ANNUAL REVIEW OF DFID STRENGTHENING SOUTH AFRICA'S REVITALISED RESPONSE TO AIDS AND HIV (SARRAH) PROGRAMME ©

On behalf of the Department for International Development (DFID) South Africa

June 2011

coffey international development
SPECIALISTS IN DEVELOPING COMMUNITIES

In association with

HSRC
Human Sciences Research Council

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This report has been prepared for the Department for International Development by Charles Wright, Consultant supplied by Coffey International Development, and John Seager, Consultant supplied by HSRC. The views expressed herein are those of the authors and do not necessarily represent the view of Coffey International Development, HSRC or DFID.

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AIDE MEMOIRE FOR THE FIRST ANNUAL REVIEW OF SARRAH

1 INTRODUCTION AND METHODOLOGY

This is the report of the first annual review of the SARRAH Programme. This internal review was conducted under the overall guidance of Bob Fryatt and Hilary Nkulu of DFID, with the field work, analysis and report drafting being conducted by Charles Wright of Coffey International Development and John Seager of the Human Sciences Research Council South Africa. The fieldwork was conducted between 23 May 2011 and 10 June 2010.

The main purpose of this report is to review the progress of the programme against the goal, purpose and outputs set out in the programme logframe and documentation. In addition, the TOR (Annex 6) stipulate a further 12 issues to be reviewed covering various elements of programme governance and management, engagement with programme partners, impacts, challenges, and aspects of value for money. The report also makes recommendations where appropriate and draws out lessons learned for the remainder of the programme.

The review is informed by a desk review of relevant documents (Annex 1) and semi-structured interviews with DFID staff, partners within the NDoH, SANAC and TAC, and the Service Provider HLSP (Annex 3). These interviews were followed by an inspection of evidence needed to validate progress made (Annex 5). The review findings, conclusions and recommendations were presented to and considered by DFID and HLSP on the 9 June 2011. Thereafter we updated the presentation. These slides form an integral part of our findings, as well as our 'scoring' of the programme outputs and workstreams (Annex 2). The slides (including attendee comments provided as PowerPoint 'Notes') represent the systematic record of workstream progress and performance. A bibliography of documents reviewed is provided in Annex 4.

The penultimate stage of the assignment was the review of the 'self evaluation' of the programme's performance by HLSP, and the completion of the assignment team's (including DFID) independent evaluation, using the Aries Annual Review Excel Template. In using the tool, the review team opted to 'score' each of the individual workstreams against their respective 'milestones' and then used these scores to inform the overall score attributed to the output. The final stage of the assignment was the drafting of this assignment report, and its subsequent finalisation.

We start this analysis with the overall context of the assignment, and some of the challenges faced. We then set out the overall findings and conclusions that have emerged, before addressing the specific issues mentioned in the TOR. Note that all recommendations made in the text are summarised in tabular form at the end of the report, including the institution responsible for follow up and due date.

2 BACKGROUND AND CONTEXT

The expenditure budget for the Health Sector in 2011/12 totals Rand 25.7 billion or £2,4 billion, an increase of 90% from just four years ago[1]. SARRAH's contribution of £25 million over five years, while sizeable in itself, only represents approximately 0.2% of South Africa's Health Budget in a single year. Indeed the aggregate of total Development partner support usually amounts to 2 – 3% of the total Health budget. Therefore Donor ability to influence substantially the allocation of health resources and the direction of spend is limited, and can only be done through carefully considered and constructed advocacy.

The NDoH has gone through a series of rapid changes in the last 18 months. This includes the appointment of the new Minister and Deputy Minister, followed by the passing of the Deputy Minister, and finally the appointment of Director General in June 2010 This has precipitated a new vibrancy and commitment within the NDoH itself and indeed within the sector as a whole, which has been underpinned by a complete review of NDoH's priorities, management and performance, from National

[1] Per National Treasury Budget – Vote 16 Health Page 4. Expenditure in 2007/8 was R13.5bn

level progressively down to District and eventually Health Unit level. This progressive turn of events has had impacts on the management and allocation of resources of SARRAH, as the Minister and later the Director General, defined the areas for assistance as well as the budget envelope for the five year period. This is key to the levels of spend allocated against priorities, and is elaborated later.

Positive Health Sector Results are already starting to be reported. At the recent HIV and AIDS conference held in Durban (6 – 9 June 2011), it was reported that there have been substantial reductions in mother-to-child transmission (MTCT) of HIV infection. This is a key indicator for measuring progress towards maternal and child health MDG targets. A survey conducted in 2010 by the Medical Research Council, on behalf of the National Department of Health, reported a national average for MTCT of 3.5%, and that the improvements observed mean that elimination of mother-to-child transmission is possible by 2015[2]. The challenges to the South African health system are still formidable, and to quote the Minister of Health in his recent budget speech (13 April 2010), "Life expectancy in South Africa has declined... Maternal mortality and child mortality rates are unacceptably high... [and] South Africa carries a significant burden of disease from HIV/AIDS and TB." However, extensive restructuring of the NDoH is underway and there is a strong commitment by government, civil society, research organisations, and donors, to ensure that the health system in general, and primary health care, in particular, improves. The encouraging PMTCT results are a sign that the Health Sector may have commenced its recovery, is in significantly better shape than 18 months ago, and the outlook is positive.

As part of this dynamic, DFID have succeeded in providing a Health Advisor to NDoH, located in their offices and supporting their Cluster Leaders and the Director General. This sought-after arrangement has enabled the development of excellent relationships between DFID, the Ministry and the Department, but nevertheless has had consequences for SARRAH which are elaborated below.

The SARRAH programme commenced in January 2010, just prior to the above organisational and leadership changes. While a preliminary contract had been signed, it only covered the first few months of the programme, in anticipation of major political developments and other possible interruptions. In March, the new Minister defined the focus and areas of assistance he wished to see from the SARRAH programme, and based on this, a workshop was held to review and finalise the logframe. However because of ongoing uncertainties, the logframe was not completed.

One of these uncertainties was the DFID Bilateral AID Review where the change in UK Government meant that all projects had to go through re-submission and re-approval, causing several months of uncertainty, and further delays in logframe completion.

The appointment of a new Director General (DG) in mid year then led to another set of changes. The DG reconsidered the Department's priorities and, in conjunction with her Cluster managers, drew up a new programme of work requiring DFID support. This led to a substantial reprogramming of the SARRAH funds, and resulted in approximately £4 million being reallocated from local service delivery (Output 1) into National Interventions, (primarily the setting up of the NHI (Output 3), and the strengthening of management and performance (Output 4). A benefit of these changes was that the DG took full ownership of SARRAH and is in control of how the funds are allocated and spent. This has had consequences for the management of SARRAH, see later comment. Simultaneously, DFID introduced the need to move onto a 'milestone matrix' basis of programme funds allocation, billing and programme management. This was new to both parties and required considerable effort to introduce.

The main SARRAH contract was only finally signed in August 2010, and the first invoice for services paid in September 2010, almost nine months after commencement. Adapting to the changes brought about by the unusual sequence of events required flexibility, pragmatism, and patience from both parties, but particularly HLSP. It is a credit to all parties that despite this difficult start up, and all the adaptive changes that had to be made, the programme has got off to a credible start and has

2 SA PMTCT Evaluation shows that virtual elimination of paediatric HIV is possible with intensified effort. Medical Research Council, 9 June 2011 http://www.mrc.ac.za/pressreleases/2011/10press2011.htm

succeeded in executing £6.3 million of work by 31 March 2011 (with a further £1.2million being work in progress), which together comprise 55% of the three year budget after only 42% of the time has elapsed.

3 KEY RESULTS AND ISSUES EMERGING

The allocation of the SARRAH budget between the five outputs is approximately as follows, followed by the overall performance score of the output.

3.1 The Results Matrix and Major Achievements

These are set out in two respective tables

Table 3.1: The Results Matrix

Output	Programme Budget £m	%[3]	Score
Output 1: Enable improvement of quality and access to HIV & AIDS and health services	£0,280	2.6%	2
Output 2: Strengthened leadership and accountability of the national response to HIV and Aids	£3,638	33.4%	3
Output 3: Support national interventions to improve access and equity to HIV and health services	£3,741	34.3%	2
Output 4: Strengthen Performance Management & Strategic Planning for HIV and Health Services, National and Provincial	£2,273	20.9%	1
Output 5: Strengthen systems for effective M&E of NSPs for HIV&AIDS and health	£0,964	8.8%	3
Programme Management Office[4]	£ 4, 120	NA	NA

3.1.1 Overall Result

The above results have culminated in a commendable overall programme score of 69,75% for the SARRAH programme, after taking a conservative view of each of the output scores.

[3] This % is based on the total funds allocated to the five outputs. It does not include funds allocated to the programme management office.

[4] In something of a 'quirk' in the programme accounting, the cost of all the 'technical leads' for each of the five outputs have been allocated to the Programme management Office. There is a strong case for reallocating these costs to the respective outputs as most of the work done by the technical leads is directly attributable to the respective outputs. Should this be done, the £ value for programme management office would decrease significantly.

Table 3.2: Synopsis of Major Achievements by Output Area

Output	Comments
Output 1: Enable improvement of quality and access to HIV & AIDS and health services	• SARRAH is part of major coordination and strengthening efforts for PMTCT (PEPFAR, GF, USAID, CDC, Unicef and others) which produced substantial improvement in MTCT. • Lessons learnt have been documented and widely reported
Output 2: Strengthened leadership and accountability of the national response to HIV and Aids	• SANAC - Considerable progress was achieved in taking what had become a largely dysfunctional set of institutions, and starting to create order by; setting up the Trust, its Board and its Committees; the Secretariat and its functions; supporting the functioning of the Plenary Council and some of its key Committees. However there are important issues to resolve - see later section 3.2 • TAC – Assisted the challenging transition of this organisation from an institution of protest, to that of watchdog and advocacy, with more structure, organisation, accountability and reporting. Challenges still remain – see later section 3.3
Output 3: Support national interventions to improve access and equity to HIV and health services	• Draft NHI policy submitted to Cabinet for consideration and planning framework to support the development of the NHI is in place. • SAHPRA Business Plan approved in November 2010. Revised medicine regulatory fees approved and submitted to Treasury for Gazetting. • Bill to establish independent OHSC approved by Cabinet and released for public comment. • PHC re-engineering task force report completed.
Output 4: Strengthen Performance Management & Strategic Planning	• The assessment of the competency of 95% of District Health Managers and Hospital Managers and classifying them into three categories according to capability • The organisation restructuring of the NDOH into six redefined Clusters • The preparation and completion of seven Provincial Transformation Plans, with two close to completion • The analysis of the financial systems and capacity at seven Provinces, and the preparation of related action plans for strengthening. In this output all the Log frame milestone indicators were achieved, despite some issues with contractor appointment and supervision, which were subsequently resolved.
Output 5: Strengthen systems for effective M&E of NSPs for HIV&AIDS and health	• SANAC M&E Unit established and Head of Unit recruited (September 2010). The Unit Head subsequently had to return to country of Origin
Programme Management Office The commissioning, management and supervision of 16 assignments / tasks, leading to the execution of 55% of the budget, after the expiry of only 42% of programme timeframe. However, per output 4 above there were challenges regarding assignments contracted by NDoH and DBSA. They are dealt with section 3.4.2	

The remainder of this section of the report highlights key issues emerging.

3.2 Concerns Relating to SANAC

The institutional development of SANAC has made many important gains in the last 12 months and a lot of effort was expended, with regard to the mobilisation of the Plenary and its Committees on the one hand, and the setting up of the Trust and its Committees on the other. However, of late there have been setbacks, and the main challenges are as follows.

3.2.1 Top Management of the Secretariat

For good reason the CEO was transferred to the Office of the Deputy President (to assume, inter alia, the role of supervising the development of the National Strategic Framework), and the COO has been appointed as the acting CEO of the Trust Secretariat. However it is not yet clear whether the acting CEO has taken, or will take up the reins of running the organisation in a systematic and effective manner. In the meantime, the remainder of the Secretariat's top structure, namely the CFO, HRM, M&E, SCM, and COO are yet to be appointed, although interviews have been held for positions of CFO, HRM, and SCM and negotiations are pending. This means that the entire top structure of SANAC Secretariat remains unproven, which is worrying given the complex nature of the Council, its work, and the dynamics of relationships throughout the wider organisation. This complexity is illustrated where lines of and leadership and authority between SANAC, the Trust, the Plenary Chairs, and the Secretariat are not always clear to all, making the work of the Secretariat all the more demanding.

3.2.2 Lower Structures of the Secretariat

From the organograms seen, it is apparent that work has been done to develop several alternative structures that could be adopted, and determine the numbers of staff needed for the various positions. However without the Top Structure being in place, it may be unreasonable to expect these structures to be finalised and agreed, especially as the some of the decisions may be contentious. The point is, however, that a lot of new recruitment will be required to fill the lower positions, as well as the top positions and the majority of employees will be new staff. This situation is exacerbated by the plethora of short term technical assistance (see next heading) that is supporting the Secretariat, but which will disappear by year end.

3.2.3 Reliance on Technical Support / Advisors

At present the immediate and pressing task of preparing the new NSF by 1 December 2011 is being handled by a somewhat disparate group of approximately 10 Technical Advisors (precise number not confirmed), funded by various donors. Anecdotally they appear to be working reasonably effectively, but it is unclear what the leadership and accountability arrangements are, and whether there is a robust workplan which is guiding the effort to a successful conclusion. Whatever the conclusion, the fact is that most of the TA support is scheduled to end in approximately December. If no action is taken, the little 'institutional memory' that has been built up in SANAC, will disappear, and the Secretariat will be left with a staff complement that is new and feeling its way within the complex dynamic that is SANAC.

3.2.4 Recommendations SANAC

DFID and HLSP need to conduct an updated situational assessment of SANAC, to determine the full status quo, the associated risks, and the immediate needs and support costs. The assessment needs to cover the institutional development needs, as well as the status regarding the development of the NSF and its related leadership / workplan / monitoring issues. While it may not be tenable to cut off funding, SANAC needs to know that this is an option, and just what their obligations are in order to maintain DFID's support. The fulfilment of SANAC obligations then needs to be reviewed monthly.

3.3 Issues Relating to TAC

After the adverse KPMG report, which gave rise to the remedial programme of action, TAC has been making a concerted effort to implement the necessary improvements, which are being monitored by HLSP. Progress on this front is encouraging, and precedent has been created which has given DFID

and HLSP a set of 'performance levers' for monitoring TAC's progress. However, their quarterly reports are not yet 'fit for purpose' for monitoring the NSP, or reporting TACs accomplishments in a structured 'performance management' manner.

3.3.1 Recommendations TAC

- HLSP has recently assisted TAC in developing a basic M&E and reporting system as a standby measure, but this will need to be expanded to cover needs of other donors, as well as fulfilling the function of monitoring the NSP. HLSP should, at TAC's request and cost, provide the necessary support, and simultaneously assess the capacity of the M&E function at TAC, which may not be experienced enough to fulfil the function adequately.
- At the end of the seven month grant agreement, DFID and HLSP need to conduct a full assessment of the status quo at TAC, and find justification for continued grant support. The trade off from TAC may well be acceptance of a set of conditions which give DFID /HLSP a further set of levers by which progress and institutional strengthening can be achieved.

3.4 Ownership of SARRAH

Section 2 Background and Context - noted that the DG had taken full ownership of SARRAH and is in control of how the funds are allocated and spent. This led to programmatic reallocations away from frontline service delivery (Output 1) into changes to National Interventions, primarily the setting up of the NHI (Output 3), and the strengthening of management and performance (Output 4). The impacts on this were twofold, as follows.

3.4.1 Impact on Design

NDoH funds were allocated to various Departmental / Cluster managers to fund activities of their choosing, provided there was a sound rationale for using programme aid, which had to be approved by the DG. This inevitably led to some compromises in the cohesion of the programme design as workstreams approved became somewhat disparate. However, the Logframe Outputs remained intact but were so broadly described that they could accommodate a very wide range of support. The potential difficulty is that the causal linkages between the new workstreams, and the outputs and purpose are tenuous at best, and the question of attribution for success will be an issue in the impact assessment. This is particularly so because DFID funding is such a minor part of NDoH's resource base.

DFID has however taken a decision that, given the competency of the Department's new leadership, the benefits of having the DG's judicious ownership and control over the allocation of SARRAH funds outweigh the downside of changes in the design and cohesion of the logframe, and difficulties with attribution. Indeed, the strong relationships that have emerged between DFID and the NDoH, are due somewhat to the programmatic flexibility of DFID and HLSP, as well as the valuable support provided by DFID's Health Advisor located in the Department. The outcome is that DFID has significant influence and profile in the NDoH and seem able to 'punch above the weight' of its aid spend.

3.4.2 Impact on Due Diligence in Programme Management

The second outcome of this 'ownership' situation is that NDoH elected to use SARRAH to fund a series of activities where, because of confidentiality issues, they did not wish HLSP to fulfil their normal due diligence role in procurement, contracting, supervising, and QA of the subcontractor. Instead, the Department (or in one case, DBSA) fulfilled and signed off on these functions. In all cases DFID and HLSP took appropriate steps to satisfy themselves that payments to subcontractors were appropriately justified, including the requirement for desensitised 'summary reports' to be prepared. We understand that HLSP and NDoH have now agreed a due diligence protocol that will be applied whenever similar situations arise.

3.4.3 Recommendations

The above two issues are highlighted as they are of 'crosscutting interest' and have impacted several outputs and workstreams. DFID and HLSP are well aware of both situations and have taken the necessary steps to ameliorate them. No specific recommendations are therefore necessary.

3.5 Timescale for Drug Registration (MCC Backlog)

HLSP invested substantial resources to assist NDoH with reducing the backlog of drug registrations and facilitate the establishment of the SA Health Products Regulator Authority (SAHPRA). A backlog of around 4500 applications was reduced to about 2000 but by the end of May 2011, despite improved efficiency, new applications had already brought outstanding applications to about 3700. The initial success was achieved by hiring 30 higher level evaluators as consultants, plus clerical staff. New posts have been advertised with an R8m budget from NDoH but will take some time to fill. A remaining concern is that these vacancies require scarce skills and even when appointed, pharmacists require further specialised training in the drug registration environment.

Despite the initial success in reducing the backlog, the workload remains too high for the current staff and will continue to grow until sufficient trained staff are in post. Although SAHPRA's establishment should improve the situation, there are quite wide variations in opinions about how quickly SAHPRA can be established, and the appropriate legislative or regulatory model to be adopted.

3.5.1 Recommendations

- Consider further HLSP/consultant support until sufficient staff are in place, provided the necessary budgets can be resourced. Whatever the outcome, HSLP should continue to monitor the backlog, possibly through an agenda item on quarterly Steercom meetings.
- Consider methods to prioritise throughput of essential drugs.
- Engage with and fully exploit the opportunities created by international collaboration on drug registration.

3.6 Partner Opinion of SARRAH

We received very complimentary feedback from almost all Interviewees, particularly NDoH and TAC, on the support they receive from SARRAH, DFID and HSLP. For example one Cluster Manager in NDoH said "Without the support of DFID and HLSP we would be nowhere. It's been an absolute lifeline and absolutely invaluable". Only one SANAC interviewee expressed any concern, and this was not of material nature. It thus appears that DFID and HLSP have developed strong relationships with Partners, and the support they are providing is held in high regard.

4 MATTERS FOR COMMENT SPECIFIED IN THE TERMS OF REFERENCE

The Terms of Reference set out a series of matters that require feedback as part of the assignment. In this section of the report we respond accordingly, in the order in which matters appeared in the TOR. Some of the topics lead into recommendations; others provide requested information only, without recommendations.

4.1 Progress against Outputs and Indicators in the Logframe

This progress is dealt with at several levels:

- A summary of progress, and its attributable score, is given in Paragraph 3.1 above – the Results Matrix. The overall score of 69.75% is commendable, especially given the unusual challenges of the first year,
- The detailed progress on each Output, and on Goal and Purpose is set out in the completed Performance Assessment Tool of this report,

- Detailed scores for each workstream within each output are provided in the PowerPoint presentation attached.

We note, however, that at the commencement of the assignment there were several outputs that did not have agreed milestones/indicators and others where the milestones needed substantial changes; this presented a challenge to the Annual Review process. During the review, the Service Provider HLSP and the Review Team made concerted efforts to finalise the logframe in order to allow the review to be more specific, but two milestones were still under discussion when the review ended.

4.1.1 Recommendation

The logframe should be fully completed and the remaining two milestones agreed.

4.2 Clarification of Lessons Learnt

At this early stage of the programme the relatively few lessons to be learnt are as follows:

- The evolution of work to rapidly decrease mother-to-child (MTC) HIV transmission rates in South Africa presents an interesting best practice that other health outcomes improvement interventions can learn from in terms of planning, lesson learning, scaling up service delivery and harmonising and aligning funding and project activities from development partners. There were three distinct phases: 1) planning and implementation of a relatively small pilot project to improve the clinical quality of service delivery based on robust research findings and enhanced social mobilisation to increase service uptake at the community level; 2) document lesson learning from the pilot as a proven quality improvement model; and 3) expand the model incrementally (6 districts to 18 districts and then national expansion), documenting lesson learning and modifying the model further to increase efficiencies and improve outcomes.
- Good Monitoring and Evaluation frameworks are central to the cohesion of any major institution or activity. There are several institutions within SARRAH that require robust monitoring and evaluation, namely SANAC, TAC, NDoH, and SARRAH's logframe itself. In all cases M&E has not yet been developed to the degree necessary to support these institutions. HLSP and DFID are aware of the situation, but the unusual circumstances of having to 'operate on the periphery', as discussed above, has made it difficult to be forceful about rectifying matters.

4.2.1 Recommendations

- The matter must be fully addressed when considering future support for SANAC and TAC (per earlier recommendations) and; the situation in the NDoH must be raised with the DG; the two remaining indicators in the SARRAH logframe must be finalised shortly.
- In any programme there can be consequences to a Beneficiary taking ownership and control of a Donor programme to the extent that the NDoH has. The question of responsibility for due diligence as well as programme cohesion comes to the forefront, and mechanisms have to be found to address these issues satisfactorily. In SARRAH's case, the protocol recently agreed fulfils this need.
- The efficiency of Annual Reviews can be improved by adopting the following recommendations:
    - The scheduling of interviews should be front-loaded as far as possible, with most meetings allocated to only one consultant – depending on the consultants' division of labour. This will allow for more interviews to be held and will compress the interviewing into the front half of the assignment,
    - The need for self assessment (if there is to be one) should be communicated to the Service Provider in ample time before the assessment, so that a full self assessment is available to the Reviewers at the commencement of the evaluation,

- The Service Provider should prepare a 'dossier of evidence' that supports all 'milestone' completions, for use by the review team.
- Pressures of work allowing, it would be most beneficial and efficient if DFID members of the review team could book time off to participate fairly extensively in the review.

4.3 Suggestions on Amendments to Logframe and Programme Management

During the Review, two meetings were held in which the logframe was discussed and amended; the first was with HLSP staff and the second with HLSP staff and local DFID representatives. Agreement was reached on revisions to some indicators and various milestones were adjusted in order to bring the logframe more in line with the anticipated programme of work. Owing to the rapidly changing HIV and AIDS situation in South Africa, and ongoing restructuring of the Partner organisations, the logframe must be regarded as a work in progress. As was noted several times during the Review, the Service Provider (HLSP) has little direct control over some of the Target Outputs for 2014, and therefore the achievement of targets (and some milestones) reflects the collective efforts of the Partners, the Service Provider and many other agencies.

This was manifested when the key assumption for the achievement of 'Purpose' was elaborated to include *"All Partners and Key Stakeholders fulfil their obligations and implement their programmes in a timely manner".* In effect this assumption acknowledges that SARRAH workstreams play a relatively minor role in the accomplishment of the Purpose and Goal of SARRAH.

4.4 The Preliminary Impacts, both Positive and Negative, of the Programme to Date

Because SARRAH represents a very small proportion of the total health budget and it is one of numerous donor-funded programmes that seek to reduce HIV and improve health, its specific impacts are difficult to isolate at this stage, particularly within the limited timeframe of this annual review.

The one impact area that is measurable and is producing results is the 'PMTCT Accelerated plan' to reduce mother to child transmission of HIV to less than 5% in 18 priority districts. SARRAH provided Technical Assistance to this programme and the results have been striking: only six of 52 districts (nationally) failed to reach the 5% target, the average being 3.47% according to an MRC study, from a baseline of 12%. Whilst the PMTCT intervention is able to report many successes in terms of process and coordination efforts, the monitoring and evaluation system (dependent on DHIS) is not yet able to report reliably on the key indicator of mother-to-child transmission for all sites. The SARRAH team has been part of efforts to coordinate PMTCT initiatives and helped to motivate a common set of indicators rather than each programme developing its own. NDoH has appointed an M&E person to assist in resolving the DHIS problems identified. The PMTC A-Plan's continued success depends on its effective management by a relatively under-resourced NDoH Cluster Maternal, Child and Women's Health and Nutrition. It would be advisable for SARRAH to maintain a watching brief over further developments of the PMTCT plan and to look for ways to help ensure that the important gains are sustained.

According to the Technical Lead on PMTCT, SARRAH's role in donor coordination played a significant role in the observed improvements to PMTCT and helped to obtain further Global Fund support[5]. The EU Health Sector Attaché spoke at length regarding efforts to ensure better donor coordination and the benefits this is producing.

[5] Ngubane, G., (undated). A national strategy to strengthen services to prevent mother to child transmission of HIV in SA: Lessons from the A-Plan . HLSP Case Study.

4.5 Project Governance Structures including Steering Committee Meetings with Partners as well as with DFID

A genuine attempt has been made to implement appropriate governance structures with partners. However there is room for improvement in the following areas.

4.5.1 NDoH Steering Committee

Several of the SARRAH Steering Committee Meetings, chaired by the Director General, have apparently been somewhat unstructured from a 'programme governance' perspective. For example the meeting we attended didn't involve review of prior minutes, did not require the consultants to report on programme status, and didn't have sufficient time set aside to deal adequately with issues arising from both sides. This is an issue that DFID and HLSP need to address jointly with the NDoH. DFID should advocate for more conventional , and 'governance orientated' steering committee meetings before the next meeting.

4.5.2 Recommendation

A potential solution to having meetings of adequate length and full agendas is for the DG to appoint one or two deputies (e.g. DDG or Cluster Managers) to chair the meeting in her absence. In addition, HLSP could usefully prepare a one page 'traffic light' summary of project status, with a one page summary of issues to be discussed at the meeting.

4.5.3 TAC

TAc have instituted a Donor forum, but the meetings are somewhat irregular and are not designed as a governance mechanism. DFID / HLSP have not been involved in the governance of TAC , except that the seven month grant extension has provided HLSP and DFID with some short term 'levers' of accountability and progress.

4.5.4 Recommendation

As mentioned in paragraph 3.3.1, if SARRAH is to continue providing grant support to TAC, then it should be under a grant agreement which sets conditions which give DFID /HLSP a further set of levers by which progress and institutional strengthening can be monitored.

4.5.5 SANAC

The SANAC governance situation has become problematic as outlined in paragraph 3.2 above. The related recommendations are set out in paragraph 3.2.4

4.6 The Quality of SARRAH's Strategy, Methodology and Approach Including an Assessment of Project Management and Implementation Performance

4.6.1 Resource Allocation under NDOH Control

SARRAH's strategy methodology and approach now rests substantially in the NDoH as commented on elsewhere. However, it is clear that this is a strategic decision taken by DFID and that there are substantial wider benefits that accrue.

4.6.2 Project Management is in Line with Good Practice

SARRAH's project management is in line with good practice both within the service provider (HLSP) and between HLSP and DFID. This is evidenced by holding appropriate Review, Technical Lead and Management meetings, which are minuted. Project management has been enhanced by the development of an effective Milestone Matrix system of control, which ensured that all workstreams are fully planned and costed, deliverables and their related costs are determined, and DFID is only invoiced on completion of milestones. DFID then ensures that the deliverables have been signed off by the beneficiaries before authorising payment. The Service Provider is providing an appropriate

level of supervision and quality assurance from both UK Head Office and within the programme in South Africa.

While there has been some programme slippage in the first year, due mainly to the major changes taking place within all programme partners, of late, slippages have diminished to acceptable levels, and performance appears satisfactory.

4.6.3 Communication between Streams

One point brought up by the three Stream Leads who have subcontract roles with HLSP, is that they believe there is insufficient cross-communication and knowledge sharing between the streams. HLSP note that they do hold quarterly meetings of stream leaders, but that at times the Stream Leaders concerned are not able to attend.

4.6.4 Recommendation

HLSP should take up and resolve this issue with the Stream Leads concerned

4.7 Measures Taken to Maximise the Efficiency of Staff Deployment and Value for Money

Good value for money is achieved when:

- inputs are correctly specified, and are acquired at 'fair cost';
- outputs (milestones) are delivered on schedule;
- output quality is 'fit for purpose'.

From observation and discussion it appears that all these facets are being properly addressed. All work streams have TOR specifying the level of effort, signed off by the project partner / beneficiary. The consultant is sourced / contracted by HLSP's resource centre in the UK, who have extensive data on competitive rates and negotiate favourable rates for the contract. A detailed costing sheet is prepared for each workstream setting out all inputs, unit costs, quantities. The total cost is then apportioned between the deliverables / milestones of that workstream. This costing sheet is submitted to DFID for approval and entered into the Milestone Matrix according to expected completion / billing dates . Technical leads are responsible for mobilisation and supervision of staff, QA, and for ensuring milestones delivered on schedule. DFID are able to monitor programme slippage, by invoices being submitted behind schedule. Quality is signed off directly by the beneficiary and indirectly by DFID. Thus a reasonable set of measures are in place to achieve good value for money.

4.8 The Programme's Strategy and Performance in Terms of Engaging with the Key Partners in Particular NDOH, SANAC and TAC

These issues have been dealt with elsewhere. Further elaboration would not add significant value.

4.9 How the Programme is taking Issues of Gender Equity into Account?

Issues of gender equity are addressed indirectly in most of the SARRAH workstreams. The PMTCT A-Plan specifically identifies women in need of special care, i.e. pregnant women who are infected with HIV. TAC includes various initiatives with a focus on women's rights and is well known for its advocacy role. SANAC currently has separate women's and men's sectors in its structure to ensure that gender issues are properly addressed. Thus SARRAH includes a significant gender focus. However, gender issues are given scant attention in the current HLSP reporting format. While the Annual Report mentions that women are at higher risk of HIV infection and mortality, apart from the PMTCT programme, no mention is made of how SARRAH addresses this concern.

4.9.1 Recommendation

Issues of gender equity should receive more explicit reporting.

4.10 The Project Influencing / Communication Strategy

Apart from a brochure and a hard copy of a PowerPoint presentation, the review team did not have an opportunity to examine the communication strategy in any detail. A website[6] has been set up which contains documentation on the various components of the programme. At this relatively early stage in the programme, communication may not be seen as a priority, but efforts should be made to raise its profile in South Africa and internationally. 'Lessons learnt' and 'case studies' should be a prominent feature of the web site.

4.11 The Programme's Monitoring and Evaluation Procedures

HLSP, DFID and the Annual Review team have drafted a revised logframe which is more closely aligned with the revised activities. This logframe should be seen as a work in progress which must be adjusted annually since the South African health system is undergoing rapid change that calls for a responsive, and preferably proactive, SARRAH programme.

TAC has very recently developed a more effective M&E system, with technical assistance from HLSP, which should allow more effective monitoring of their activities. There is a commitment from the Technical Lead to provide short term support until the new system is running. There are some concerns that the complex nature of TAC and the consequent M&E demands may exceed current TAC M&E capacity. Ongoing M&E support may therefore be required while the new system is assessed. Future grant agreements with TAC must address M&E shortcomings in order to provide essential information on lobbying, advocacy and formal submissions to government. If HLSP is to provide ongoing TA, this will have implications for the core grant to TAC.

A critical role for SANAC is to coordinate national HIV and AIDS M&E. South Africa has some of the best HIV and AIDS data in the world yet the information is neither properly coordinated nor optimally used. The SANAC M&E Unit is not yet operational; a Director was in post briefly but had to leave owing to funding issues (changing priorities of another donor). The DG has set up a national committee on M&E, with implications for both SANAC M&E and NSDA M&E; SARRAH should work with this committee to ensure its own M&E is aligned with new systems and to offer support where necessary.

Several of the initial SARRAH milestones have been compromised by circumstances beyond HLSP's control, but most, if not all, of the revised activities will contribute to MDG 6 targets for HIV & AIDS.

HLSP reporting should be revised to highlight linkages between the many SARRAH elements and how best to communicate this to the South African public. Some potentially useful approaches using 'mind maps' were proposed by the Service Provider.

4.12 An Assessment of the Key Challenges Threatening Sustainability of Achievement

There are several topics to bring together under this heading, some of which have been discussed above. None represent a major threat to sustainability.

4.12.1 Need for Additional Programme Funds

In paragraph 2 above it was noted that by March approximately 55% of programme funding had been spent in the first 15 months. While this is laudable it means that in future the ratio of Project Management Office cost, which is substantially a fixed cost, to programme costs (variable) will increase to unsustainable levels. This could lead to a cut back on the PMO and the unfortunate slowdown of the momentum built. The solution is to fully utilise the capacity of the PMO by bringing forward funds that had been programmed for years 4 and 5. We understand that discussions along these lines are already underway.

[6] http://www.sarrahsouthafrica.org/

A second issue regarding the PMO is the level of misunderstanding that seems to have built up amongst partners (NDoH and SANAC) concerning the costs of the PMO and how they are treated. There seems to be a need for open communication and explanation, with full support from DFID, designed to placate the critics.

4.12.2 The Complexity of Setting up the NHI

This is the most complex workstream of SARRAH and hitherto the scope, the tasks and the expected timelines seemed to have been disjointed and overly ambitious. At the time of the review, while the complexity and risk of delay in implementing NHI was acknowledged, the point was well made that the NHI groundwork contributes to the overall strengthening of the Health Sector in the short term, whilst NHI itself is a much longer term intervention.

However, of late, and with the support of SARRAH funds (a project manager and other key HLSP technical support), a more comprehensive, properly sequenced, longer timeline workstream seems to be emerging, using mind-map software to good effect. The prospects for a successful NHI are therefore improving. The key challenge, which seems well in hand, is to see this robust design, planning, and budgeting through to its conclusion, and then to make available SARRAH resources to fund some of the key managerial, performance improvement, and service delivery interventions.

4.12.3 SANAC and TAC – Decision to Maintain or Withdraw Support

This subject has been discussed above and appropriate recommendations made. Both Institutions have key challenges that if not properly managed and improved could lead to ineffective use of DFID funds.

4.13 The Milestone Matrix Including Budgets

The Milestone matrix developed for SARRAH has been briefly explained under project management and value for money, in paragraphs 4.6 and 4.7 above. It is used to compile and calculate workstream and milestone budgets which are then submitted to and approved by DFID. The milestone matrix is an effective management tool, and should be used as such to the fullest extent.

4.13.1 Recommendations

- The milestone matrix should also be used to monitor programme slippage by formally updating the timing of milestone billing whenever a change is envisaged. The milestone matrix and any envisaged changes should be a standing item on the agenda of the DFID / HLSP bi weekly review meetings.
- HLSP and DFID have been through a steep learning curve in designing and applying the Milestone Matrix model. Consideration should be given to capturing this learning and methodology in a DFID 'How To' guide.

5 CONCLUDING REMARKS

Overall SARRAH's progress and achievements in the first 15 Months have been commendable. DFID and HSLP are performing their roles and functions to good effect, and workstreams are delivering most of the required milestones and deliverables in a timely manner. Achievement of Purpose and Goal will however be inextricably linked to political commitments, and will require extensive resolve and capacity from those partners who are responsible for implementing the plethora of changes necessary to uplift management and service delivery throughout the Sector. This is obviously outside DFID/HLSP control.

Such implementation therefore needs to be carefully monitored by the SARRAH programme, while SARRAH's resources are used to create or strengthen other catalytic "tipping points" that will lead to improved service delivery and wide positive outcomes in the long term.

6 SUMMARY OF RECOMMENDATIONS

This summary text has been abbreviated from the main text.

Table 6.1: Summary of Main Recommendations

Ref.	Recommendation	Responsibility	Due
3.2.4	**Recommendations SANAC** Conduct an updated situational assessment to determine the full status quo, the associated risks, and the immediate needs and support costs.	HLSP	July 2011
3.3.1	**Recommendations TAC** • HLSP should, at TAC's request and cost, provide the necessary M&E support, and simultaneously assess the capacity of the M&E function at TAC. • At the end of the seven month grant agreement, DFID and HLSP to conduct a full assessment of the status quo at TAC, and find justification for continued grant support.	HLSP HLSP	July 2011 Sept 2011
Assess. Tool Output 3	**Recommendations POC** • Given slow progress, there is now a need to explore other options for engaging with Parliamentarians such as the Health Portfolio Committee. • Continue to monitor progress on POC. Draft options paper on suitable mechanisms for engaging Parliamentarians with recommendations by 1 August 2011	DFID HLSP	Aug. 2011 Aug 2011
3.5.1	**MCC Backlog** • Consider further HLSP/consultant support until sufficient staff are in place, provided the necessary budgets can be resourced • Consider methods to prioritise throughput of essential drugs. • Engage with and fully exploit the opportunities created by international collaboration on drug registration.	HLSP	July 2011
4.2.1	**Logframe** The logframe should be fully completed and the remaining two milestones agreed.	HLSP DFID	July 2011
4.2.1	**Lessons Learnt** The efficiency of Annual Reviews can be improved • The scheduling of interviews should be front-loaded • The need for self assessment communicated to the Service Provider in ample time • The Service Provider should prepare a 'dossier of evidence' • Beneficial and efficient if DFID members of the review team could book time off to participate fairly extensively in the review.	DFID/ HLSP	2012

4.5.2	**NDoH Steering Committee** The DG to appoint one or two deputies (e.g. DDG or Cluster Managers) to chair the meeting in her absence. HLSP to prepare a one page 'traffic light' summary of project status, with a one page summary of issues to be discussed at the meeting.	DFID HLSP	August 2011
4.5.4	**TAC** To continue providing grant support, DFID /HLSP need a grant agreement which provides a further set of levers by which progress and institutional strengthening can be monitored.	DFID HLSP	September 2011
4.6.3	**Stream Leaders Communication** • HLSP should take up and resolve this communication issue with the Stream Leads concerned	HLSP	July 2011
4.9.1	**Gender equity** Issues of gender equity should receive more explicit reporting.	HLSP	July 2011
4.13.1	**Milestone Matrix** • The milestone matrix should also be used to monitor programme slippage and should be a standing item on the agenda of the DFID / HLSP bi weekly review meetings. • HLSP and DFID should consider producing a DFID 'How To' guide.	DFID DFID / HLSP	July 2011 September 2011

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APPENDIX 1: ANNUAL REVIEW

Department for International Development

South Africa

Annual Review of the Strengthening the Revitalized Response to AIDS and Health Programme (SARRAH)

Appendix 1: Outputs 1-5		Milestone scores
Output 1	Enable the improvement in quality of and access to HIV&AIDS and health services in selected districts	
Impact Weight revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Impact Weight** (%)	10%	
Risk revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Risk**	Medium	
DFID Share revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **DFID Share**	TBC	
Indicator 1	Mother-To-Child Transmission rate	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	5% MTC transmission at national level by 2011.	
What progress has been made in the period covered by this review?	Milestone has been reached in aggregate at national level, and now stands at 3.5%. However, 6 out of 52 districts have not quite reached this target.	1
If Indicator 2 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 2	Utilisation rate of Primary Health Care Facilities	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	2.8 visits per capita	
What progress has been made in the period covered by this review?	In 2010 utilisation rate of Primary Care Facilities was 2.4 visits per capita and therefore the milestone has not been reached. The PHC re-engineering initiative and the NHI work under way are aimed to contribute to greater utilisation of these facilities. The milestones going forward may need to be adjusted.	0
If Indicator 3 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 3	Proportion of pregnant women attending antenatal clinic visits 4 times in NHI pilot districts	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	tbc once pilot districts have been selected	
What progress has been made in the period covered by this review?	n/a	0
If Indicator 4 is required for this Output, click on the '+' sign to the left of this worksheet		
If Indicator 5 is required for this Output, click on the '+' sign to the left of this worksheet		
If Indicator 6 is required for this Output, click on the '+' sign to the left of this worksheet		
Output Performance for Output 1	2	1
Impact Weighted Score	7.50	
Justification for the Score	The arithmetic mean score of the three milestones is 1. However owing to the fact that two of the indicators are catagorised as 'too early to judge', the overall score has been downgraded to 2.	
Output 1 Recommendation 1	Milestones for utilisation rates in primary care facilities need to be adjusted downwards to reflect trend over last 3-4 years	
Output 1 Action Point 1	Review milestones and/or consider applying indicator to NHI pilot districts only	
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.		
If Output 2 is required, click on the '+' sign to the left of this worksheet		
Output 2	Strengthened leadership and accountability of the national response to HIV and Aids	
Impact Weight revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Impact Weight** (%)	30%	
Risk revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Risk**	Medium	
DFID Share revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **DFID Share**	TBC	

Indicator 1 Is this a Standard Indicator? Milestone for this review (if any) What progress has been made in the period covered by this review?	SANAC secretariat established and functional No (1) Agreed SANAC Staff and organogram and all senior management posts filled; (2) SANAC secretariat legal status agreed & structures defined; and (3) SANAC Secretariat Annual Report against progress on the NSP. (1) HR strategy, top structure and employment conditions approved by Board of Trustees (BOT). CEO and COO appointed. However, three other senior management posts not yet filled (CFO, HR and SCM managers) due to decision by BOT to readvertise all senior positions to ensure accountability and good governance. Key sub-committees have been authorised and convened by the BOT (ad-hoc governance committee and remunerations committee and are functioning). However, there remain key challenge around leadership and working relationships between the Secretariat and BOT. Furthermore SANAC sector committees are many (19 in all) and several are not functioning well; (2) Deed of trust is updated to reflect a working relationship between SANAC structures, the Trust and the Secretariat and the Board of Trustees. However the Trust Deed is not absolutely final as lawyers are incorporating clauses to ensure the Trust is not taxable (3) SANAC secretariat workplan yet to be approved by Board of Trustees, but midterm review against NSP has been produced Nov 2009, and final	3
If Indicator 2 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 2 Is this a Standard Indicator? Milestone for this review (if any) What progress has been made in the period covered by this review?	All party Parliamentary Oversight Committee established and functional No Membership agreed with all political parties for the creation of POC including key mandates and TOR Very little progress made since meeting with Chief Whip in May 2010. ToRs for POC finally endorsed by Rules Committee March 2011. POC expected to be functional in the course of 2011. Score3	3
If Indicator 3 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 3 Is this a Standard Indicator? Milestone for this review (if any) What progress has been made in the period covered by this review?	TAC quarterly progress monitoring of the NSP No Review of quarterly reports Four NSP reviews produced over past 12 months with the last review published in March 2011. The reviews do not yet fulfil the objective of monitoring the NSP in an effective manner and the structure and content need to be enhanced. In addition, targeted dissemination would improve its effectiveness as a advocacy tool. Score 3	3
If Indicator 4 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 4 Is this a Standard Indicator? Milestone for this review (if any) What progress has been made in the period covered by this review?	No of citizens empowered to monitor government performance of NSP Yes 45,000 citizens empowered Milestone has been achieved as 47,178 citizens are reported to have been empowered to monitor government performance on NSP. Score 1	1
If Indicator 5 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 5 Is this a Standard Indicator? Milestone for this review (if any) What progress has been made in the period covered by this review?	Effective lobbying and advocacy of government on key issues in relation No 1 Submission (on Social Assistance Bill) Milestone Achieved - TAC has challenged government on key issues including the formal submission on Social Assistance Bill above,and contributions on the Drug stockout issue in Clinics, and theTara Clamps in KZN. Score 1	1
If Indicator 6 is required for this Output, click on the '+' sign to the left of this worksheet		
Output Performance for Output 2 **Impact Weighted Score** **Justification** for the Score	3 **15.00** The arithmetic mean score of the 5 milestones is 2. However owing to slippage and concerns since March with SANAC, and ongoing issues with TAC reporting, the overall score has been downgraded to 3	2
Output 2 Recommendation 1 **Output 2 Action Point 1**	SANAC - DFID and HSLP to take stock of likelihood of the leadership, governance, and institutional issues - and the associated risks- being resolved in the near future, and to devise a strategy for the way forward. Draft a paper outlining issues, challenges, options and recommendations. To be produced by HSLP by 1 July 2011	
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.		
Output 2 Recommendation 2	With regards to TAC, to increase direct support in the areas of M&E system and to improve quarterly reviews of the NSP by providing TAC with a template which guides the structure and content of the reviews, so that they become an effective tool to assess NSP progress. The reports must also be based on evidence collected in its model districts.	

Output 2 Action Point 2	For HLSP to develop indicators and a robust reporting process and format for TAC to report against these indicators which will help them in turn to improve the quality of the review reports. To be completed by 1 July 2011	
Output recommendation 3	With regards to POC, given slow progress, there is now a need to explore other options for engaging with Parliamentarians such as the Health Portfolio Committee.	
Output 2 Action Point 3	Continue to monitor progress on POC. Draft options paper on suitable mechanisms for engaging Parliamentarians with recommendations by 1 August 2011.	
If Output 3 is required, click on the '+' sign to the left of this worksheet		
Output 3	Support National Interventions to improve access and equity to HIV and health services	
Impact Weight revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Impact Weight** (%)	31%	
Risk revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Risk**	Medium	
DFID Share revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **DFID Share**		
Indicator 1	Progress toward the establishment of the NHI	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	(1) Draft NHI policy submitted to Cabinet for consideration; (2) Planning framework to support the development of the NHI approved by Ministerial Adviser.	
What progress has been made in the period covered by this review?	(1) Draft NHI policy submitted to Cabinet in March 2011 for consideration. It is still under discussion; (2) Planning framework for the NHI developed and approved by Ministerial Adviser on 14 March. Six technical papers finalised. Summary paper presented to NHI Ministerial Adviser. PMU Unit for NHI set up and functional. Report on purchasing options submitted. Data mapping under way. ToRs agreed for package of services to be delivered at district level in pilot districts. NHI communications strategy revised. Score 1	1
If Indicator 2 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 2	Timescale for drug registration	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	Approved Business Plan for SAHPRA	
What progress has been made in the period covered by this review?	SAHPRA Business Plan approved in November 2010. Savings of R4.7bn made in December 2010 NDOH ARV tender, in part due to number of ARVs newly registered. Submission on revised medicine regulatory fees approved by Minister and submitted to Treasury for publication in Government Gazette. This is a landmark as it is fundamental to the viability of SAHPRA in ensuring a sustained and viable income. However, backlog is increasing rapidly as a result of insufficient NDOH human resources to process the applications despite the allocation of R8 million in 2011 to facilitate this. Part of the problem relates to recruitment of staff with scarce skills. Occupational Specific Dispensation may assist here. Score 4 - Slippage in Backlog	4
If Indicator 3 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 3	Steps in SAHPRA establishment	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	Relocation to Civitas building	
What progress has been made in the period covered by this review?	Relocation to Civitas building realised in July 2010. Legal framework for SAPHRA not yet agreed (Agency vs. Public Entity model) and while the latter appears preferable it could lead to delays in establishment of SAPHRA since new legislation would be required. A fundamental decision needs to be taken quickly as to the preferred legal status of SAHPRA since this will create a revenue stream for the ongoing development and sustainability of SAHPRA i.e. achievement of this indicator. Score downgraded to 2 because of legislation	2
If Indicator 4 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 4	Establish Office of Health Standard Compliance	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	Bill to establish independent OHSC approved by Cabinet and released for public comment	
What progress has been made in the period covered by this review?	Milestone met - National Health Amendment Bill approved by Cabinet on 30 November 2010. It was formatted and released for public comment on 25 January 2011. Score 1	1

If Indicator 5 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 5	Improved performance of key programmes of PHC - increased coverage of basic package of PHC	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	PHC re-engineering task force report completed	
What progress has been made in the period covered by this review?	Milestone met - PHC re-engineering discussion report completed. Score 1	1
If Indicator 6 is required for this Output, click on the '+' sign to the left of this worksheet		
Output Performance for Output 3	2	2
Impact Weighted Score	23.25	
Justification for the Score		
Output 3 Recommendation 1	Regarding NHI, to ensure that all work can be adapted to changing government policy on NHI as it emerges.	
Output 3 Action Point 1	In 2011 regular meetings between SARRAH Technical Lead and Ministerial Adviser on NHI. To start July 2011	
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.		
Output 3 Recommendation 2	Regarding drug registrations, HLSP to closely monitor recruitment and deployment of new NDOH evaluators to ensure timely processing of drug applications	
Output 3 Action Point 2	HLSP to request Benguela to report on monthly basis on recruitment of NDOH evaluators and status of backlog. To start July 2011	
Output 3 Recommendation 3		
Output 3 Action Point 3		
If Output 4 is required, click on the '+' sign to the left of this worksheet		
Output 4	Strengthen performance management & strategic planning for HIV and health services at national and provincial levels.	
Impact Weight revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Impact Weight** (%)	19%	
Risk revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Risk**	Medium	
DFID Share revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **DFID Share**		
Indicator 1	Competency of public sector district and hospital managers	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	First competency assessment completed	
What progress has been made in the period covered by this review?	Milestone completed - First competency assessment completed in December 2010. Assessment of 96% of District Health Managers and Hospital CEOs completed. Assessment tool and methodology rated as 'robust' by the HLSP Governance Advisor. Score 1	1
If Indicator 2 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 2	Organisational development of the public health sector (a restructured NDOH)	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	Top structure of NDOH designed, change strategy prepared	
What progress has been made in the period covered by this review?	Milestone completed - Top structure of NDOH was designed and change strategy finalised and accepted by Minister and DG in December 2010. Although the consulting firm reported directly to the DG, and was not subject to HSLP normal QA procedures, the HSLP Governance Advisor did review the 'non confidential' assignment outputs.Score 1	1
If Indicator 3 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 3	Service Transformation Plans agreed and monitored through APP	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	Framework for development of 7 Plans	
What progress has been made in the period covered by this review?	Milestone completed - Framework for development was finalised and approved. Service Transformation Plans for 7 Provinces completed and signed off, namely Gauteng, Free State, Limpopo, Mpumalanga, Northern Cape, North West, Western Cape(autonomously). Eastern Cape to be completed in June 2011. (No Suggestions) Natal to be completed in July 2011. Score 1	1
If Indicator 4 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 4	Number of national and provincial DoHs with an Unqualified Audit Opinion	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	Review of seven provincial financial management structures and systems completed	
What progress has been made in the period covered by this review?	Milestone completed - Financial Management Improvement Project conceptualised by CFO's office to facilitate a process of reducing the number of qualified provincial audits. Financial Management team of consultants selected by NDOH and contracted by HLSP. Seven reviews of provincial financial management structures and systems completed. In addition, Financial Management Improvement Plans were completed for these 7 provinces by January 2011. Score 1	1
If Indicator 5 is required for this Output, click on the '+' sign to the left of this worksheet		
If Indicator 6 is required for this Output, click on the '+' sign to the left of this worksheet		

Output Performance for Output 4	1	1
Impact Weighted Score	19.00	
Justification for the Score		
Output 4 Recommendation 1		
Output 4 Action Point 1		
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.		
If Output 5 is required, click on the '+' sign to the left of this worksheet		
Output 5	Strengthen systems to effectively monitor and evaluate national strategic plans for HIV&AIDS and health	
Impact Weight revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Impact Weight** (%)	10%	
Risk revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **Risk**	Medium	
DFID Share revised/needs revision?		
If Yes, why was/is this?		
Original or Revised **DFID Share**		
Indicator 1	SANAC M&E systems strengthened to monitor and evaluate Multisectoral responses in HIV & AIDS in the public and private sectors.	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	(1) M&E Head appointed and Unit established; (2) Mobile monitoring system for HCT	
What progress has been made in the period covered by this review?	(1) SANAC M&E Unit established (now called Strategic Management Information Unit) and Head of Unit recruited and appointed in September 2010. Unfortunately, funding for this post from the Clinton Foundation was short term and ended in March 2011. There has been a delay in continuing the position given that under new governance guidance any new positions within the SANAC secretariat, whether funded through Government or donors, need to be approved by the Board of Trustees of the National Aids Trust. (2) The HCT mobile monitoring service provider was selected by NDOH / SANAC in August 2010. HLSP commissioned an independent assessment of the proposal of the service provider which revealed costing gaps. Subsequently, the DG requested that NDOH m-health strategy be developed to show how this fits with this. Implementation delayed until m-health strategy has been developed and approved. Score 3	3
If Indicator 2 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 2	Joint national monitoring of the NSDA	
Is this a Standard Indicator?	No	
Milestone for this review (if any)	NDSA signed	
What progress has been made in the period covered by this review?	NDSA was signed in October 2010. With regards to NDOH M&E framework, it was submitted and signed off by DG in December 2010. HLSP unsighted on the final report. However, in the interim the DG established an M&E Task Team which in effect has made the report redundant. Score 3	3
If Indicator 3 is required for this Output, click on the '+' sign to the left of this worksheet		
Indicator 3		
Is this a Standard Indicator?		
Milestone for this review (if any)		
What progress has been made in the period covered by this review?		
If Indicator 4 is required for this Output, click on the '+' sign to the left of this worksheet		
If Indicator 5 is required for this Output, click on the '+' sign to the left of this worksheet		
If Indicator 6 is required for this Output, click on the '+' sign to the left of this worksheet		
Output Performance for Output 5	3	3
Impact Weighted Score	5.00	
Justification for the Score		
Output 5 Recommendation 1	Reference is made Output 2, recommendation 1. If the decision is taken to further support SANAC, HLSP to assist Board of Trustees in recruitment process of high calibre M&E specialists and to provide support in developing an M&E framework that is linked to the NDOH M&E framework.	
Output 5 Action Point 1	See Output 2, recommendation 1 and take action as per recommendation within the next 4 months. October 2011	
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.		
Output 5 Recommendation 2	Offer technical assistance to NDOH M&E task team to further the M&E framework.	
Output 5 Action point 2	Put on agenda of next NDOH SARRAH steercom in July 2011 to provide SARRAH inputs into development of M&E framework. July 2011	
Output 5 Recommendation 3		
Output 5 Action Point 3		

Appendix 1: Outputs 6-10

If Output 6 is required, click on the '+' sign to the left of this worksheet

If Output 7 is required, click on the '+' sign to the left of this worksheet

If Output 8 is required, click on the '+' sign to the left of this worksheet

If Output 9 is required, click on the '+' sign to the left of this worksheet

If Output 10 is required, click on the '+' sign to the left of this worksheet

Appendix 1: Project Scoring

Review Date (dd/mm/yyyy)	09/06/2011
Impact Weighting (must = 100)	**100%**
Total Impact Score	**69.75**
Output Risk	**Medium**

Method of Scoring: Sources of Information

Using the drop-down menu for each box, enter "X" for each Source of Information used in the review.

Quantitative data from national systems	X
Quantitative data from project/programme study	X
Government assessment	X
Joint donor review	
Independent consultant review	X
DFID staff review	X

Scoring Responsibility: Partners Involved

Using the drop-down menu for each box, enter "X" to indicate Partners Involved in the review.

National Government partner	
National non-Government partner	
Independent consultant	X
Donor partners	
DFID staff	X

Donor partners	

Comment here on the Method of Scoring and Scoring Responsibility.	The overall output score was informed by scoring the relevant milestones individually, with downward adjustment of overall output score, where there appear to be medium term risks. The scoring was done by the external consultants on the evaluation team.
Scoring Recommendation 1	
Scoring Action Point 1	

Appendix 1: Knowledge Sharing and Evidence

Lesson category	
1. Working with partners	There is a very high level of ownership of the SARRAH Programme within the principle partner (NDOH). This has been facilitated by a number of factors, including DFID having a physical presence in the NDOH (Senior Health Adviser); NDOH being given ownership of a large proportion of the SARRAH budget in terms of planning and commissioning and a clear vision of the DG in terms of using the SARRAH resources to implement catalytic "tipping points" that will leverage wider positive outcomes in the long term. While it is clearly an important window of opportunity to be closely engaged with a partner who is providing energetic and innovative leadership in taking forward an ambitious health sector reform agenda, the reform process is inextricably linked to political commitments and this sometimes results in difficult to achieve project delivery deadlines being set. The SARRAH programme is beginning to realise a significant contribution to the SAG's health sector reform agenda and has the potential to make a significant positive impact in terms of health systems strengthening and improved health outcomes, although it is important to keep in mind that critical enabling factors for success (e.g. political
Working with Partners Recommendation 1	As SARRAH inputs are high profile and supportive of efforts that are far bigger and broader than the workstreams, continuous risk mitigation is essential and this is best done collaboratively through the forum of the SARRAH Steering Committee Meetings chaired by the Director General. Steer Comms to date have been too sporadic and too few. This is an issue that DFID and HLSP need to address jointly with the NDOH
Working with Partners Action Point 1	DFID to advocate for more regular and effective steering committee meetings before the next Steer Comm. A potential solution is for the DG to appoint one or two deputies (cluster leaders) to chair the meeting in her absence. In addition HSLP could usefully prepare a one page 'traffic light' summary of project status, with one page summary of issues to be discussed at the meeting.
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.	
2. Best Practice / Innovation	The evolution of work to rapidly decrease MTC HIV transmission rates in South Africa presents an interesting best practice that other health outcomes improvement interventions can learn from in terms of planning, lesson learning, scaling up service delivery and harmonising and aligning funding and project activities from development partners. There were three distinct phases: 1) planning and implementation of a relatively small pilot project to improve the clinical quality of service delivery based on robust research findings and enhance social mobilisation to increase service uptake at the community level 2) document lesson learning from the pilot as a proven quality improvement model 3) expand the model incrementally (6 districts to 18 districts and then national expansion), documenting lesson learning and modifying the model further to increase efficiencies and improve outcomes, while simultaneously expanding and integrating the model into broader MCWH service delivery whilst mobilising additional resources from donor partners and partners (through harmonisation and alignment) to fund and sustain the intervention at national level. As a result MTC transmission was reduced from 12% nationally in 2007 to <5%
Best Practice / Innovation Recommendation 1	Publication of an article in an international journal and other means of dissemination
Best Practice / Innovation Action Point 1	Publish report on SARRAH web site by August 2011 and prepare paper for submission to international journal by September 2011
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.	

3. Project Management	Project management is in line with good practice both within the service provider (HLSP) and between HLSP and DFID. This is evidenced by holding appropriate Review, Technical Lead and Management meetings, which are minuted. Project management has been enhanced by the development of an effective Milestone Matrix system of control, which ensured that all workstreams are fully planned and costed, deliverables and their related costs are determined, and DFID is only invoiced on completion of milestones. The Service Provider is providing an appropriate level of supervision and quality assurance from both UK Head Office and within the programme in South Africa. While there has been some programme slippage in the first year, due mainly to the major changes taking place within all programme partners, of late, slippages have diminished to acceptable levels.	
Project Management Recommendation 1	HLSP (and DFID) have been through a steep learning curve in designing and applying the Milestone Matrix model; consideration should be given to capturing this learning and methodology in a DFID 'How To' guide.	
Project Management Action Point 1	HLSP to assess feasibility of this recommendation and, if feasible, provide a budget proposal and workplan.	
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.		

Other Comments

If appropriate, comment on the effectiveness of the institutional relationships created or enhanced by the project, e.g., comment on processes and how relationships have evolved.	In addition to the information in box 1. Working with Partners, the Review took note of the highly complementary comments received from all Partners. For example, one of the NDOH Cluster Managers said: "Without the support of DFID and HLSP we would be nowhere. It's been an absolute lifeline and absolutely invaluable".	
Key issues, points of information or additional comments that may be useful for this or other project teams.		
Other Recommendation 1		
Other Action Point 1		
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.		

Evidence: Key documents

Quest No.		
Evidence Recommendation 1		
Evidence Action Point 1		
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.		

Appendix 1: Conditionality and Sustainability

Conditionality

If conditions are attached to this project, was disbursement suspended during the review period because of the conditions?	No
If Yes, what was the cause?	
Date Suspended (dd/mm/yyyy)?	
What were the consequences?	
Conditionality Recommendation 1	
Conditionality Action Point 1	
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.	

Sustainability

Comment on how likely is it that the benefits arising from this project will be sustained after the end of project.	Too early to determine.
Sustainability Recommendation 1	
Sustainability Action Point 1	
If more Recommendations or Action Points need to be identified, click the '+' box on the left-hand side.	

Appendix 1: Recommendations and Action Points

Recommendations		Person / team who will action the recommendation
A1: Goal		
R1	There is a sense that the SARRAH programme is beginning to realise a significant contribution to the SAG's health sector reform agenda and has the potential to make a significant positive impact in terms of health systems strengthening and improved health outcomes. However it is important to keep in mind that critical enabling factors for success (e.g. political agendas, policy development and legislative changes) are outside DFID/HLSP control, as are the plethora of implementation actions that need to be taken by Partners in a timely manner, if the desired health outcomes are to be achieved .	N/A
R2	0	
R3	0	
A1: Purpose		
R1	0	
R2	0	
R3	0	
A1: Risk		
R1	0	
R2	0	
R3	0	
A1: Logframe		
R1	0	
R2	0	
R3	0	
A1: DSOs		
R1	0	
R2	0	
R3	0	
A1: Cross-Cutting Markers		
R1	0	
R2	0	
R3	0	
A2: Outputs		
R1.1	Milestones for utilisation rates in primary care facilities need to be adjusted downwards to reflect trend over last 3-4 years	HLSP
R1.2	0	
R1.3	0	
R2.1	SANAC - DFID and HSLP to take stock of likelihood of the leadership, governance, and institutional issues - and the associated risks- being resolved in the near future, and to devise a strategy for the way forward.	
Action	Draft a paper outlining issues, challenges, options and recommendations. To be produced by HSLP by 1 July 2011	HLSP
R2.2	With regards to TAC, to increase direct support in the areas of M&E system and to improve quarterly reviews of the NSP by providing TAC with a template which guides the structure and content of the reviews, so that they become an effective tool to assess NSP progress. The reports must also be based on evidence collected in its model districts.	
Action	For HLSP to develop indicators and a robust reporting process and format for TAC to report against these indicators which will help them in turn to improve the quality of the review reports. To be completed by 1 July 2011	HLSP

R2.3	With regards to POC, given slow progress, there is now a need to explore other options for engaging with Parliamentarians such as the Health Portfolio Committee.	
Action	Continue to monitor progress on POC. Draft options paper on suitable mechanisms for engaging Parliamentarians with recommendations by 1 August 2011.	HLSP
R3.1	Regarding NHI, to ensure that all work can be adapted to changing government policy on NHI as it emerges.	
Action	In 2011 regular meetings between SARRAH Technical Lead and Ministerial Adviser on NHI. To start July 2011	HLSP
R3.2	Regarding drug registrations, HLSP to closely monitor recruitment and deployment of new NDOH evaluators to ensure timely processing of drug applications	
Action	HLSP to request Benguela to report on monthly basis on recruitment of NDOH evaluators and status of backlog. To start July 2011	HLSP
R4.1	0	
R4.2	0	
R4.3	0	
R5.1	Reference is made Output 2, recommendation 1. If the decision is taken to further support SANAC, HLSP to assist Board of Trustees in recruitment process of high calibre M&E specialists and to provide support in developing an M&E framework that is linked to the NDOH M&E framework.	
Action	See Output 2, recommendation 1 and take action as per recommendation within the next 4 months. October 2011	HLSP
R5.2	Offer technical assistance to NDOH M&E task team to further the M&E framework.	
Action	Put on agenda of next NDOH SARRAH steercom in July 2011 to provide SARRAH inputs into development of M&E framework. July 2011	HLSP
R6.1	0	
R6.2	0	
R6.3	0	
R7.1	0	
R7.2	0	
R7.3	0	
R8.1	0	
R8.2	0	
R8.3	0	
R9.1	0	
R9.2	0	
R9.3	0	
R10.1	0	
R10.2	0	
R10.3	0	

B: Scoring		
R1	0	
R2	0	
R3	0	

C: Knowledge Sharing		
	Working with Partners	
R1	As SARRAH inputs are high profile and supportive of efforts that are far bigger and broader than the workstreams, continuous risk mitigation is essential and this is best done collaboratively through the forum of the SARRAH Steering Committee Meetings chaired by the Director General. Steer Comms to date have been too sporadic and too few. This is an issue that DFID and HLSP need to address jointly with the NDOH	
Action	DFID to advocate for more regular and effective steering committee meetings before the next Steer Comm. A potential solution is for the DG to appoint one or two deputies (cluster leaders) to chair the meeting in her absence. In addition HSLP could usefully prepare a one page 'traffic light' summary of project status, with one page summary of issues to be discussed at the meeting.	DFID
R2	0	
R3	0	
	Best Practice / Innovation	
R1	Publication of an article in an international journal and other means of dissemination	
Action	Publish report on SARRAH web site by August 2011 and prepare paper for submission to international journal by September 2011	HLSP
R2	0	
	Project Management	
R1	HLSP (and DFID) have been through a steep learning curve in designing and applying the Milestone Matrix model; consideration should be given to capturing this learning and methodology in a DFID 'How To' guide.	
Action	HLSP to assess feasibility of this recommendation and, if feasible, provide a budget proposal and workplan.	HLSP
R2	0	
R3	0	
C: Other Comments		
R1	0	
R2	0	
R3	0	
C: Evidence		
R1	0	
R2	0	
R3	0	
D: Conditionality		
R1	0	
R2	0	
R3	0	
D: Sustainability		
R1	0	
R2	0	
R3	0	
Additional Recommendations arising		
R1		
R2		
R3		

Action Points		Person / team who will lead on the Action Point
A1: Goal		
AP1.1	The SARRAH programme needs tocontinue to monitor the sucess of key implementation activities of Programme partners, so that desired outcomes and impacts are realised.	Note - These Action Points have already been recorded directly under the Recommendation to which they apply. What follows is therefore a duplication.
AP1.2	0	
AP1.3	0	
A1: Purpose		
AP1.1	0	
AP1.2	0	
AP1.3	0	
A1: Risk		
AP1.1	0	
AP1.2	0	
AP1.3	0	
A1: Logframe		
AP1.1	0	
AP1.2	0	
AP1.3	0	
A1: DSOs		
AP1.1	0	
AP1.2	0	
AP1.3	0	
A1: Cross-Cutting Markers		
AP1.1	0	
AP1.2	0	
AP1.3	0	
A2: Outputs		
AP1.1	Review milestones and/or consider applying indicator to NHI pilot districts only	
AP1.2	0	
AP1.3	0	
AP2.1	Draft a paper outlining issues, challenges, options and recommendations. To be produced by HSLP by 1 July 2011	
AP2.2	With regards to POC, given slow progress, there is now a need to explore other options for engaging with Parliamentarians such as the Health Portfolio Committee.	
AP2.3	Continue to monitor progress on POC. Draft options paper on suitable mechanisms for engaging Parliamentarians with recommendations by 1 August 2011.	
AP3.1	In 2011 regular meetings between SARRAH Technical Lead and Ministerial Adviser on NHI. To start July 2011	
AP3.2	0	
AP3.3	0	
AP4.1	0	
AP4.2	0	
AP4.3	0	
AP5.1	See Output 2, recommendation 1 and take action as per recommendation within the next 4 months. October 2011	
AP5.2	0	
AP5.3	0	
AP6.1	0	
AP6.2	0	
AP6.3	0	
AP7.1	0	
AP7.2	0	
AP7.3	0	

AP8.1	0	
AP8.2	0	
AP8.3	0	
AP9.1	0	
AP9.2	0	
AP9.3	0	
AP10.1	0	
AP10.2	0	
AP10.3	0	
B: Scoring		
AP1.1	0	
AP1.2	0	
AP1.3	0	
C: Knowledge Sharing		
	Working with Partners	
AP1.1	DFID to advocate for more regular and effective steering committee meetings before the next Steer Comm. A potential solution is for the DG to appoint one or two deputies (cluster leaders) to chair the meeting in her absence. In addition HSLP could usefully prepare a one page 'traffic light' summary of project status, with one page summary of issues to be discussed at the meeting.	
AP1.2	0	
AP1.3	0	
	Best Practice / Innovation	
AP1.1	Publish report on SARRAH web site by August 2011 and prepare paper for submission to international journal by September 2011	
AP1.2	0	
AP1.3	0	
	Project Management	
AP1.1	HLSP to assess feasibility of this recommendation and, if feasible, provide a budget proposal and workplan.	
AP1.2	0	
AP1.3	0	
C: Other Comments		
AP1.1	0	
AP1.2	0	
AP1.3	0	
C: Evidence		
AP1.1	0	
AP1.2	0	
AP1.3	0	
D: Conditionality		
AP1.1	0	
AP1.2	0	
AP1.3	0	
D: Sustainability		
AP1.1	0	
AP1.2	0	
AP1.3	0	
Additional Action Points arising		
AP1.1		
AP1.2		
AP1.3		

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APPENDIX 2: PRESENTATION

Department for International Development

South Africa

Annual Review of the Strengthening the Revitalized Response to AIDS and Health Programme (SARRAH)


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DFID SARRAH Annual Review 1
June 2011
In conjunction with
Human Sciences Research Council
South Africa
HSRC
Human Sciences
Research Council

Approach to Presentation

- Present findings in order of Outputs
- Brief overview of all outputs but concentrating on areas of concern
- Each Output will show
  - the Output budget and % of total budget
  - Logframe indicators and required milestones
  - Findings for each workstream
  - Recommendations, where necessary
  - Assessment score
- Summary observations against TOR/scope of work

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Purpose of Presentation

- Present findings, conclusions and recommendations
- Corroborate anecdotal evidence
- Provide agreed scoring on milestones
- Obtain feedback from DFID and HLSP
- Agree on remaining tasks

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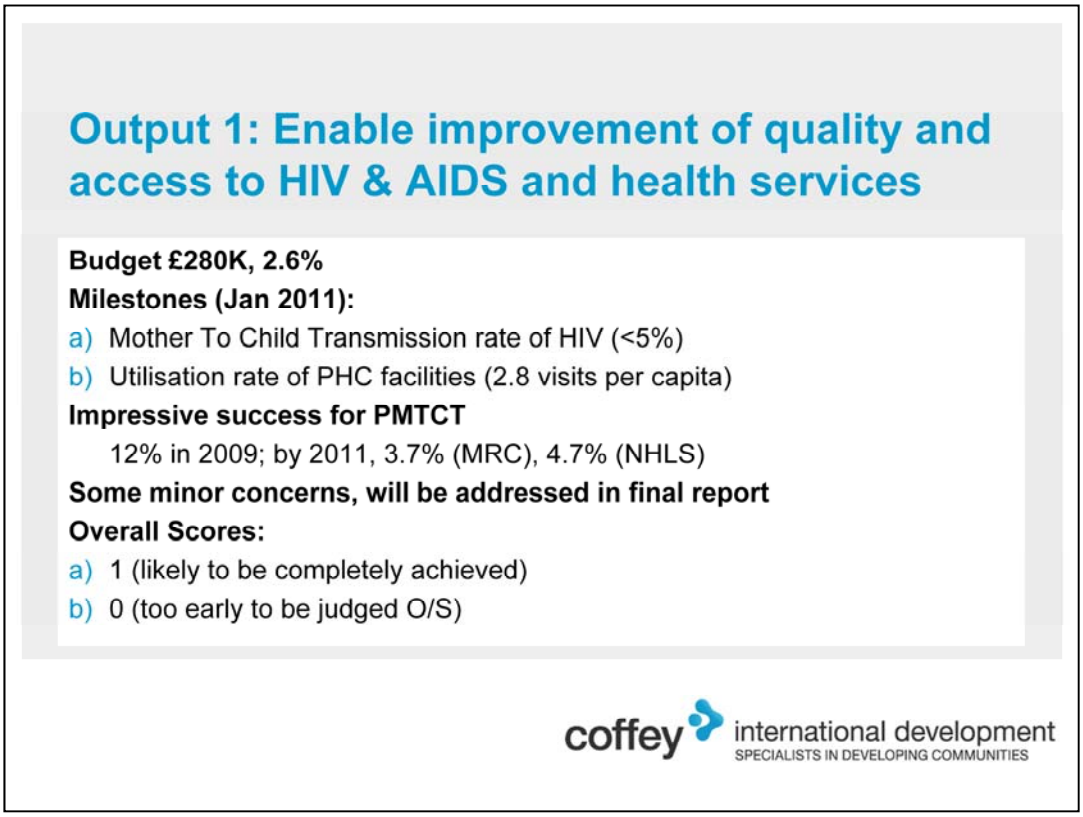

Challenges

Success story, but SARRAH role ends June 2011 (other donors cover this area, e.g. Global Fund, PEPFAR)

Success cannot be ascribed to SARRAH alone (many players)

Apparently good results but only 60% of infants are tested at 6 weeks - *What about the other 40%?*

PMTCT now part of under-resourced MCWH&N Cluster. Will NDoH be able to sustain PMTCT A-plan?

Recommendations

•Successful PMTCT has been demonstrated; SARRAH should ensure that an effective programme continues.

•The available milestone results are national. In future, rates for the PMTCT-A plan areas should be compared with other areas.

•Introduce competency assessments for PMTCT managers (Cf. Hospital managers study).

•Keep PMTCT indicators at top of KPAs for NDoH managers.

Other observations

SARRAH's role in donor coordination played a role in the observed improvements to PMTCT and helped to get the Global Fund extension.

Further details available in Ngubane, G., *A national strategy to strengthen services to prevent mother to child transmission of HIV in SA: Lessons from the A-Plan* . HLSP Case Study.

Output 2: Strengthened leadership and accountability of the national response to HIV and Aids

Budget £3 638K, 33.4%

Logframe Indicators:

- SANAC Secretariat established and functional
- TAC quarterly progress monitoring of the NSP
- TAC – 45000 Citizens empowered
- TAC – National Submissions to Government
- POC Established and Functional

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Output 2: Strengthened leadership and accountability of the national response to HIV and Aids

Findings : SANAC

- Major progress, with many challenges
- Legal and Institutional Structures of The Trust almost in place, finalisation of Trust Deed should allow tax exemption.
- Trust Committees established, substantially functional ...
- But Secretariat not yet fully functional
- CEO in place until March 2011, COO currently Acting CEO and establishing control and working relationship with Board and Staff
- Five key positions still to be filled (CEO, CFO, HR, SCM, M&E)
- Too much reliance on TA
- M&E is complex, but currently weak
- Sectoral Committees - too many are insufficiently active.

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Output 2: Strengthened leadership and accountability of the national response to HIV and Aids

Challenges: SANAC

- Capacity not yet adequate – both top and lower levels
- Pressure to produce NSF by December
- Risk of substandard product – needing further support and close supervision

Recommendations: SANAC

- Updated Institutional Development Needs/Plan to be prepared, including funding
- More support from SARRAH to be agreed and actioned
- Close Monitoring needed

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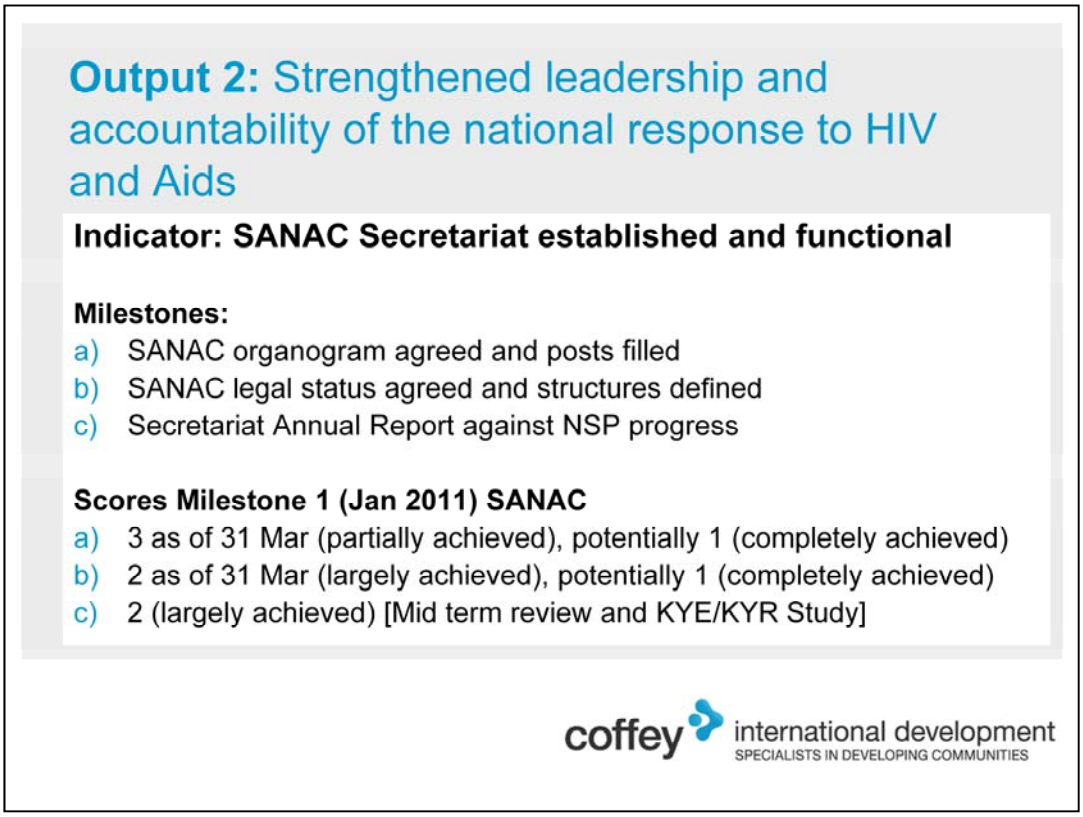

Observations

The Mid Term Review was commissioned by SANAC in 2009 and completed in 2010.

Know Your Epidemic/Know Your Response (KYE/KYE) project, funded by World Bank, managed by SANAC Research Sector, provided further in-depth analysis for monitoring progress on the NSP.

SARRAH contributed M&OD work for the restructuring of SANAC, the National AIDS Trust (NAT) and Board of Trustees (BOT). High level managers on various contracts have to be migrated across to NAT which has caused delays. Existing staff have to reapply for posts. Relationship between CEO and COO have been difficult but should be resolved once new appointments are made and positions are confirmed.

The question remains whether the major M&OD work during 2010 is going to bear fruit. The NSF donor forum meets bi-weekly, chaired by a member of SANAC who is funded by a donor. The workplan and budget are in place and Provincial Strategic Plans are being developed. Some provinces need support and this responsibility is being shared among donors – HLSP is supporting Gauteng through Charles Dalton, a full time consultant hired to drive NSF. With the previous CEO of SANAC (Dr Similela) now in the Presidency, with responsibility for driving the NSF (among other things), the chances of success should be improved.

Output 2: Strengthened leadership and accountability of the national response to HIV and Aids

Findings: TAC

- **Financial** - Appropriate action taken re shortcomings in KPMG report – i.e. 7 month grant extension, and close monthly monitoring
- **Operational** – Determined, committed HQ Management, becoming organised, focussed
- Quarterly Review of NSP not yet in a format to determine effectiveness / impact etc, or assess performance -
- Not easy to determine escalation of issues to National Level
- **M&E –** Weak but recent HLSP intervention has provided first basic framework, and reporting template
- **HLSP -** Well regarded by TAC

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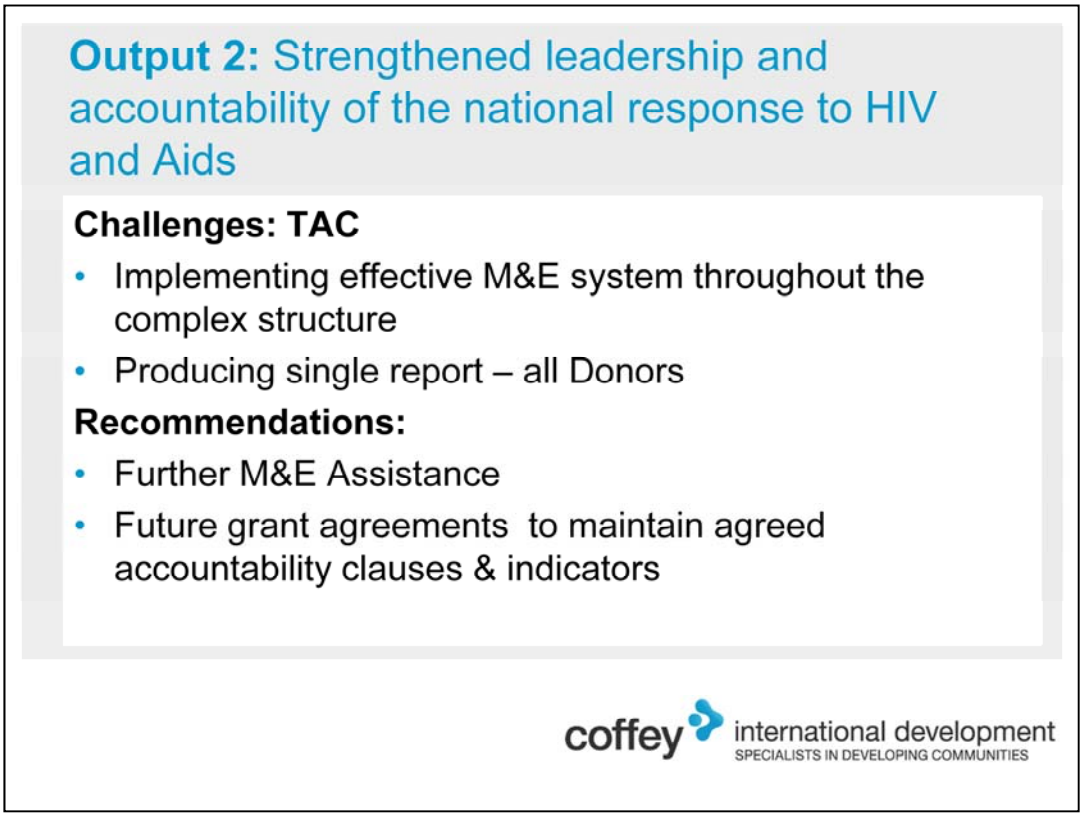


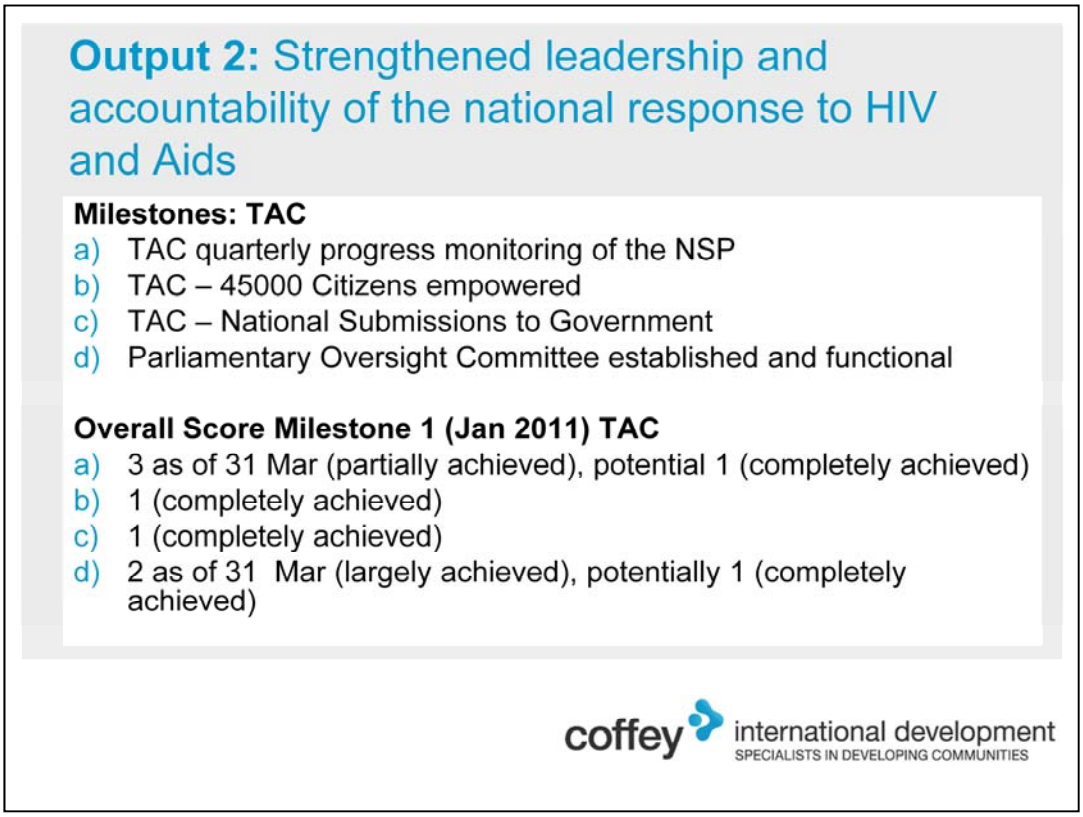
Observations

Although the new M&E template prepared with HLSP assistance will help provide a focused summary of activities, TAC will still have to do quarterly reports to donors, at least for the short term.

Recommendation

The burden of reporting to around twenty donors is considerable and efforts should be made to reach agreement on a uniform reporting requirement. Otherwise it is likely that the COO will spend most of his time preparing reports and meeting donors.

The TAC M&E person will need ongoing support.



Observations

The relatively low scoring for Milestone a) (TAC quarterly progress monitoring of the NSP) is because the quarterly reports exist but are unsuitable for assessing TAC's ability to monitor the NSP or lobby government.

The new grant agreement is designed to address these concerns. In the current reporting period one formal submission to government on the Social Assistance Bill was made, and other contributions on drug stock-out situations in clinics and the TARA clamp. A submission on NHI is in preparation and another will be developed on the NSF (2012-16).

Recommendations

•TAC's ability to undertake effective lobbying and advocacy is one of its key roles and must be properly monitored.

•Ensure that future grant agreements with TAC include M&E and reporting requirements that provide information on lobbying, advocacy and formal submissions to government.

Output 3: Support national interventions to improve access and equity to HIV and health services

Budget £3 741K, 34.3%

Logframe Indicators:

- Progress towards establishment of NHI
- Timescale for drug registration
  - Steps in SAHPRA establishment
- Establish Office of Health Standards Compliance

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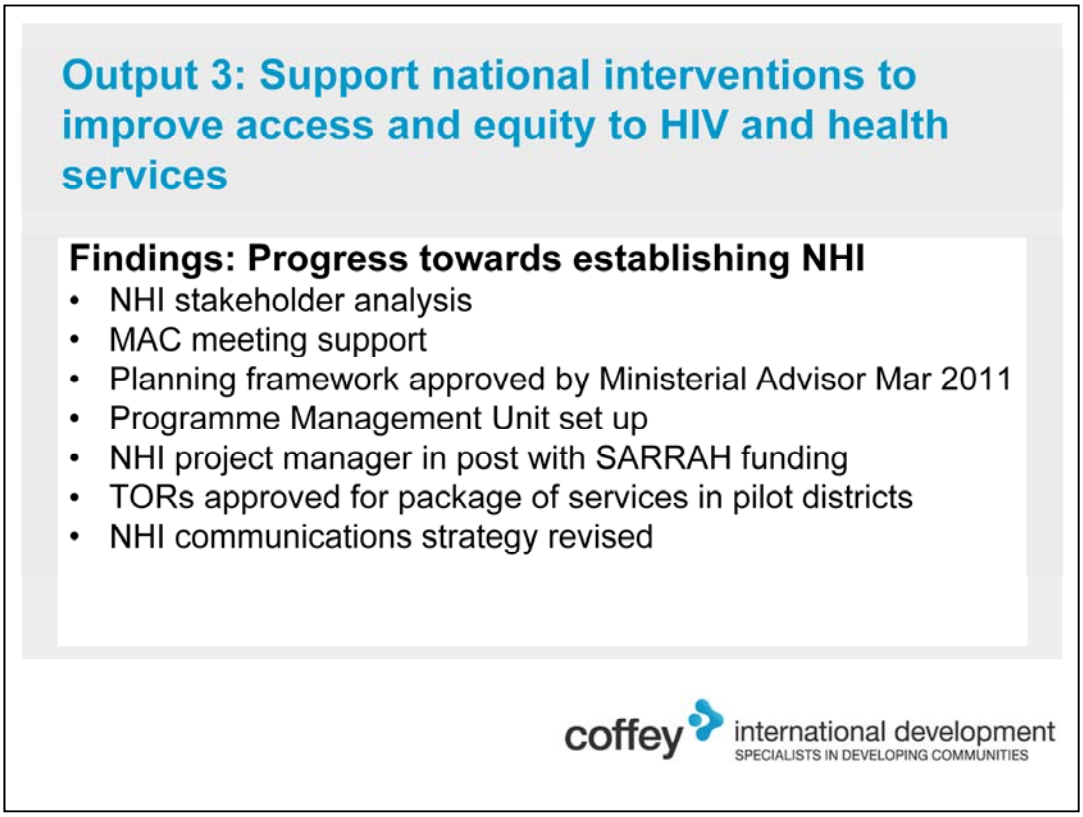
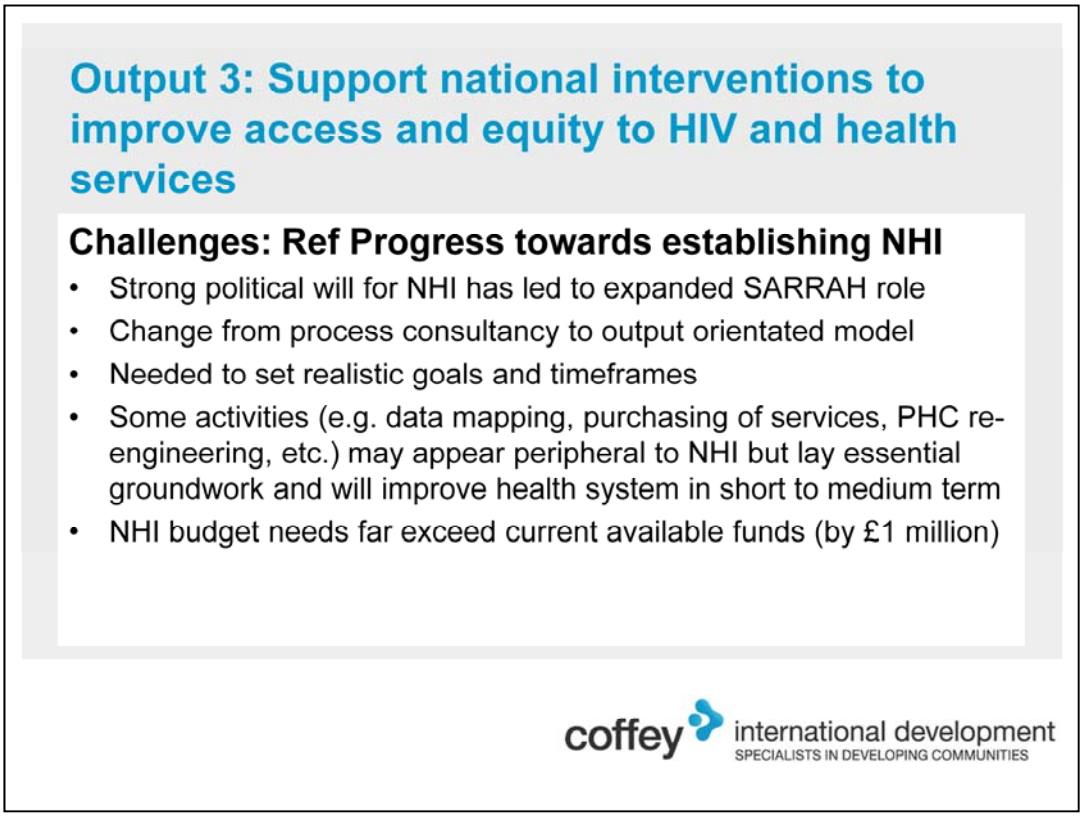


Observations

The Programme Management Unit in NDOH is apparently functioning well under the leadership of Dr Aquina Thulare.

A SARRAH-funded Project Manager is in place. Technical Advisors have been appointed for District Health Systems and the Package of Services.



Observations

The strong political will for establishing NHI presents both challenges and opportunities. This enthusiasm sometimes produces unrealistic timelines although this has been addressed to some extent; the proposed roll out has been extended from five to 14 years. However, pressure for interim deliverables still places considerable demands on officials and consultant. Governance of the process is such that people are unwilling (or not permitted) to make decisions without getting ministerial approval, which can lead to inordinate delays.

Recommendation

Although NHI is a politically sensitive topic, efforts need to be made to delegate more authority to Steering Committees.

Output 3: Support national interventions to improve access and equity to HIV and health services

Indicator: Progress towards establishment of NHI

Milestones (Jan 2011)

a) Draft NHI policy submitted to cabinet
b) NHI planning framework approved by Ministerial Advisor

Scores

a) 2 as of 31 Mar (largely achieved), potential 1 (completely achieved)
b) 1 (completely achieved)

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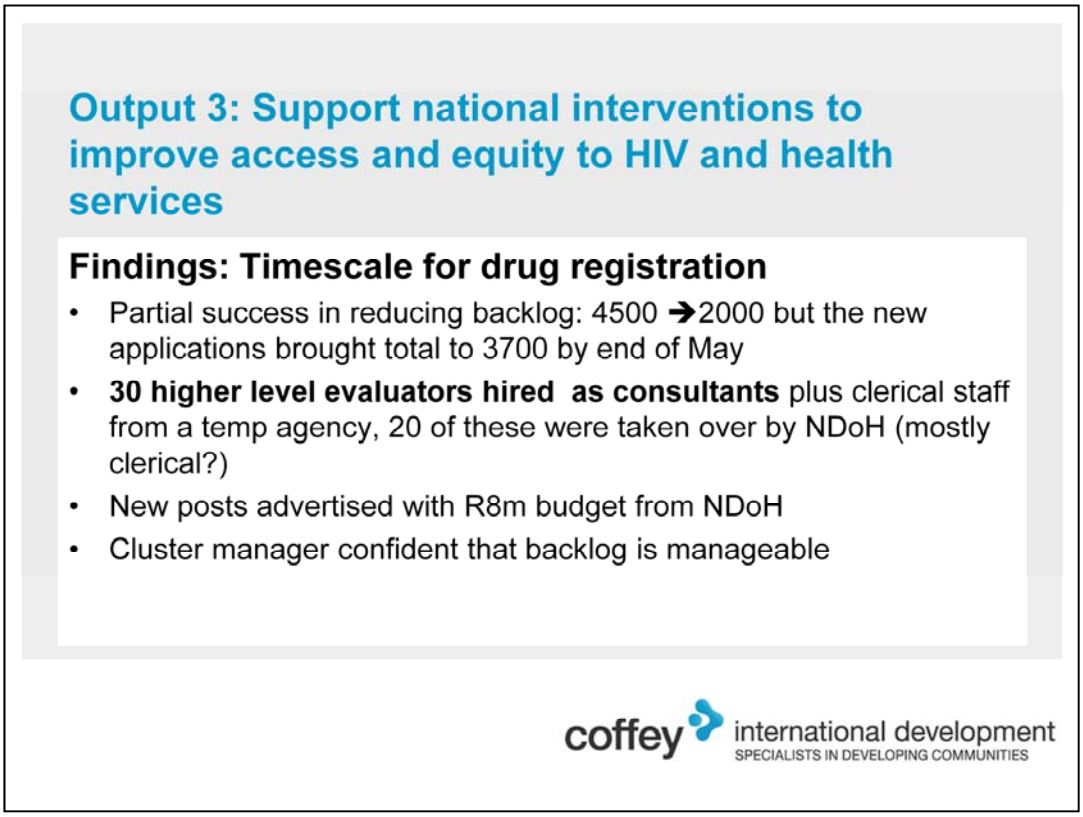

Observations

Despite initial success in reducing the backlog, the workload remains too high for the current staff and will continue to grow until sufficient trained staff are in post.

Recommendations

Methods to prioritise throughput of *essential* drugs should be considered.

Engage with and fully exploit the opportunities created by international collaboration on drug registration.

Output 3: Support national interventions to improve access and equity to HIV and health services

Challenges: Timescale for drug registration

- Scarce pharmaceutical/regulatory skills (currently use external consultants but NDoH needs dedicated staff)
- OSD may help but this process is being delayed by labour issues
- New recruits need 6 months training once appointed
- Every day of delay increases backlog

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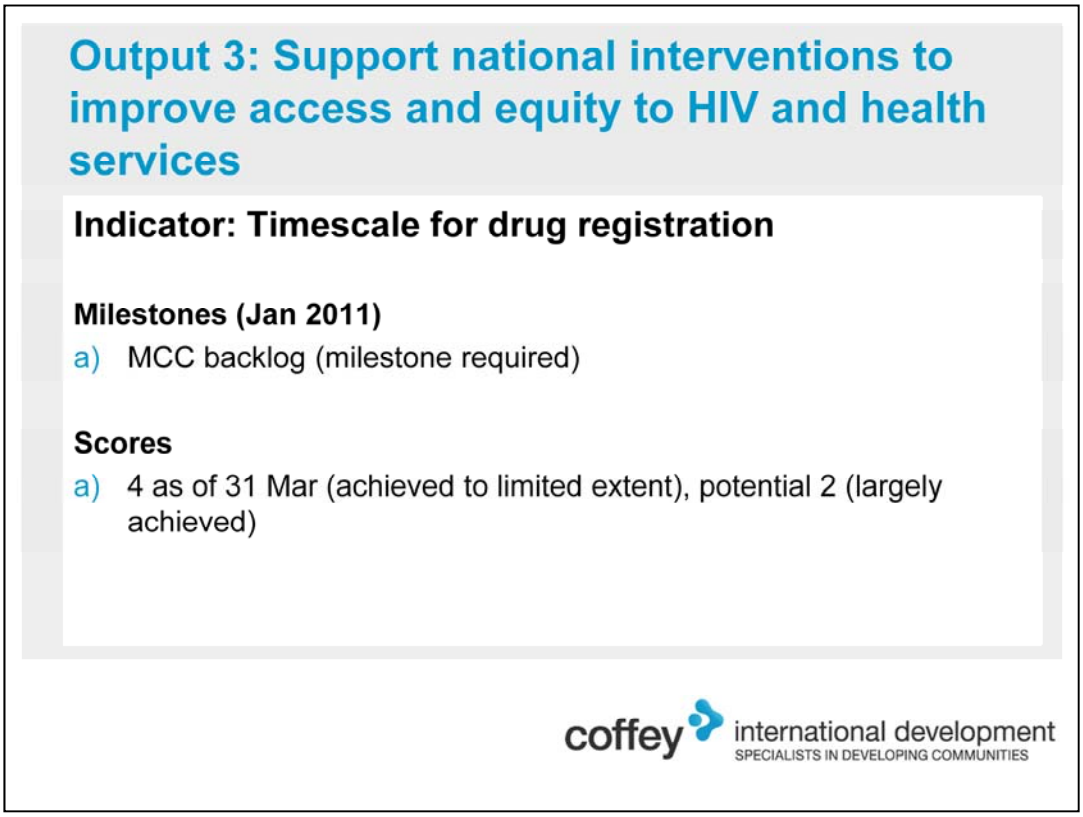

Recommendation

A robust indicator for acceptable times for drug registration is needed.

Output 3: Support national interventions to improve access and equity to HIV and health services

Findings: Steps in SAHPRA establishment

- SAHPRA business plan approved Nov 2010
- Backlog project and SARRAH helped register new ARVs, which contributed to R4.7bn saving in Dec 2010
- Legislation options drafted – Agency or Schedule 3 Public Entity
- Strong commitment from Minister and DG
- Pharmaceutical companies have agreed to stepped increase in tariffs
- Possible implementation of Agency model by end of 2011 (regulation required) OR Public Entity by end of Financial Year (legislation required)

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Observation

There are some quite wide variations in opinions about how quickly SAHPRA can be established. The DG expects this to happen by the end of the year but the necessary legal framework and labour issues could cause delays.

Output 3: Support national interventions to improve access and equity to HIV and health services

Indicator: Steps in SAHPRA establishment

Milestones (Jan 2011)

a) Approved business plan
b) Relocation to Civitas

Scores

a) 1 (completely achieved)
b) 1 (completely achieved)

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Output 3: Support national interventions to improve access and equity to HIV and health services

Findings: Establish Office of Health Standards Compliance

- Assisted with development and publication of National Core Standards for Health Establishments (Dec 2010)
- Supported provincial orientation and training
- Provided comment on draft National Health Amendment Bill
- National Health Amendment Bill, making provision for OHSC, released for public comment Jan 2011 and submitted to Parliament 25 May 2011
- Cluster Manager described SARRAH contributions as “an absolute lifeline”

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Output 3: Support national interventions to improve access and equity to HIV and health services

Challenges: Establish Office of Health Standards Compliance

- Scoping the OHSC without promulgated bill
- NDoH restructuring incomplete
- Tight, possibly unrealistic, timeframes

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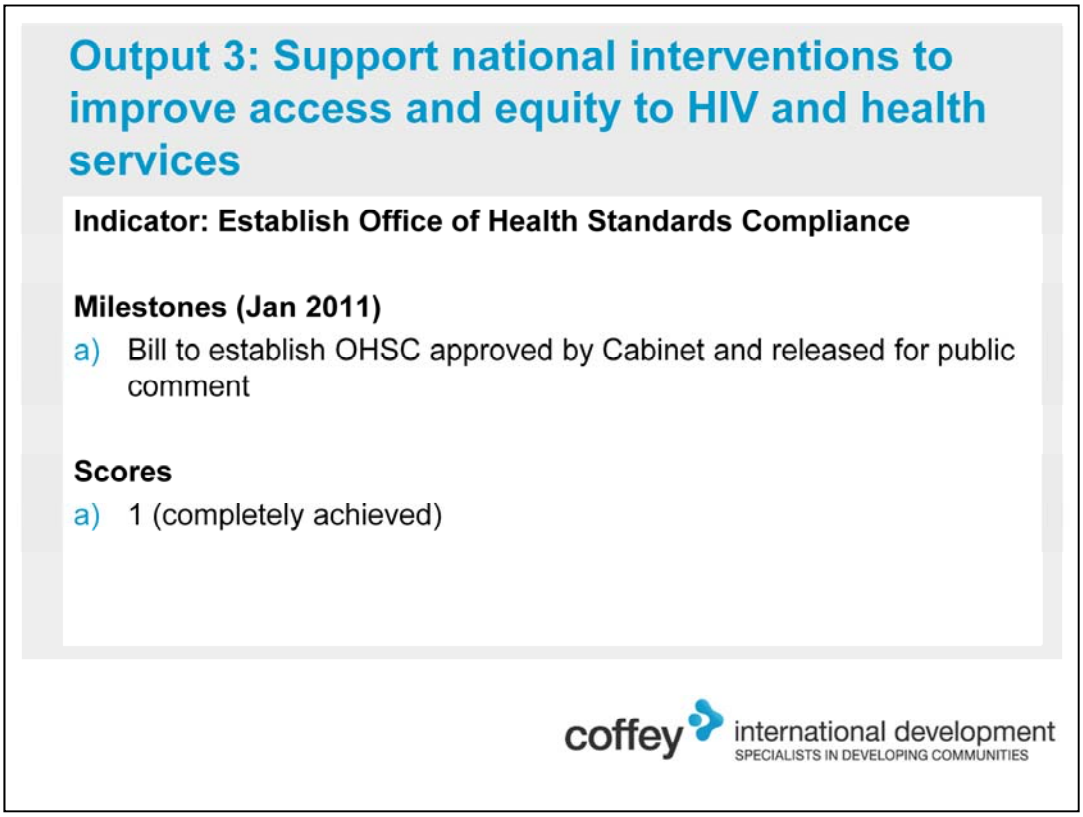

Observations

The National Health Amendment Bill was approved by Cabinet on 30 November 2010. It was formatted and released for public comment on 25 January 2011. Public comment process closed on April 25th. SARRAH programme assisted in processing all the comments leading to a revised Bill which was submitted to the DG Health on 22nd May.

Output 4: Strengthen Performance Management & Strategic Planning for HIV and Health Services, National and Provincial

Budget £2 273K, 20.9%

Logframe Indicators:

- Competency of public sector district and hospital managers
- Organisational development of the public health sector (a restructured NDoH)
- Provincial Service Transformation Plans agreed and monitored through Annual Performance Plan
- Number of national and provincial DOHs with an Unqualified Audit Opinion

Observation: These workstreams are discrete and somewhat disjointed workstreams.

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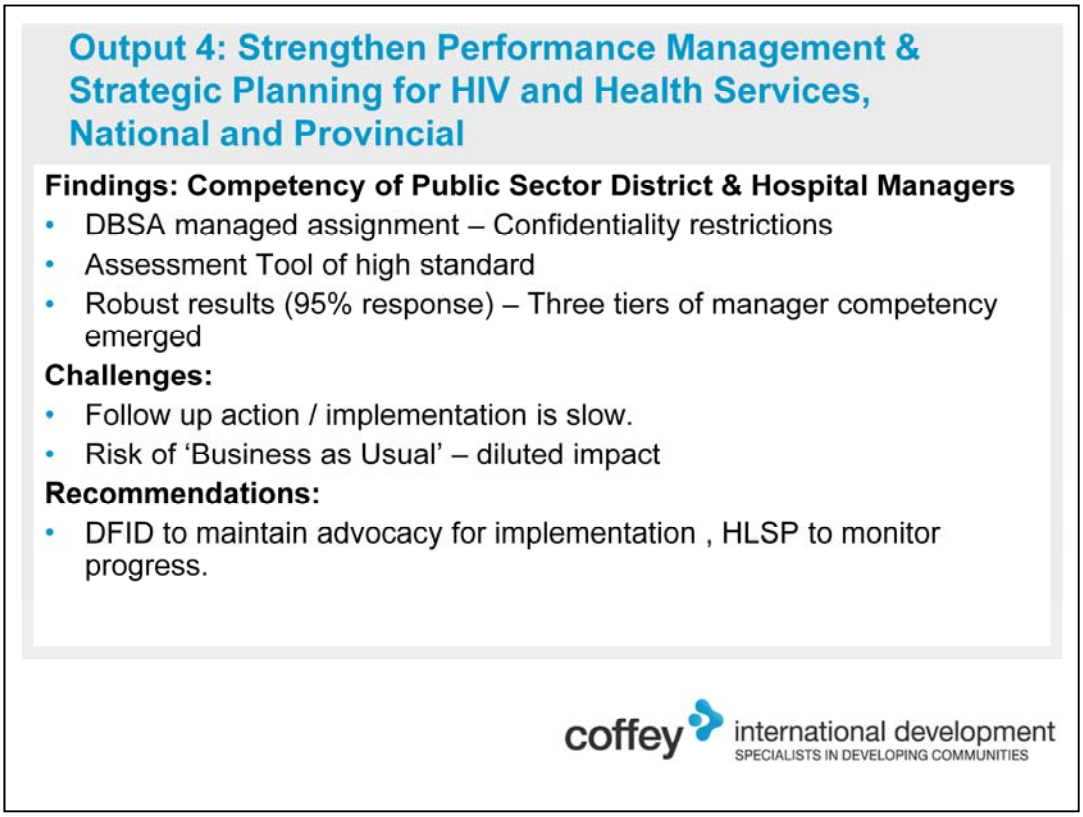

Observations

Following the Competency Assessment, a Task Team was set up (May 2011), and remedial action has already begun. Although the report is strictly confidential, David Jarvis at DBSA would be able to provide further information on its consequences.

Output 4: Strengthen Performance Management & Strategic Planning for HIV and Health Services, National and Provincial

Indicator: Competency of public sector district and hospital managers

Milestones (Jan 2011)

a) First competency assessment completed

Score

a) 1 (completely achieved)

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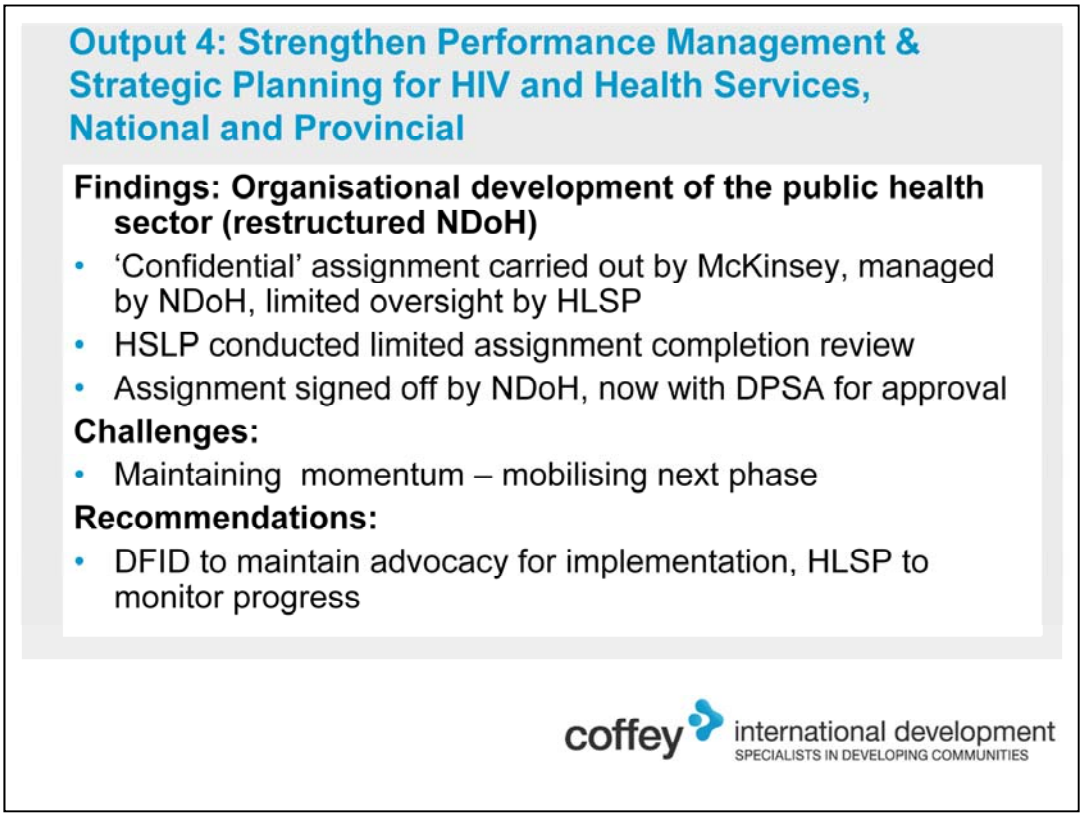

Observations

The report has been submitted to DPSA and top positions will have to be advertised. One union still to be consulted.

Output 4: Strengthen Performance Management & Strategic Planning for HIV and Health Services, National and Provincial

Indicator: Organisational development of the public health sector (a restructured NDoH)

Milestones (Jan 2011)

a) Top structure of NDoH designed, change strategy prepared

Score

a) 1 (completely achieved)

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Output 4: Strengthen Performance Management & Strategic Planning for HIV and Health Services, National and Provincial

Findings: Service Transformation Plans agreed and monitored through APP

- Second attempt after 2006 assignment stalled
- 7 STPs completed, 2 close to completion (EC, KZN)
- HLSP fully involved, various 'wrinkles' addressed
- NDoH Project Manager now overloaded with other priorities, progress has slowed
- National Technical Review Panel not yet convened

Challenges:

- Risk of assignment going into 'limbo'
- Data / standards from STPs must inform related interventions

Recommendations:

- DFID to maintain advocacy for convening National Technical Review Panel, HLSP to monitor/support implementation progress.

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Output 4: Strengthen Performance Management & Strategic Planning for HIV and Health Services, National and Provincial

Indicator: Provincial Service Transformation Plans agreed and monitored through Annual Performance Plan

Milestone (Jan 2011)

a) Framework for development of 7 plans

Score

a) 1 (completely achieved)

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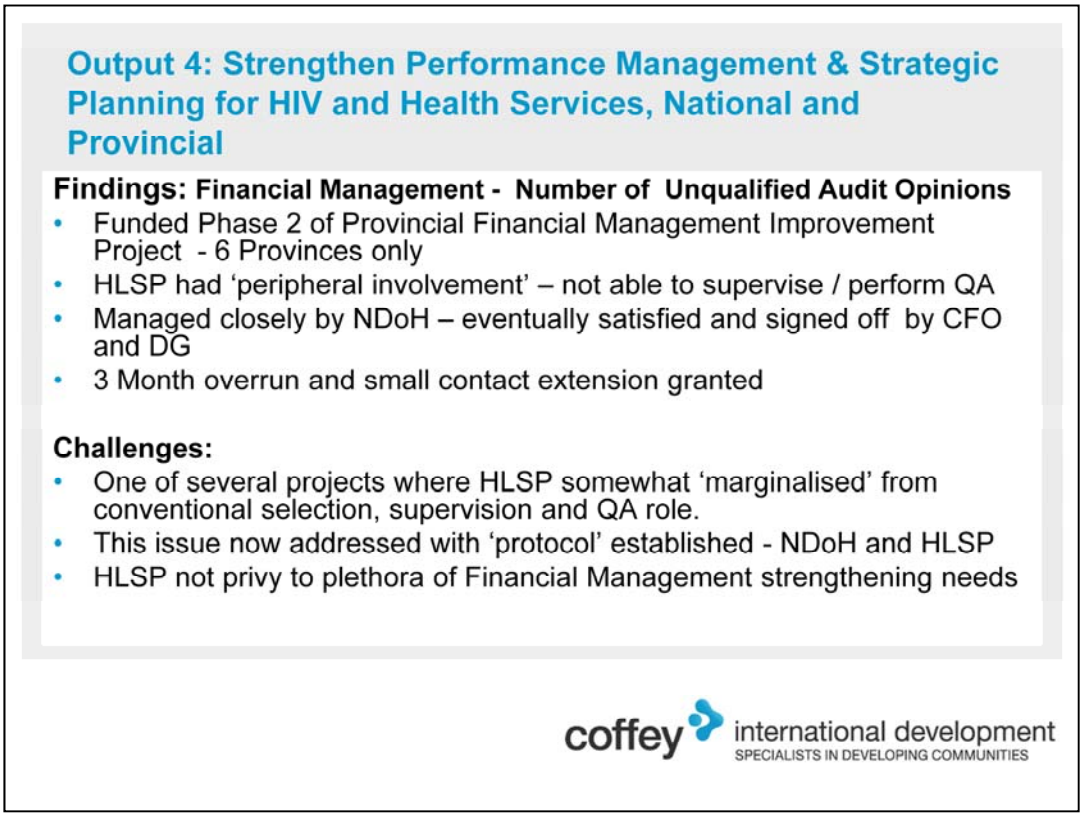
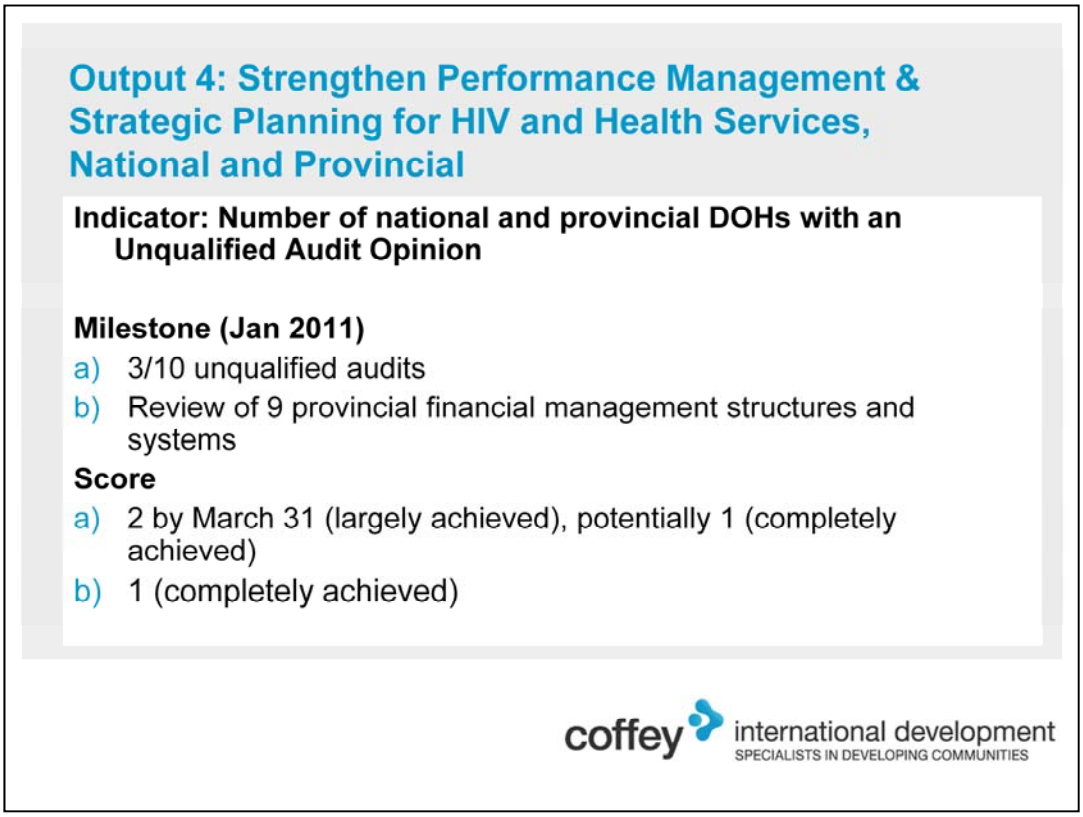


Observations

Although the full report is not available, a summary is available with sensitive information removed.

A Financial Management Improvement Unit has been set up within CFO's office.



Observations

3/10 unqualified audits achieved according to Dr Tumi Funani (NDoH) as of 7/6/11.

Output 5: Strengthen systems for effective M&E of NSPs for HIV&AIDS and health

Budget £964K, 8.8%

Logframe Indicators:

- SANAC M&E systems strengthened – covering multisectoral response in both public & private sectors
- Joint national monitoring of the NSDA

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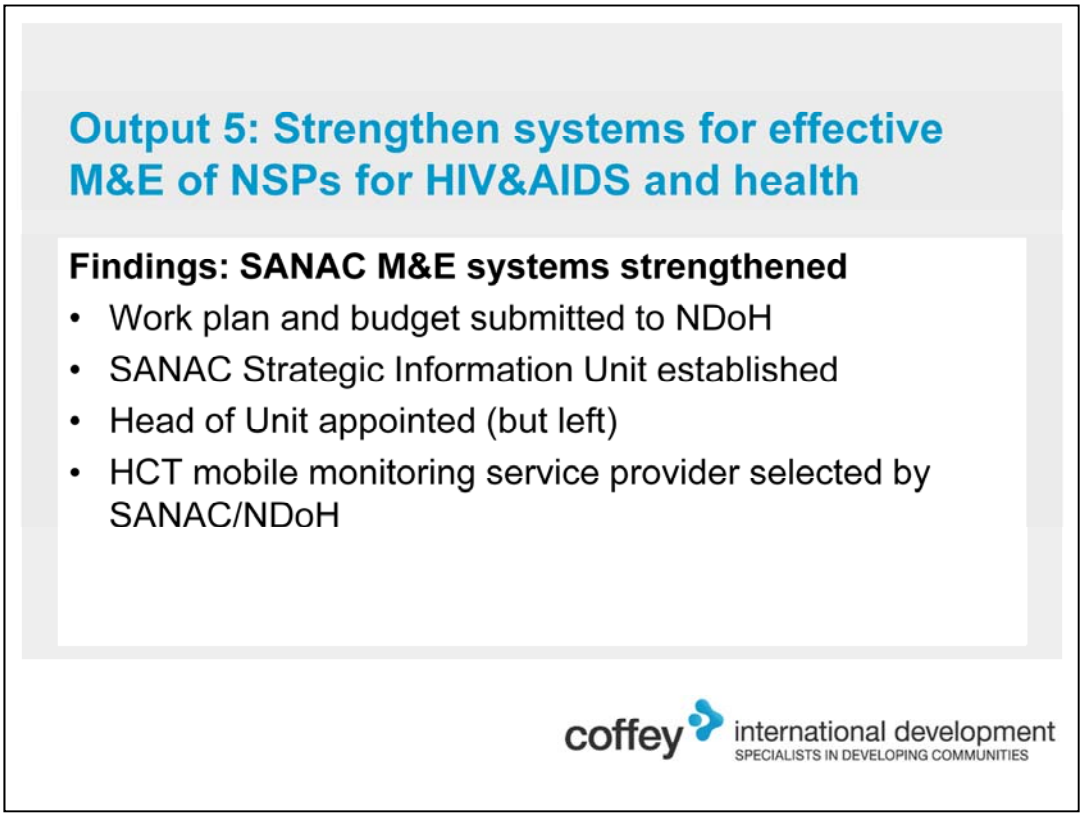
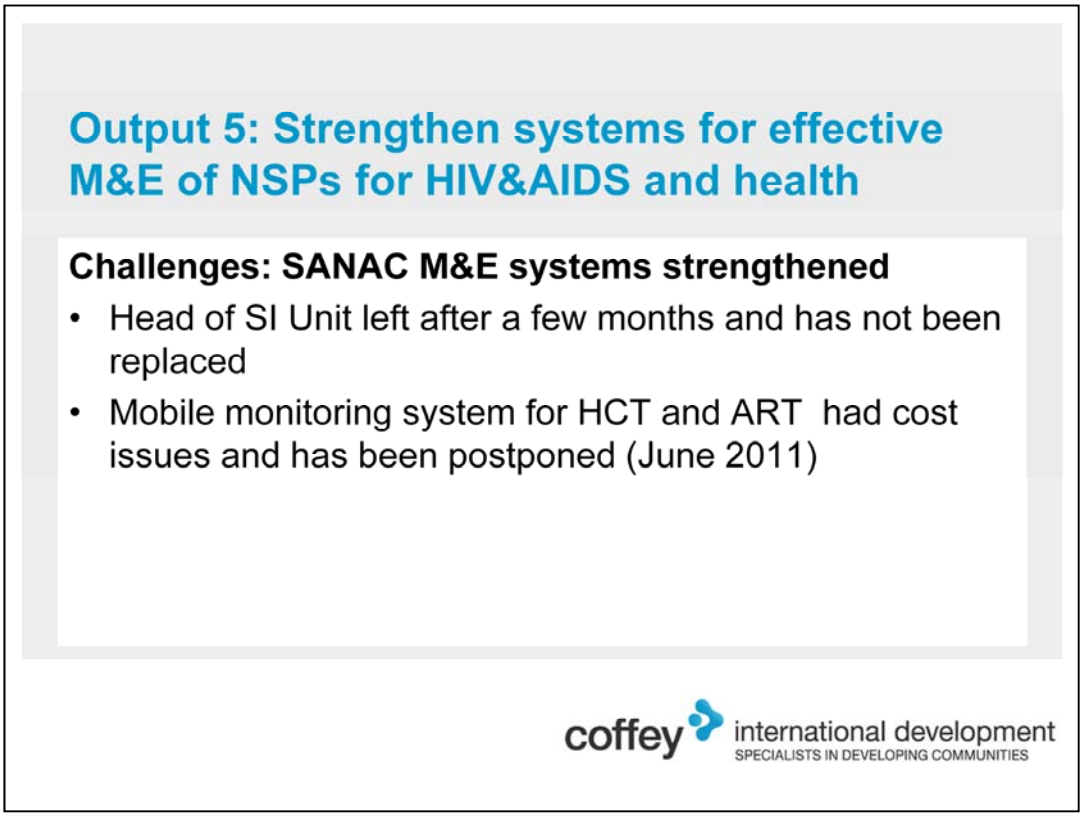


Observations

Clinton Foundation (CF) funding covered the Head of Unit salary but was withdrawn with realignment of CF funds. Subsequent delay in reappointing was because posts have to be approved by the SANAC Board of Trustees.



Observations

The DG has set up a national committee on M&E which has ramifications for both SANAC M&E and NSDA M&E.

HLSP completed the independent review of the mobile monitoring system and raised some concerns (cost omissions). This information and other parallel developments caused the project to be put on hold.

Output 5: Strengthen systems for effective M&E of NSPs for HIV&AIDS and health

Recommendations: SANAC M&E systems strengthened

- Appoint Head of SANAC SI Unit ASAP
  - in interim, request ongoing support from Henry Damisoni (UNAIDS)
  - strive to link SANAC M&E with NSDA M&E

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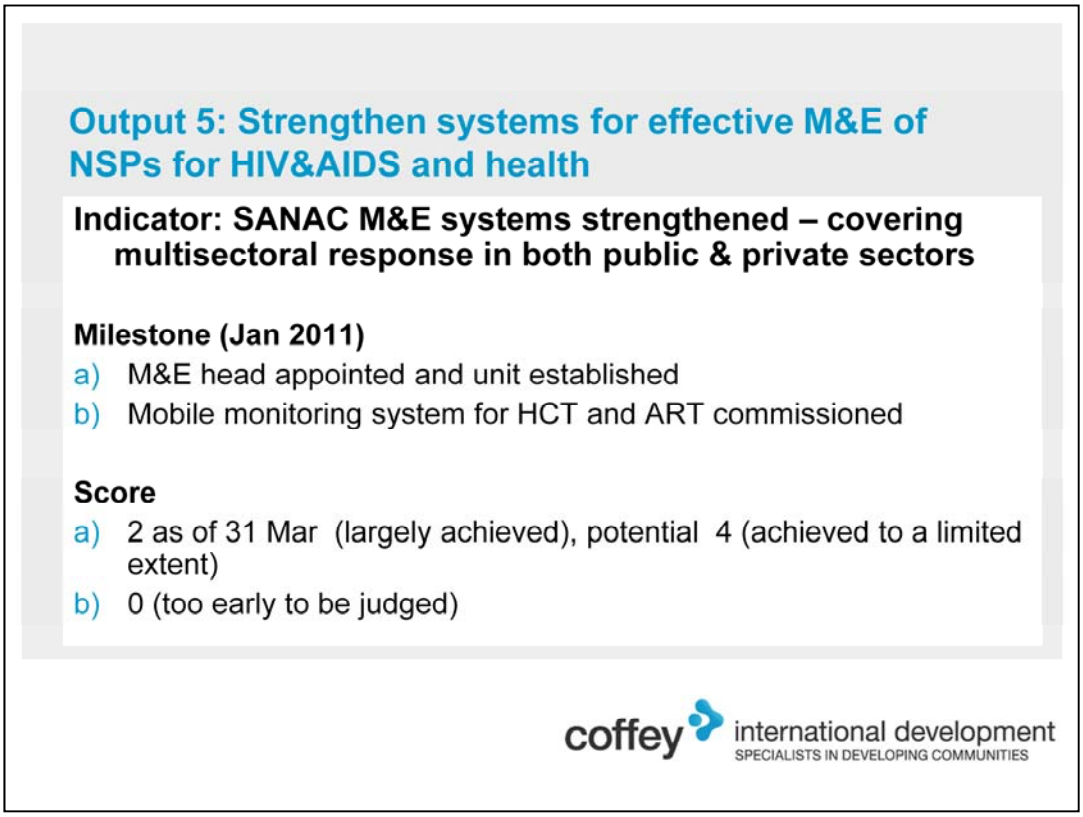

Observations

The M&E head was appointed within the reporting period but left immediately thereafter, thus the score changes from 2 to 4.

Matrix item 6 : Donor Coordination and Alignment

Findings :

- 27 Donors in total
- Now aligned with NSDA
- ODA Coordinating Forum launched in January
- Bi-annual meetings – next in June
- SARRAH and DFID held in high regard (EU, NDoH)
- Donor Coordination Group working well – N. Moleketsi

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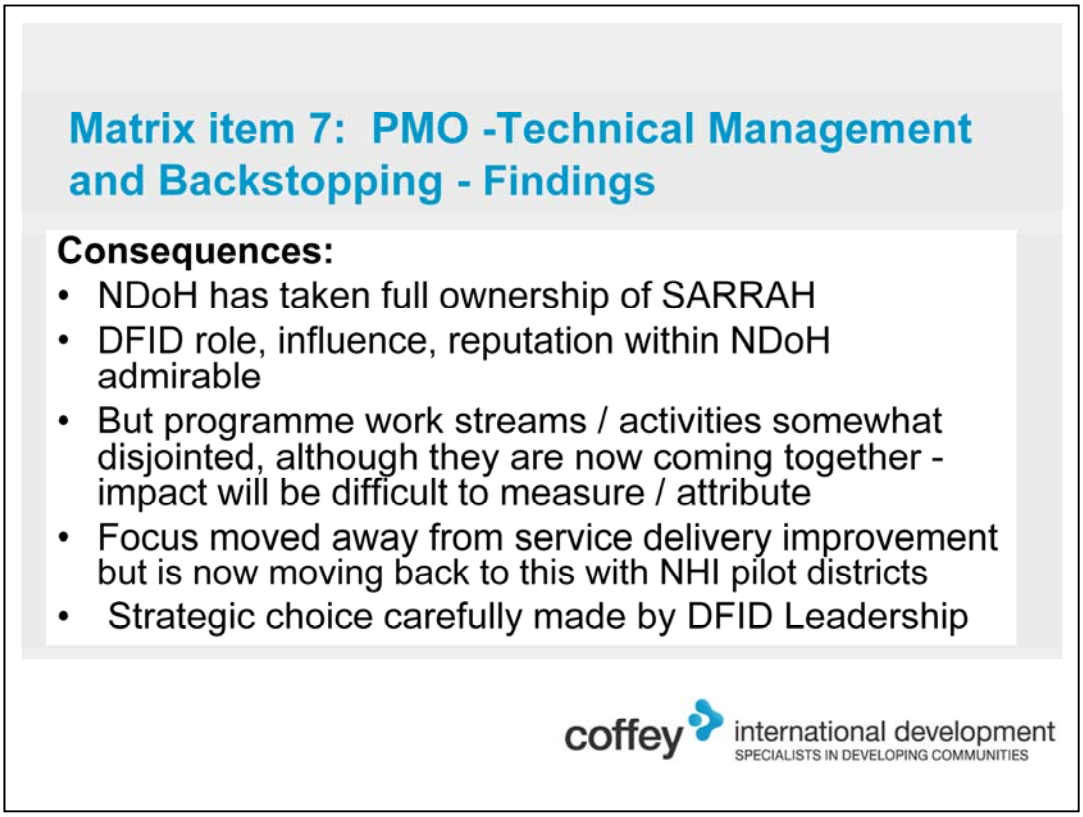
Observations

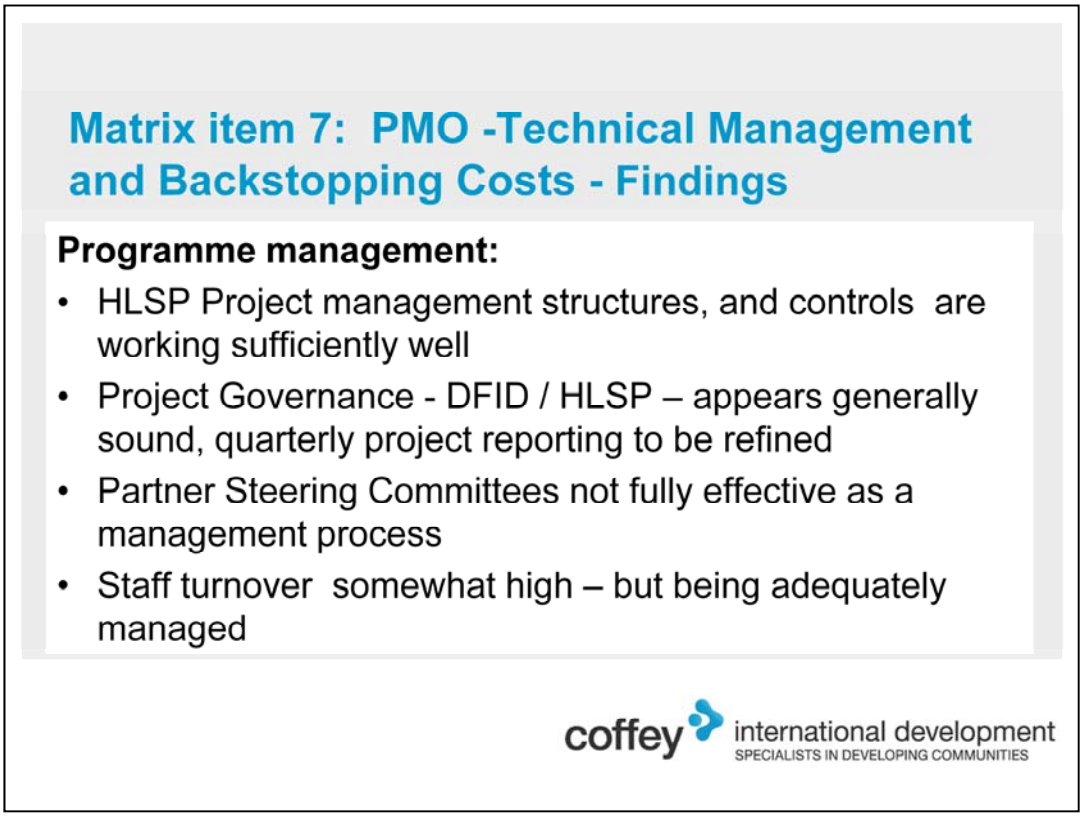
Initially, the expectation was that the previous contract would run straight into new one but this was delayed by the change of UK government and the need to review DFID priorities. The initial contract was signed in Dec 2009 and work began on schedule in January 2010 but when the work was fully scoped, contract amendments became necessary. However, these amendments were not approved until August 2010. This delay effectively meant that HLSP had to fund the project from its own resources for the first several months.



Recommendation

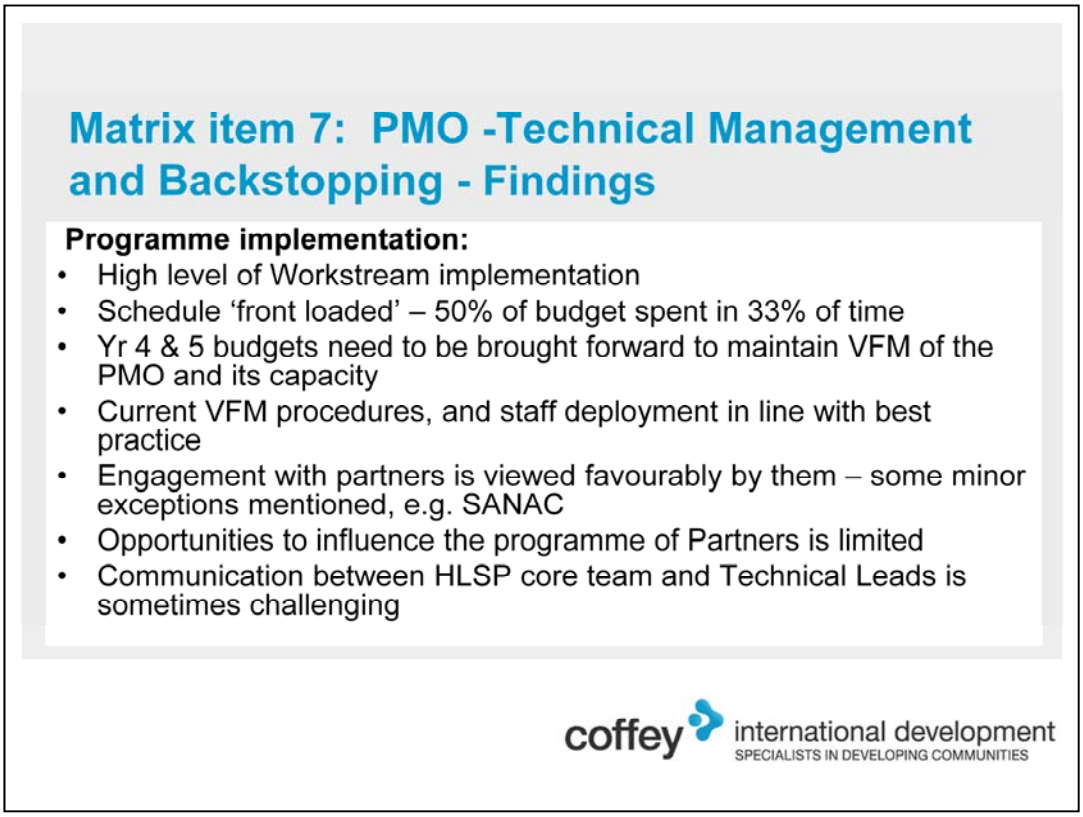
HLSP and DFID need to agree on how the many programmes fit together. The Resource Centre in NDoH will soon provide mind maps that should assist with this process.

HLSP quarterly report format should be revised to highlight linkages between the many SARRAH elements and this needs to be communicated to South African public.



Recommendation

DFID and HLSP should try to ensure that Steering Committees become effective means for two-way exchange of information between the Service Providers and Partners.



Observation

There has been some confusion created by Technical Leads having overarching responsibilities which go beyond HLSP project and even SARRAH. For example, some TLs are doing work for HLSP, NDOH and DFID UK, with some inevitable overlap.

Matrix item 7: PMO -Technical Management and Backstopping - Findings

Programme M&E, Quality, Communication, Gender

- Milestone Matrix an effective management and M&E method
- Service Provider only paid on delivery of quality milestone outputs - and subject to retention
- Delays in milestone completion immediately apparent, requiring justification
- Logframe now updated but may still have gaps
- Project influencing and communication with Partners of diminished importance – given NDoH stance
- Gender is addressed in PMTCT, TAC, SANAC but needs to be more explicitly reported

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Remaining tasks as at 15:00 9 May 2011

- Final agreement on logframe
- Interview with DG
- Review HLSP self assessment
- Complete independent assessment (DFID/Coffey)
- Discussion of 'lessons learnt'
- Inspection of evidence
- Prepare draft report
- Review by DFID & HLSP
- Prepare final report
- Upload assessment to Aries
- Publish one or two case studies on SARRAH DFID web site

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Thank you

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APPENDIX 3: SARRAH ANNUAL REVIEW INTERVIEW LIST

Department for International Development

South Africa

Annual Review of the Strengthening the Revitalized Response to AIDS and Health Programme (SARRAH)

APPENDIX 3

1 ANNUAL REVIEW INTERVIEW LIST

Table A3.1: Interview List

Institution	Name
	Rose-marie de Loor
	Kenneth Grant
	John Wilson
	Catherine Brown
	Myles Ritchie
	Crispen Olver
	Nicholas Crisp
	Gugulethu Ngubane
	Makomenyani Masekela
	Saul Johnson
HLSP	Itumeleng Funani
NDOH	DG Precious Matsoso
	Valerie Rennie
	Carol Marshall
	Mandisa Hela
	Nelly Malefetse
SANAC	Rev Zwo
	Mirriam Chipimo
TAC	Vuyiseka Mabula
	Stephen Harrison
	Phillip Mokoena
POC	Mirriam Chipimo
Development Partners	
EC	Esther Bouma
CHAI	Celicia Serenata

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APPENDIX 4: BIBLIOGRAPHY

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APPENDIX 4

Table A4.1: Bibliography

Title	Author	Date
Communications Strategy	HLSP	
Delivery Agreement	President's Office/ NDOH	
Equal treatment	TAC	April 2011
Fast Track to Quality	NDOH	2011
Grant Agreement	HLSP	1 March 20111 March to 30 September 2011
Health budget summary Vote 16		
Holding Government and other Stakeholders Accountable for and Effective Delivery Response to HIV	TAC	2010 – 2011
Key Initiatives to Strengthen heath Facility and district health management		
Key Points from the Workshop of Health Data Advisory and Co ordination Committee (HDACC) of the Department of Health (DOH) in South Africa and International experts from the United National (UN) Agencies		23 May 2011
MCC Back Log	Nicholas Crisp	May 2011
National Core Standards	NDOH	2011
National Core Standards	NDOH	2011
NDOH Annual Performance Plan 1st Draft	NDOH	February 2011
NDOH Proposed Organisational Structure		
NSP Report 3		September, October, November 2010
Outline Strengthening the Provision of Quality Health Care by Healthcare Facilities		
Overview of Health Sector Reforms in South Africa	DFID	April 2011
PMTCT in South Africa	Dr Ngubane	May 2011
Refocusing the governance framework	Jack Eldon	April 2011
Report Visit to South Africa	Kenneth Hill	23 May 2011
Reprogramming Areas to be Supported under the New UK Programme of Support on Health and HIV & Aids	Minster	02 November 2010

Title	Author	Date
SA National Strategic Plan on HIV and Aids and STI's Mid Term Review	HAD	30 November 2010
SANAC Procedural Guidelines	SANAC	27 May 2008
SARRAH Annual Report	HLSP	January to December 2011
SARRAH Quarterly Report	HLSP	January to March 2011
SARRAH Website	HLSP	
Stakeholder Analysis Paper	DIFID	April 2011
Strategic Plan	NDOH / John Wilson	2010/11 – 2012/13
TAC Indicator Reference Sheets – Draft 1.3	Cell Life	14 January 2011
The Aid Effectiveness Framework For Health In South Africa	NDOH	21 January 2011

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APPENDIX 5: CORROBORATION OF MILESTONE ACHIEVEMENT

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South Africa

Annual Review of the Strengthening the Revitalized Response to AIDS and Health Programme (SARRAH)

APPENDIX 5

Table A5.1: Corroboration of Milestone Achievement

Output	Milestone	Score	Evidence	Seen/ Approved	Comments
Goal 1	Under 5 mortality rate: 80 per 1000 live births	1	HRSC Data	Y	
Purpose 3	Aid effectiveness framework approved by MoH and Treasury and shared with donors		Aid Effectiveness framework doc	Y	
1	a) Mother to child transmission rate <5%	1	Report: *A national strategy to strengthen services to prevent mother to child transmission of HIV in SA: Lessons from the A-Plan*	Y	Indicators are national and not specific to pilot districts. NHLS figure awaiting ministerial approval
2.1	a) SANAC organogram agreed and posts filled	3	SANAC Organogram	Y	
2.1	b) SANAC legal status agreed and structures defined	2	National AIDS Trust Constitution	Y	
2.1	c) Secretariat Annual Report against NSP progress	2	NSP mid-term evaluation	Y	
2.2	a) TAC quarterly progress monitoring of the NSP	3	Quarterly reports	Y	Poor quality reports but revised template now in place
2.2	b) TAC – 45000 Citizens empowered	1	E-mail from Phillip Mokoena (TAC COO) 08/06/11	Y	
2.2	c) TAC – National Submissions to Government	1	TAC Submission on Social Assistance Bill	Y	Information requested from TAC (MR)

3.1	a) Draft NHI policy submitted to cabinet	2	Independent verbal reports (DG, Cluster Manager)	Y	Confidential document, unable to inspect
3.1	b) NHI planning framework approved by Ministerial Advisor	1	Documentary evidence of "Approval"	Y	
3.2	a) MCC backlog (milestone to be confirmed)	4	Report: *MCC backlog and SAHPRA case study*	Y	
3.3	a) Approved business plan	1	SAPHRA Business Plan	Y	
3.3	b) Relocation to Civitas	1	Site visit 24/05/11	Y	
3.4	a) Bill to establish independent OHSC approved by Cabinet and released for public comment	1	Draft bill	Y	
3.5	a) PHC re-engineering report completed	1	PHC re-engineering discussion report	Y	
4.1	a) First competency assessment [of public sector district and hospital managers] completed	1	Independent verbal reports (DG, Cluster Manager, DFID Health Advisor, DBSA)	Y	Highly confidential document(s)
4.2	a) Top structure of NDoH designed, change strategy prepared	1	Report: *National Department of Health Proposed Organisational Structure*	Y	
4.3	a) Framework for development of 7 [STP]plans	1	STP plan for Gauteng (random selection)+D2	Y	
4.4	a) Review of 9 provincial financial management structures and systems	1	Summary report	Y	
5.1	a)M&E head appointed and unit established	2	Interview with Acting CEO SANAC Trust Secretariat	Y	Head was appointed but left due to interruption of funding (CHAI)

5.1	b)Mobile monitoring system for HCT and ART commissioned	X		N/A	Cost and other concerns placed project on hold

Table A5.2: Indicators Specified in the Annual Review Scope of Work Requiring Documentary Evidence

Scope of work	Evidence	Seen/ Approved	Comments
The project governance structures including steering committee meetings with partners as well as with DFID	Minutes of Steering Committee meetings, SANAC, NDOH and DFID (last quarter 2010)	Y	
The quality of SARRAH's strategy, methodology and approach including an assessment of project management and implementation performance	Minutes of DFID/HLSP bi-weekly meetings (last quarter 2010)	Y	
Measures taken to maximise the efficiency of staff deployment and value for money	Documentary evidence of consultant rate negotiation by UK HLSP	Y	
The project influencing and communication strategy	Report: *Communications Strategy* and Website http://sarrah.camb-ed.com/HOMESUPPORTFORHIVANDHEALTH.aspx	Y	
The programme monitoring and evaluation procedures	Logframe	Y	
The milestone matrix including budgets	Milestone matrix	Y	

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APPENDIX 6: TERMS OF REFERENCE

Department for International Development

South Africa

Annual Review of the Strengthening the Revitalized Response to AIDS and Health Programme (SARRAH)

APPENDIX 6

1 TERMS OF REFERENCE

1.1 Objective

- Review of progress against outputs and indicators in the logframe.
- Clarification of lessons learnt.
- Suggestions on amendment to logframe and programme management arrangements.

1.2 Scope of Work

In addition to the above, the Annual Review will include a focus on:

- What have been the preliminary impacts, both positive and negative, of the programme to date?
- The project governance structures including steering committee meetings with partners as well as with DFID.
- The quality of SARRAH's strategy, methodology and approach including an assessment of project management and implementation performance.
- Capacity to supervise consortium partners, maintain appropriate quality controls and internalise lessons learnt.
- Measures taken to maximise the efficiency of staff deployment and value for money.
- The programmes strategy and performance in terms of engaging with the key partners in particular NDOH,SANAC and TAC.
- How the programme is taking issues of gender equity into account?
- The project influencing / communication strategy
- The programmes monitoring and evaluation procedures.
- An assessment of the key challenges threatening sustainability of achievement.
- The milestone matrix including budgets.

1.3 Inputs

The review team will be comprised of an external consultant, representatives from DFID Southern Africa office. The review logistics will be facilitated by representatives of the Service Provider - HLSP.

The external consultant will lead the review and other members of the review team will be Bob Fryatt – Senior Health Adviser; Hilary Nkulu – Programme Manager and Anna Guthrie – Regional Health and AIDS Adviser.

It is envisaged that up to 15 days will be required for the Team Leader.

1.4 Methodology

- The Service Provider will be supplied with a blank Annual Review form for self evaluation. The Service Provider will complete draft content for Part A and C of the Annual Review form and will send this draft to the DFID Programme Manager by 20 May 2011.
- During the annual review process, the annual review team will review this draft and revise the form based on the review mission findings.
- The review team will: review project documentation and relevant DFID policy documents; conduct interviews / meetings with project stakeholders; consortium members and other relevant institutions.
- The annual review team will agree a final content for annual review form, and score the project.
- The annual review team will present key findings, conclusions and recommendations to DFID, HLSP and Partners by 3 June 2011.
- A draft report will then be produced and shared with key partners.
- The Service Provider will take responsibility for gathering all relevant programme documentation and coordinating the programme of meetings, consultations, interviews and visits. DFID-SA will take responsibility for gathering all relevant DFID policy documentation to the review team.

1.5 Outputs

- *A narrative report (max 10 sides, plus Annexes if essential) to be completed by the 10th of June 2011.*
- A final draft revised logical Framework (required) by the end June 2011.
- *A completed scoring report uploaded on Aries system by the 17th of June 2011.*
- One or two case studies to be published on the SARRAH and DFID websites by end June 2011.

1.6 Timeframe

The annual Review will take place in May 2011, with the core week being 23 May to 27 May 2011.

1.7 Team Leader

The Team Leader will be expected to:

- Manage the assignment to ensure all outputs are met.
- Pay particular attention to the Logical Framework; Milestone Matrix and programme governance/institutional arrangements for the programme;
- Make recommendations on the future of the programme to enhance programme delivery;
- Provide support to the other review team members;
- Take responsibility for providing a first draft of the narrative report and a revised annual review scoring template. Circulating for comments and submitting a final draft to DFID-SA;

1.8 Background

The goal of the SARRAH program is ambitious with indicators representing achievement of MDG 4, 5, 6 some of which are thought possible but many are unlikely[1]. South Africa is undergoing a major revitalization of the health system with the aim of tackling the main causes of ill health – HIV & TB, maternal and child mortality, non-communicable diseases and injuries & violence. It has set targets that would see it returning to the health outcomes associated with middle income countries such as Brazil, see Figure. The purpose of SARRAH program is to improve governance of the national response to HIV and health work[2] by supporting reforms in the public health sector, in the National AIDS Council, and through improving accountability through Parliament and Civil Society. The support is programmed to support implementation of the Presidents Negotiated Service Delivery Agreement (NSDA) for Health (see Box below) which provides a unified strategy on health and HIV with clear targets and indicators related to impact.

Negotiated Service Delivery Agreement for Health: *"A long and Healthy Life for All South Africans"*
Output 1: Increasing life expectancy
Output 2: Decreasing maternal and Child Mortality
Output 3: Combating HIV & AIDS and decreasing the burden of disease from Tuberculosis
Output 4: Strengthening Health System Effectiveness

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

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

[1] http://www.statssa.gov.za/news_archive/Docs/MDGR_2010.pdf
[2] SARRAH Purpose statement is *"Improved governance of an integrated, effective response to HIV & AIDS and Health in South Africa". Budget £25million over 5 years (2010-2014).*

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

DFID Southern Africa
12 April 2011