successfully resolved. Direct observation of what is currently in place in terms of physical infrastructure is required in order to make an assessment of NHIRD's efficiency which has not yet been possible.

An assessment of the efficiency SARRAH's support to SNAC was presented in section 3.1.3.

[3] Department of Health, Service Delivery agreement for outcome 2: A long and healthy life for all South Africans. www.info.gov.za/view/DownloadFileAction?id=135747. Accessed on the 16th October 2012

3.2.4 Effectiveness and Sustainable Impact

effectively monitor and evaluate national strategic plans for HIV & AIDS and health is effective, especially in relation to the support for QA and NHIRD. Although SARRAH provided support to SANAC that was viewed by many interviewees as helpful, evidence of SANAC's overall effectiveness is weak this stage.

The effectiveness of the SARRAH's contribution to QA is partly determined by the recognition of key stakeholders of SARRAH's role in developing and implementing the core standards. The Office of Health Standards Compliance (OHSC) has been very complimentary about the role played by SARRAH in this process describing it as "an absolute lifeline." The comprehensive budget bid and organisational structure prepared with SARRAH support and submitted to National Treasury for the Medium Term Expenditure Framework (2012-2014) was warmly accepted and received a letter of endorsement to prioritise funding and support for the OHSC from the Office of the Minister of Finance. A SARRAH funded-consultant has been retained by the NDoH to continue to work closely with the OHSC implementation team, which also indicates a degree of sustainability.

However, an independent review of the NCS by a team of ISQua-accredited surveyors found a number of shortcomings in the standards in their current form. Numerous examples are cited in the work-stream report where the systems and processes to ensure good QA are inconsistently applied or lack the rigour and objectivity required for accurate measurement. Moreover, potential sustainability is challenged by a range of capacity constraints identified within NDoH.

"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)." ***Stakeholder Interviews***

SARRAH's contribution towards the establishment of NHIRD is considerable given a relatively short period. SARRAH funded all of the technical support during the first phase of the design, including two HISP staff seconded to the department, while NDoH provided the hardware. One interviewee commented that "Many were surprised at how much was achieved in such a short time." Another interviewee stated that SARRAH contributed towards establishing an 'enabling environment' through its development of standards, questionnaires, measures and database which could produce preliminary reports for facilities conducting assessments.

The evaluation team was denied access to the NHIRD system so verifying its functionality has proved impossible to date, although NHIRD's information respondents in the NDoH said, despite some delays in achieving the milestones on time, NHIRD is now fully operational and is effective. By these accounts, NHIRD 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 HIV and Syphilis survey data, child health, HIV Counselling and Testing Campaign data, and human resources data from the national (PERSAL) and municipal HR systems. As one interviewee noted, "Being web based makes the system easily accessible, subject to authorisation."

The sustainability of NHIRD, however, remains questionable. SARRAH support was critical for getting the system off the ground and its ongoing functionality depends on seconded staff supported by SARRAH. The seconded HISP employees are only contracted to May 2014 and NHIRD needs more programmers and developers to maintain the system.

Evidence on the effectiveness of SARRAH's support to SANAC was presented in Section 3.1.

3.2.5 Conclusion

Below is an overall assessment of SARRAH's success in strengthening systems to effectively monitor and evaluate national strategic plans for HIV & AIDS and health through its work on SANAC, NHIRD and Quality Assurance. SARRAH's overall score against that outcome is 2.41.

Table 5 - Meta-Evaluation Summary Table

Work-stream	Criteria	Data Source 1		Funding[4]	Weight	Total	Overall score
		Finding	Quality of Evidence				
SANAC	Relevance	3	Strong	£1,568,636	59%	**3**	**2.05**
	Effectiveness	2	Medium			**2**	
	Efficiency	2	Strong			**2**	
	Impact	1	Weak			**1**	
	Sustainability	3	Weak			**2**	
Quality Assurance	Relevance	4	Medium	£820,500	31%	**4**	**2.90**
	Effectiveness	3	Strong			**3**	
	Efficiency	3	Medium			**3**	
	Impact	2	Strong			**2**	
	Sustainability	2	Medium			**2**	
NHIRD	Relevance	4	Medium	£271,000	10%	**4**	**3.00**
	Effectiveness	3	Medium			**3**	
	Efficiency	3	Weak			**2**	
	Impact	4	Weak			**3**	
	Sustainability	3	Medium			**3**	
					100%		
SARRAH	*Relevance*				*0.2*	**3.41**	**2.41**
	Effectiveness				*0.3*	**2.41**	
	Efficiency				*0.2*	**2.31**	
	Impact				*0.15*	**1.51**	
	Sustainability				*0.15*	**2.10**	

Recommendations relating to SARRAH's work on SANAC were presented in Section 3.1. The evaluation team's recommendations relating to the Quality Assurance and NHIRD work-streams are as follows:

- The positive assessment of the NCS by those in the national office is not always endorsed by those who are grappling with the application of the standards at facility level. 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. **The evaluation team would recommend further investigation of the application of the NCS at facilities and the operation of the OHSC, once it becomes fully operational.**
- Considerable progress appears to have been made towards the establishment of a national health and related data repository in a relatively short period. However, the restricted access to information by the evaluation team has made formal verification almost impossible. Given that the 2012 evaluation is of a very new and still evolving system, further investigations will be necessary as it matures. 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. **The evaluation team recommends a more substantial evaluation of the data management, and the ICT systems in the 2014/15 evaluation cycle.**

[4] 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

3.3 What has been SARRAH's role in strengthening performance management and strategic planning for HIV and health services at National and provincial level

SARRAH has funded and supported a number of mostly relatively small, yet strategic initiatives designed to make the South African Health system better able to manage its human, financial and physical resources, assess the performance of its health services and plan ahead more effectively and strategically. The list of relevant initiatives includes work-streams which aimed at tackling the **financial management** shortcomings in the national and provincial health sectors (Asset Management, Conditional Grant Management, Provincial Financial Management), others focusing on **its human resource and organisational** deficiencies (Organisational Support to the National Department of Health, Assessment of DHMs and CEOs, Human Resource Strategy, Service Transformation Plans), and the large and strategic **Quality Assurance** work-stream whose mission was to design and implement a system of accreditation of South African health facilities based on their compliance with National Core Standards (NCS).

This section seeks to summarise the findings from individual mid-term evaluations of all of these work-streams to inform a general assessment of how successful SARRAH was in strengthening performance management and strategic planning for HIV and health services at National and provincial level.

3.3.1 What support has SARRAH provided

One of the ways in which SARRAH supported the South African health sector was in strengthening NDoH's capacity to manage, and make efficient use of, its large **financial resources**, at the central and provincial levels. A number of activities were undertaken to that effect.

- Asset Management: support was provided to NDoH to verify thousands of its physical assets in departments and health facilities across the country, and set up sustainable asset management systems, with the objective of ensuring adequate control and maintenance of assets, avoid unnecessary duplication and optimise the allocation of capital resources.
- Conditional Grant Management: Health conditional grants account for about 95% of the total South Africa's National Department of Health (NDoH) budget. Generally all grants come with conditions with regards to how they should be utilised and reported. SARRAH provided technical support to reduce the discrepancies between planned and actual expenditure of conditional grants.
- Provincial Financial Management: SARRAH provided support to the office of the Chief Financial Officer (CFO) and the DG in order to strengthen PFM at national and provincial levels.

SARRAH also supported NDoH in addressing what it and DFID had identified as some of its most urging human resource and organisational challenges, in particular through four key work-streams:

- Organisational Support to NDoH: since 2010 there has been renewed interest and commitment to organisational restructuring which would improve decision-making for better service delivery. Also, several health sector initiatives depend on a revised and strengthened NDoH for their effective implementation. SARRAH supported NDoH in the redesign of its organisational structures.
- Human Resource Strategy: SARRAH was commissioned to develop a Human Resources strategy report for NDoH, to identify where the health sector human resource gaps are, how they are likely to evolve in the future and what steps the government should take to ensure that the NHI project is adequately staffed.
- Service Transformation Plans: SARRAH also helped NDoH in sourcing and contracting consultants to assist provinces in developing their Service Transformation Plans (STP), which are long-term plans (ten years), designed to help provinces to improve service delivery by assessing provincial health needs against existing health services and budget.

- Assessment of DHMs and CEOs: The assessment of District Health Managers (DHMs) and Chief Executive Officers (CEOs) is one of the National Department of Health's (NDoH) Ten Point Plan, deliverable in terms of overhauling the healthcare system and improving its management. SARRAH provided an independent team of consultants to develop assessment tools and also to conduct the assessment.

Finally, SARRAH led a large work-stream of activities designed to strengthen the Quality Assurance of public health facilities in South Africa, in particular through the development of National Core Standards (NCS) for health establishments, as well as a national process of certification, managed by the Office of Health Standards Compliance (OHSC), which will formally assess each health facility for compliance against these standards, with the purpose being to ensure that compliance is a prerequisite for facilities wishing to participate in NHI.

3.3.2 Relevance

SARRAH has clearly worked towards addressing well identified needs for the South African health sector, and the Relevance therefore scores relatively highly. It is unclear whether SARRAH was the necessarily most appropriate mechanism for funding and implementing these various initiatives from a political perspective, although it did offer NDoH a high level of flexibility and enabled the quick allocation of resources to, and procurement of, discrete tasks.

Evaluation findings indicate that the relevance of supporting the South African government to increase its Public Financial Management capacity is strong and difficult to dispute. Maintaining adequate asset control in an organisation as large as the Department of Health which has hundreds of facilities and tens of thousands of assets is a massive undertaking. Poor asset control negatively affects the day-to-day running of health facilities and can lead to unnecessary duplications of equipment and poor maintenance. In addition, qualified audits were reported in 60% of department of health facilities by the Auditor General in 2012[5] and in most case the qualifications were the result of a history of poor asset management[6]. In 2010-11 the KwaZulu-Natal health department received a qualified audit 'mainly due to weak internal control environments over assets and leave.'[7] Similar findings were reported for the Eastern Cape[8] and Mpumalanga[9] and many were repeat findings from 2009-10. Addressing this issue was therefore selected as an indicator for the SARRAH programme.

Equally, there is strong evidence that large differences between planned expenditure and actual expenditure of conditional grants had always been a concern for the South African government. Poor grant management has led to grants being regularly under-spent or over-spent, which has resulted in inefficient allocation of grants, including those relating to HIV and AIDS, in a country where the death toll from sexually transmitted diseases and the inequalities in access to health are notorious.

Public Financial Management is a critical national issue. NDoH, like other departments such as the Department of Public Works and Home Affairs, has been receiving qualified audits over a number of years, which illustrates systemic issues in PFM across the country and in the health sector in particular and which need addressed if the sector's financial and capital resources are to be allocated efficiently and in a way that ensures equality in access and optimal quality of health services.

Research findings also suggest that SARRAH's work in strengthening the South African's health system's organisational structures and human resources was designed to address real short-term and long-term needs. In that sense it is therefore clearly relevant.

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[5] Auditor-General, 2012, Audit outcomes of national and provincial government: Financial year ended March 2012. Presentation to Cabinet

[6] Auditor General, 2011, "General report on the national audit outcomes 2010-11"

[7] Auditor General, 2011. General report on the outcomes of the KwaZulu-Natal Provincial Government 2010-11

[8] Auditor-general, 2011. "General report on the outcomes of the Eastern Cape provincial government 2010-11

[9] Auditor-general, 2011. 2010-11 General report on the provincial audit outcomes of Mpumalanga

The human resource shortages the public health sector suffers from in South Africa are well documented. Examples include the 25% attrition rate in medical professions, or the fact that 23% of medical school graduates plan to leave the country. Only one graduate doctor out of three, and one dentist out of ten, ends up working in the public sector. The shortages are exacerbated in rural areas, and based on current trends will only become more so if no action is taken: of the approximately 1300 medical graduates, about 35 end up working in rural areas. The 43.6% of South Africans living in rural areas are served by 12% of the nation's doctors and 20% of the country's nurses. Over a fifth of urban have medical aid, compared to 5% of rural people. In the past, the South African Government had developed a number of human resource strategies such as the HRH framework. These rapidly became out of pace with the requirements of the public health sector when the NHI gained prominence in the health policy agenda in South Africa.

Human resource shortages and obsolete organisational structures were also evident within the department of Health. One of the new policies which place new demands on the NDoH is Primary Health Care Re-engineering, which operates in three streams, namely a District-based model of specialist clinicians designed to improve key Millennium Development Goal health indicators; a School Health Programme; and a Ward-based PHC model. The other policy having a major influence on the NDoH is National Health Insurance which calls for a wide range of new approaches to facility management and staffing. Work in strengthening the organisational structure of NDoH was warranted.

"In terms of organisational effectiveness and performance NDoH scored the second lowest of about 1000 organisations assessed by McKinsey in 2010. 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." ***Stakeholder Interviews***

"NDoH Restructuring was required in order to meet the demands of the NSDA." ***Stakeholder Interviews***

Such challenges are also present at the provincial level, which was the reason for NDoH requiring the provincial departments to produce 10-year Service Transformation Plans (STP) to improve service delivery by assessing provincial health needs against existing health services and budget. Most STPs had inadequate draft plans, and these had not been finalised for several years, which highlighted capacity shortages which needed filled. SARRAH's role in helping regions through that process can be seen relevant in that respect.

Health officials had long also been concerned about the poor performance of hospitals, in relation to both health outcomes and management. They had attributed poor performance to:

- A 1994 policy that allowed hospitals to be run on business principles at the expense of suitable skills;
- The fact that some of the hospital managers were teachers, nurses and even clerks, whose highest qualification was a matric certificate and had no clinical background;
- Political patronage which promoted unskilled people into senior positions

No in-depth research was conducted, as far as the evaluation team is aware, to understand the real impact of any of these potential drivers on the performance of health facilities. While these seem plausible, and while patronage and indeed corruption are notoriously rampant across a range of sectors in South Africa, the rationale for this strand of SARRAH activities does not appear to be solidly grounded in evidence, except for a study by Pillay (2008) who conducted a self-administered survey among public health and private health managers and found that competences of managers varied greatly from one facility to the next. Hospital managers perceived themselves not to be competent in management; however, specific areas where they felt more competent were in planning,

self-management and leading[10] . Specifically, health care skills were the area in which the managers felt least competent. The areas where hospital managers felt competent (planning, self-management and leading) and those where they felt least competent (legal/ethical skills and specific health care skills) were the same for both public and private healthcare managers. More public health managers (94.9%) than private health managers (80.5%) indicated that they required further development in order to competently perform their tasks[11] . Given that most public managers were over 50 years, Pillay (2008) argued that it was critical that the public sector focuses on building the capacity of individuals within the ranks to take up the management of public health facilities.

"It can no longer be business as usual. Planning, organisation, and delivery of health services must reflect an added sense of urgency[12]." ***Minister of Health***

3.3.3 Efficiency

While the relevance of SARRAH's activities to strengthen performance management and strategic planning for HIV and health services at National and provincial level was highly rated by the evaluation team, evaluation findings on the extent to which these were delivered efficiently are mixed, though generally positive.

Financial resource management

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'.

By contrast, assessing the efficiency of the work conducted under the Provincial Financial Management work-stream is challenging given that reports produced by the consultant who provided technical assistant to NDoH was never shared with HLSP in order for them to push on with implementing the training phase of the project. While some of its findings and recommendations seem to have been partly considered and used as a basis for elements of a speech given by the Minister in 2012, it has proven impossible to date to verify objectively whether the work was conducted to a high standard.

The evidence also suggest that activities undertaken to strengthen conditional grant management were delivered with some efficiency through competent regional teams which made visits to provinces where conditional grant managers were trained and given on-going support. Evidence shows that concerns raised by the Auditor General in 2011 were looked into with some depth by being included in the 2012/13 strategic plans. The consultant hired was praised by some stakeholders for his efficiency.

"Hiring a consultant was efficient. When one is a consultant there is a work ethic. A consultant has to submit 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." ***Stakeholder Interviews***

Organisational and human resources management

There are concerns about providing support for the organisational reconfiguration of provincial health departments and of health sector organisations at district and local level. Performance management

[10] Pillay R. (2008), *Managerial competencies of hospital managers in South Africa: a survey of managers in the public and private sectors*, Human Resources for Health 2008, 6:4
[11] Pillay R. (2008), *Managerial competencies of hospital managers in South Africa: a survey of managers in the public and private sectors*, Human Resources for Health 2008, 6:4
[12] Dr P.A. Motsoaledi, Minister of Health, NDoH Strategic Plan 2010/11–2012/13:4

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. Direct recipients of the support were generally satisfied with the quality of the work carried out by the consultancy commissioned for this piece of work, McKinsey, and with the process involved.

"SARRAH was key to getting the job done because NDoH needed high-end consultants" ***Stakeholder Interviews***

Evidence also suggests that the consultation process and finalisation of the Service Transformation Plans proved a more lengthy process than initially anticipated. There were obvious challenges in working with provincial health departments which delayed finalisation of the STPs reports. For instance, the Kwazulu-Natal NDoH did not accept technical assistance on the costing component of their STP, but delayed close-out of the project by several months by not delivering this part of the report. The data also suggests that some provincial managers were initially unwilling to sign off on the work completed by consultants. There were concerns that this could be problematic if the STPs are questioned at a central level. It also meant that there were delays in payment for consultants working for HLSP. A mitigation strategy was developed involving the production of a full report on the status of all the STPs and the support provided. The evaluation team scored the delivery partners' efficiency in undertaking these activities highly given the constraints faced.

Concerns were expressed that the HR strategy was developed with little consideration of involvement of other existing expertise in the areas of policy formulation in human resources, although the report was delivered within the agreed timeframes and to a standards deemed acceptable to NDoH.

"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 to comment, we were given very short time to respond" ***Stakeholder Interviews***

Work in developing the tools for assessment of DHMs and CEOs seems to have been conducted satisfactorily by the delivery partners, especially considering the very acute sensitivities to manage in this particular work-stream, which relate primarily to the disclosure of senior individuals' fitness for the position they were occupying at the time of the assessment. Completion of the assessment reached 92% overall among DHMs, which is robust by any measure. Based on the limited information made available to the evaluation team as to the quality, and the take-up of the assessment results, efficiency was scored relatively highly.

The evaluation's findings relating to the Quality Assurance work-stream efficiency were presented in section 3.2.3 above.

3.3.4 Effectiveness and Sustainable Impact

Evaluation findings on the extent to which the support provided was effective in achieving its objectives are mixed, though generally positive. The same cannot be said of the potential for generating a sustainable impact on South Africa's health system, which has been difficult to demonstrate at this stage, and which often falls outside of SARRAH's control and relies heavily on the wider capacity of NDoH to build on the work done, adopt the products delivered, train the necessary number of staff and keep funding the initiatives at least until NHI becomes fully operational, i.e. in the mid-2020s.

Financial resource management

Stakeholders indicated that the improved management of assets would contribute to 'the budget being implemented as intended in a controlled and predictable way', that assets would be more optimally used and maintained with proper asset management procedures. This appeared to be particularly the case for equipment that was under-utilised or inadequately maintained. 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.

A positive spin-off is training hundreds of local matriculates as Interns, providing work experience and, potentially, employment in Asset Management Units. **Sustainability** of the asset management system depends overwhelmingly 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.

There is also clear evidence that SARRAH was **effective** in implementing intended conditional grant management plans especially on capacitating provincial managers and NGOs in legal and financial management laws and regulations, on timeous submission of business plans, and reports by provincial CG managers. SARRAH was also effective in putting in place a functioning financial monitoring system, developing the understanding of conditional grant management including monitoring expenditure, compiling reports to National Treasury, developing indicators, allocating funds to programmes, disbursing funds to institutions, etc.

"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***

Short-term **outcomes** can be observed including the presence of trained conditional grant managers in all areas pertaining to managing the grants efficiently in order to realise positive health outcomes in ordinary citizens. It is too soon to evaluate medium and long-term impact. The 2012/13 strategic plans will need to be evaluated in 2014 in order to assess impact. It is also too early to assess the extent to which there has been a reduction in the gap between planned grant expenditure and actual grant expenditure, although some early findings indicate mixed results, with WC, KZN and Gauteng being some of best performing provinces with NW and Mpumalanga the least performing provinces.

An indication of **sustainability** is the fact that NDoH hired the former SARRAH consultant as a Director to continue with this work. In addition, a new unit that deals with the conditional grant of HIV and AIDS was established. The unit was staffed with two Deputy Directors (DDs), two Assistant Directors (ASDs) and an Administrator. All financial managers' positions have been filled by managers whose Key Performance Areas (KPAs) are realigned with acceptable national standards. Conditional grant systems have been put in place, training has been conducted and the CFO established a forum of all conditional grant managers within the department to deal with common experiences that they encounter.

"SARRAH intervened by requesting expenditure records, interrogate them and assist with developing plans, speak to the concerned parties or report back to the DG who will require explanation to the province. Therefore, SARRAH played a critical catalyst/facilitative role" ***Stakeholder Interviews***

Diagnosis of the PFM problems faced by the seven provinces where the programme was meant to be implemented was completed and a training curriculum developed, however 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** except for North West. Indeed the analysis of the AGSA's audit opinions bears this out. Besides NDoH reporting that there has been a reduction of the number of provinces receiving qualified audits, the evaluation team could not find any evidence supporting improvement in financial management practices in the provinces. The evaluation team could not access the most critical parts of the reports due to them being said to be NDoH's property.

Apart from the National NDoH reporting continuation of monitoring of PFM in provinces, it is not clear who is doing this and whether there are standards set to measure improvement. The consultant that was supported by SARRAH has since left and the function is now rationalised within the relevant NDoH units. Therefore, there are **no sustainability** measures that can be reported against the financial management work-stream.

Organisational and human resources management

Effectiveness of the work conducted in the organisational redesign of NDoH is difficult to evidence due to McKinsey's report not being made available, and appears relatively weak to date. NDoH appears to be satisfied with the project and the initial realignment of responsibilities has been achieved. A comprehensive organisational redesign has been developed and implementation is in progress. However, there is much work still to be done and the decision-making structure remains "quite opaque and centralised". 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.

"The McKinsey report has not been made available. HLSP's only information came from a presentation of the findings which were considered too sensitive for wider distribution." ***Stakeholder Interviews***

Overall, there appears to be little risk that the interventions will not be followed through since the changes have been approved by DPSA, which provides an indication of the potential sustainability of the work-stream. 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.

"Evidence of improvements is that the HCT results were made available for the first time and people are working together to make things better." ***Stakeholder Interviews***

"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***

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 PHC priorities. Further, we have no data that confirm implementation of the STPs. Thus we cannot assess how the STPs contributed to, or are in the process of contributing to, an improvement in health services. The implementation of STPs is internal to the NDoH and SARRAH can only assume that the reports are being used and are informing the national health insurance (NHI) preparation work. The STPs are not available on departmental websites, probably due to their sensitive nature, but a review of SARRAH's annual reports and plans of provincial departments indicated that some departments are currently still in the stage of approving their STPs. 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.

It is too early to state whether the HR strategy has had any impact on HR strengthening in South Africa. However evidence from the evaluation points to 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. Sustainability in the case of the HR strategy is ensuring that it is translated into practical plans for implementation. There is no evidence as yet to demonstrate the potential for sustainability, as there currently exist no operational plans nor budget and selection of activities from the plan have been on ad-hoc basis.

One of the key observable outcomes of assessment of the DHMs and CEOs is that the NDoH had to redefine the eligibility criteria of the hospital CEOs across the board. This is something that had been recommended in 2003 but had not occurred, and can be directly linked to SARRAH funding of the assessment exercise. Thus when the new adverts went out, it was very clear what types of skills set were required and there was no chance of unqualified people applying to fill positions requiring healthcare qualifications and experience. However, given that the restructuring of the health sector is currently taking place through the advertisement for a number of positions in each of the provinces, establishing the impact and sustainability of the assessment of CEOs and DHMs might take much longer than anticipated.

Findings relating to the effectiveness and impact of the QA work-stream were presented in section 3.2.4.

3.3.5 Conclusion

Below is an overall assessment of SARRAH's success in strengthening performance management and strategic planning for HIV and health services at National and provincial level through its work on Quality Assurance, organisational redesign of NDoH, assessment of DHMs and CEOs, STPs, Human Resources and Financial Management. SARRAH's overall score against that outcome is 2.76.

Table 6 - Meta-Evaluation Summary Table

Work-stream	Criteria	Data Source 1		Funding[13]	Weight	Total	Overall score
		Finding	Quality of Evidence				
Quality Assurance	Relevance	4	Medium	£820,500	15%	4	2.90
	Effectiveness	3	Strong			3	
	Efficiency	3	Medium			3	
	Impact	2	Strong			2	
	Sustainability	2	Medium			2	
NDoH	Relevance	4	Medium	£633,000	11%	3	2.90
	Effectiveness	2	Weak			2	
	Efficiency	4	Medium			4	
	Impact	3	Medium			3	
	Sustainability	3	Medium			3	
Assessment of CEOs	Relevance	3	Weak	£1,149,437	21%	2	2.35
	Effectiveness	3	Medium			3	
	Efficiency	3	Medium			3	
	Impact	2	Medium			2	
	Sustainability	1	Weak			1	
Provincial Financial Management	Relevance	3	Weak	£215,000	4%	3	1.70
	Effectiveness	1	Weak			1	
	Efficiency	1	Weak			1	
	Impact	2	Weak			2	
	Sustainability	2	Weak			2	
Conditional Grant Management	Relevance	4	High	£72,200	1%	4	3.35
	Effectiveness	4	Medium			3	
	Efficiency	3	Medium			3	
	Impact	3	Weak			3	
	Sustainability	4	Strong			4	
STPs	Relevance	4	Weak	£249,800	5%	3	2.40
	Effectiveness	3	Weak			2	
	Efficiency	3	Weak			3	
	Impact	3	Weak			2	
	Sustainability	2	Weak			2	
Human Resources	Relevance	4	Weak	£198,000	4%	4	2.40
	Effectiveness	2	Weak			2	
	Efficiency	2	Weak			2	
	Impact	2	Weak			2	
	Sustainability	2	Weak			2	

[13] 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

Asset Management	Relevance	4	Strong	£2,168,523	39%	**4**	**3.05**
	Effectiveness	3	Strong			**3**	
	Efficiency	3	Medium			**3**	
	Impact	3	Medium			**3**	
	Sustainability	2	Weak			**2**	
					100%		
SARRAH	*Relevance*				*0.2*	**3.38**	**2.76**
	Effectiveness				*0.3*	**2.73**	
	Efficiency				*0.2*	**3.00**	
	Impact				*0.15*	**2.52**	
	Sustainability				*0.15*	**1.93**	

The evaluation team's recommendations are as follows:

- It is still too early to be able to assess the proportion of facilities that are fully compliant with the new asset management processes according to the revised standard operating procedures. However, improved management of assets should contribute to the development of a more credible budget which is linked to policy priorities. **The evaluation recommends that the final evaluation follows up on the Asset Management work-stream in 2014 to assess the extent to which it has produced the intended results**.
- Findings suggest that SARRAH's work on conditional grant management has led provincial departments to be able to submit their business plans aligned with policy priorities, as well as monthly and quarterly expenditure reports to the NDOH on time. Another achievement attributed to SARRAH is the increased membership of the CFO's forum. This membership has promoted the budget process to adopt a more consultative approach, as it assists the forum to fully understand the challenges experienced by the Comprehensive HIV and AIDS conditional grant in the provinces. **The evaluation team recommends that the final evaluation follows up on the conditional grant management work-stream in 2014 to assess the extent to which it has produced the intended results**: a reduction in the mismatch between planned grant expenditure and actual grant expenditure.
- Evaluation findings also suggest that the SARRAH's PFM work is relatively low risk and of potentially high impact. However, 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 in provincial health departments. Nevertheless, **the evaluation team recommends that this work is completed as PFM is crucial if the implementation of NHI is to be possible and successful**.
- The restructuring of the NDoH appears to progressing steadily, and the new organogram appears to be well aligned to the requirement of the NSDA. There is evidence of improved decision making within the department and a sense of improved morale, which was apparently very low at the beginning of the process. **Further evaluations of this work-stream will need to be undertaken during 2013 and again in 2014/15 to assess impacts of the NDoH work-stream**.
- **The evaluation team recommends that the final evaluation follows up on the STP work-stream in 2014, to assess the extent to which STPs have been developed, and implemented as a result of SARRAH's support**.
- Findings suggest that at this point, the implementation of the SARRAH-developed 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. Moving forward and in order to realise the input of the HR strategy, **there seems to be a need to develop a detailed and**

concrete HR development plan, through the identification of capacity within the departments of health, training and research institutions and NGOs.

- **This report recommends that the next phase of the assessment of CEOs and DHMs be conducted in close co-operation with the NDoH** to ensure a greater response rate than what was achieved in the process evaluation. Given that the restructuring of the health sector is currently taking place through the advertisement for a number of positions in each of the provinces, establishing the impact of the assessment of CEOs and DHMs might take much longer than anticipated. **The evaluation team therefore recommends that the final evaluation follows up on this work-stream in 2014, to assess the outcomes of the changes in management in health facilities and health authorities which will have occurred.**

3.4 What has been SARRAH's role in supporting national interventions to improve access and equity of HIV and health services

While improving access and equity of HIV and health services is at the core of most of the work carried out by SARRAH, the evaluation team identified two work-streams which were designed to contribute more directly to the high-level objective of improving access to healthcare, and for which the likelihood of detecting a measurable effect seemed highest: the support to establishing the National Health Insurance (NHI), and the support to setting up the South African Health Products Regulatory Authority (SAHPRA).

3.4.1 What support has SARRAH provided

Support to establishing the National Health Insurance

The planned National Health Insurance scheme aims to provide access to quality health care, free at the point of use, for all South Africans. It is a very ambitious undertaking which is estimated to need 14 years to be implemented. SARRAH has committed a substantial part of its programme (about 12% of the budget or £2.43 million) to supporting the development of the NHI, which is a priority for the South African government, through a range of activities which include designing aspects of the NHI, logistical and communication support, and support for the selection of the NHI pilot districts and the implementation of the pilots, as well as technical support to a range of teams involved in preparing South Africa to roll out NHI.

Support to setting up SAHPRA

Access to quality, safe and affordable medicines remains one of the key challenges to an effective national response to HIV and health in South Africa. The Medicines Control Council (MCC) is a statutory body that was established in 1965 to oversee the regulation of medicines in South Africa. A number of inefficiencies were identified in MCC; among which were staff and skill shortages, an inefficient governance structure and obsolete IT systems for tracking applications, and these have contributed to a large backlog of medicine applications submitted but not processed in a timely manner, or left unprocessed altogether. For this reason, and after a report was submitted by a ministerial task team on MCC evidencing the institution's shortcomings, legislation was passed in 2008 which would formally replace MCC with a new structure, the South African Health Products Regulatory Authority (SAHPRA).

A substantial part of the SARRAH programme (over £2 million or 11% of SARRAH's total budget) was dedicated to help address this problem, in two distinct phases. Phase 1, which involved directly supporting MCC to process medicine applications with the view to reduce, if not eliminate, the backlog of unprocessed applications. Phase 2 initially involved setting up SAHPRA as a legal entity and implementing the project, but further discussions with senior political representatives resulted in a change of tack and a change in SARRAH's terms of reference, which were changed to support in the design of SAHPRA instead of its implementation.

3.4.2 Relevance

The SARRAH NHI work forms one part of numerous activities in support of the National 10-point Plan and it has been suggested by the HLSP technical lead and others that having a specific NHI work-stream 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. Moreover, activities conducted under this work-stream are more directly related to the national NHI initiative than the other work-streams, in particular through its role in selecting the NHI pilot districts, designing and implementing these pilot activities, which seems to justify the work-stream's title.

Given the complexity and ambition of the NHI project, combined with the fact that it seeks to partly emulate other international models of free and universal healthcare, one of which is the UK's National Health Service (NHS), evaluation findings seem to indicate that a degree of DFID funded technical assistance and expertise is widely perceived as appropriate across the South African health sector. The type of support provided, mostly in the form of targeted, strategic pieces of research and design on various aspects of NHI, was sanctioned and allocated by the South African Department of Health itself

in order to address visible needs, which further strengthens the widely shared perception that the type and scale of support provided so far were relevant.

Evaluation findings with regards to the relevance of the support provided under the SAHPRA work-stream are not as unequivocal however. The backlog of applications for new medicines to be registered was undoubtedly seen all round as a major issue directly impacting on the availability of affordable and effective medicines in health facilities across the country. The need to process those applications as soon as possible is widely perceived in the South African health community as a matter of urgency, and there is little doubt that SARRAH's assistance in reducing the backlog was relevant. Similarly to the technical assistance provided under the NHI work-stream, the sanction and support of NDoH indicates processing the backlog of applications as well as supporting the establishment of SAHPRA is aligned with government priorities.

What can be questioned however is not the alignment of SARRAH support with government priorities, but the very rationale for establishing SAHPRA. The MCC is widely perceived to be an inefficient body, as evidenced by the backlog of applications and the extensive literature exploring the shortcomings of this 48 years old, understaffed institution. The relevance of merely replacing an existing body, the MCC, with another one, SAHPRA, without seriously addressing what are believed by a number of stakeholders to be the core reasons behind its failure, can be contested. These issues include the lack of skilled medicine regulators and the reliance on an ageing cadre of experts, insufficient levels of transparency and the poor communication between political representatives and the pharmaceutical industry.

"It was felt that money was not used wisely since establishing SAHPRA was based on misconception and did not deal with existing problematic issues, did not take seriously input from the industry. Funds could have been put into real dialogues between government and the industry." ***Stakeholder Interviews***

While it can be argued that in line with the amendments in the Medicines Act of 2008, time to set up an independent and efficient body replacing the MCC had arrived, there is a view that taken in isolation, this measure will not effectively address the issues facing the regulation and access of medicines in South Africa.

3.4.3 Efficiency

SARRAH's contributions to the implementation of NHI are taking place at many levels and are laying the foundations for a complex system. The Minister's road show is a necessary public relations exercise and explains that NHI cannot be achieved overnight. Strengthening the public 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 positive response is because the private sector is beginning to realise that medical schemes will continue to exist and because there are business opportunities, although there are affordability issues. The groundwork being done by SARRAH and others is helping to pave the way for evidence-based decision making. There is a slightly haphazard sense about the diverse range of activities in this work-stream but it is the responsiveness of the SARRAH programme to the changing requirements of the evolving NHI programme that is one of its strengths. The work-stream's performance against the efficiency criterion will need to be assessed at the final evaluation stage as activities relating to the implementation of the NHI pilots are yet to be carried out.

Findings relating to activities undertaken under the SAHPRA work-stream are, here again, less unequivocal. The Phase 1 milestones, relating to addressing the application backlog, were all achieved in time, which suggests SARRAH was efficient in carrying out its tasks. The Phase 2 milestones, on the other hand were seldom achieved, mostly due to shifting goal posts and the fact that the phase got suspended for a significant period. When Phase 2 resumed, the initial terms of reference, which initially required SARRAH to implement SAHPRA, were changed: SARRAH was now required to design SAHPRA.

In spite of this unexpected turn of events, the evidence suggests that the consultant who was contracted by SARRAH to begin working on the design of SAHPRA was isolated, lacked credibility within the

community of stakeholders, and that he did not adopt a sufficiently collaborative approach in carrying out his activities.

"The SARRAH funded consultant provided Technical Assistance but it appears that he was isolated by MCC/NDoH; Although he worked very hard on the framework, he ignored the input from the industry and came up with his ideas instead; the framework itself failed to address existing problems in the MCC e.g. the poor attitude of MCC reviewers and secretariat, guidelines, regulations and the ACT that were not ready for this entity." ***Stakeholder Interviews***

Evidence therefore suggests that while SARRAH's efficiency (doing things in the right way) was satisfactory with regards to the Phase 1 activities, it has so far not performed as well against this criterion as far as Phase 2 activities are concerned.

3.4.4 Effectiveness and Sustainable Impact

Support to establishing the National Health Insurance

South Africa is doing more health system strengthening than almost any country and a characteristic of the NHI work is that the government is labelling much normal health systems strengthening work as NHI. For example, strengthening district specialists was under way before the NHI Green Paper was published but is now identified as part of the NHI. Health service delivery in the Pilot Districts needed major overhaul before NHI could be introduced and SARRAH has provided general support to improving the health system.

In terms of overall effectiveness, the preparatory work done in the pilot districts is, to date, the most concrete contribution to NHI being implemented. SARRAH provided technical support at several levels and contributed important groundwork necessary for decisions to be taken by NDoH about the selection of 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. The Leadership Academy is another initiative that can be seen as crucial to NHI, as is the national Human Resource strategy for hospital management.

As indicated above, SARRAH has undertaken important preparatory work for NHI. It is difficult to judge conclusively whether South Africa is in a better position to implement NHI as a result of SARRAH but it is likely that 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.

"All activities contribute to strengthening the health system and especially PHC but it is too early to show impact." ***Stakeholder Interviews***

When asked whether there is any risk that SARRAH investments will be wasted, the informants' consensus is that they cannot be because all the initiatives contribute to essential health system strengthening. The majority of politicians are supportive of NHI as a way to expand access to quality healthcare to the vast majority of South Africans.

"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." ***Stakeholder Interviews***

"Buy-in by private sector appears to be positive." ***Stakeholder Interviews***

Support to setting up SAHPRA

The fact that the backlog of applications seems to be approximately as large as it was prior to SARRAH beginning its work, suggests that Phase 1 activities, while undertaken efficiently and in compliance with the terms of reference, were not effective in achieving their stated objective of eliminating, or at least reducing the backlog of medicine applications. The lack of access to reliable backlog data, combined

with contradicting views regarding the state of the backlog among stakeholders, have made it difficult for the evaluation team to assess the extent to which the backlog has actually been reduced as a result of SRRAH or not. However, triangulation of data obtained from interviews as well as document review suggests that the backlog, far from having disappeared, is broadly as large as it was prior to SARRAH activities taking place.

"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." ***Stakeholder Interviews***

Some also expressed the view that part of the backlog was due to thousands of drug applications which are for drugs that are non-essential and contribute to bogging the system down, arguing that what is really needed is a system to prioritise essential drugs and get them licensed. While this claim has proved difficult to verify objectively, the evaluation team will keep on investigating this issue going forward with the view to provide a more informed assessment in the final evaluation report.

SARRAH's activities under Phase 2 in reaching their stated objectives of designing and helping to set up SAHPRA do not seem to have been highly effective either. Indeed, to this date and to the evaluation team's knowledge, SAHPRA has still not been established as a legal entity. However it should be recognised that the lack of progress is in large part due to the suspension of Phase 2 activities for a period of circa six months during which no progress could be achieved, and to the fact that when Phase 2 activities resumed, SARRAH's terms of reference had changed: SARRAH was no longer expected to implement SAHPRA, but only to design it. It can therefore reasonably be argued that the poor effectiveness shown so far results from forces largely outside SARRAH's control, and that it cannot be directly imputable to the programme.

While it is too early to judge what the impacts of this work-stream could be and whether they have the potential to be sustainable, it can be said that unless tangible progress towards increasing the pace of processing applications and establishing SAHPRA as a legal, and functioning entity can be observed, SARRAH's impact in the area of medicine control and access in South Africa is likely to be marginal.

3.4.5 Conclusion

Below is an overall assessment of SARRAH's success in supporting national interventions to improve access and equity of HIV and health services through its work on NHI and SAHPRA. SARRAH's overall score against that outcome is 2.36.

Table 7 - Meta-Evaluation Summary Table

Work-stream	Criteria	Data Source 1		Funding[14]	Weight	Total	Overall score
		Finding	Quality of Evidence				
NHI	Relevance	4	Strong	£1,539,513	34%	**4**	**2.85**
	Effectiveness	3	Medium			**3**	
	Efficiency	2	Medium			**2**	
	Impact	3	Weak			**2**	
	Sustainability	4	Medium			**3**	
SAHPRA	Relevance	3	Strong	£2,958,838	66%	**3**	**2.10**
	Effectiveness	1	Medium			**1**	
	Efficiency	3	Medium			**3**	
	Impact	2	Medium			**2**	
	Sustainability	2	Medium			**2**	

[14] 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

		100%		
OUTPUT 3	*Relevance*	*0.2*	**3.34**	**2.36**
	Effectiveness	*0.3*	**1.68**	
	Efficiency	*0.2*	**2.66**	
	Impact	*0.15*	**2.00**	
	Sustainability	*0.15*	**2.34**	

The evaluation team's key recommendations are as follows:

- The SARRAH NHI initiatives are diverse in nature but appear to be contributing to the body of essential information for decision-making. There is a slightly haphazard sense about the diverse range of activities in this work-stream but as has been mentioned in the SARRAH reviews, it is the responsiveness of the SARRAH programme to the changing requirements of the evolving NHI programme that is one of its strengths. Time will tell how many interventions are eventually incorporated into NHI but most of them will contribute to improved health systems. **It is recommended that the ongoing work in the pilot districts is closely monitored and more in depth evaluation undertaken as the work proceeds**.
- **To resolve some of current inefficiencies within MCC, a working IT system** that allows MCC to (1) track the number of applications submitted, (2) number of applications processed, (3) number of applications requiring additional information from applicants, (4) number of applications approved, (5) record timelines for each process and (6) an effective communication mechanism to inform applicants of the progress of their applications **should be put in place**. At this stage it is reported that there is a system, but it does not seem to perform as intended.
- **Separate application evaluators and a project manager (specifically for this work) should be appointed to fast-track the backlog**.
- **To widely consult and engage with all stakeholders before resuming with the activities of establishing SAHPRA**, a communication strategy with stakeholders, through the stakeholder forum, should be effectively used to update stakeholders about the progress made in addressing backlogs, invite and openly receive input and provide feedback to enquiries and questions from NDoH.
- **The sustainability of SAHPRA should be made one of the key criteria when setting it up**. This independent entity is forecast to employ 400 members of staff, almost three times as many as MCC, and on a full-time basis, unlike the part-time academics serving in the various MCC committees. A commitment to a ring-fenced budget to sustain the organisation would appear critical.
- **It is also recommended that SARRAH maintains its technical assistance work until SAHPRA becomes a fully staffed and operational body**. Since a substantial amount of funding has already been used under this work-stream, not following through would present high risks of seeing this large contribution not achieving its goals.

4 VALUE FOR MONEY

4.1.1 Overall Approach

The SARRAH Evaluation Strategy sets out a '3Es' approach[15] 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*.

Scope of this VfM Assessment at the Mid-Term Stage

The Evaluation Strategy 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. This complements two Annual Reviews completed in June 2011 and June 2012 by Coffey International Development.

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 four assessment tool questions as follows:

> *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 determined that given the scope and focus of the Value for Money Review that it would be appropriate for this mid-term evaluation to focus on SARRAH's effectiveness i.e. the extent to which outputs and translating into desired outcomes.

At this stage in the programme lifecycle of SARRAH, many of the work-stream activities will have completed or are nearing completion. Through a range of different types of interventions SARRAH intended to support, strengthen and catalyse improvements in the South African health system. 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 proposed that this mid-term evaluation should adopt a process evaluation approach that focuses on what has been delivered, how and with what intermediate results and effects.

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

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.

VfM Assessment Methodology

This mid-term evaluation will use and build on the findings from the Value for Money Review of SARRAH and its two Annual Reviews completed to date at both the work-stream and overall programme level. The evaluation will make use of these 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 contribution of £25m over 5 years only represents 0.2% 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 the National Department of Health 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 mid-term evaluation has used the following value for money effectiveness criteria[16]:

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.

   Key VfM questions:

   1.1 What evidence is there that this work-stream has levered in additional resources (financial or in-kind)?

   1.2 What is the likelihood (evidence) that this work-stream will have a significant scale of effect?

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.

   Key VfM questions:

   2.1 How credible and realistic are the assumptions underpinning the work-stream?

   2.2 What is the likelihood and risk that the work-stream will or will not deliver their intended purpose?

At this mid-term stage in SARRAH's lifecycle, this value for money assessment is focused on evidencing the contribution of the programme to its logframe outputs and outcome as shown in the Outcome Mapping (Annex _) presented in the Evaluation Strategy. The purpose of the value for money 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.

[16] 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)

Each work-stream has been assessed against the above effectiveness criteria used the value for money scoring mechanism[17] set out in Table _. Evidence supporting this assessment has been drawn from the analysis undertaken against the key evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability. Annex _ presents the Value for Money Assessment for each of the work-streams, which includes the performance assessment of the economy and efficiency of each work-stream undertaken for the previous SARRAH Value for Money Review.

Assessment of SARRAH's Value for Money

To be completed in next draft

[17] 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)

Table _: Value for Money Assessment Sheet

VfM Criteria	VfM Question	Score descriptors				
		1	**2**	**3**	**4**	**5**
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 described and supported by some evidence*	*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*	*Some 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*	*Some assumptions about externalities are realistic and credible; some questions about coverage and depth*	*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*	*Some risk of underachieving but managed to enable achievement of purpose*	*Low risk of underachieving; likely will achieve purpose*	*Probable will achieve or exceed purpose*

5 CONCLUSIONS & RECOMMENDATIONS

5.1 Overall performance of SARRAH

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. Overall, **the mid-term rating for SARRAH is 2.50**, 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 will probably increase as the initiatives start to bear fruit in a more detectable way.

Table 9 - Meta-Evaluation Summary Table

Work-stream	Criteria	Data Source 1		Funding[18]	Weight	Total	Overall score
		Finding	Quality of Evidence				
SANAC	Relevance	3	Strong	£1,568,636	12%	3	2.05
	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	2.85
	Effectiveness	3	Medium			3	
	Efficiency	2	Medium			2	
	Impact	3	Weak			2	
	Sustainability	4	Medium			3	
SAHPRA	Relevance	3	Strong	£2,958,838	22%	3	2.10
	Effectiveness	1	Medium			1	
	Efficiency	3	Medium			3	
	Impact	2	Medium			2	
	Sustainability	2	Medium			2	
Quality Assurance	Relevance	4	Medium	£820,500	6%	4	2.90
	Effectiveness	3	Strong			3	
	Efficiency	3	Medium			3	
	Impact	2	Strong			2	
	Sustainability	2	Medium			2	
NDoH	Relevance	4	Medium	£633,000	5%	3	2.90
	Effectiveness	2	Weak			2	
	Efficiency	4	Medium			4	
	Impact	3	Medium			3	
	Sustainability	3	Medium			3	
NHIRD	Relevance	4	Medium	£271,000	2%	4	3.00
	Effectiveness	3	Medium			3	
	Efficiency	3	Weak			2	
	Impact	4	Weak			3	

[18] 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

	Sustainability	3	Medium			**3**	
PMTCT	Relevance	4	Strong	£280,000	2%	**4**	**3.20**
	Effectiveness	3	Medium			**3**	
	Efficiency	3	Medium			**3**	
	Impact	3	Medium			**3**	
	Sustainability	3	Strong			**3**	
TAC	Relevance	3	Weak	£1,511,000	11%	**2**	**2.20**
	Effectiveness	2	Weak			**2**	
	Efficiency	4	Weak			**3**	
	Impact	3	Weak			**2**	
	Sustainability	2	Weak			**2**	
Assessment of CEOs	Relevance	3	Weak	£1,149,437	8%	**2**	**2.35**
	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**	**1.70**
	Effectiveness	1	Weak			**1**	
	Efficiency	1	Weak			**1**	
	Impact	2	Weak			**2**	
	Sustainability	2	Weak			**2**	
Conditional Grant Management	Relevance	4	High	£72,200	1%	**4**	**3.20**
	Effectiveness	4	Medium			**3**	
	Efficiency	3	Medium			**3**	
	Impact	3	Weak			**2**	
	Sustainability	4	Strong			**4**	
STPs	Relevance	4	Weak	£249,800	2%	**3**	**2.40**
	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**	**2.40**
	Effectiveness	2	Weak			**2**	
	Efficiency	2	Weak			**2**	
	Impact	2	Weak			**2**	
	Sustainability	2	Weak			**2**	
Asset Management	Relevance	4	Strong	£2,168,523	16%	**4**	**3.05**
	Effectiveness	3	Strong			**3**	
	Efficiency	3	Medium			**3**	
	Impact	3	Medium			**3**	
	Sustainability	2	Weak			**2**	
					100%		

SARRAH	*Relevance*	*0.2*	**3.20**	**2.50**
	Effectiveness	*0.3*	**2.23**	
	Efficiency	*0.2*	**2.75**	
	Impact	*0.15*	**2.13**	
	Sustainability	*0.15*	**2.13**	

5.2 Cross-cutting Recommendations

This section attempts to list some of the cross-cutting recommendations which can be made at this advanced stage in the implementation of the SARRAH programme:

- **Maintain support to struggling initiatives which have already absorbed a significant amount of SARRAH resources until completion**. Activities carried out under some of the large work-streams including 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 underpins these initiatives are 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 the technical and financial support until completion and attainment of intended outcomes. Not following through would present high risks of seeing this large contribution not achieving its goals.
- **Enforcing a much higher level of oversight from DFID and HLSP of activities commissioned and funded under SARRAH**. It has become apparent throughout this evaluation that the products of a range of SARRAH-funded projects and initiatives have been made inaccessible to DFID's, or HLSP's scrutiny. 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. It is recognised that the DFID-funded programme accounts for just 1% of the mighty R 26 billion South African health budget. It is also recognised that the implementation model, which consists of a unique and very close partnership between DFID and NDoH, is highly desirable to ensure that SARRAH can contribute effectively to national health policies in South Africa. However this model seems to have morphed, in a number of instances, into an asymmetrical partnership in which 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 allowed much more regularly following rigorous data protection systems and procedures. Otherwise, it is probable that a number of initiatives, accounting on aggregate for a significant share of the SARRAH budget, will not be traceable and evaluable, and consequently will not comply with the transparency and accountability requirements which UK technical assistance projects are subject to.
- **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. This is an obvious synergy which, depending on progress made against the M&E related work, and on the accessibility of data by independent evaluators, should be exploited going forward.
- **Monitor emerging needs and gaps for SARRAH to address on current work-streams**. SARRAH's flexibility and its capacity to respond to needs jointly identified by NDoH and DFID and unblock resources quickly and efficiently have been consistently praised by a range of stakeholders across the programme. 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 the expertise acquired to date, the evaluation team would recommend that this is applied within the current streams of work, so as to avoid SARRAH spreading itself too thinly in the future.