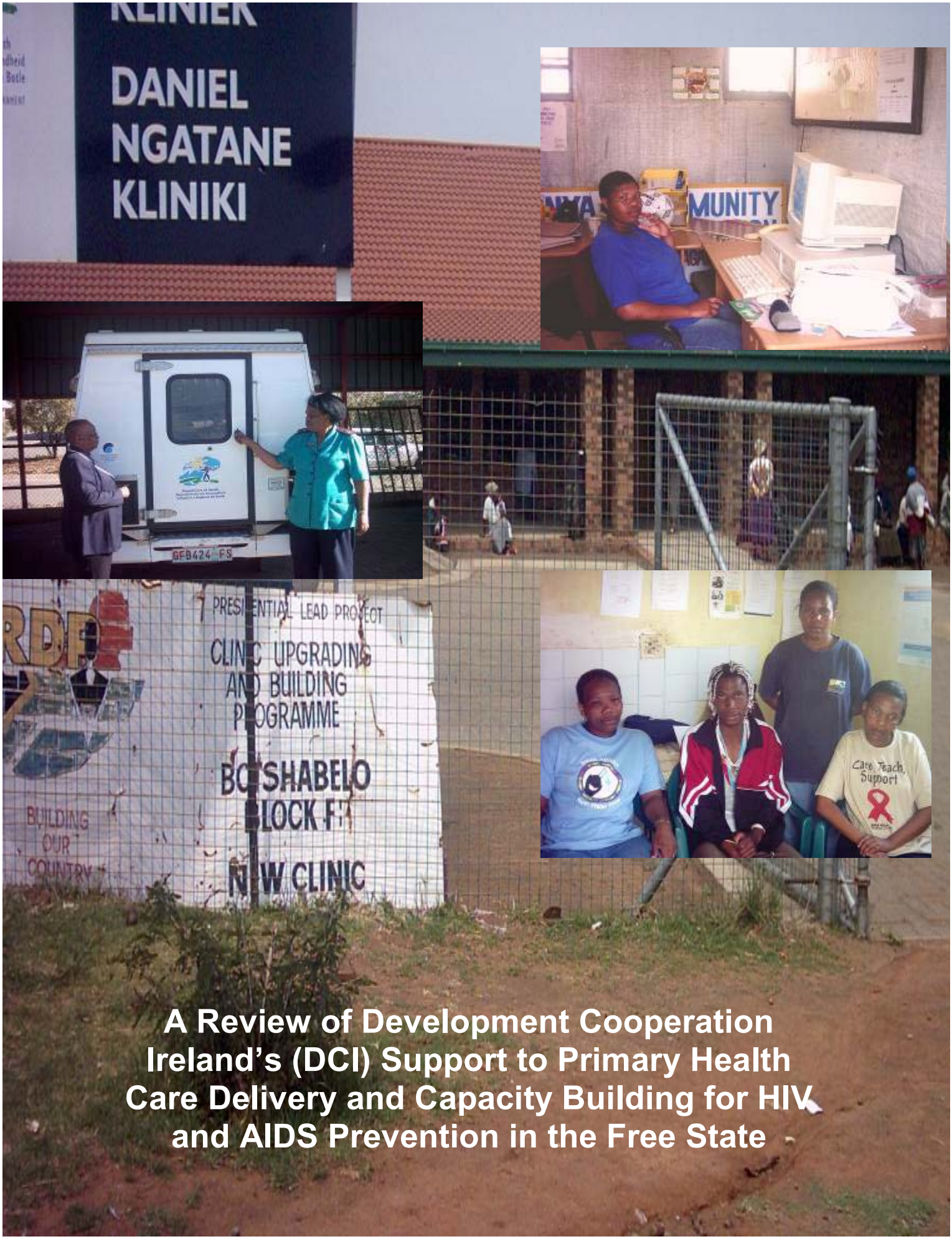

A Review of Development Cooperation Ireland's (DCI) Support to Primary Health Care Delivery and Capacity Building for HIV and AIDS Prevention in the Free State

FREE STATE DEPARTMENT OF HEALTH AND DEVELOPMENT COOPERATION IRELAND

Compiled by

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ACRONYMS

ABET	Adult Basic Education and Training
AHCW	Ancillary Health Care Worker
AIDS	Acquired Immune Deficiency Syndrome
BP	Blood Pressure
CADRE	Centre for AIDS Development, Research and Evaluation
CCTV	Closed Circuit Television
CFO	Chief Financial Officer
CHBC	Community Home Based Care
CHC	Community Health Complex or Community Health Centre
CSP	Country Strategy Paper
CSSD	Central Sterilising Department
DCI	Development Cooperation Ireland
DMOs	District Medical Officers
DOH	Department of Health
DOTS	Direct Observed Treatment System
ENT	Ear, Noise and Throat
HIV	Human Immunodeficiency Virus
HR	Human Resource
HRD	Human Resource Development
HWSETA	Health and Welfare Sector Educational Training Authority
iCAM	Interactive Computer-aided Media
IEC	Information, Education and Communication
NGO	Non-governmental Organisation
NQF	National Qualification Framework
OD	Organisational Development
OPD	Out Patient Department
PAEG	Programme Appraisal and Evaluation Group
PHC	Primary Health Care
PFMA	Public Finance Management Act
PWC	PriceWaterhouse & Coopers
RDP	Reconstruction and Development Programme
SAQA	South African Qualifications Authority
STIs	Sexually Transmitted Infections
TB	Tuberculosis
VAT	Value Added Tax
VCCT	Voluntary Confidential Counselling and Testing

List of key informants interviewed

	Name	Organisation
1	Me D Grobler	Department of Health Free State
2	Me G B Gogo	Department of Health Free State
3	Me S R Khokho	Department of Health Free State
4	Me S Hugo	Department of Health Free State
5	Dr R D Chapman	Department of Health Free State
6	Mr F P De Villiers	Department of Health Free State
7	Me T B Mothibedi	Department of Health Free State
8	Mr E Watkins	Department of Health Free State
9	Mr Ronald Nemukula	Regenesys
10	Mr Willem Coetsee	TDA Human Resources Consultants
11	Mr Theo Vester	Genesis
12	Mr Sandile Busakwe	PriceWaterhouse & Coopers
13	Ms Nicole McHugh	Development Cooperation Ireland
14	Ms Annalize Fourie	Development Cooperation Ireland

List of participants in the feedback workshop

	Name	Position
1	Mr M S Shuping	Head of Department – Free State
2	Mr F P De Villiers	Finance – Department of Health
3	Me D Grobler	Programme Manager – Department of Health
4	Me G B Gogo	HR & OD Component Manager
5	Me T Tshabalala	Manager Governance Unit
6	Me S R O Khokho	General Manager
7	Dr R D Chapman	Executive Manager
8	Ms T Mathebula	DCI – HIV/AIDS Advisor
9	Me C Mokobe	HIV/AIDS Manager – Department of Health
10	Me T B Mothibedi	Manager PHC complex - Botshabelo
11	Ms N McHugh	DCI – Development Specialist
12	Ms P Tshose	CADRE – Review Team Member
13	Mr B Magongo	CADRE – Review Team Leader

Executive Summary

Introduction

A review of the programme on support to primary health care and capacity building for HIV and AIDS prevention, commissioned jointly by the Free State Department of Health and the Development Cooperation Ireland (DCI), was conducted by the Centre for AIDS Development, Research and Evaluation (CADRE) in November 2005. The review focused on three areas of support under the programme agreement:

- *Human and organisational development:* This component focused on development of capacities of individuals and institutions within the Free State DOH in order to enhance the Department's service delivery in line with service needs.
- *Implementation of the Community Health Centre (CHC) complex system:* This component implemented activities that seek to facilitate optimal effectiveness of the delivery of primary health care services in Botshabelo community health complex.
- *Capacity building for NGOs working on HIV and AIDS in the Free State*: This component focused on supporting the Free State Department of Health in its efforts to increase the capacity of NGOs to account for and deliver HIV and AIDS activities in the province.

The review took into consideration the outcomes of a mid-term review that was conducted for the programme in early 2003.

Scope

The scope of the review was as follows:

- Provide a commentary on the relevance and appropriateness of the programme
- Determine the effects on, impact of and value added by DCI funding of the programme
- Examine and document the extent to which cross-cutting issues (HIV and AIDS, gender, good governance, human rights, environment) were addressed by the programme
- Identify and document key lessons and challenges that could inform the new programme
- Assess the process used in the overall management of the programme
- Provide recommendations on the future programme direction

Method

Interviews were conducted using semi-structured interview guides with senior managers, programme staff and service providers in all the components of the programme. Documents and routine data, including financial records, were reviewed to provide qualitative and quantitative information that would highlight progress made since the start of the programme. A feedback session to senior managers was also conducted to inform the recommendations made in the review.

Summary of review findings

Management

- In general, the objectives and plans of the programme were met, and in some areas even exceeded, and the programme was implemented within the agreement framework.
- There were delays in the start up of the programme, which resulted in the programme timeframes shifting on a number of occasions. Initially the programme was planned to run between 2001 and 2003; this time frame was shifted to end of 2004, and finally to June 2005.
- The areas of support identified for the programme are sound and strategic for improving the quality of service delivery and strengthening provincial capacity to run an efficient health system.
- Structures to provide oversight support and management of the programme operations were set up at the onset. The functions and areas of responsibility of these structures were outlined.

There were challenges in the management processes during the implementation of this programme. These can be summarised as:

- Delays caused by transferring funds from National Treasury to the Department
- Slow expenditure on programme activities
- Failure of the Steering Committee to meet regularly and to deal with operational challenges when they arose
- Changes in staff who were initially assigned tasks in the management and oversight of the programme
- The absence of full-time staff to manage and guide the programme operations and to provide support to implementing units
- Delays caused by the tedious and sometimes lengthy tendering processes.

Management responses to these challenges included:

- Assigning component managers to each of the components of the programme and allowing them to take decisions on how to speed up implementation
- Reviewing activities in the plans to ensure that activities could be implemented within the time frames
- Negotiating extensions of the original programme timeframe to accommodate slow systemic processes that delayed start of activities – for example, tendering of services, procurement of equipment, and transfer of funding
- Appointment of a full-time overall programme manager to ensure coordination, support and guidance to the programme.

The table below outlines the performance of management against recommendations made by the mid-term review.

Mid-term review recommendations	**Findings of the final review**	**Comments**
Three-year allocations of funds should be extended over four years	❑ The programme was extended twice to cover a period from 2002 to 2005, which was within the mid-term review recommendation. ❑ The initial allocation of R10,255,500 by DCI was all spent within this period and of an extra R3,913,440 in accumulated funds made available for this programme, R3,261,318 was either spent or fully committed at the time of the review.	Recommendation implemented
Reconfirm strategic vision, goals and deliverables between the Department and DCI	❑ The strategic vision and goals remained the same, but fitted within the provincial strategy. ❑ Deliverables were adjusted and redefined according to revised plans for each component. ❑ In all the components of the programme reporting included indicators for monitoring targets. In most components all of the targets were met, and in some cases exceeded. ❑ Some activities encountered challenges that needed to be addressed by policy guidelines for effective and efficient implementation; these included the implementation of the patient shuttle system	Recommendation implemented
Steering Committee functions should be clarified with emphasis on tight management, control and strategic leadership with effective communication, coherence and	❑ The Steering Committee appointed the General Manager Southern Free State Region to take charge of the Steering Committee.	Recommendation implemented

Mid-term review recommendations	Findings of the final review	Comments
coordination between components	❑ No unauthorised spending was found during the review ❑ Meetings of the Steering Committee were regular since 2004.	
Steering Committee should have full authority to authorise deviations in the programme	❑ All decisions taken to revise or change scope and/or nature of activities in the programme were taken by the Steering Committee in consultation with DCI, including allocating extra money that was accumulated in the programme.	Recommendation implemented
A dedicated project manager should be considered	An overall programme manager was appointed in February 2005, with responsibility for coordination and reporting on all component activities to the Steering Committee.	Partially implemented, as she is also a component manager
Components should follow emerging needs as long as they are in line with programme framework	All components, but particularly in the last extension period, added activities there were not in the initial activity plan, but which were responsive to emerging needs and in line with the programme framework.	Recommendation implemented

Recommendations of the final review

- A deliberate effort to integrate all activities of this programme into senior management activities and agendas is recommended.
- The monthly meetings of the programme management committee must be retained until the end of the next funding cycle in 2007, but should focus on integration, documenting good practice, and roll-out of activities.
- Policies on the following – patient shuttle systems, performance of private service providers and feedback systems, staff performance on funded training courses, and a review of the present NGO policy – need to be undertaken.
- Management must ensure that management and financial systems in the province are not a hindrance in the implementation of programme activities.

Human resource and organisational development

Overall the component performed well and activities planned to be implemented were completed. The following were observations made by the review:

- A total of 809 staff were trained through this programme in the province. Although training started very slowly in 2003, significant numbers of staff were trained in 2004 and 2005.
- The iCAM system was strengthened and it provided an additional vehicle to scale up training under this programme.
- The training provided cut across technical and support disciplines in the province. More women than men were trained in this programme, which indicates a level of awareness about including females in training programmes.
- The majority of training covered leadership, project management, customer management, office management and ABET.
- Although spending on activities started late in the programme, the component was able to spend about R5.6 million of the available funding under this programme.
- The courses used participatory adult learning approaches. Participants were exposed to concepts of the discipline, worked in groups and were given exercises to practice what they had learned. Most of the courses offered by the service providers were accredited courses, which provide career paths for staff.

The table below outlines the performance of the human resource and organisational development component. The table lists the activities planned under the component, recommendations made by the mid-term review, and observations from the final review.

Activities	Mid-term review recommendations	Findings of the final review	Comments
❑ Training of district medical officers ❑ Training of managers in health management ❑ Training in general office skills ❑ Training in leadership and motivation for managers ❑ Training of managers in project management ❑ Training in Adult Basic Education and training of Ancillary Health	Speed up the tempo of implementation Continue outsourcing training to external service providers	The number of staff trained in the programme increased significantly, from 15 in 2003 to 423 in 2004 and 371 in 2005 (at time of the review) ❑ All training in the programme was outsourced to external service providers, including iCAM ❑ Training sessions for programme areas in many cases were run in parallel by different training service providers	Recommendation implemented Recommendation implemented

Activities	Mid-term review recommendations	Findings of the final review	Comments
Workers ❑ Training in Advanced Midwifery and Community Development ❑ Training of managers in public health∗ ❑ Audit of career management and skills	Strengthen the use of iCAM technology and recognition with accreditation bodies	❑ iCAM contributed significantly to the training of staff under this programme ❑ The number of training studios in the province has increased and training covers a wider range of professional disciplines. ❑ All iCAM courses are accredited with SAQA and some tertiary institutions, for example, the University of Free State. ❑ Over R15 million has been invested in strengthening iCAM by the province to expand its accessibility and improve the technology over the past 3 years	Recommendation implemented

∗This activity was added during the last extended plan of the programme

Recommendations of the final review

- The iCAM medium of instruction must continue to be used, especially for formal courses and qualifications, to ensure its optimum usage. However, this system could benefit from a cost benefit and efficiency evaluation.
- Training service providers' contracts must include clauses that require them to conduct pre-training assessments on staff competency, job grading and position, work environment and staff profiles, including preparedness for the training before commencing with training.
- The selection of staff for training must be planned in advance to ensure that they are well informed and prepared for training.
- Material produced for training must be catalogued, stored and made available to all staff both electronically and in hard copy form.
- The proposed activities for the 2005-2007 plan under this component need to be in line with recommendations and be aligned to the existing component, rather than adding a new sub-component of training governance structures.

Botshabelo community health centre complex

The overall performance of this component was generally good. However, there were a number of issues that the programme grappled with during

implementation. These issues included operationalising the patient shuttle system and systematic documentation of lessons that can be replicated in other districts.

The following are some of the major findings on this component by the review.

- The component was able to implement most of the activities identified and planned. The only activity that was not implemented was operationalising the inter-facility patient carrier.
- Grading of facilities was done and was in line with the requirements of the primary health care core package.
- Referral pamphlets were designed, printed in SeSotho, and distributed in all the facilities in the complex. The initial target of producing 120,000 pamphlets was met and an additional 120,000 were reprinted during the extension period.
- All vehicles identified to be procured under this component were bought; only one motorbike was purchased instead of three. Allocation of these vehicles is still unclear; this process needs to be finalised using a consultative process with relevant managers affected by allocation of the vehicles.
- Branding of facilities in the complex and vehicles bought under this programme was completed. All clinics were mounted with clinic name and service package boards.
- Primary health care equipment planned to be procured under this component was bought and allocated appropriately to facilities. On inspection, most equipment was in working order, although some were found not to be working. Those found not in working order included BP machines (23 out of 51); diagnostic sets (9 out of 63); and Glucometers (5 out of 35).
- Office equipment which was meant to strengthen the management systems of the complex was bought and delivered to the PHC complex management offices and clinics. The equipment included computers, printers, fax machines, heaters and other equipment listed in the report.
- PHC and hospital OPD utilisation data indicated a shift in patients' first contact with facilities. More patients were utilising PHC as first contact with the health care system in the complex. This is illustrated with data presented in the report.
- The inter-facility patient shuttle system had not been implemented at the time of this review. The reasons given were that a policy decision needs to be put in place to guide the operation of the system.

The table below outlines performance of the Botshabelo community health complex component. The table lists the activities planned under the component, recommendations made in the mid-term review, and observations from the final review.

Activities	Mid-term review recommendations	Findings of the final review	Comments
❑ Design, print and distribute 120,000 referral pamphlets* ❑ Procure 6 patient carriers, 8 sedans, 3 motorbikes, 4 LWB bakkies, 4 mobile capsules* ❑ Design and produce clinic name boards, service package boards and road signs ❑ Grade all facilities according to PHC core package ❑ Improve management capacity (procure computers and photo copy machine)* ❑ Train nurses in Advanced Midwifery*	Strengthen and support component management	❑ The component has a manager but she is also responsible for the whole DCI support programme. ❑ Equipment was provided for component management, including computers, printers and vehicles to support and strengthen activities of the component	Recommendation implemented
	Ensure adequate mechanisms for authorisation of expenditure	❑ Expenditure on the component followed all the requirements of the programme and province. ❑ The component managers had no powers to authorise expenditure. That function remained with the Steering Committee.	Recommendation implemented
	Roll-out lessons learnt from piloting in Botshabelo	❑ There were attempts to initiate roll-out activities to other sub districts, for example, the referral system is being introduced to the other sub-districts in the Motheo District. The grading of clinics has become a provincial policy. ❑ No attempts were made to document systematically lessons learned from the site. This needs to be pursued.	Recommendation not implemented, although there are attempts to address it.
	Utilise equipment appropriately and ensure refunding of inappropriate expenditure	❑ All equipment purchased for PHC facilities under this programme was properly allocated. ❑ There was no indication of any inappropriate expenditure, nor misallocation of equipment under this programme	Recommendation implemented

Activities	Mid-term review recommendations	Findings of the final review	Comments
	Do a situation analysis to grade clinics according to PHC package	❑ All facilities in the complex were properly graded according to the PHC core package ❑ All facilities were providing all the services that were graded against them and seem to be functioning well.	Recommendation implemented

∗ These activities were revised during the last extension plan. For example, an additional 120,000 referral pamphlets were printed; 2 patients' carrier and 4 sedans were added: additional computers with software were bought (15), as well as 25 printers and 9 fax machines; 8 more nurses were added to the original target and included 2 nurses from the neighbouring sub-district of Thaba Nchu.

Recommendations of the final review

- A policy and guidelines for the patient shuttle system need to put in place as soon as possible.
- The allocation of vehicles needs to be formalised to avoid confusion on how the vehicles are to be utilised.
- Equipment purchased by the Department must be durable and of high quality and must come with a warranty. The supervisory systems should be able to detect malfunctioning equipment and ensure the competency of staff in using new equipment.
- The lessons and good practice that have been identified in this component must be rolled out to other parts of the province.
- The training of Advanced Midwifes must continue to ensure that the 24-hour clinics operating maternity units are staffed with technical competent personnel.
- The activities planned for 2005-2007 need to be aligned with the recommendations made in the review.

Capacity building for NGOs providing HIV and AIDS services

Overall, this component of the programme appears to have had a positive impact upon the operations and management of many of the NGOs which participated in the training and mentoring activities. It is clear that it made a significant contribution to the development of certain NGOs which were particularly 'ripe' for such an opportunity and which, as a result of the training, were able to expand their operations and operate with a high degree of professionalism. The following observations were made from this review.

- Based upon the observations it seems that organisations that successfully completed the training cycle are performing better and more professionally in a range of key areas than they were before the training.

- The review suggests that one of the biggest areas of impact was financial management systems. Almost without exception, the NGOs visited had functioning financial systems and procedures were in place.
- The training encouraged NGOs to approach their work in a more systematic and professional manner, including the development of policies and guidelines on key organisational issues, the creation of management structures, and the formation of job descriptions that help everyone within the organisation understand their roles.
- Across this spectrum of NGOs reviewed, there was not a single organisation which seemed *not* to have benefited from the training in some way. However it is necessary to underscore that the relative returns from the training seem to have differed significantly based on the NGOs' relative stages of development and organisational sophistication.
- The review suggests that the material covered in the training, especially the training manual, was relevant and of great practical use to many of the NGOs that participated.
- The ICAM-based training was the weakest link in the overall training programme and its use in programmes such as these needs to be critically evaluated.
- The component coordinator at the Department of Health in Bloemfontein was actively involved in 'trouble shooting' various problems within the programme, including assistance to the service providers in locating and communicating with NGOs that were elusive or difficult to find.
- Institutional participation rates in the programme were relatively high – during the various training components uptake among invited NGOs ranged from 89-95%. The number of individual NGO representatives attending the trainings, however, was less than expected – averaging 62% of expected attendees for the year one and year two trainings.
- The service provider selected for this component delivered fully on the project activities in accordance with project documentation. However this review suggests that, despite their satisfactory delivery on project objectives, a management consultancy such as the one that was appointed may not have been the most appropriate type of entity to undertake work of this nature.

The table below outlines the performance of the capacity building for NGOs providing HIV and AIDS services component. The table lists the activities planned under the component, recommendations made in the mid-term review, and observations from the final review.

Activities	Mid-term review recommendations	Findings of the final review	Comments

❑ Compilation of best practice guide for NGOs ❑ Training and mentoring of 150 NGOs ❑ Compile NGOs policy ❑ Preparation of training manuals† ❑ Refresher courses for 30 NGOs† ❑ Train the trainer course† ❑ Mentoring of 30 NGOs† ❑ Marketing and promoting NGOs policy† ❑ Procurement of computers for 30 NGOs† ❑ Training on financial sustainability†	Demonstrate perseverance with NGOs	❑ NGO attendance rates increased during year two of the training. ❑ The Department and the service provider worked together to locate and encourage NGOs that were either difficult to locate or did not participate regularly in the training. ❑ A selected group of NGOs that did not achieve competency in the first two years of training was invited to participate in a 'refresher course' during the extension period	Recommendation implemented
	Ensure appropriate nominees and continuation of training	❑ The nomination of attendees for training and mentoring was left to NGOs to decide. This led to a mismatch of attendees in some cases, for example, executive members attended training and were not available for mentorship.	Recommendation not implemented appropriately
	Translate manual into SeSotho	❑ The manual was not translated into SeSetho at the time of the review, although SeSotho-speaking class assistants were introduced into the iCAM trainings.	Recommendation not implemented
	Ensure involvement of DOH officials in training and development initiatives to ensure long-term sustainability	❑ There is active involvement of DOH officials, especially the component manager, in the training, component oversight, and monitoring. ❑ There were structured feedback meetings between the service providers and DOH officials on component activities. ❑ A "training the trainer" programme has been initiated to ensure sustainability.	Recommendation implemented

† These activities were added in the 2005 extension plan and were not part of the original plan

Recommendations of the final review

- An in-depth evaluation of the component must be conducted with the view to providing the province with clear guidelines on how to work with NGOs;

revising the present NGO policy; and developing a monitoring and evaluation framework for NGO support in the province.

- Actively involve regional and district HIV and AIDS coordinators in the implementation of component activities. This will reduce the workload of the component manager, who must be responsible for coordination and providing strategic support to the coordinators.
- Train coordinators on NGO management and monitoring and evaluation to enable them to provide quality support to the NGOs.
- The NGO support programme must adopt a two-tiered approach to training, working first with the more established, funded NGOs, and then rolling out a modified version of the training to smaller, unfunded or newly established organisations.
- Training for NGO capacity building should use face-to-face instruction as opposed to iCAM or distance learning approaches as most NGOs have different levels of educational attainment and backgrounds.
- The mentoring visits to NGOs should occur over a shorter period of time to encourage regular attendance and participation. This is important to build confidence and commitment from NGO staff.
- The training manual for NGOs must be translated into SeSotho as a matter of priority. This can increase the usefulness of the manual to NGOs and trainers who have been selected to roll out the training.
- Clear indicators for evaluating programme success need to be established, including expected levels of competence by organisations participating in the programme.
- The proposed activity plan for 2005-2007 on this component may also need to be aligned to the recommendations made in this review and respond to future plans as informed by the evaluation of the component.

Background

The Centre for AIDS Development, Research and Evaluation (CADRE) was commissioned jointly by the Free State Department of Health (FSDOH) and Development Cooperation Ireland (DCI) to conduct a final review of support provided by DCI to the Free State government since 2001. In December 2001, Development Corporation Ireland (DCI) approved a three-year programme to support the Department of Health in the Free State. The programme was to focus on three strategic areas of the health system, including:

- ***Human and organisational development:*** This component focused on development of capacities of individuals and institutions within the Free State DOH in order to enhance the Department's service delivery in line with service needs. Capacity building in this programme has supported human resource capacities in health management, district medical services, financial accountability, project management and customer care.
- ***Implementation of the Community Health Centre (CHC) complex system:*** This component implemented activities that seek to facilitate optimal effectiveness of the referral system between the satellite clinics; to ensure that skilled human capacity is in place; and to ensure that the system is adequately supported with necessary medical equipment and patient transport and support vehicles to enhance the functioning of the system.
- ***Capacity building for NGOs working on HIV and AIDS in the Free State*:** The main focus of this component has been to support the Free State Department of Health in its efforts to increase the capacity of NGOs to account for and deliver HIV and AIDS activities in the province.

Mid-term review

Since approval of this programme in 2001, implementation time frames have been extended twice: the first extension was from December 2003 to December 2004, and the second extension was from December 2004 to June 2005. These extensions were necessitated on a number of grounds, including delays in receiving funds from the Reconstruction and Development Programme (RDP) account of the National Treasury, complex processes for acquiring outsourced services, and bottlenecks associated with government procurement system.

A mid-term review was conducted in 2003 by the Centre for Health Systems Research and Development at the University of Free State. The findings of the review indicated a very slow start to programme activities and made recommendations on how to accelerate the implementation process. Some of the broad recommendations from the review included the following:

Human and organisational development:

- Speeding up training, ensuring that outsourced training is supported by the province, and ensuring that adequate monitoring and control mechanisms are in place to ensure adherence to contractual agreements
- Strengthening iCAM training systems for appropriate use and functionality, and ensuring that iCAM training courses are accredited with SAQA for value and credibility
- Decentralising tertiary services projects and finalising training materials for governance structures
- Re-investing un-utilised funds from this component into the component by increasing numbers of staff trained in areas like Project Management and Advanced Midwifery, which are in die need of capacity

Community Health Centres Complex System:

- The district health management team needs to be supported and strengthened to ensure sound decision making, monitoring and control of resources from the programme and to ensure that resources are properly utilised to meet the objectives of the programme
- A plan needs to be developed to roll out this system to other districts to ensure that referral systems are strengthened throughout the province
- There must be an alignment of proper technology to service levels; for example, equipment like the portable ENT sets suitable for labour wards should be replaced with wall-mounted ENT sets for consultation rooms. Computers should be provided for clinics, district managers and the hospital
- A situational analysis for priority setting for PHC services must be conducted. This will inform the province on compliance with the delivery of the PHC package, the types of equipment needed to deliver quality services, and will allow PHC facilities to be graded appropriately

Capacity building for NGOs:

- The working relationships between NGOs and the Department of Health in the province need to be strengthened
- The number of NGO staff trained in financial management should be increased in order to have an effect on drop out rates
- Training manuals must be translated into SeSotho for better access and use by NGO staff
- Training should focus at all levels of NGO structures to ensure sustainable functionality of these organizations

Last funding cycle – 2005-07

The Department of Health in the Free State has also compiled and submitted a draft work plan for 2005-2007 to DCI under this programme, which should also indicate an exit strategy for this programme. The draft work plan is said to have been aligned to national and provincial strategic plans for the same period and seeks to address three fundamental areas: a situation analysis that will allow the province to strengthen its capacity and generate new skills to support new initiatives in the province; creating a sustainable environment for logistical support to the programme, especially for infrastructure and resources; and ensuring accountability through monitoring programme implementing units in the province.

Scope of the review

The scope of this review covered the following broad areas identified by DCI and Free State Department of Health as foci for the final review:

- Provide a commentary on the relevance and appropriateness of the programme in terms of the DCI Country Strategy Paper (CSP), development principles, and current developments in the health sector in the province and in South Africa in general
- Determine the effects of, impact on and value added by DCI funding in relation to meeting the programme objectives and outputs as outlined in the Programme Appraisal and Evaluation Group (PAEG) document of 2001
- Examine and document the extent to which cross-cutting issues (HIV and AIDS, gender, good governance, human rights, environment) have been addressed by the programme
- Identify and document key lessons and challenges that can inform the new programme
- Assess the process used in the overall management of programme components and the management of the funds and comment on whether or not this process can be improved
- Provide recommendations on future programme directions in relation to:
    - Management systems that could ensure better management of the programme, e.g. monitoring and evaluation framework to be used by DCI and DOH
    - Opportunities to integrate cross-cutting issues
    - Priority areas for future support in the province, considering the reduction of DCI funding for 2005-2007

- Approaches for consolidating future DCI support in the province

Methods

The review utilised both quantitative and qualitative methods to ascertain the extent to which the stated objectives of the programme were met during the implementation in each of the three components of support. Collection of information for the review included: review of documents and reports from the province; semi-structured interviews with mid-level managers and staff; and discussions using an unstructured interview guide with provincial senior managers, NGO managers and service providers contracted by the province to provide capacity building to provincial and NGO staff. A feedback workshop with senior managers in the Department of Health in the Free State and the DCI team was conducted to better inform the content and recommendations of this review.

The approach to this review adopted a framework that allowed reviewers to look at the following areas of programme support:

- ***Overall programme management and strategic intentions.*** This area of programme support provided programme plans, management processes, reporting guidelines, coordination mechanisms, monitoring and evaluation and sustainability plans for the whole programme in the province. The reviewers conducted in-depth interviews with senior managers and steering committee members to understand how the programme was planned, implemented and monitored over the period. Documents were also reviewed, including programme plans, internal and external reports, policy documents and provincial strategic plans.
- ***Human resource and organisational development.*** This area of support provided capacity development activities to both provincial and NGO staff in order to improve service delivery to the population. Capacity development has included formal training and workshops for all levels of staff, including managers, service delivery and support staff. The reviewers collected secondary data from human resource development reports, training plans and reports on the numbers of staff trained, their levels of responsibility, gender and race. Interviews were also conducted with staff who benefited under this programme. Service providers who were sourced to provide these services were also interviewed.
- ***Support to the Community Health Centre complex in Botshabelo.*** This component was implemented in a pilot site to strengthen and improve the delivery of primary health care services in this community. Support included improving the quality of equipment for clinics and the district hospital, improving the referral system to discourage clients from bypassing PHC facilities straight to the hospital, training staff, and improving supervision. The reviewers assessed utilisation of services and referral patterns using

information from the district health information systems and interviews with facility managers using a structured interview questionnaire. The level, quality, and functionality of the equipment were reviewed using records and an observation checklist.

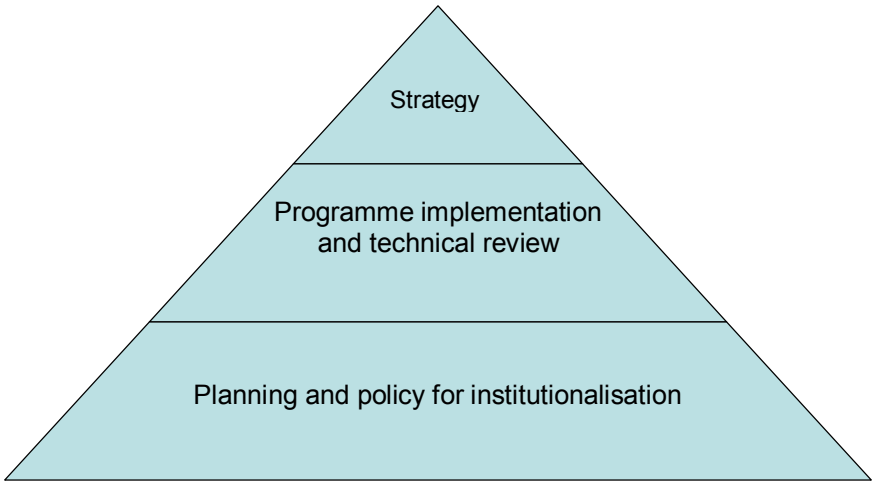
- ***Capacity building for NGOs working with HIV and AIDS in the Free State.*** NGOs working to support HIV and AIDS activities were supported through this programme to increase their capacity to plan, manage and account for services they provide in the province. The review of NGOs covered governance structures, management systems, impact of capacity development efforts, and institutional arrangements. Documents and reports from NGOs, service providers and the province were systematically reviewed by the review team. Semi-structured interviews were conducted with NGO managers, service provider staff and provincial managers.

Report framework

The report is structured to cover three broad programmatic areas:

- **The strategic intent of the programme** – issues that relate to provincial and programme strategies, management principles, policy guidelines and planning of health services
- **Programme implementation** – focusing on the three components of the programme (human resource and organisational development, community health centres complex, and capacity building for NGOs). The review will seek to provide analytic insight into the planning, implementation, monitoring and evaluation of these components

Figure1. Review framework of DCI funding to FSDOH



- **Institutionalisation of programme outcomes** – the conclusions and recommendations from this review will address issues relating to overall programme performance, planning and policy shifts for better performance

Across these broad areas, a number of cross-cutting issues will be discussed to provide contextual and process understanding of programme operations. These will include:

- Organisational effectiveness: management and financial systems, impact of services, and sustainability of organisations' initiatives
- Strategies for enhancing relationships, including communication, funding, reporting processes, and support
- Monitoring and evaluation of the programme to ensure the existence of a culture of learning from programme implementation
- Lessons learned in relation to DCI funding, informing good practice as well as perspectives on future plans

Review of programme

I. Overall management and contextual approach to the programme

Strategy

The conceptualisation of this programme was premised on the overall vision and strategy of the Free State Department of Health. Some key elements of the Department's vision and strategy relevant to this programme are:

- To strengthen management and technical capacities that would allow for the creation of new skills and insight to support new initiatives / programmes
- To provide logistical management to programmes that links infrastructure and resources
- To ensure that the monitoring function is adhered to, with structures to support management and financial accounting systems.

The overall intended outcome for this programme was to empower and support the efforts of the Free State Department of Health, including those services provided by NGOs, through training, capacity building and the provision of essential resources critical in improving technical, management and planning skills in the province. It was aimed at enhancing the skills base, effective

utilisation of resources, and health service delivery including HIV and AIDS services to the community.

The three components identified by the FSDOH to be supported by this programme were based on the following strategic vision of the Department:

- The Department has placed high priority on human resources and organisational development and has developed a training strategy linked to the strategic plan of the province. This training plan is comprised of two pillars: the development of individual skills and technical capacities and the development of institutional capacity to meet needs and demands.
- Transforming health services to primary health care founded on the district health systems model is fundamental to the province's goal. The Department will explore all avenues that will enhance the performance and functioning of a district health system, which takes into account good quality care, adequate infrastructure and equipment, and proper management systems.
- The Department has recognised that its struggle in combating HIV and AIDS requires concerted efforts to work with partners in addressing and responding to this epidemic. It has therefore forged partnerships with several NGOs in the province to render the necessary services related to HIV and AIDS prevention, care and support at community level. The services provided by the partners must, however, be in line with the framework and strategy for HIV and AIDS services in the province.

Financial management

The budget for the overall programme was R10,255,500 (€1,411,236). The budgeting was structured such that each component had its own budget and which was allocated on a year to year basis. Each component was expected to develop its own activity plan with budgets against those activities on a yearly basis. Table 1 below indicates the original budgets and allocation to each component of the programme over the three years. However, a number of challenges experienced by the programme affected the original budget allocations for the components. These changes are outlined separately in the review of each component.

Table1: Proposal Budget of the Programme over 3 Years (2001 – 2003)

Components of FSDOH programme	2001		2002		2003		Totals/component	
	Rand	Euro	Rand	Euro	Rand	Euro	**Rand**	**Euros**
Human resource and OD support	1 069 000	143 398	1 770 000	244 286	344 000	47 427	**3 183 000**	**435 111**
Community health centres complex	1 710 000	236 006	1 525 000	210 473	1 375 000	189 715	**4 610 000**	**636 194**
Capacity building for NGOs support	162 500	22 427	900 000	124 213	1 400 000	193 221	**2 462 500**	**339 861**
Totals	**2 911 500**	**401 830**	**4 195 000**	**578 937**	**3 119 000**	**430 469**	**10 255 500**	**1 411 236**

It is important to also note that the overall allocation of R10,255,500 accrued extra income for the programme through foreign exchange rate fluctuations (which were positive due to the weaker Rand), interest accumulated whilst money was still with National Treasury, and Value Added Tax (VAT) that was claimed back by the province (see Table 2 below)

Table 2: Summary of Total Budget and Expenditure to November 2005

Components	Budget (R)	Expenditure (R)
Human resource and organisational development	3 183 000	5 651 624
PHC community health centres complex	4 610 000	5 028 732
NGOs capacity building	2 462 500	2 836 462
Subtotal	**10 255 500**	**13 516 818**
Accumulation (Exchange rate, interest & VAT)	**3 913 440**	**0**
Totals funds available and spent	**14 168 940**	**13 516 818**

According to the funding agreement between the government and DCI, as well as the requirements of the Public Finance Management Act (PMFA), funds allocated to the programme were to be deposited to the National Treasury's RDP account. Money deposited in this account can accumulate interest over time and is also affected by foreign currency fluctuations from the time of deposit. These monetary policies had generated a surplus of R1,053,117 in interest as of 30 August 2005 and an additional R2,032,708 was gained from exchange fluctuations. Another R827,615 was gained by the Department from VAT claimed

back from service providers. These financial policies generated R3,913,440 above and beyond the original allocation of R10,255,500, making a total of R14,139,440 available to be spent on this programme, as indicated in Table 2 above.

Programme management

An operational framework for the programme was set up by the Free State Department of Health at the outset of the programme. The framework included a steering committee that was comprised of senior managers in the Department. The Head of the Department was responsible for the overall strategic oversight of the programme. Three other senior managers were to be responsible for management of each of the three components. This arrangement seems not to have worked due to the fact that the managers assigned to these components had other demanding responsibilities for their units. Thus, there was slow movement on the programme from 2001 to 2002, related to setting up systems and aligning activities to provincial programmes strategies, and developing detailed activity plans and budgets for each component.

It was only in 2003, after the mid-term review, that new component managers were drafted into the programme. The overall programme manager was appointed on a full-time basis in early 2005. Following these changes, the systems allowing funding flows between National Treasury, Provincial Treasury and the Department of Health started to move more quickly. The Steering Committee also started to function better during this period, meetings became regular, follow-ups were made on issues raised during meetings, progress reports started to improve, and activities on the ground started to be more visible.

Box 1: Comments from Senior Manager & Steering Committee Member

" …DCI would tell us that they have transferred funds to us …and why are we not spending? From our side there will be no indication that the money had arrived from Treasury. The process is slow, the systems do not work as fast as we would like, and these are inevitable delays. For the first two years we could not spend at the levels we would have liked".

There were a number of systemic challenges faced by both DCI and the Department of Health, including:

- Complexities in channelling funding through state institutions, especially bi-lateral funds that require transfer directly to the RDP account of the National Treasury
- Un-aligned financial years between the government and DCI

- Accumulation of interest and the surplus created by fluctuations in exchange rate and VAT claimed back from service providers.

Channelling funding between state institutions: The process for transferring money from DCI to National Treasury to Provincial Treasury and then to the Free State Department of Health could be daunting and difficult to manage. DCI would expect to see the province starting to utilise the money once DCI had made a transfer to Treasury, however the process for transfers can be long and tedious. This process contributed to the slow start and delays in the implementation of the programme, and was also exacerbated by the absence of a dedicated person to follow up and trace movements of the funds through all these complicated channels.

The delays in the start up of the programme can be better illustrated by the expenditure over the period 2002–2004. At the end of 2002, the programme rolled over R2,306,698 that was not spent in that year. In 2003, the budget for the year was R6, 368,831, which included roll-over from the previous year. The total expenditure in 2003 was R2,316,199 representing a little over one third (36.4%) of the total budget for that year. In 2004, the budget was R6,223,516 and expenditure for that year was R3,028,439, which represented 48.7% of the budget. In October 2004, there was R7,413,818 in unspent money for the programme. The steering committee realised it would not be able to spend all the remaining funds in the programme and negotiated with DCI to extend the programme to June 2005 to allow time for the Department to spent this money.

Box 2: Comments from Senior Management

" …In January all expenditure is stopped and you can not spend until the start of the new financial year ….This is really a problem because DCI will always ask why did you not spend in this quarter and we go to pains explaining this. It would be better if the accounting officer is allowed to have some systems to by-pass this bottleneck, for example, use a cheque account that would allow the accounting officer to spend during that period …Of course there is a need to set up a checks and balance system so that funds can be monitored and accounted for. This method is used by other departments with credit cards - why not use it here?"

Uneven financial years: The difference in financial years (FY) between the Department and DCI has been cited as another contributory factor to the delays in spending funds. The Department's financial year starts in April and ends in March, whilst DCI's financial year starts in January and ends in December. The Department closes its books for the year in January or February, and government spending stops until the end of March. Once this directive is issued, the finance department will stop all requests for expenditure, without taking into consideration that there are donor funds that can be spent during this

period. This directive had the potential to impede expenditure on programme activities.

Additional unbudgeted funds: The funds accumulated through exchange rate fluctuations, interest and VAT added additional pressure for management to find an efficient way of spending the available funds. The Department had to develop activities within this programme to enable them to utilise the extra funds.

Management interventions

In 2003, a number of strategic interventions were put in place by the province to respond to some of the implementation challenges identified in the mid-term review, including appointing new component managers to dedicate time to the implementation of the programme activities. The programme activities were also linked to existing Department activities - for example, the human resource and organisational development component was to be managed by the human resources manager in the province and all programme activities were aligned to the provincial HR plan.

In early 2005, an overall manger was also appointed to fast track implementation. The rationale behind this was to strengthen overall implementation oversight and coordination and to liaise with the finance unit to ensure that bottlenecks on expenditure and transfer of funds were attended to swiftly. However, there remained a huge challenge of spending funds that had been rolled over during the previous two financial years.

Box 3: Comment from Senior Manager

One senior manager put this kind of expenditure this way: "…. There was a period where component managers were told to spend, spend, spend ….resulting in some over-expenditure in some of the activities. This required us [the Department] to justify and negotiate with DCI on these over-expenditures. But I guess everyone was under pressure to be seen spending".

In 2003, component managers started to identify activities that could lead to an acceleration of spending. For example, the community health centre complex component purchased 3 patient carriers, 6 sedan vehicles, 1 motorbike, 4 mobile capsules and 4 LWB bakkies – and in that same year put in an additional order for 3 patient carriers and 4 sedans. The period was marked by increasing spending on the programme.

In October 2004, as preparation for requesting an extension of the programme, the Steering Committee reviewed and identified strategic, feasible, and implementable activities across all components to allow the programme to utilise

available funds. An extension was granted by DCI through June 2005. The extension period involved:

- identifying activities in each component that would be feasible to implement and add value in the programme outputs
- adding other activities relevant to the component that might facilitate implementation
- closely monitoring implementation though component managers
- empowering the overall programme manager to play an active leadership role in moving the programme forward

The streamlining of interventions during the extension period and the active and visible support from senior management enabled the following to happen:

- Proactive approach to the implementation of activities by component managers. For example, the human resource and development manager ran training on each activity in parallel using different service providers. This approach cut down on time spent on tendering processes as a number of training programme were tendered at the same to different service providers.
- Activities that were originally planned with no added value were revised and adjusted. For example, the community health centre complex had planned to purchase 3 motorbikes, but only one was bought and the reality on the ground was there was no need for two extra motorbikes. The funds were reallocated to other activities in the complex.
- The programme manager was given more time to concentrate on managing and providing leadership in the implementation of the programme. This provided a vehicle for close management of and quick reaction and response to issues affecting the programme plan.
- The Steering Committee and the programme management committee were forced to take an active approach to the overall programme to ensure that the new targets and deadlines were met.

II. Human resource and organisation development

The overall goal of this component was to develop the capacities of individuals and institutions within the Free State Department of Health in order to enhance its service delivery in line with service needs. The goal is underpinned by a number of objectives which were to address the following human resource development (HRD) areas:

- Human resources management

- Health management
- District medical services
- Financial accountability
- Project management
- Customer care

These efforts were to provide individual staff with skills required to enable them to provide good quality services, thus also improving their morale and the image of the public service. A number of activities were outlined to meet the objectives of the component, including:

- Training of district medical officers in public health
- Training of managers in health management
- Training of support staff in general office skills, including financial management
- Training of supervisors and managers on leadership and motivation
- Training of senior and mid-level managers on project management
- Training of front-line service providers on customer care
- Training of lower-level staff on learnership programmes ABET levels 1-3
- Training of ancillary health care workers for home-based care and step-down facilities to prevent the spread of HIV and AIDS
- Training of primary health care nurses in advanced midwifery

General overview of the skills development unit

The Skills Development Unit was set up to provide strategic capacity development efforts across all health personnel in the Free State. The Unit covers a range of functions relating to human resource development, including ensuring that there are processes and activities that support building skills in technical areas of the Department; ensuring that skills development activities, especially training, are of high quality; ensuring that training cuts across all areas and levels of staff; and ensuring that there are programmes for further training of staff.

The overall function of the Skills Development Unit is to ensure that the Department has adequate managerial, technical and support skills and capacity to deliver quality services to the population of the province. The functions can be described as follows:

- Assessing and monitoring the quality of services provided by service providers, instructional design, principles and standards of the NQF, transferability of skills (for example, are course materials such as manuals appropriate), and the appropriateness of the medium of instruction
- Identifying skills shortages, gaps and needs in the Department. The process includes reviewing personnel job descriptions to identify skills requirements and needs, and sending personnel to relevant training courses that match skills gaps and needs

The policy on capacity development in the province seeks to promote and support learning environments that are conducive for staff. They are provided with time to attend training sessions and may be provided with mentoring if required. However, staff are also expected to fulfil their responsibilities to acquire new skills and to meet expectations on improving their performance in executing their functions. The Department also has a responsibility to monitor the quality of training provided, to assess service providers in line with the legislation, and to monitor the work of service providers via reports they submit to the Department on activities completed.

Component review

The mid-term review found that training was at various stages due to a number of factors, including delays in identifying suitable service providers, delays in quotations, tender processes, and accreditation with quality assurance bodies. Challenges found in the review and recommendations made are summarised in Table 3 below.

Table 3: Summary of Challenges and Recommendations from Mid-term Review

Challenges	Recommendations
Training was in different stages due to delays in finding suitable external service providers	Speed up the tempo of implementation and continue outsourcing training to external service providers
Too little funding was received to undertake some of the training programmes on one year of allocated funding	Reallocate some of the unused funds to the training component and increase the number of Advanced Midwifes to be trained
The technical nature of the iCAM mode of training mandates good technical support and functionally decentralised training centres, especially with regards to communication between lecturers and learners	Strengthen the use of iCAM technology and recognition with accreditation

Budget and expenditure

In this review, the original budget has been used against expenditure for all the components and adjusting the budgets has been purposively avoided because it was difficult to link the extension plans to original plans as new activities were added and or initial targets were changed. The table below is intended to illustrate shifts made within the component for each budget lines.

The original budget for this component was R3,183,000; an additional R2,468,624 was made available from the additional funds accumulated over the course of the programme. This additional funding for the component represents almost half of the money that was generated through exchange rates and interest. This was because the component was perceived by the Department as having the absorptive capacity to utilise the funds, as well as the fact that capacity building was seen as a high priority needing support.

Table 4: Human Resource and Organisational Development Component 2002-2005

Activity title	Total budget (R)	Expenditure (R)
Training of District Medical Officers (DMOs) in Public Health	150 000	33 500
Training in Diploma in Health Management	64 000	900 000
Training in General Office Skills	90 000	930 064
Training in Leadership and Motivation for managers	600 000	148 771
Project management Training	120 000	354 966
Customer Service Training	160 000	158 610
Training for ABET (Levels 3-4)	960 000	360 000
Career Management Programme/Skills Audit	80 000	20 000
Training of Ancillary health care workers	919 000	826 863
Review/evaluations	40 000	377 000
Capacity building on governance structures (2005 addition)		913 840
Uncategorised expenditure in 2002/3		628 010
Funds made available from accumulated funds	**2 468 624**	
Total	**5 651 624**	**5 651 624**

Table 4 above indicates the following:

- A significant amount of money was allocated to this component from the extra funding accumulated in this programme as a whole.
- The original budget allocation for certain line activities may have been an underestimation. For example, health management, office skills, and project management expenditures far exceed the original budget.
- In some activities where it seems there was under-expenditure, the reasons were multiple: in the case of training of district medical officers, the planned activities were changed, whilst in the ABET training a cost effective medium of instruction was utilised. The rationales for some of the changes are discussed in sections below.
- Overall the component was able to spend all its initial allocation and also spent a substantial portion of the additional available funding under this programme.

Training

Table 5 below indicates that the first year of the programme was a challenging one. A small of staff members (15) were enrolled to study. Only two training activities were conducted that year: training of district medical officers in public health and training of nurses in advanced midwifery. Staff enrolled in these programmes did not perform well, as two of the medical officers and six of the nurses failed their respective courses. It was also during this period that iCAM training was introduced into the province as a medium of training. However, this medium of training was new, requiring massive investment for set up and maintenance.

Box 4: Comments from iCAM students

: "…..It was very difficult at the beginning - the system would break down and there will be no lessons ….Very discouraging, because I have never had a class on TV. There are buttons that you have to touch to ask questions and interact with the teacher, but as you get used to it, it has become the most convenient and effective medium of learning. …I now go to work, come to class at the designated time, listen to my lecture and go back to work. I don't worry of being away from home".

The iCAM system took off very slowly, as the province had to gain experience in running this type of training medium. Students also had to adapt to this new learning technology. There were fewer studios that were used by students due to the cost associated with setting up the studios. Students who used this technology had challenges in the beginning; they were not used to this form of instruction, nor were they experienced in using this technology as a medium for interaction. However, as they got used to it, they found a number of benefits and advantages in using iCAM as a medium of learning, and found it to be convenient and user friendly once one became accustomed to it.

Table 5: Staff Trained under the Human Resource and Organisation Development Component 2003-2005

	Total enrolled					Training outcomes			
Areas of training	**Gender**	**2003**	**2004**	**2005**	**Total**	**Completed training**	**Still in training**	**Completed to date**	**Targets**
Public Health	Female	2	0	0	2	1	0	3	5
	Male	3	0	0	3	2	0		
Health Management	Female	0	15	18	33	15	18	25	80
	Male	0	10	2	12	10	2		
General Office skills	Female	0	77	40	117	117	0	161	160
	Male	0	19	25	44	44	0		
Leadership and motivation	Female	0	11	69	80	80	0	106	112
	Male	0	5	21	26	26	0		
Project Management	Female	0	38	44	82	82	0	108	128
	Male	0	14	12	26	26	0		
Customer Management	Female	0	57	37	94	94	0	160	68
	Male	0	46	20	66	66	0		
ABET (Levels 3)	Female	0	57	64	121	121	0	145	150
	Male	0	13	11	24	24	0		
Ancillary Health Care workers	Female	0	42	0	42	42	0	46	50
	Male	0	4	0	4	4	0		
Advance Midwifery	Female	10	15	6	31	18	13	18	34
	Male	0	0	2	2	0	2		
Totals		**15**	**423**	**371**	**809**	**772**	**35**	**772**	**787**

As iCAM started to function better in 2004, a huge number of staff were trained. By the end of 2004, 423 staff had undergone training in almost all the training areas that were planned for this component. At the time of the review in October 2005, almost all the targets – some revised for the extended period – had been met. The success can be attributed to the introduction of iCAM training and the interventions that were set up to support capacity building efforts in the province.

The face to face training in the component went through a lengthy and laborious tendering process. Training programmes that used this type of training medium include project management, customer care, and leadership and motivation. The tenders were advertised, selected, awarded and negotiated with service providers in 2003. Table 5 indicates that no training took place in these areas

until 2004, when this process was completed. This may suggest a need to build time into the programme timeline to accommodate such processes, without exerting pressure and frustration on managers who are struggling to meet deadlines.

Figure 2 indicates that more females than males were selected for training courses across all the areas that the component provided training on. It is also important to note that there were more females trained even in areas perceived as male-dominated, such as project management, leadership, and health management.

Figure 2: Distribution of Staff Trained by Gender

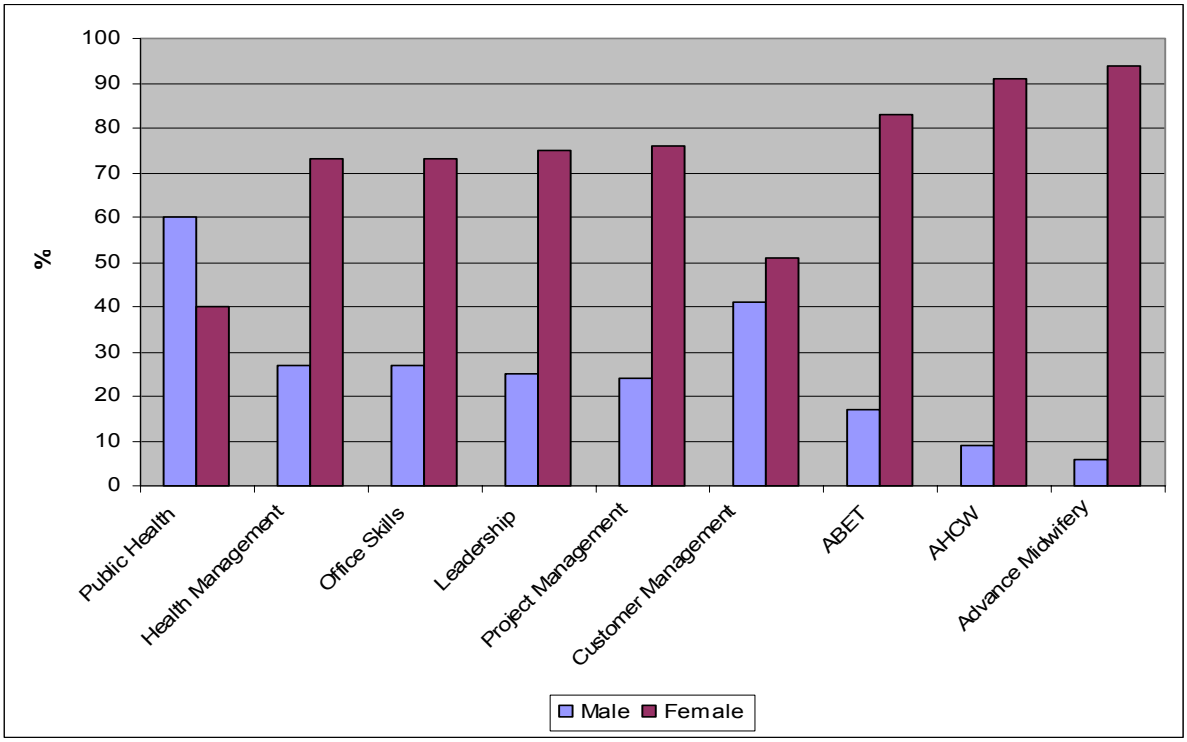
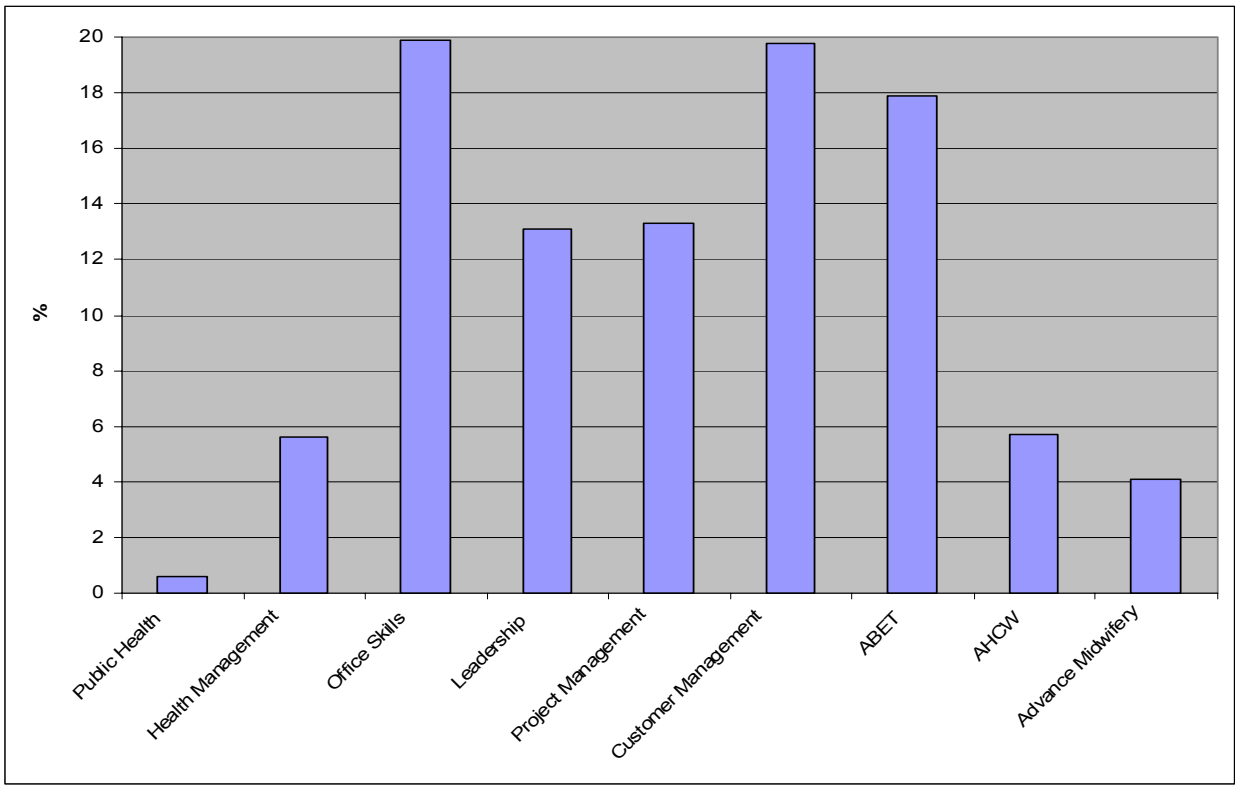


Figure 3 below indicates that there was massive investment in capacity building in the areas of office management, leadership, project management, customer management and basic education. This seems to be inline with the Bathopele principles in terms of strengthening staff skills outside the generic clinical skills required in the health industry.

Figure 3: Distribution of Staff by Course Category



Summary of progress since 2002

Training of district medical officers in public health

The original plan was to train 5 district medical officers in public health in conjunction with the University of Free State. These officers were enrolled with the University of Free State in 2002 for a one-year Diploma course. Of the five district medical officers, two failed the course but were allowed to enrol in short-term courses. By the end of this activity, only R33,500 had been utilized, leaving a surplus of R116,500.

A consultative process was undertaken within the Department to review the training of medical officers, since the Department had learned that the University of Free State could no longer offer the course. These developments prompted the Department to review training needs for a wider range of managers and professionals. In 2004, the province identified the University of Pretoria as a suitable institution to provide training to managers on health management. The 2004 plan for this activity was to train 5 PHC managers, 5 district managers and

2 medical doctors in health management with the University of Pretoria. Due to university registration deadlines, this cohort of staff was only enrolled in the programme in January 2005. However the number of staff enrolled in the programme rose from 5 to 15. The original budget for this activity over two years was R150,000; at the time of the review R795,000 had been committed to cover the cost of this training.

Training of managers in health management

The original target for this activity was to train 80 managers to receive a Diploma in Health Management. The process for identification of staff and registration started in 2002. This required the Department to identify staff, negotiate their availability and find a suitable institution to provide the service. The University of Free State was selected as the service provider for this course. The preferred training method was iCAM because it allowed easier access to training across the province and would not require staff to be transported and accommodated outside their working centres. By the end of 2003, 25 managers had undergone training and completed the course. The original budget for this activity over the three year period was R64,000, however training of these managers cost the Department R105,000.

It is important to note that, by 2004, the Department had identified health management as an area in which to focus capacity building efforts. Thus they converted some of the unutilised budget from the training of District Medical Officers to train managers on health management at the University of Pretoria. The decision not to use iCAM for this training programme is not very clear.

Training in general office skills

The implementation of this activity was delayed by restructuring of directorates in the province. The original aim of this activity was to train clerks in financial accountability, but after the restructuring, the Department realised that the priority need for support staff was broader than just financial accountability. They identified office management skills as an area where capacity building was needed for accounting clerks, secretaries, administration clerks and general clerks. The change in the scope and content of

Box 5: Comments from staff who attended financial management course

I am responsible for financial matters in my section. I have now a better understanding and skills of how to prepare financial reports… and the materials I got from that course I used as reference for better understanding end execution of my tasks.

this area also contributed in the delay. PriceWaterhouseCoopers (PWC) was appointed towards the end of 2003 as a service provider. Due to these changes to the mandate, PWC requested time to prepare training material focusing on the new need.

Training in this area only started in March 2004. By the end of 2004, 90 staff had undergone the training at a cost of R89,464. The Department realised that the target of 160 staff was unrealistic for the budget that had been allocated for this activity, and a management decision was taken by the Steering Committee to make an additional allocation of R50,000. At the time of the review, an additional 44 staff were trained at a cost of R45,600. This brings the total number of staff trained in general office management skills to 134 and the total cost to R135,064.

Leadership and motivation training for managers

This activity had targeted to train 112 managers and supervisors on leadership and motivation skills. During the inception phase (2002), a significant amount of time was spent on the tendering process. An initial tender for this course was awarded to an organisation that was later dissolved, requiring the Department to re-apply to have this tender awarded to another service provider. A new service provider – TDA Human Resource Management Consultants – was appointed, however their start was also delayed by bureaucratic requirements in the provincial financial management systems.

The first training took place in November 2003, with 8 staff being trained; in 2004 only 27 staff were trained. This was caused by multiple problems, including cancellation of training due to the lack of availability of staff to attend the training on the scheduled dates. The other problem was the failure of the Department to recognise that the service provider contract had expired, thus forcing cancellation of all other training until a new contract had been signed. Signing a new contract requires going through the whole tendering process, which is complex, tedious and time consuming.

After the expiry of this contract in June 2004, no training took place until a new tender was awarded and training only commenced again in February 2005. In 2005, the Department trained 52 staff on leadership and motivation, which brings the total staff trained in this activity to 106 and the total cost to R148,825 (from a total budget of R600,000 for this activity).

Project management training for managers

This activity was designed to target mid- to senior-level managers to be trained on project management. Activity planning started in 2003, and similar problems were encountered that were experienced by the other training activities. The tender for this activity was awarded to PriceWaterhouseCoopers in August 2003. However, the process for implementing this activity included setting up preparatory meetings with the service provider where a decision was taken to start the training in January 2004.

Box 6: Comments from staff who attended a project management course

"The clinic upgrading and building programme is always time-bound, therefore, the course has helped me to apply the skills I have learned. …As I am new in this job, I have now gained confidence in conducting my job. ….However, practical sessions and assignments must be dealt with during the training course, because the work we do hampers completion of training outside classroom."

The initial target for training was 128 managers. Training commenced in May 2004 and 52 managers were trained by the end of the year. This training cost the Department R98, 256 from a budget of R120,000 over the three-year period. Again, the Department realised that the allocated budget would not cover the remaining number of staff. Negotiations with DCI resulted in agreement to extend the period and to re-allocate funding for the remaining 76 managers with additional budget of R265,000.

In 2005 a number of training sessions were conducted resulting in 68 managers being trained between February and May 2005. To date a total of 120 managers have been trained in project management in the province at a total cost of R353,256.

Customer care training for frontline service providers

This activity was aimed at improving the skills of frontline service providers in dealing with clients, thus reducing the number of complaints from clients. Initially the Department had intended to train 68 frontline staff on customer care. It took the whole of 2003 to get in place all the systems required for training to take place.

The tender for this training was also awarded to PriceWaterhouseCoopers and training commenced in March 2004. Four training sessions were conducted in 2004 with a total of 93 frontline staff trained. The Department took a decision to

continue training more frontline providers, as the budget left for this activity would allow them to train more and the Department had identified a need to train more frontline service providers.

In 2005, additional training in customer care resumed, with one training conducted in March and another one in May conducted by Regenesys. A total of 139 staff have been trained in customer care since the start of the programme: this far exceeds the targeted number of staff to be trained. The total cost for providing this training was R158,610, which was within the total budget of R160,000 for this activity over the three-year period.

Adult Basic Education and Training (ABET) (levels 3-4) and Ancillary Health Care Workers Training

This activity underwent a long consultative process between the Department, the Health and Welfare Sector Educational Training Authority (HWSETA), and service providers. Workshops were also held as part of the consultative process, including meeting with stakeholders. This culminated in the accreditation of the courses, learning programme documentation, and grading of Ancillary Health Care Workers (AHCW) qualification recognition.

The plan was to train 150 ABET learners for NQF qualification level 3 and 605 (NQF 4) Ancillary Health care workers. Due to the high cost of training for NQF level 4, the Department aligned the qualification in level 3 such that those progressing to level can choose to do the generic NQF level 4 of AHCW. The target for ACHW was then revised to a target of 50.

In 2004 the Department registered 145 ABET (NQF level 3) learners. They were expected to write their exams in February 2005. In September 2004, 46 AHCW (NQF level 4) were enrolled in the programme: although 50 were selected, four turned down the offer indicating that they got employment somewhere else. These learners were also expected to complete their training in 2005.

The initial budget for this programme was R960,000 to cover training for 150 ABET learners and 650 AHCWs, which was later revised to 50. By 2005, a total of 145 ABET learners and 46 AHCWs were trained at a cost of R786,863.

Advanced Midwifery and Community Developers training

The objective of this activity was to build capacity in the PHC complex that would support changes towards improving the functionality of the whole complex. Its focus was to train enough midwifes to manage efficiently the maternity units in

the 24-hour health centres in the complex and also to train community developers who would provide support and education to the communities on the systems and changes in the delivery of PHC services in the complex.

The plan indicated a need to train10 nurses in advanced midwifery and 2 community developers for the complex. However, on discussion with the University of Free State and DCI, the Department opted to increase the target for advanced midwifery to 34 and community developers to 5. In 2003, the School of Nursing at the University of Free State was appointed to run the courses for advanced midwifery for the Department staff. By February 2005, 33 nurses had been enrolled in the programme: 10 in 2003, 15 in 2004 and 8 in 2005. iCAM was used as a method of instruction for this programme. The decision was taken after reviewing the cost benefit, accessibility to the course by staff across the province, and the fact that the university had allowed adding primary health care training modules via the iCAM programme.

Box 7: Comments from advance midwifery student who used iCAM

I needed to prepare for each class. This made it very easy for me to understand what the facilitator was explaining. I felt great when I was giving inputs and taking active participation. However, before nurses are enrolled into this course they must take a test first, because some nurses think Advance Midwifery is a walk over – its not.

The pass rate was poor in the 2003 and 2004 intake: both groups had almost half of the students not completing their courses successfully. One of noted contributing factors to the high failure rate was the fact that, in most cases, students were unable to access required numbers of practical cases from maternity institutions. Another factor was that most of the nurses who failed had failed pharmacology, which was later investigated and corrected with the University of Free State. We may note here that perhaps the Department could have planned and prepared better for this activity. First, they could have anticipated problems in finding enough cases for the students within the maternity institutions in the area; second, they could have improved distribution of students across maternity departments where they would have a chance of finding suitable cases for the course. The original budget for this activity was R300,000; at the time of the review all the training conducted had cost the department R293,000.

Career management programme and skills audit

The object of this activity was to conduct a qualifications audit for the entire Department of Health in the province. This exercise was crucial in the development of the Department's workplace skills plan. The outcome of this work is to be used in developing a career management programme which will provide an opportunity for the Department to determine the skills required at all levels of service delivery. This will, in turn, inform the human resource plan for the Department.

Table 6: Workforce Analysis

Occupational category	African		Coloured		Indian		White	
	Male	Female	Male	Female	Male	Female	Male	Female
Unskilled (Level 1 - 3)	1 559	3 376	55	95	6	1	191	97
Semi-skilled (Level 4 – 7)	1 579	3 730	127	422	8	6	369	1 157
Skilled technical (Level 8 – 9)	385	1 572	19	101	8	14	102	654
Professional (Level 10 – 12)	145	80	11	9	10	1	248	185
Senior Management (Level 13)	10	5	1	1	3	0	41	10
Top Management (Level 14 – 16)	4	2	0	0	0	0	30	2
TOTAL = 16 431	3 682 (22.4%)	8 765 (53.4%)	213 (1.3%)	628 (3.8%)	35 (0.2%)	22 (0.1%)	981 (6%)	2 105 (12.8%)

Source: Department of Health, Human Resource Plan Draft July 2005

The audit was completed and the report contains useful planning information on human resource development and management. Table 6 above and Table 7 below are examples of the information that is contained in the Department's draft human development plan. The information indicates the staffing levels by categories and skills areas and the level of staffing in scarce skills. The information, interestingly, is broken down into gender and racial groupings. One might note that in the Department, senior and top management is largely in the hands of white males. This might be an issue that needs to be kept on the radar to find interventions that would address equity at this level of management in the Department.

The scare skills analysis data clearly shows skills areas that are grossly under-staffed; some of these are critical for a well-functioning health system. This picture may assist in developing strategic plans to address the issue of skill development and retention planning in the Department.

Table 7: Scarce Skills Analysis

Occupational category	African		Coloured		Indian		White	
	male	female	male	female	male	female	male	female
Clinical Psychologist	2	6	0	1	0	1	3	6
Dentist	9	9	1	0	4	5	20	7
Medical Natural Scientist	1	1	0	0	0	0	1	4
Medical Officer	132	38	6	5	14	3	144	95
Pharmacist	20	18	1	1	0	1	17	66
Registrar	9	3	3	1	2	1	99	37
Specialist	15	4	2	0	5	0	150	36
Clinical Technologist	5	2	1	1	0	0	8	19
Dental Technician	0	0	0	0	0	0	1	0
Medical Orthotist Prosthetics	4	0	1	0	0	0	6	3
State Accountant	11	10	2	1	0	0	2	3
Optometrist	2	2	0	1	0	0	0	1
Orthopaedic Shoemaker	1	0	1	0	0	0	1	0
Dietician	0	5	0	0	0	0	0	33
Physiotherapist	5	16	2	4	0	1	5	39
Radiographer	40	35	6	5	0	0	1	93
Speech – and Audiologist	2	1	0	1	0	0	0	15
Occupational Therapist	4	8	0	0	0	0	0	53
Oral Hygienist	2	6	0	0	0	0	0	1
Dental Therapist	3	2	0	0	0	0	0	0
Totals	**267**	**166**	**26**	**21**	**25**	**12**	**458**	**511**

Source: Department of Health, Human Resource Plan Draft July 2005

Views of Human Resource Development Service Providers

We interviewed and reviewed documents from a number of service providers under this component. The exercise was aimed at understanding the context in which training is conducted, the processes used by training service providers in planning, presenting and evaluating their training sessions, the feedback loop between the service providers, participants and the Department, and limitations in running courses of this nature.

There were varying degrees of frustration expressed by training service providers in relation to the tedious and sometimes delayed tendering process. However, all of the training service providers acknowledged the fact that government has a lot of red tape and that it may take time to get tendering processes finalised.

The planning of training programmes by service providers seemed to focus on content. All of the service providers set aside time to prepare training materials that would be suitable for the client. Although most of these courses have a standard content framework, the service providers went beyond the standard packages and prepared material that is tailor made for the specific client and proposed participants. All the providers use a similar format – a mixture of presentations, group interactions or group work, and individual exercises or assignments. In some cases – for example, project management – there were specific manuals that were developed and participants would go through the manual during the course. The content planning seems to have been well planned and technically sound, and provided guidance beyond the classroom setting. A number of the course participants reported they were using these materials as references in their current job responsibilities.

Table 8: An Example of SAQA Unit Standards for Customer Care

NQF level	No of credits	Unit standard title	Unit standard number
5	20	Identify internal and external stakeholders	10023
		Manage customer requirements and needs and implement action plans	10053
		Identify, suggest and implement corrective action to improve quality	10144

However, there was a gap in pre-training planning on assessing the competencies of participants in the areas of training, the relevance of training to the present job, and the level of complexity at which the training should be

pitched. Only one service provider reported to have a pre-selection assessment of participants, and to match competencies and job levels to the requirements of the course. In many cases service providers will meet participants or learn about their backgrounds for the first time during the first day of training. There were reported cases where even the participants did not know why they had been selected for the training. This kind of preparation undermines the quality of a training session (i.e. they are not tailor made for the participants), the quality of participation from participants (as they may be less motivated to be in the course), and the level of commitment from both the trainers and participants, as the efforts may seem to have lacked proper consultations and a transparent selection process.

Table 9: An example of typical project management courses

DURATION	WHAT TO EXPECT	METHOD OF TUITION
6 Days (4 days course **plus** 2 days practical training), **plus** one day feedback session after completion of a work-related project	□ Practical Application and exercises (customised for the specific client) □ Study Pack □ Certificate □ Qualified Facilitator □ Delegates will have to complete a practical project after the MS project training session, after which one feedback session will be held to evaluate projects	□ Facilitation, lecturing and interactive adult learning □ Case studies and group work on practice projects (for the duration of the course) □ Daily sessions will start with feedback and discussion of progress reports on practical assignments □ Presentation skills will also receive attention

All service providers seem to use a participatory approach and formal teaching in their presentations. The amount of information they provided per training course was limited by matching the duration and the national qualification standards requirements for those courses. The other challenge was that the skills that were expected to be achieved by participants were to be objectively assessed at the end of the course so as to certify their learned competencies in the subject area. Most of the service providers had to issue a certificate of competency after completing all the course requirements. The requirements for completion vary between service providers, but they all had a passing grade that is made up of classroom presentations, group work presentations, individual or group

assignments, and classroom content assessment at the end of the course. Each service provider had its own system of weighting marks for students in each of these elements. All of the service providers required participants to fulfil requirements before awarding certificate of completion. However, some of the service providers awarded a only a certificate of attendance at the end of the course.

The form of evaluation that was used most commonly by most service providers was written assignments given to participants to complete in their own time after the presentation of the course. The time frame for submission ranged from one to two months. All the service providers commented that they found this practice not too successful with government employees, and all of them reported very poor submission rates, regardless of the amount of time given and the number of reminders made to participants. For example, one service provider on project management reported that they had only one participant out of 75 who submitted the assignment.

Since all of the courses provided under this programme were linked to SAQA qualification, there must be systems built into the planning of these courses such that participants are compelled to complete all requirements for certification.

All contracts between the Department and service providers require a report to be submitted by the service provider at the end of the contract period. Some service providers have created an interim reporting structure where the service provider meets with the Department's key staff to provide feedback. For example, the consortium led by PriceWaterhouseCoopers that provided training and support for NGOs had this type of a structure in place with the component manager. However, for short courses, face-to-face feedback never took place. All service providers had evaluation forms filled in by participants at the end of the training, where they were asked to evaluate the training. Feedback from these evaluations formed part of the final report sent to the Department.

Issues on training service providers

For all the efforts and resources that were utilised for training in this programme, there a number of issues that need to be highlighted:

- In planning these trainings, although limited by time, capacity, and cost, the Department has to make sure that service providers for training are given a list of participants, their level of responsibility and work area prior to start of a training programme. The service providers must make sure that they conduct

a competency and job-training analysis before the start of the training. This important for two reasons: (i) the service provider will have a better understanding of the participants, and thus prepare their training to suit the level of participants; and (ii) this provides participants with the opportunity to prepare themselves for the training.

- The training provided by service providers must have a certificate of competency – not attendance – such that the course outline must state the number of credits and the NQF level for that course. There were courses in this programme that did not provide these, mainly because the number of days allocated for the training was not enough to meet the SAQA requirements. This must be discouraged as it does not provide a motivation to attend and to fulfil competency requirements, nor it does justify the cost of the course.
- The Department must set strict procedures and policy guidelines for staff who attend such courses. A number of staff who attended these courses neither submitted their assignments nor passed the course, whilst all these courses were fully paid for them. These courses are linked to career progression; therefore staff who attend these courses need to adhere to qualification requirements. There must be both incentives for those who do well in these courses and disincentives for those who fail to meet requirements. There are no guidelines on these issues for courses that are run by the Department. Some of these service providers charge a fee for participants who fail, but who may supplement or rewrite their exams; one of the service providers was charging R500 for rewriting exams. Those who fail need to be forced to re-write and pay these fees on their own.
- The written reports submitted by training service providers cannot provide certain crucial and valuable feedback to the Department that could be covered via verbal feedback sessions focusing on processes and challenges during and after training. The service contracts given to all training service providers in the province must make it mandatory for these institutions to present a verbal report to the managers responsible, including HR managers, not only on outcomes, but also on training processes. None of the written reports addressed the shortcomings that were picked up by the review, nor did these reports provide feasible and useful recommendations on challenges where participants fail to submit or fail courses. HRD is one of the most expensive investments by the Department and certainly for this programme; yet there is compelling evidence that these trainings are treated as workshops or short breaks from work.

III. Botshabelo Community Health Centre Complex

The broad goal for this component was to improve the health status of South Africa through support for health sector reform. This activity was to be implemented using a framework that would allow transformation of health service delivery in the complex, in particular primary health care, to be in line with the

concept of a district health system. DCI had previously supported the development of facility infrastructure in the complex as part of contributing towards this goal. However, it was evident that people were bypassing the PHC facilities and seeking PHC services at the district hospital. To minimise this practice, the component was to assist in developing systems that would allow effective and efficient management of patient flows to the different levels of care in the complex.

The broad goal was to be achieved through the following key areas:

- Facilitating optimal effective referral system between the satellite clinics, community health centres, and the district hospital
- Providing the necessary training to improve the skills of health workers to ensure a well-functioning CHC complex system
- Purchasing essential medical equipment to support the facilities in the CHC complex
- Procuring patient transport and support systems to enable movement of transferred patients between levels of care
- Providing general support (management, equipment, training) necessary for supporting the CHC complex system.

A number of activities to be implemented in the CHC complex were identified by the Department. These activities were to respond to the key areas identified above. These activities included:

- Designing, printing and distributing referral booklets in the complex
- Implementing a transport system that would enhance efficiency of the referral system
- Designing sign boards and branding of clinics and community health centres in the CHC complex
- Training PHC nurses in advanced midwifery to better manage the maternity units in the community health centres and training of community development officers in health promotion and community development
- Purchasing transport to be used for inter-facility transfer of patients to avoid unnecessary delay, clinic supervision to allow supervisors to frequently visit clinics, rapid transportation of medical supplies, documentation and tests
- Purchasing equipment that would enhance the efficient management of the complex, including communications

The Context of the Complex

This is an overview from observation of the facilities and interviews conducted with facility managers visited by the review team in Botshabelo community health complex. The complex has 13 PHC facilities and one district hospital. Of the 13 facilities, 8 were graded into Grade 1 (8-hour facilities with no maternity unit and no visits by a doctor) and 5 were graded into Grade 2 (24-hour facilities with a maternity unit that are visited by a doctor for 3-4 hours every day, Monday to Friday). Botshabelo is a semi-rural area that is still developing and forms part of Mangaung local municipality. The government has managed to upgrade some of the Botshabelo health facilities and one clinic is still under construction.

Infrastructure

In general, most of the facilities in the complex are sound and well looked after. The structural design of these facilities is suitable for the delivery of health services. All of them have waiting areas, although varying in size. In most of the Grade 2 clinics, there are two waiting areas – one for general poly clinic and the other for Maternal and Child Health (MCH) services. They have electricity, piped water and toilets inside the building. All the clinics have well-maintained outside surroundings with vegetable gardens. The Grade 2 clinics have security systems, which include CCTV for monitoring visitors at night.

The internal and external maintenance of some of the buildings was problematic. Some of the clinics visited had leaking taps and toilets, the cabinet doors were falling off or didn't have handles, and some had broken windows, cracking walls and leaking roofs. Some facility managers felt that the need to have a maintenance system in place in order to maintain quality care and service. For example a Section B community health centre, which also caters for three eight-hour clinics, is one facility that needs a major revamp.

Services

Primary health care facilities in the complex render the whole PHC core package. However, due to the grading systems, Grade 2 clinics render more services that Grade 1 facilities. A referral system has been put in place refer patients between the facilities.

The referral system is one of the systems that has been enhanced by the DCI programme. At the clinics visited, most managers mentioned the positive results brought about by the system. All the clinics had their referral education material displayed on the notice board in the form of illustrations that patients are able to understand. These were in a local language to make it more accessible to patients. The clinic managers had noticed changes in the intake of patients and in patients' understandings of the referral system.

All the clinics had an element of community participation through clinic committees comprised of community members. The clinic committees' role is to foster communication between health care workers and community members. Four of the clinics in the complex were selected for best practice awards in the province through a competition run by the National Department Health for service excellence.

Staffing

Staff interviewed at all the clinics complained about being overworked and understaffed. Most of the clinics had community members helping them as volunteers and some used the vegetable garden to generate funds for their volunteers. There were also volunteers for lay counselling and TB management (DOTS) and members who were on in-service training for different programs. Receptionists were available in all the clinics. All the 24-hour facilities reported to be visited by a doctor for 3-4 hours a day between Monday and Friday.

Clinic equipment

Most clinics had the minimum essential clinical equipment for diagnosis and management of conditions presented at PHC facilities. However, there were complaints from facility managers that some of the new equipment was breaking down quickly. Problematic equipment included BP machines, diagnostic sets and glucometers. None of the clinic managers knew about any plan to introduce a patient shuttle system in the facilities. Most clinics hade a working telephone and some had a fax machine. There was only one clinic that reported to have a malfunctioning phone line during the time of the review.

Component Review

The mid-term review found that this component had progressed well. It indicated that most of the equipment procured was appropriate and was well-located in the facilities. It suggested that a vehicle needs analysis be done to inform the numbers required and the allocation of these vehicles. It also pointed out a lack of communication on issues relating to deviation from budgets and expenditure that required authorisation from the Steering Committee and approval by DCI. Table 10 below provides a summary of some challenges and recommendations made during the mid-term review.

Table 10 Mid-term review summary of challenges and recommendations

Challenges	Recommendations
Lack of experience in managing donor funding and lack of support from Steering Committee	Strengthen and support component manager and ensure adequate mechanisms for authorisation of expenditure deviation
Rationalising allocation of equipment to appropriate facilities in the complex	Utilise equipment appropriately and ensure refunding of inappropriate expenditure
Delays in procurement of name boards due to debates in coming with agreed names	Speed up the process of naming of facilities and procure name boards for facilities
Extending benefits to other local areas and also other districts	Devise a plan for a roll-out of lessons learned from pilot in Botshabelo

Budget and expenditure

Overall the component was able to spend the total allocated budget. There was some under-expenditure or over-expenditure in certain activity lines – for example, the referral systems and transport systems had some under-

expenditure, whilst medical equipment and training of midwives may have been overspent.

The variations in expenditure were covered by the additional funds made available by the funds by the programme as a whole. This component received R418,732 from the additional funds. All requirements in terms of procurement of equipment and vehicles, training of staff, and production of pamphlets for this component were met, and in some cases exceeded, as presented in the review of activities.

Table 11: Budget and expenditure for CHC complex component

Activity title	Total budget (R)	Expenditure (R)
Referral system	120 000	73 532
Patient transport and support system.	2 980 000	2 499 547
Medical equipment	800 000	1 047 440
General support for CHC complex system	410 000	429 373
Training of Advance Midwifes.	300 000	978 840
Totals	**4 610 000**	**5 028 732**

Review of activities

Improving and strengthening the referrals system

This area combined a number of strategies, including grading of PHC facilities; designing, producing and distributing referral information leaflets; introducing a patient shuttle system; procuring patient carrier vehicles; and designing and posting displays of clinic name boards, service packages and road signs for clinics.

Grading of facilities

This activity started with an audit of the PHC package and drug supply system. This was to enable the Department to align graded facilities to its allocated service package for each level. The facilities were graded into two levels: Grade 1 clinics are open eight hours a day. They do not have a doctor visit and they do not have a maternity unit. Grade 2 clinics are community health centres. They are open 24 hours and are visited by a doctor from Monday to Friday. Patients who are seen at Grade 1 facilities who are found to need a doctor are referred to

Grade 2 facilities where they are seen by a doctor. Those seen by a doctor in Grade 2 facilities, but needing specialised care or tests, are referred to the district hospital.

Referral pamphlets

The initial plan was to design, print and distribute 120,000 referral pamphlets over the duration of the programme. The target number of pamphlets were produced and distributed in 2003. In 2004 a reprint of another 120,000 pamphlets was done as a response to the mid-term review recommendation of printing more pamphlets. To date the complex has produced 240,000 pamphlets, which are being distributed in all the facilities in the complex. The budget for this activity was R85,000 and the total cost for designing and printing the pamphlets cost the Department R73,532.

However, there is no system in place in the complex to monitor the distribution of the pamphlets. It is not known how many of these pamphlets have been distributed to date and how many are left. It was also found that facilities use different methods for distributing the pamphlets. Some clinics have pamphlets placed in a display box where patients can have unrestricted access to them. In other clinics pamphlets are distributed by clerks during registration. The clerk will check with patients if they need a copy and distribute to those who require them. In some cases, patients make a personal request to staff to have copies of pamphlets to take with them.

Procurement of transport

The original plan for transport procurement was to buy eight Condors to be used as patient shuttles, 12 sedans to be used by supervisors and managers of the PHC complex, four Long Wheel Base bakkies with four mobile capsules to be used as mobile units, and three motorbikes to be used for transporting medical specimens between PHC centres and the hospital. All the vehicles were bought and one motorbike was purchased, instead of three.

The Botshabelo PHC complex has been allocated four of the Condors to be used as patient shuttles and the others have been allocated to other areas in the district. The bakkies have been fitted with mobile capsules and used by the district as mobile units. The sedans have been allocated to supervisors and managers in the complex, including the programme coordinating office. The motorbike has been allocated to Botshabelo and is being used to transport supplies and specimen between facilities and the district hospital.

Operationalisation of the shuttle system has not yet been implemented in any of the facilities in the complex. There are a number of policy questions and decisions that need to be taken before putting such a system into operation. These include policies related to the provision of free transport to patients that are not classified as acute and the role of the patient shuttle systems versus emergency services. In other words, there is a need to develop guidelines that will guide the operation of a shuttle system to avoid misuse by both community and staff. Ensuring the safety of these vehicles and the provision of adequate drivers are some of the issues the Department is grappling with.

Another policy issue that needs to be sorted out is the question of equity: if the Botshabelo complex is supported with a patient shuttle system, will the province do the same with other communities since the PHC grading practice is a provincial policy? How does the Department justify the implementation of this system in one part of the province and not in other parts of the province? The procurement of these items cost the Department R2,499,547 – a huge investment that needs to be put into full operation.

<u>Branding of PHC facilities</u>

Clinic name boards with operation times have been put up outside all 13 clinics in the complex. These boards are large, attractive, visible and placed in a position that any one passing by the clinic can see and notice. Service package boards have been designed and produced. They are being posted in clinics in the complex. Road signs have not been designed yet; the Department is still negotiating with the municipality on this activity as it requires municipal approval.

Clinic equipment

The activity also sought to strengthen the ability of PHC facilities to cope with the demand created by the grading system, through the provision of essential equipment to support clinicians in effectively managing patients' conditions at these levels. A number of pieces of equipment, typical to PHC facilities with a maternity wing, were procured and delivered to these facilities (see Table 11 for list and numbers procured).

Table 12: Equipment Audit in the PHC Facilities in the Complex (n=13)*

	# equipment	# Functioning	# Not Functioning	# procured DCI
Diagnostic sets	35	26	9	63
Baumanometers	51	28	23	51
Instrument trolleys	37	35	2	10
Linen carriers	16	16	0	2
Patients lockers	86	86	0	6
Examination couches	89	89	0	5
ANC/maternity beds & mattresses	34	32	2	47
Incubators	7	5	2	2
Infant resuscitation machines	4	4	0	2
Foetal doplers	13	10	3	13
HB meters	12	4	8	0
Glucometers	17	12	5	35
O2 cylinder trolleys	22	22	0	16
Placenta scales	5	4	1	5
Footstools single	127	127	0	10
O2 regulators & humidifiers	20	20	0	18
Emergency/patient trolleys	18	18	0	26
Clinic name boards	13	13	0	13
Service package boards	10	10	0	13
Clinic road signs	1	1	0	0
Totals	**687**	**624**	**63**	**337**

*A complete list of all equipments purchased under the DCI programme is found in Table 13 below

During this review, the number of pieces of essential equipment that were in the facility register – both functioning and not functioning – was assessed. The equipment present was compared with that reported to have been purchased by the programme, as presented in Table 11. Of the total essential equipment audited during the review in the 13 clinics, about one third of the items (233) were procured through the programme; this clearly indicates the significant contribution made by the programme in the delivery of quality PHC services. However, the review also found that a significant proportion (10%) of equipment items were out of order or in repairs in the clinics. These included

Baumanometers, haemoglobin meters, glucometers and diagnostic and ENT sets. These are basic pieces of equipment for proper diagnosis and management of most common conditions presented at PHC level.

The allocation of this equipment seems to have been conducted in a rational manner. All the equipment that relates to obstetrics was allocated to 24-hour clinics, as they have maternity units. Diagnostic equipment was allocated across all facilities. The ultrasound sonar and some of the surgical instruments were correctly allocated to be shared by all PHC facilities in the complex. The rationality to allocate both the ultrasound sonar and surgical instruments is in line with the operational framework of the grading system. All surgical instruments in the complex are stored, cleaned, sterilised and packed in the central sterilizing department (CSSD) in the hospital and are delivered to facilities requiring them in the complex. The ultrasound sonar can be equitably accessed by all members of the community if located in a central point - in this case, the only facility designated to be a referral point for all facilities is the district hospital. The district hospital also has the added advantage that it has full-time technical skills to fully utilise the ultrasound sonar machine.

Improving management support systems

A need was identified to enhance administrative and management functions in the complex. Certain office equipment was identified as essential to improve the operation of the complex. The original plan was to buy computers with software and printers, fax machines and a photocopier. A total of 26 computers with 25 printers was purchased. All clinics were allocated a computer and a machine; the remainder were allocated to the complex PHC office for support staff. A computer training programme for nurses has been planned to enable them to use the computers. Thirteen fax machines have been procured for the Department under this programme. The procurement of a photocopying machine was abandoned after the realisation that such equipment cannot be purchased under the Department policy, but leased. The money budgeted for this item was then shifted to procure more computers. The equipment has been strategically located in the complex, the district, and the coordinating office for the programme.

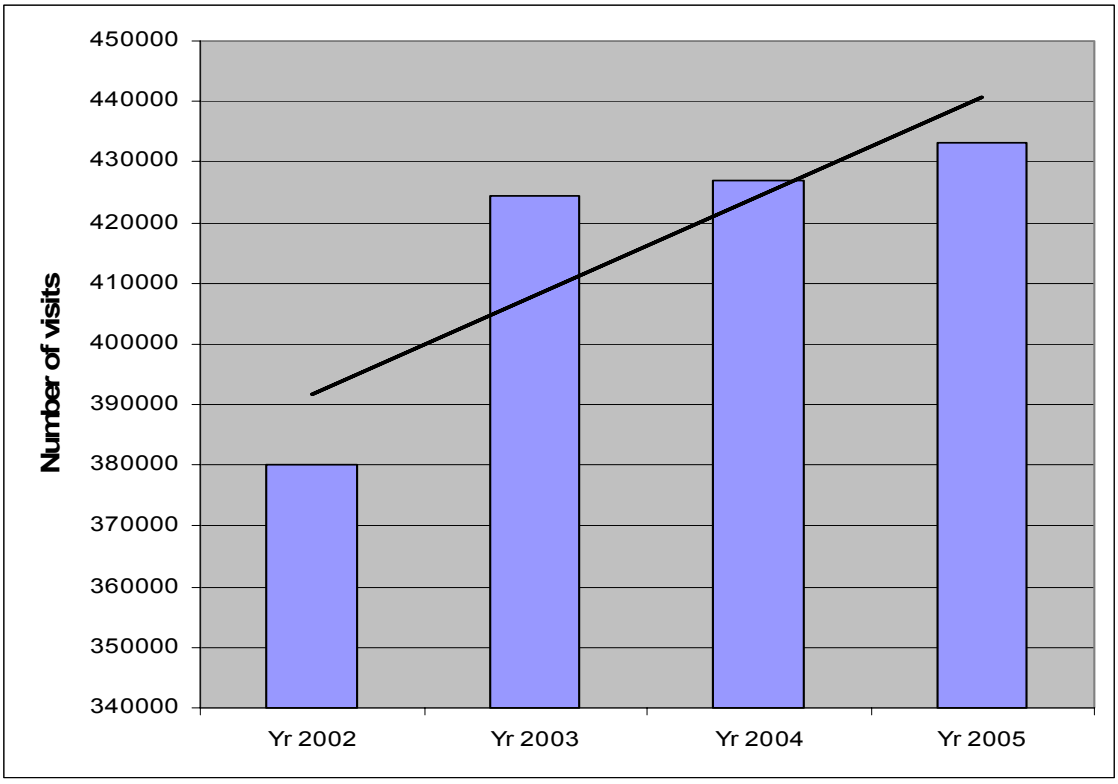
Outcomes of interventions

Although the grading of PHC facilities is a provincial policy, the Botshabelo community health centre complex used an aggressive approach to promote the concept by educating the community about the new system, upgrading

equipment and infrastructure to support services, training staff on services provided in the grade level of the facility, and planning a shuttle system to ease referrals to other grades. It also created a conducive environment for coordination by ensuring that all the PHC facilities, including the hospital, play an active role in the implementation of this system.

The strategic aim of this initiative is to ensure that patients start to seek care at the lowest level of health care delivery – the PHC facilities. This move will ensure that patients with minor ailments will be seen and treated at primary health care level and referred to district hospital for higher level or specialised care. If the system is working, one of the indicators would be increased numbers of patients seen at PHC level and decreased numbers of outpatient department (OPD) patients in the hospital.

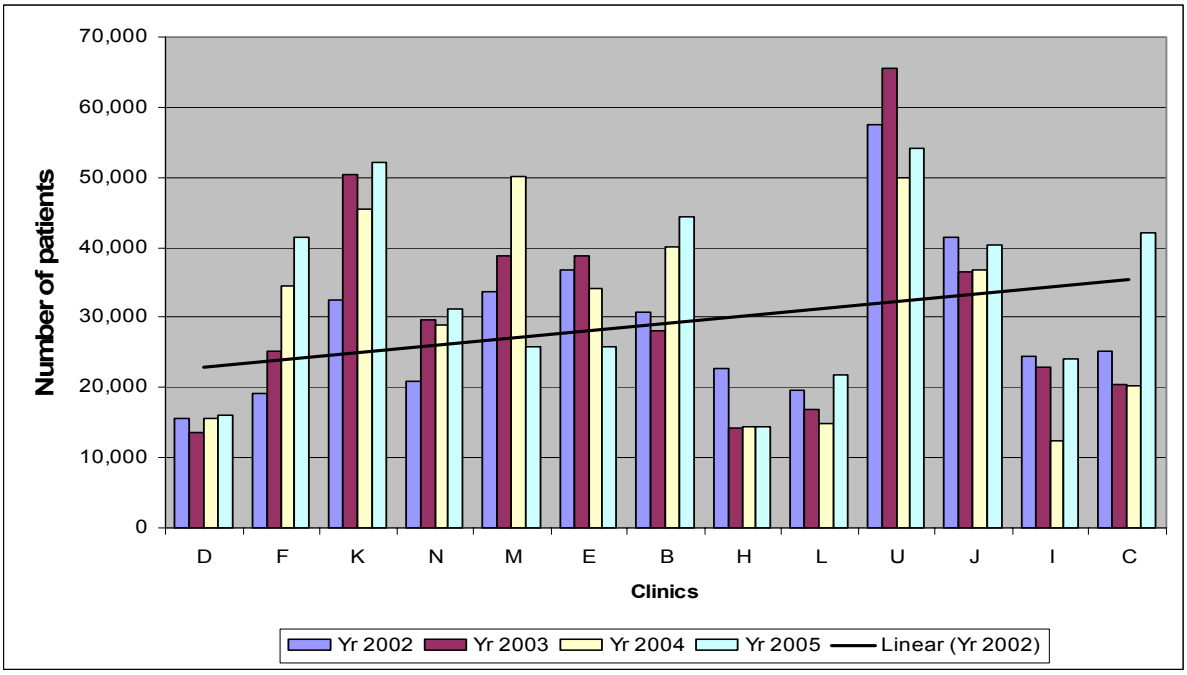
Figure 4: PHC Head Count 2002-2005



We reviewed facility utilisation since 2002 for PHC facilities. Figure 4 above indicates that there has generally been an increase in the utilisation of PHC facilities. In 2002, 380,064 visits were made to all 13 facilities in the complex, exclude mobile units. In 2005, the projected number of visits in all these facilities is estimated at 433,367 – an increase of about 12% since 2002.

We also reviewed records to determine if there were shifts between the graded facilities in the complex. This revealed that each facility was unique, as shown in Figure 5 below. At some clinics - for example, D, H and L – the number of visits has remained constant, whilst clinics F, K and B have seen an increase in patient visits. In clinic E there has been a general decline in the number of patient visits. These variations may be better explained by in-depth research into the utilisation of facilities. This review can not provide answers for such variations, as it was not within its scope.

Figure 5: Botshabelo PHC Complex Head Count 2002-2006

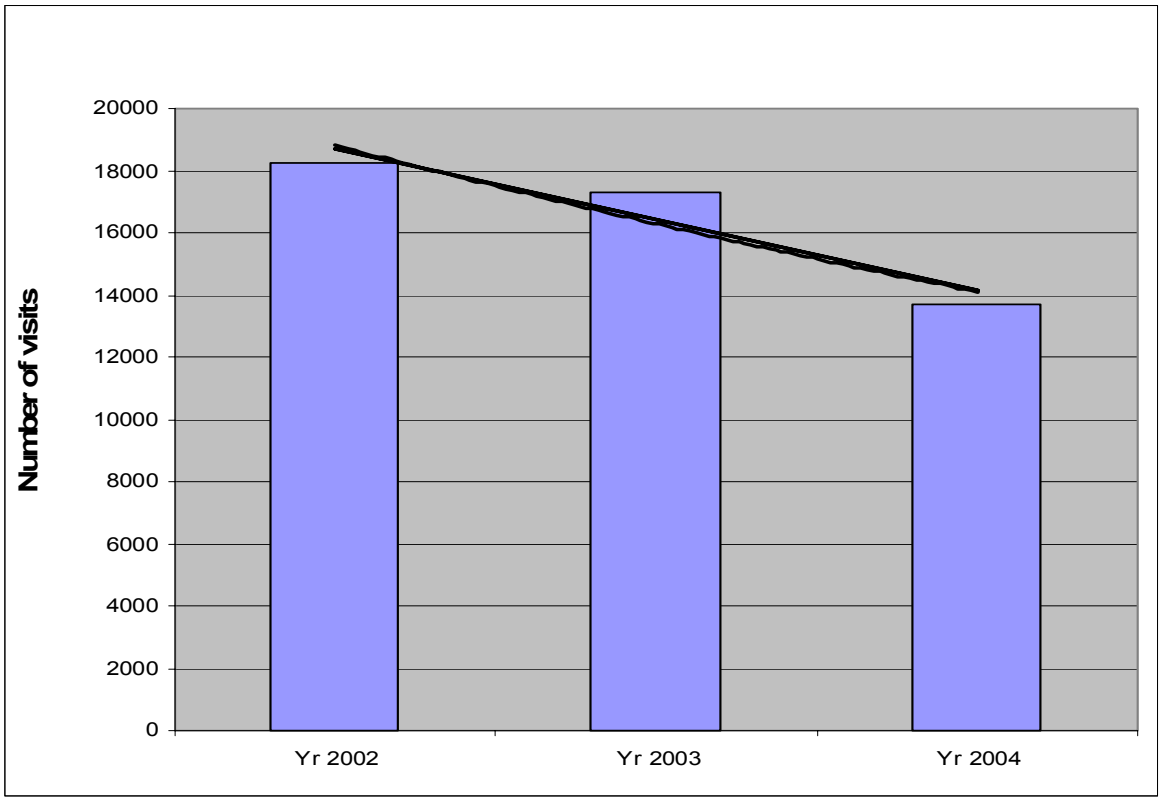


However, it should be noted that not all Grade 2 clinics have the same number of feeder clinics. For example, clinic B has 3 feeder clinics, M and J have two, K has one and U has none. In addition, less than 500 meters from Clinic M is a Roman Catholic centre which provides minor ailment services and ARV services to the community. The centre also has doctor visits for patients on ARVs.

In general, the Grade 2 clinics (except clinic J) have seen an increase in the number of head count visits since 2002, although this might fluctuate from year to year. The fluctuation may be attributed to numbers of referrals made to these clinics by their feeder clinics.

We also reviewed the district hospital outpatient head count data. In the hospital outpatient data we were only able to access data from 2002 to 2004. We found a marked decrease in outpatients numbers, from 18,245 in 2002 to 17,293 in 2003 and 13,368 in 2004 (see Figure 6). Similarly, the number of outpatients seen by a doctor in the OPD also decreased from 15,933 in 2002 to 14,466 in 2003 and 10,395 in 2004. This represents a 15% drop in the number of outpatient visits and patients seen by a doctor at OPD between 2002 and 2004. The decrease may be attributed to the referral system operated by the complex.

Figure 6: Hospital Outpatients Headcount 2002-2004



The figures suggest that the referral system is functioning well in the complex and that the support provided by DCI to this complex has positively contributed to the functioning of the system. It is important to note, however, that there is a need to closely monitor the trends overtime and to improve both the communication between the PHC facilities and the hospital as this was found to

be somewhat lacking as such information is not frequently shared by managers of the facilities.

Table 13: List of Items Purchased by the FSDOH for the Community Health Centres Complex

Item description	Total purchased	Item description	Total purchased
Diagnostic sets (portable)	45	Episiotomy scissors	20
Diagnostic sets (wall mounted)	18	Footstools single	10
BP machines (portable)	45	Patients trolleys	13
BP machines (wall mounted)	6	Patient carriers vehicles (Condors)	8
Instrument trolleys	10	Sedan vehicles	11
Linen carriers	2	LWB LDVs vehicles	4
Patients lockers	6	Motorbikes	1
Examination couches	5	Mobile capsules	4
ANC mattresses	32	Printers	25
Maternity beds	5	Computers	26
Maternity mattresses	10	Software	25
Poison lockers	2	Fax machine	9
Incubators	2	Photocopier	0
Infant resuscitation machines	2	Name boards	13
Ultrasound sonar machines	1	Service package boards	13
Foetal doplers	13	Road signs	0
Glocotrend II meters	35	Household fridges	4
Oxygen regulators	25	Immunisation fridges	13
Oxygen humidifiers	35	Polishers	10
Gas cylinder trolleys	16	Stoves	5
Suction apparatus	13	URNS	14
Placenta scales	5	Heaters	35
Kidney dishes	30	Wheel chairs	13
Bowls	40	Heavy duty staplers	10
Surgical scissors	10		
Needle holders	20		
		Total items	**745**

Facilities managers' views on CHC complex implementation

As part of the review all 13 PHC facility managers and two complex clinic supervisors were interviewed to determine what value, if any, has been added by the programme and what changes have been brought about. This exercise was also done to review some of the interventions reported to be implemented in the complex, including the introduction and implementation of a supervisor's manual, the integration of PHC services in the whole district, and the implementation of the referral system.

It was clear that the supervisor's manual was introduced and is being used by supervisors and PHC facility managers in the complex. Most of the managers (13 out of 15) reported having seen a copy of the manual in the clinic; the two who were not sure about the existence of the manual were acting as managers of these facilities on the day of our visit. Of the 13 who had seen the manual, eight indicated that they were trained on how to use the manual and have found it easy to use. They also reported that the manual is a useful tool for managing PHC facilities: they cited the usefulness of the manual for detecting problems in the facility early and noted that it gives suggestions on corrective measures to be taken for problems identified. It was also said that the manual provides useful guidelines for facility managers on procedural issues when running a health facility. Overall they have found the manual to be practical and note that it allows active interaction with supervisors. It also promotes best practice.

Most of the managers (10 out of 15) were aware of efforts to strengthen functional integration in the Mangaung local area. They were aware that the district operates under one district management and that there were technical task teams that were dealing with human resources, budgeting, support systems, integration, HIV and AIDS and quality assurance. There seems to have been an effort from the district to ensure that facility managers and supervisors understand the importance of integration by making sure that facility heads know and understand the functions and responsibilities of structures at district level.

The referral system was the most visible intervention in this programme. A number of systems were reported to have been put in place during the introduction of this system. This included the grading of facilities, production and distribution of referral pamphlets, and introduction of a patient shuttle system. Almost all the facility managers, apart from one supervisor, did not know about the shuttle system and how it should operate. This was also in line with the briefing provided by the sub-district manager and programme manager, who indicated that facilities have not been informed about this system.

However all facility managers knew about what was expected to be achieved with the shift to grading facilities and introducing the referral system. The facilities are educating patients and distributing the referral pamphlets. However, there was a divided feeling about the usefulness of the systems. Some facility managers felt it has been useful in that it has taught patients not to go directly to the hospital and that doctors are now always available in the clinics. Those who saw the system as problematic made reference to inconveniences caused to patients by the system, such as not thinking about how to deal with patient files, and to the fact that this system is open to misuse by patients.

IV. Capacity building for NGOs providing services on HIV & AIDS

This component focused on developing the organisational capacity of NGOs providing HIV and AIDS prevention and care services in the Free State. It was designed to address challenges experienced by the Department of Health in partnering with local NGOs around service delivery. While the Department relies on NGOs throughout the province to render key services in information education and communication (IEC), community home-based care (CHBC) and other areas, experience has shown that many NGOs have limited capacity in proposal development, financial management, project management, reporting and other key organisational competencies necessary for the effective management of external financing and delivery of services to the community. There are also NGOs that wish to become more involved in delivering HIV and AIDS services – or which are located in areas where the Department of Health is seeking NGO partners – but which do not possess the essential skills required to ensure accountability and effective service delivery.

The approach adopted by the programme was to strengthen the strategic and managerial capacity of 150 NGOs across the Free State through a capacity-building programme of training and mentoring activities. The outcome of the component would be strengthened NGO capacity to deliver services effectively and to account for the use of financing. It was also hoped that the partnership between the province and NGOs would be strengthened, resulting in improved responses to HIV and AIDS demands at community level.

The original component objectives were:

- Development of a best practice guide (manual) for NGOs
- Training of volunteers from 150 NGOs in basic principles of organisational management, financial management, human resources management, and project management
- Mentoring of 150 NGOs in organisational management, financial management, human resources management, and project management
- Compilation of an NGO policy document for the Department of Health

The plan to implement this component was structured in phases, with responsibility for the capacity building activities awarded by tender to a consortium of service providers led by PriceWaterhouseCoopers. The initial plan envisioned an eight-phase process to be completed by December 2004.

During the extension period January-June 2005, additional activities were incorporated into the component – some implemented by the service provider consortium led by PriceWaterhouseCoopers, and some implemented directly by the Department of Health. In the extended plan, these objectives included:

- Training of volunteers from 30 NGOs in basic principles of organisational management, financial management, human resources management, and project management ('refresher course')
- Mentoring of 30 NGOs in basic principles of organisational management, financial management, human resources management, and project management
- Training of 20 NGOs as master trainers
- Development and marketing of the provincial NGO policy
- Empowering NGOs to have access to computers
- Empowering all participating NGOs with organisational development skills

Component implementation and achievements

Between 2002 and end 2004, this component of the programme met its intended objectives of providing capacity-building services to 150 NGOs in the province. The programme extension in 2005 incorporated additional elements of capacity building, including preparing representatives of 13 NGOs to serve as master trainers in the province, inviting selected NGOs from the programme to attend a 'refresher course' of training, providing computers to 30 NGOs that previously had no access to them, and providing training on financial sustainability.

The NGO capacity building was implemented through a two-stage process. Seventy-five NGOs underwent the two-part training in year one of the programme, and an additional 75 underwent the same training in year two. First, representatives from participating NGOs attended a five-day basic training course that covered management skills, project management, human resource management, and tax and financial management. The content of this training was based upon the material contained in a 350-page

'Best Practice Guide for NGOs,' which was given to each participant for use and future reference. Lectures delivered in Bloemfontein were broadcast through the iCAM system to participants at regional training centres throughout the province. Classroom assistants were present to assist in relaying questions and clarifying material as necessary. Lunch was provided, but participants had to cover their own travel and/or accommodation costs.

Second, in the months following the iCAM training, representatives from the Consortium visited each participating NGO six times in a series of face-to-face 'mentoring visits' designed to ensure that the NGOs were applying the principles covered in the initial training session. The visits began with an operational assessment of each NGO (organisational systems, policies in place, infrastructure, etc.), followed by mentoring and compliance testing in key areas including human resource management, cash book/financial management systems, management skills, and project management. During the sixth visit, each NGO was assessed in these core competencies. NGOs that achieved 70-80% or higher[1] on the evaluations were considered to have completed the training successfully and received certificates.

A summary of the phases, activities and completion dates for the component is included in the table below.

Table 14: Implementation Phases of NGO Component

Phase Number	Responsible for Delivery	Activity	Completed
1	Consortium	Compilation of Best Practice Guide for NGOs	November 2002
2	Consortium	Training of first 75 NGOs	November 2002
3	Consortium	Mentoring of first 75 NGOs	June 2003
4	Consortium	Review of expenditure and of project	
5	Consortium	Compile NGO policy document	October 2003
6	Consortium	Training of second 75 NGOs	August 2003
7	Consortium	Mentoring of second 75 NGOs	June 2004
8	Consortium	Review of expenditure and of project	
Extension 1	Consortium	Preparation of manuals for Train the Trainer	March 2005
Extension 2	Consortium	Refresher course for 30 NGOs	March 2005
Extension 3	Consortium	Train the Trainer course	March 2005
Extension 4	Consortium	Progress report	May 2005
Extension 5	Consortium	Mentoring visits for 30 NGOs	July 2005
Extension 6	Consortium	Mentoring visit 1-3 progress report	June 2005
Extension 7	Consortium	Final report	August 2005
Extension	Department	Market and promote NGO policy	June 2005
Extension	Department	Provision of computers to 30 NGOs	May 2005

[1] 75% or higher during the extension period in 2005.

Table 14: Implementation Phases of NGO Component

Phase Number	Responsible for Delivery	Activity	Completed
Extension	Department	Financial sustainability training	September 2005

Table 15 below summarises the number of NGOs and NGO representatives that were reached during the various phases of the project, the levels of attendance among invited NGOs/individuals for each phase of the project, and the levels of competence achieved.

Table 15: Reach, Attendance and Competence in Key Capacity-Building Components

Activity	Total # NGOs trained	Target	% competent	Total # individuals trained	Total # individuals expected	% competent	Attendance
Training of first 75 NGOs (Nov 2002)	71*	75	N/A	125	255	N/A	89% of invited NGOs attended
Mentoring of first 75 NGOs (June 2003)	76‡	75	19% completed 'successfully' 40% completed and 'on track'	N/A	N/A	N/A	Average 61% attendance at all mentoring sessions
Training of second 75 NGOs (Aug 2003)	81†	75	N/A	248	344	N/A	95% of invited NGOs attended
Mentoring of second 75 NGOs (June 2004)	77	75	16% completed 'successfully' 44% completed and 'on track'	N/A	N/A	N/A	Average 70% attendance at mentoring sessions
Refresher course for 30 NGOs (March 2005)	18	30	N/A	36	60	N/A	60% of invited NGOs attended
Train the Trainer course (March 2005)	13	14	N/A	24	28	30% in first assessment 50% after second assessment	93% of invited NGOs attended
Mentoring visits for	34	30	50%	N/A	N/A	N/A	Average

Activity	Total # NGOs trained	Target	% competent	Total # individuals trained	Total # individuals expected	% competent	Attendance
30 NGOs (July 2005)			completed 'successfully' 76% completed and 'on track'				80% attendance at mentoring sessions

[*] *Year 1 training: 67 of 75 invited NGOs attended and 4 uninvited NGOs attended. Total=71*
[‡] *Year 1 mentoring: A total of 76 NGOs were reached in some way by the mentoring, but the number that actually completed the full cycle of mentoring appears to be 30, according to Year 1 report from service provider consortium.*
[†] *Year 2 training: 71 of 75 invited NGOs attended and 10 uninvited NGOs attended. Total = 81*

Participation Rates

As the above table shows, the component met its objective of capacitating 150 NGOs, although this did not occur strictly as planned – i.e. two cohorts of 75 NGOs taking part in training and mentoring in each of two years. During each phase of the project, some invited NGOs did not attend training or mentoring for various reasons, while other NGOs that were not invited did in fact attend. There were significant challenges around attendance rates (discussed further below) and it is therefore difficult to state exactly how many NGOs were capacitated through the various phases of the project, but 152 NGOs completed the five-day iCAM training and 70 NGOs (30 in Year One and 40 in Year Two) completed the full cycle of mentoring visits.

In terms of the five-day iCAM training, if targets were met in terms of the number of organisations trained, expectations were not met in terms of the number of individuals from these NGOs that were trained. During year one, 255 individuals were expected and only 125 participated (49%), while in year two 344 were expected and only 248 were trained (72%). Overall, 373 of 599 – or 62% - of the individuals who were expected to attend the training participated. It should be noted that individual attendance during year two of the programme was significantly higher than in year one, which likely reflects the redoubled efforts made by the PWC Consortium and the Department of Health to ensure higher levels of take-up among participating NGOs during year two.

Attendance at mentoring visits was not consistent, with perceptible fall-off in attendance over the course of the six visits. During year one, there was an average of 61% attendance over the course of the mentoring visits, ranging from a low of 56% during visits four and five to a high of 69% during visit three. During year two, there was an average of 70% attendance at mentoring visits over the six-visit cycle, ranging from a low of 54% during visit five to a high of 80% during

visit three. Attendance rates during the 'refresher course' in 2005 were higher, with an average of 80% attendance. As in the case of the five-day training, attendance rates at mentoring visits increased from year one to year two (and into the extension period), again reflecting the efforts made by the Consortium and the Department to ensure higher rates of participation among NGOs.

Competency Rates

The capacity-building programme delivered by the PWC Consortium included institutional competency assessments at the end of the mentoring visits and individual competency assessments at the end of the 'train the trainers' session.

The institutional competency assessments were designed to evaluate the extent to which NGOs understood and had implemented key elements of the training programme. Organisations which received 70-80% or higher were deemed to have successfully completed the training and were considered qualified to receive and manage funding from the Department of Health. Nineteen percent of the NGOs met this standard (70%) in year one and 16% met it (80%) in year two. Fifty percent of NGOs in the 'refresher course' (2005) were deemed competent.

Certificates of competence were given to candidates in the train the trainer session who got an average of 50% or more on the training. Among the 24 participants at the train the trainer session, 30% received certificates of competence during the first assessment. A re-assessment opportunity was offered to those candidates scoring between 40% and 50%. A higher pass rate during this second assessment pushed the overall competency rate among trainer candidates up to 50% overall.

Component Review

The mid-term review conducted in 2003 concluded that, overall, the component was well-managed and on track. A tender process had resulted in the appointment of a consortium led by PriceWaterhouseCoopers, and also involving Marang and Gobodo, to deliver the training and mentoring services to NGOs. A best practice manual had been developed, the first 75 NGOs had undergone the training via iCAM, and the first mentoring visit (of six) had been undertaken. The mid-term review also noted that appropriate management and monitoring systems were in place, including regular meetings between the Department of Health and the PWC Consortium.

The review also made a number of recommendations about how to address emerging challenges within the component. These are overviewed in the table below.

Table 16: Recommendations Emerging from Mid-term Review

Challenge	Recommendation
Difficult to work with NGOs because of high turnover rates, large number of volunteers and difficulty with communications	Consortium and Department need to be patient and persevere in their dealings with NGOs
Varying levels of education and English proficiency among NGO participants	Translation of training manual into SeSotho. Continued use of class facilitators at iCAM sessions.
DOH not actively involved in the training and capacity building provided by Consortium. NGO coordinator position vacant at time of mid-term review.	Province to designate an official to be responsible for the component to ensure full involvement of DOH and to contribute to sustainability of component. Greater involvement of district coordinators.
Attendance by NGOs at training sessions lower than desired. Concern that the 'right' people may not be attending from NGOs.	All nominated NGOs should attend training and should send management-level representatives.
NGOs requiring different levels of training are being trained through the same approach.	NGOs should ideally be categorised and targeted for training on the basis of their experience, capacity, structure and functioning.

The final programme review, conducted in October 2005, involved interviews with the component manager at the Free State Department of Health and site visits and interviews with ten NGOs in Bloemfontein, Botshabelo, Kroonstad and Wepener that took part in the capacity building activities between 2002 and 2005. It also included a careful review of reports prepared by the service provider consortium for the Department on the progress of the programme. Main findings from this review are presented below.

Reflections on training content and process

Most but not all of the NGOs visited during the review had participated in the five-day introductory training and the cycle of mentoring visits. In one instance, the respondents had no recollection of a five-day training course, but had been visited by PWC Consortium representatives for mentoring visits. In another case,

the respondent could only recall one day of training followed by a mentoring visit on financial management. There are various possible explanations for this inconsistency in participation, which runs as a thread throughout the component. It is possible that non-attendance is related to high personnel turnover within many NGOs (e.g. different people attended different parts of the training) or to the difficulties in logistics and communication experienced by the Consortium in dealing with NGOs. However it should be noted that based on the small sample visited in this review, not all organisations appear to have completed the full cycle of training as outlined in the project documentation.

Training Course. Concerns were raised by several respondents about the use of iCAM as a mode of instruction. Among the problems raised were the lack of interactivity (difficult to ask questions and to hear questions being asked in other sites), difficulty with audibility in some of the venues, low levels of concentration among participants, cramped conditions, and challenges related to English being the sole medium of instruction.

Box 8: Comment from NGO representative about iCAM

"The iCAM system made it cheaper for the Department, but it made it less positive for participants. I was there, I've seen it myself – people couldn't concentrate on it. They enjoyed the lunch, rather than the content of the sessions."

Respondents from one organisation, who attended the first cycle of training in 2002, said that there were so many complaints following the iCAM training that the organisers 'changed the system' and held follow-up workshops with face-to-face instruction. Although this version of events was not corroborated in the interview with the Department of Health, it was acknowledged by both the DOH and the PWC Consortium that a number of technical difficulties were experienced with iCAM during year one of the training in particular, and that this led to the introduction of class assistants who assisted with the technology, with translation into SeSotho where needed, and with clarification of material and content on site.

Still, despite these changes, the general sense from respondents is that the iCAM-based training was not as accessible and valuable as the mentoring visits which followed. A number of respondents mentioned that 'people attend training for the free lunch'. The fact that NGOs needed to cover their own transport and accommodation costs to attend the training may relate to the fact that fewer people participated per NGO than were invited.

Best Practice Manual. All but one of the NGOs visited in the review had received copies of the Best Practice Guide (manual) provided at the training

session. Respondents were unanimous in expressing that the manual had proved to be very useful in their daily work. In several instances the manual was prominently visible in the NGO offices, suggesting regular use. Some organisations saw the need for the manual to be translated to SeSotho for easier use for people who are not that literate in English. Others noted that, although comprehensive, the depth of information in the manual was limited and that more detailed sub-sections or follow-on volumes on project management, for example, would have been useful.

Mentoring Visits. In contrast to the more mixed assessments of the five-day introductory training, the mentoring sessions were found to be useful by most organisations. The respondents mentioned that the sessions were more interactive; could be conducted in SeSotho, which helped in working through more complex material; and allowed for more in-depth clarification and chance to ask for more information where necessary. Respondents saw the mentoring sessions as an opportunity to evaluate and test the knowledge that was acquired during the training sessions.

Despite generally positive reviews, however, respondents noted some concerns about the process. The trainers provided by the PWC Consortium did not, for the most part, have an understanding of community organisations, HIV and AIDS, or development issues and in this sense could not 'relate' to the context in which the NGOs work. One organisation noted that there was a high turnover of trainers during the mentoring visits – 'different faces' – which meant that each new trainer would have to be brought up to speed with the organisation and what had already been covered in previous visits. In one instance, the trainer sent to work with the NGO on financial management did not know how to use the Excel spreadsheet provided by the Consortium at the training and was therefore unable to trouble-shoot the problems the NGO was experiencing in its use.

Some organisations expressed the wish that the mentoring visits had been longer, noting that the trainers did not have enough time to spend at the NGOs because they were visiting more than one organisation in a day. This points to a discrepancy between the project documentation, which indicates two-day visits to each participating organisation, and the findings from the review that most mentoring visits lasted several hours or half a day at the most.

Train the Trainers. Two of the NGOs visited in the review had sent representatives to the train the trainers session (held during the extension period in 2005), having been selected by the Consortium as among 14 NGOs province-

wide that, on the basis of their capacity and experience, could assist the Department in capacitating smaller organisations in their districts. The process used to recruit participants for this session was criticised by one of the organisations that noted the poor performance of the participants – only 7 of 24 participants (30%) were deemed competent in the initial assessment, raising questions about both how they had been identified and their ability to train others in the material.

Box 9: Comment from NGO Representatives on Usefulness of the Training

"The training was useful. It taught us how to do things: budgeting, how to handle finances, how to develop, how to become a better organisation."

"It was very, very good. It was interesting….It's changed our thinking capacity. It empowered us."

The organisation noted that the Consortium had directed generic invitations to the chairperson or secretary of selected NGOs to send two representatives to the training, rather than hand-selecting promising individual candidates. One result of this approach is that, due to high turnover of staff among NGOs, the individuals sent to the training may have been new to the organisation and may not have undergone the initial cycle of training, meaning that they were essentially starting 'from scratch' during the train the trainer workshop. In other cases, local-level internal organisational politics may have determined who was sent to the workshop. They noted instances of people 'taking their girlfriends' and treating the workshop 'like a vacation for a week.'

Application of the training

Box 10: Comment from NGO Representative on Usefulness of the Training

"I think we are working much better than the way we were two years back or three years back. In 2000 when we started, our idea was just helping people who were infected - getting the money and doing to the job. We did not go to the nitty gritties in terms of how to fund a structure as an NGO, the reporting mechanisms, and even how to handle ourselves. We did not care much, but now we are taking everything serious."

Most of the respondents interviewed felt that the topics covered in the training programme were appropriate and relevant to their work. The mentoring sessions were highlighted as a useful and practical follow-on to the five-day introductory training. Respondents noted using the manual as a reference in developing organisational policies or in solving certain organisational challenges.

Organisational structure and governance. All the organisations visited had executive or management committees in place and the committees seemed to be meeting regularly – usually once a month. The role of these committees includes functions such as financial reporting, approval of planned expenditure, feedback

on the organisational activities, monitoring of activities against the business plans, and general organisational planning.

The composition and functioning of these committees differ depending on whether the organisation is a consortium of member organisations (i.e. as per the DOH NGO policy) or an individual entity. In the case of consortia, which are more complex organisationally, activities are often structured into programmes or 'clusters' – e.g. home-based care, IEC – and cluster heads or coordinators sit on the executive committee. In other cases, member organisations forward one representative to sit on the consortium's executive committee. Individual member organisations also have their own executive or management committees which meet regularly and focus on the same types issues as that of the executive committees of the consortium. In one instance it appeared that this organisational-level management committee had become more or less defunct, but in all remaining cases these governance structures appeared to be operational.

Following the training, some of the more established organisations had constituted an external Board of Directors, comprised of professionals and community stakeholders, to meet twice yearly to review the organisation's work and strategic direction. One organisation had begun with a management committee and moved on to a Board of Directors. They felt that this helped them in fundraising, since they were now able to explain the way their operations are structured and their proposals are 'more in line with what funders require.' This organisation had succeeded in upgrading and diversifying its funding base to include support from the National Department of Health, as well as from United Nations and international NGO donors. The chairman noted, 'If it weren't for that training, I don't think we'd be where we are now.'

Financial management. The financial management component stood out for most of the organisations as one of the most useful elements of the training. The PWC Consortium provided NGOs with an Excel-based financial management

programme or a manual cash-book system in the case of organisations without access to computers. This system appeared to be relevant to the work of most of the organisations and was assisting them to produce financial reports, including income and balance statements and petty cash registers. All organisations currently receiving external funding were using or intended to begin using an electronic financial management system. One organisation that had experienced difficulty with the Excel-based spreadsheet was using a different computerised system (Pastel).

Organisations were asked to explain the financial procedures they employ, and each one was able to do this in detail. Organisations appear to have in place procedures for approving expenditures, cheque requisitions, multiple signatories for cheque issuance or cash withdrawals, documentation and capturing of expenses, and monthly financial reconciliation. Some organisations with larger annual budgets employ a part-time bookkeeper to oversee accounts, while many (if not all) organisations undergo annual audits to produce audited financial statements.

Box 11: Comment from NGO Representative on Usability of the Financial Management System

"The system has its own codes, its own ledgers, its own income and expenditure – it is easy to understand. It is not difficult."

Several respondents reflected upon the difference in their approaches to finances before and after the training. According to one: "[Before] one would just say, 'I want to do this programme today,' without following the right procedures in terms of cheque requisition, asking money in advance and reporting and the like. Petty cash – we did not know how to handle petty cash." The treasurer of another organisation said, "Speaking about me, I did not know how to balance the books." Among almost all the organisations interviewed, there was a very clear and proud sense of organisational accountability that appears to have been encouraged by the smooth functioning of the systems promoted in the training. The financial systems appeared to be well-integrated into general organisational functioning – e.g. monthly financial reports would be produced and discussed at executive or management committee meetings.

The reviewers encountered only one case where it appeared that the financial systems taught in the training had not been employed, or that procedures had not been observed correctly. The organisation in question was struggling to produce audited statements for a R120,000 grant it had received to implement a specific project. A report had been submitted to the funder, but without the audited financial statement, the report could not be accepted and the project

couldn't be closed out. This appeared to be harming the organisation's chance to receive follow-on funding.

It should be noted that several of the NGOs visited did not have their own computers. While some of these had access to computers either through their consortium or via other arrangements, others did not. Difficulty with access to computers must be emphasised as an obstacle to the implementation of the proposed financial system.

Organisational policies and human resource management. The training programme worked with NGOs to develop and implement a range of internal policies, including financial procedures, organisational procedures (use of equipment and telephones, working hours, etc.), codes of conduct, disciplinary codes, job descriptions, employment contracts, leave policies, and other guidelines regulating human resource issues. This appeared to be the least consistently implemented area of the training. While some organisations had quite comprehensive policies in place and were able to show these to the reviewers, a number of organisations had few or no policies in place at the time of the review. The most commonly developed policies were in relation to finances, terms and conditions of employment, and job descriptions.

Although this area may not be as consistently implemented as others, it was apparent that the 'Best Practices' manual was a clear help to many organisations in developing what policies they did have in place. When asked how they went about developing their policies, almost all organisations cited the manual; some had consulted additional resources such as the Internet or the government gazette. Among organisations that were still intending to develop certain policies, it was evident that the manual would be the first point of reference. This provides further evidence that the manual is seen as a useful, accessible tool to many of the NGOs.

Human resource issues emerged as complex and challenging areas for NGOs and it appears that the training was a useful starting point for them – even if the training was unable to address the full spectrum of issues. One respondent noted that, 'The training makes a difference. The way we used to control things was not good. For example, there didn't used to be systems for tracking people who take time off…. Now we are aware of requirements for funeral or home leave for staff. The labour relations component was useful.' Another organisation which had recently completed the training commented that they learned a lot through the human resources component: 'Through that we learned – because we are dealing with volunteers – and through that we learned the legal implications of

human resources.' Another organisation noted that the mentoring session on human resources 'helped the organisation employ the right people based on qualifications and competencies,' not friendship or familiarity.

Box 12: Comment from head of NGO consortium on challenges of managing volunteers

"If you pay peanuts, you get monkeys."

The issue of managing volunteers emerged repeatedly as a fundamental challenge for NGOs. Very few NGOs can afford to pay full-time staff and utilise networks of up to 80 volunteers – some of whom may receive stipends and some of whom do not. A common observation is that volunteers want to be remunerated for their work, and when funding is not available, it undermines volunteers' commitment and reliability. NGO consortia that rely heavily on their member organisations' volunteers (including volunteer 'team leaders' for fairly large-scale project implementation), struggle to manage them, because they have no direct authority over the volunteers who are affiliated to the individual member organisations. In cases such as these, codes of conduct and disciplinary policies are of limited usefulness.

Project planning, project management, monitoring & reporting. Most organisations interviewed have strategic or business plans that guide their activities and allow them to track progress against their overall budgets. In some instances it appeared that these plans may be overdue for updating and review, but in the majority of cases it seemed evident that business plans were an integral part of organisational operations.

Box 13: Comment from head of NGO consortium on value of quarterly meetings at Department of Health

"You can also move – you can grow. Look at your peers – they've done it. They've started from scratch and this is where they are."

In the case of NGO consortia, the drafting of a business or strategic plan is a joint effort involving all the member organisations (or cluster heads for programme areas). The member organisations or clusters draw up their own plans with budgets and time frames and submit them to the executive committee, which consolidates them into an overall work plan. Once approved and funded, this plan guides the allocation of funding to member organisations/clusters on a quarterly basis.

The business plan is the framework against which activities are monitored and progress evaluated. Programme coordinators or cluster heads report on progress during executive committee meetings. Some organisations have developed on-going systems for monitoring that volunteers are delivering the services they are meant to be delivering. Volunteer caregivers working for one organisation keep

notebooks where they record all the activities they undertake – these notebooks are submitted regularly to the chairperson of the consortium who checks in with patients to ensure that the visits happened as reported. As the chair commented: 'I send my spies also. Because the problem is that I've signed for the funds….If they don't do the work, I'm paying them, I'm having a problem.'

Written reports are submitted to the Department of Health on a quarterly basis, according to a prescribed format. NGOs are also invited to attend quarterly report-back meetings at the Department where they can present their progress and learn from the work of other organisations. These meetings were regarded as valuable by many respondents.

Discussion

Management

The management and planning of the programme was based on a sound strategic intention. The activities of this programme fit well with the goal of strengthening the overall health system in the province. It is clear that the programme started very slowly. There are a number of reasons for the slow start of the programme. These include:

- Inactive steering committee which was critical for creating an enabling environment for the programme to be seen as addressing high priority issues in the province, thus giving the programme a visible status.
- There were a number of changes that took place in the management of the components, as initial managers of these components did not take active steps to accelerate the implementation of planned activities.
- The complexities and sometimes frustrating procedures for transferring funds between government structures were not taken into consideration from the outset to allow time for setting up systems before implementing activities.
- The unsynchronised financial years between the funding agency (DCI) and government created planning, implementation and logistical problems for component managers. This issue needs to be addressed at the outset with the financial section of the Department. This would allow the programme to function normally, even if the government financial system is halted.

It is clear, however, that the provincial management was committed to ensuring that the programme was implemented in accordance with the priorities of the province. This is evident in some of modifications made to the initial plans of the programme over the course of its lifetime. Apart from the changes made, the

Steering Committee took it upon itself to ensure that they request extensions when it was clear that they would not complete the activities on time. They also developed clear and feasible plans to ensure that activities were implemented within the proposed time frames. The management in the province planned and implemented effective interventions to address both systemic and management issues relating to this programme. These included:

- Re-constituting the Steering Committee and giving the General Manager of the Southern Free State Region the responsibility of heading the Steering Committee. This actuation improved the visibility and perceived commitment of the committee by the component managers.
- The secondment of a full time programme manager. This was the most important intervention to fast track implementation of the programme. The programme manager was able to take charge of the overall implementation and provided support to the component managers to deal with most of the systemic challenges of the programme.
- The active involvement of the finance section in both the steering and operational committees provided needed support to ensure that the Department aligned the financial management system of the programme to the provincial system.

Management lessons that can be derived from this programme include:

- If a steering committee is created, it must be part of the provincial senior management committee. This means that issues relating to the programme are discussed at the most senior level in the province.
- Programme plans and activities must be integrated, from the outset, into the relevant provincial programme plans. This means, for example, that activities related to human resource development or NGO support must not be seen as donor-funded 'add-ons,' but rather as part of the overall provincial plan.
- There must be a dedicated person to coordinate programme activities. This person must be appointed and given all the necessary support and decision making powers over the programme, including making decisions on expenditure, revising overall plans, championing integrated planning and setting up and monitoring indicators for programme activities across components or implementing units.
- There must proper financial management and monitoring systems, agreed upon by the donor and province, in such a programme. For the first two years of this programme, time was spent trying to align programme activity expenditure lines with the provincial expenditure guidelines. This made it difficult to monitor accurately the expenditure associated with this programme, as activities of the programme also changed.

Human resource and organisational development

The human resource development component of the programme involved unique activities to be funded by a donor. It was unique in the sense that the training not only focused on skills under the core functions of the Department - it cut across a number of core functions and support activities.

Like all the other components, it also started very slowly with problems in getting tenders through, activities under-budgeted, experimenting with the iCAM system, and difficulties in finding suitable training service providers for other areas. It seems clear that once the tendering process was completed, training commenced smoothly. A lot of effort and investment has been put into the iCAM training system. By the time it started functioning and more studios were installed around the province, training became easy to access and the number of staff enrolled in training programmes grew rapidly.

A significant number of personnel were trained through this programme. By the time of this review, a total of 809 staff had attended training in a number of disciplines funded by the programme. In most of the proposed areas of training, the targets that were set by the province were met, and in some cases they were exceeded. In the few areas where targets were not met, it was largely due to costs associated with the type of training to be used for those activities. In most cases the budgets were set before doing cost analysis for such courses.

It seems gender was considered when selecting staff for training. Overall, the majority of staff trained in this programme were females. It is also important to note that there were more women than men trained in health management, leadership and project management – areas which have traditionally been dominated by males in the health care industry. This deliberate move is also in line with DCI's policy of mainstreaming gender across programmes and activities.

When iCAM started to function better, the Department was able to enrol a huge number of staff. For example, between 2004 and 2005, the department had 794 staff trained, and the majority of them were enrolled in the iCAM training programme. iCAM as a medium of instruction seems to have started to function properly. Although its set up was not part of the DCI funding, the move by the Free State Department to experiment with this medium of training has contributed positively in the capacity building process in the province. It may be time to evaluate this system properly for its efficiency and cost effectiveness. If found to meet these criteria, It may well set an example of an efficient and cost

effective training method that can be adopted by other departments and provinces in the country.

Most of the key recommendations made by the mid-term review in this component were implemented. The iCAM training was scaled up and has been adopted as a viable training method in the province. The component manager has been able to speed up training by contracting parallel training service providers and has seen numbers of personnel enrolled in training grow from 15 in 2003 to 423 in 2004 and 371 in 2005. Un-utilised funds have been used in training more nurses in advanced midwifery, more managers in project management, leadership, customer care and health management. Overall, the recommendations made were implemented successfully.

Botshabelo community health centres complex

The community health centre complex in Botshabelo seems to be a good example for setting up a well-functioning model. The activities funded through the DCI programme have contributed positively in strengthening the Botshabelo community health complex. Most of the activities planned to be implemented under this component were completed, except the operationalising of the patient shuttle system and the mounting of clinic road signs.

The grading of clinics went well: all facilities in the complex were graded and staffed, and equipment to support the graded facilities was purchased and delivered to these facilities.

The referral system was set up and implemented. Promotional leaflets were designed, produced and distributed. These leaflets are written in a local language and are available in all facilities in the complex.

The PHC utilisation figures indicate that a growing number of community members are seeking health care at PHC facilities first. Doctors are always available on the scheduled days and times in all facilities designated to have a doctor visit. The numbers of patients seen by doctors at the hospital outpatient department has been decreasing over the past three years. There are indicators that the grading and referral system is working.

Large billboards with clinic names and boards for service packages have been mounted in all the facilities in the complex. These boards play a crucial role in informing the community about how to take decisions on utilising these facilities. These activities may seem minor, however they play a pivotal role in selling the facilities to their communities. The community has a sense of ownership of these

facilities as they can see their heroes' names attached to facilities belonging to their community.

The number and types of clinical equipment for facilities procured under this programme have contributed positively to entrenching trust by users of these facilities. The most common reasons for communities' failure to use facilities or to bypass PHC facilities to hospitals is a lack of essential equipment to make diagnosis and to arrive at appropriate care for patients. A huge investment has been made in equipment; this has also improved the morale of staff and it may well have created confidence in users of these facilities. The increase in numbers of patients using these facilities may be attributed to availability of equipment in these facilities to deal with common conditions presented to them.

The allocation of the equipment was informed by the decision to grade facilities. We have found that equipment was allocated based on need and function of these facilities – for example, maternity beds and incubators were allocated to facilities running maternity units. The ultrasound sonar was placed at the hospital, as it is the central place that would not restrict access based on the grading principle. There was no other suitable location for such a valuable piece of equipment for pregnant mothers other than the hospital. This applies to instruments that need sterilisation: instead of issuing them to facilities, they were pooled together and can be shared from the CSSD which is responsible for sterilising and keeping such instruments.

Apart from clinical equipment procured under this programme, a number of pieces of support and administrative equipment was purchased. These include computers, printers, fax machines, stoves, and floor polishers. Such equipment is essential in improving the image and morale of staff. All clinic managers felt management cares about them and the conditions in which they are working. In almost all the clinics there were handwritten graphs on utilisation on different services: once they are trained in using computers they will feel empowered to generate these attractive and accurate graphs and reports on their performance.

The procurement of transport to support the complex was completed in time. Transport was requested for a number of functions in this programme. There was transport that was supposed to support outreach programmes in the complex. Four mobiles units were purchased and two are being used in the complex and the other two have been allocated to another sub-district in the district. Although this was not part of the original plan, it indicates a sound decision by the Department management to share resources and to think about rolling out some of the activities to other sub-districts in the province.

The procurement of sedan vehicles may have created a bit of uneasiness amongst managers in the districts and province. Although these vehicles were to be used for supervision and management support, it seems the allocation strategies were not well thought through from the beginning. There needs to be a clear guideline on how to allocate these vehicles; presently they have been allocated as needs and priorities arise. The Botshabelo community health complex managers view these vehicles as belonging to them and they need to be part of decision making or be informed about allocation. This is an indication of lack of clear guidelines on how these vehicles are to be used. In future, if such activities are to be part of a programme, a needs assessment should done first and allocation should be done according to need.

The patient shuttle system has not started operating, although all the required vehicles were purchased two years ago. From a reviewer perspective, although this may be one activity that has not been completed in the component, the delay in moving this activity to finality may be a wise one. The introduction of patient shuttle transport will no doubt enhance the referral system and assist communities to see the value of this system. However, a policy, perhaps with guidelines, is needed to guide its operation.

Capacity building for NGOs

Overall, this component of the programme appears to have had a positive impact upon the operations and management of many of the NGOs which participated in the training and mentoring activities. It is clear that it made a significant contribution to the development of certain NGOs which were particularly 'ripe' for such an opportunity and which, as a result of the training, were able to expand their operations and operate with a high degree of professionalism.

Based upon the observations of the component manager at the Department of Health (who is also responsible for overseeing funding relationships between the DOH and NGOs), and upon the interviews conducted in the field as part of this review, organisations that successfully completed the training cycle are performing better and more professionally in a range of key areas than they were before the training. The Department of Health has observed a positive change in the quality and detail of the financial and activity reports being submitted, in the governance structures in place within NGOs (including NPO registration), and in the ability of NGOs to publicly present on and document their work.

The review suggests that one of the biggest areas of impact was financial management systems. Almost without exception, the NGOs visited had functioning financial systems and procedures in place that regulate all aspects of the use of organisational funding, from approval of expenditures through to monthly budget reconciliations. Given that financial accountability was one of the major areas of concern which this component set out to address, the fact that the financial management systems appear to be understood and utilised by many NGOs should be seen as a significant accomplishment.

The training also appears to have helped NGOs work 'in a more organised way,' as one home-based care NGO commented. The training encouraged NGOs to approach their work in a more systematic and professional manner, including the development of policies and guidelines on key organisational issues, the creation of management structures, and the formation of job descriptions that help everyone within the organisation understand their roles. Although not all the NGOs had a full array of internal policies in place, almost all the NGOs did have some policies in place and regarded them seriously and with pride as tools that assist them to work in a more professional and less ad hoc manner.

The NGOs visited as part of the review ranged from a large, well-established 19-member consortium with an annual budget exceeding R1 million, to small volunteer-driven member organisations providing IEC services with no external funding at present. Across this spectrum of capacities and experience, there was not a single organisation which seemed not to have benefited from the training in some way. However it is necessary to underscore that the relative returns from the training seem to have differed significantly based on the NGOs' stages of development and organisational sophistication.

It seems evident that the better-established NGOs – including those already receiving funding and/or those which had undergone some prior training – reaped greater rewards from the training than did the small CBOs without funding or offices that were being trained with the objective of making them 'fundable.' While the content of the training addressed fundamental organisational building blocks, it did so in a way that was perhaps more appropriate to the already established organisations which were 'primed' to use and absorb the material. For example, at least two well-functioning consortia took significant leaps forward in the time that has elapsed following the training, including graduating up to National Department of Health funding (from provincial), accessing additional sources of funding from private and international donors, and establishing external Boards of Directors. In these cases, it appears that the training helped

these organisations to consolidate their operations, but also to take them to a new level in terms of reach and professionalism.

This stands somewhat in contrast to the experiences of smaller organisations that were either newly established or which had no active sources of funding – and often no office space, computers, or full-time staff. While the training may have exposed such organisations to the operational standards and expectations to which they would need to rise in order to receive funding from the Department, it appears that they might have benefited more from a separate course of training that was more appropriately oriented on their current level of development. As the DOH component manager noted, the less-resourced, less-established organisations tended to be more focused on the challenges of implementing day-to-day work with few or no resources, than on developing systems that – for the time being – remained quite abstract and divorced from their reality. There was difficulty in motivating such organisations to participate in the training, given that they needed to cover their own travel and accommodation expenses and that there was no guarantee that funding would simply 'flow' following the training. Having said this, in all of the NGOs visited, it did appear that there were benefits derived from the training, even if these were somewhat more 'shallow' in the case of groups that were still struggling to establish themselves. Perhaps the Department needs to consider funding training as part of its own NGO funding system to encourage NGOs participation in training programmes.

It is noted that, during the mid-term review conducted in 2003, a recommendation was made about the desirability of segmenting the NGOs into two training tiers on the basis of experience and capacity – largely to address the aforementioned concerns.

Approach to the training

The review suggests that the material covered in the training was relevant and of great practical use to many of the NGOs that participated. The manual was frequently cited as a useful reference and was clearly being employed regularly in the day-to-day operations of a number of the NGOs that were visited. The financial management system, despite some glitches, also appears to have added real value to NGOs' work. The mentoring visits were regarded highly by NGO respondents, although it should be noted that there was a sense that the trainers sent to 'the field' were not well versed in the reality of community-level NGO and CBO work.

It is clear that the iCAM-based training was the weakest link in the overall training programme and that its use in programmes such as these needs to be critically evaluated. Those NGOs that attended the refresher course (where iCAM wasn't used) or who were being trained when iCAM broke down and the training switched to 'manual' mode, were complimentary about the face-to-face instruction provided. It seems apparent that, although more labour intensive and expensive, face-to-face instruction is preferable to the less interactive distance-learning model.

NGO selection, participation and performance

The 150 NGOs that were invited to participate in the programme were organisations that were currently or previously funded by the Department of Health, or NGOs that were un-funded partners of the Department at a district level (i.e. they were proposed by district-level DOH representatives). The reviewers were not able to ascertain the rationale, if any, which guided the segmentation of the 150 NGOs into 'year one' and 'year two' cohorts.

It should be acknowledged that the logistics and coordination aspects of this component were extensive and it is therefore not surprising that this emerged as an area of chronic difficulty and challenge for the service-providing Consortium, which was responsible for communicating directly with the NGOs around the programme; for the Department of Health, which played a role in both monitoring and motivating the NGOs' participation; and indeed for the reviewers, in their efforts to make site visits to a sample of participating NGOs. As is spelled out clearly in the programme progress reports, and as was reiterated in the interview with the component manager, communication and coordination with 150 NGOs was a significant challenge throughout the project. It manifested itself in low initial attendance rates for the training, and sometimes in confusion over times and venues for the mentoring visit. Many NGOs do not have land lines; due to the high turnover of NGO chairpersons and representatives, personal cell phones are not always reliable ways to maintain contact with organisations. While in some instances consortia were helpful in conveying information and making appointments, in other cases they were not and there were serious challenges in communicating information about the programme to participating NGOs as a result.

By all accounts, the component coordinator at the Department of Health in Bloemfontein was actively involved in 'trouble shooting' various problems within

the programme, including assistance to the PWC Consortium in locating and communicating with NGOs that were elusive or difficult to find. However it is unclear the extent to which district-level HIV and AIDS coordinators, who should be aware of NGO activity related to HIV and AIDS in their districts, were assisting in this process.

Institutional participation rates in the programme were relatively high – during the various training components uptake among invited NGOs ranged from 89-95%. This is significant, given that NGOs had to cover the costs of transport and accommodation to attend the iCAM trainings. The number of individual NGO representatives attending the trainings, however, was less than expected – averaging 62% of expected attendees over both years of training. In addition to this, there appear to have been challenges in securing consistent participation of the same individuals across the full training cycle. This was acknowledged by the Department and the PWC Consortium as a problem, and as the programme progressed, efforts were made to underscore to participating NGOs the importance of attending the full cycle of activities and in having the same individuals involved throughout. In the review there were a few cases in which it was apparent that respondents had attended part, but not all, of the training activities, while in other cases, the same small number of people had attended the full programme. This inconsistency is likely related to factors largely outside the Department and the Consortium's control, as decisions about who attends training happen at the organisational level. However it should still be noted that this does have implications for the effectiveness of the training programme.

Given the scope and cost of the training programme, it is of concern that the levels of competency attained by NGOs and trainer candidates were quite low. Only 19% and 40% of NGOs were deemed either competent or 'on the right track' following mentoring in year one, with 16% and 44% attaining these ratings, respectively, in year two. Perhaps of greater concern, given the more selective nature of the train the trainer session, is that only 30% of trainer candidates passed the initial assessment with 50% or higher. After a reassessment, the pass rate increased to 50%.

The scope of this review does not allow us to comment definitively on the factor or factors which may explain these low competence rates. It is likely, however, that these might include: the fact that NGOs of very mixed profiles and levels of operation participated in the programme and that invitations to the train the trainer course were issued generically to selected NGOs, rather than to specific individuals within them. Without reviewing the assessment tools used, it is difficult to comment on whether the expectations were 'reasonable' given the

broader context in which the NGOs work, or whether standards were set somewhat too high. However, it would have been reassuring to see this question addressed more explicitly in the Consortium's progress reports, where issues of competency or lack thereof were not discussed and attention focused almost exclusively on numbers-oriented monitoring of programme progress.

Role of the Service Provider and the Department of Health

The selected service provider, a Consortium led by PriceWaterhouseCoopers, delivered fully on the project activities in accordance with project documentation. The Consortium and the Department of Health had regular contact with one another in the form of weekly progress meetings which allowed for trouble-shooting and resolution of emerging issues. Some of the challenges experienced by the Consortium – and outlined in the programme progress reports – are ones that may have been inescapable – particularly in relation to maintaining contact with such a large number of community organisations.

However this review suggests that, despite their satisfactory delivery on project objectives, a management consultancy such as PriceWaterhouseCoopers may not have been the most appropriate type of entity to lead the undertaking of work of this nature. The reason for this lies primarily in its 'corporate' orientation (as one respondent noted) and its limited understanding of developmental issues at community level. This was manifested in particular in the Consortium's quite perfunctory approach to project implementation and reporting which focused primarily on 'numbers' and fulfilment of deliverables, rather than on the quality and appropriateness of the approach in terms of ensuring actual capacitation, and in a general lack of familiarity with NGO operational issues, which may have led the Consortium to underestimate the amount of time and effort that would be required to implement the required components.

The provincial-level Department of Health personnel involved with this component should be commended for their role in ensuring the programme's success. The reviewers were favourably impressed by the component manager's clear and firm grasp of even small details related to the project implementation, by her active involvement in monitoring and trouble-shooting throughout the time she was involved in the project, and by her clear sense of the strengths and limitations of the training programme.

Comments from NGOs in the field suggest that the component manager in Bloemfontein is more aware of and supportive of their work than are the local HIV and AIDS coordinators who should be closely informed of their activities, but do

not always appear to be. It should be noted that, during the course of the review, the reviewers saw first hand the way communication between the Department and the NGOs it 'partners' with can break down on the ground – in one location where more than 15 NGOs had taken part in the training, according to the lists provided by the component manager in Bloemfontein, the local HIV and AIDS coordinator struggled to locate and make contact with any of the NGOs on the list, did not possess contact information for the NGO chairpersons, and in multiple cases did not know where the NGOs were physically located.

Other issues highlighted by the review

'Under-capacitation' vs 'super-capacitation'. In a small number of instances, the reviewers identified situations where a small number of individuals at the senior management level of organisations or consortia had participated in many different training programmes (some of which duplicated the material presented in this training cycle) and had, in effect, become 'super capacitated' in relation to their associates and peers within the organisation or consortium. It raised questions about striking the difficult balance between the need to target training appropriately at individuals at a senior or managerial level (as opposed to ordinary members or volunteers who might not remain long with the organisation), and the need to 'spread the wealth' to achieve greater depth of skills within organisations.

Related to this are questions about how the lessons gained from training are shared within organisations, and how to ensure that the benefits of training reside not within individuals, but within the larger organisations. In a particularly striking example, the chairperson of one consortium, who has extensive experience within the NGO sector and who was trained as a trainer through this programme, engages in private capacity building work (which he charges at commercial rates) in addition to his work with the consortium. The stipends paid by the Department of Health for him to train smaller NGOs pale in comparison with what he can earn privately, and questions therefore arise about the benefit the Department will derive from him as a trainer given these disparities.

NGO Consortia. While not falling under the auspices of this review, the NGO consortium-based funding mechanism employed by the Department of Health in the Free State was often 'the elephant in the room' during interviews with NGOs in the field. In other words, a training programme such as this one can not be assessed without consideration of the role of NGO consortia in the funding, coordination, and development of AIDS service organisations in the province.

During the course of the review, we encountered examples of consortia that appeared to be functioning quite productively and harmoniously, other examples where they were fairly neutral or at least not evidently problematic, and cases where, by all estimations, the consortium model was not only not functioning as intended, but seemed to be detrimental to many of the organisations and actors involved. As is recommended below, the Department should undertake a detailed examination of this mechanism to assess whether it is functioning as intended, whether it is leading to – or hindering – the capacitation of smaller organisations, and whether it is meeting the objective of reducing duplication of similar activity at district level.

Recommendations

Management

- The senior management team of the Free State Department of Health must make a deliberate attempt to integrate all activities of this programme into their normal activities and agenda. This will address the challenges of systems bottlenecks and allow the component managers to deal with programme implementation challenges.
- The programme management committee which meets monthly must be retained until the end of the next funding cycle in 2007. It needs to focus on integrating the implementation of the programme, documenting good practice, assisting the province to roll-out activities that are localised (like the community health complex), monitor and evaluate activities under these components, and play a prominent role in forming policy and planning on these activities.
- A number of policy decisions need to be made. These must be informed by well-conducted reviews and research into a number of functions raised by the programme. The following are examples:

    - A policy and guideline on patient shuttle systems is urgently needed to ensure that the activity is cost effective and is run efficiently.
    - A policy and guidelines on performance of private service providers and feedback system should be developed. This will ensure that private service providers have a contractual responsibility to inform and assist the Department in improving its systems beyond submitting a written report.
    - A clear policy and guidelines are needed on staff performance on training courses funded by the Department. For example, if staff fail to submit assignments, there must be disincentives and if staff perform well there must be added incentives, such as performance bonuses.
    - The NGO policy needs to be reviewed and guidelines may need to be developed for use by regional coordinators on how to work with and

monitor NGOs funded by the Department. At present the policy is very vague in many aspects of operation.

- Management must adopt a user-friendly system that would allow business to go on, especially with donor funds, during the end of the financial year for government. The system will require the Chief Financial Officer (CFO) and the Head of the Department to issue guidelines to all heads of units and clusters on how to access money during this period. The system must ensure that donor funds are not restricted by the process of closing the financial books.

Human resource and organisational development

- As much as we applaud the strategic decision of training conducted under this component, which is focused not only on clinical training, the province needs to make sure that there is balanced training for the scarce skills in the province. The draft human resource plan in the province shows that the scarce skills are represented by about 0.05% of the total staff complement in the province. The activities of human resource and organisational development must be seen to be addressing areas of scare skills in the province.
- The iCAM medium of instruction should continue to be used, especially for formal courses and qualifications, to ensure its optimum usage. This might be a good vehicle to address skills shortages in the province. The province has already invested heavily in it, therefore programmes like this one might provide the right assistance to ensure its optimal operation.
- The service providers contracted on this component seem to have made efforts to deliver good training for the staff. However, there were a number of problems they had to deal with, including logistics, staff meeting competency or qualification requirements, pre-assessment of staff, and quality feedback after training. All these issues need to be addressed when drawing up contracts with service providers. For example, it must be a requirement that training service providers undertake a quick pre-training assessment before starting a training programme and these assessments must be aimed at understanding the competency levels of the participants, knowing participants' job profiles and responsibilities, understanding individual circumstances, and preparedness for the training. These are crucial undertakings for effective training for working people.
- The selection of staff for training must be planned in advance. Staff selected for training must be informed in advance. The rationale for selecting them must be stated. They must be informed of the expectations during and after training. They must be informed about their responsibilities and outcomes of the training programme. This will improve their performance, participation, commitment and morale in the training programmes.
- All the training programme materials we have reviewed have failed to mainstream HIV and AIDS. This is a missed opportunity. The notion that these

are health workers who know enough about HIV and AIDS is a wrong one. At every given opportunity, where more that 800 staff have been exposed to some training, HIV and AIDS must be included in all training programmes conducted by the province. This will send a clear message on how important HIV and AIDS is in the province. It will be a good practice for the province to make it mandatory for training service providers to allocate time in their training to discuss HIV and AIDS as it pertains to the subject area

- The component has produced volumes and volumes of training materials through the contracted service providers. A concerted effort must be made to catalogue, store and make these available to all staff both electronically and in hard copy form. Some of the training materials we have reviewed are very useful and easy to use. The investment made in them must not end with the contracted courses, but be shared with staff in the province.
- The proposed activities for the 2005-2007 plan under this component seem to be sound and attempt to address some of the recommendations made. The sub-component in the plan that addresses traditional healers and governance structures needs to be integrated into the existing components rather than standing alone as an additional sub-component. The traditional healers' activities must be integrated into the NGOs support component and the governance structures must remain within the human resource and organisational development component. This will consolidate the systems and operations of these programmes within the Department units' mandates.

Botshabelo community health complex

- There is a need to plan and implement the patient shuttle system. The planning must include developing a policy on implementing and managing patient shuttle services that can be adopted for the whole province.
- The designing and mounting of clinic road sign must be speedily concluded with the relevant municipal officials to ensure easy access to these clinics. Some clinics need such signage for visitors in these areas. It would be also useful to include the opening times or grade level of these facilities in the road signs to avoid going to facilities when they are closed.
- The allocation of sedan vehicles and patient shuttles must be formalised. During the allocation process, there is a need to first define the need and demand for such vehicles. The allocation must not only be tied to the Botshabelo complex, but also start to address demands and needs to roll-out the strengthening of community health complexes in the whole district and even beyond.
- To ensure that equipment purchased by the Department is durable and of high quality, a system must be in place to monitor their functionality. The supervisory systems developed in the complex should be the vehicle to monitor this. Companies that have supplied the equipment should be tied in to

a warranty period so that if equipment starts to malfunction before the warranty period expires, it can be replaced at no cost.

- The lessons and good practice that have been identified in this component must be rolled out to other parts of the province. For example, the processes used in grading the facilities, the referral system and the support to the referral system are good examples. This also includes the processes and implementation of the supervisory manual. The issue of the patient shuttle system must also be explored beyond Botshabelo, as there are enough vehicles to use to pilot this activity. We would advise that the introduction of a shuttle system should be started with the whole district of Motheo, focusing mostly in Naledi and Manstopa areas. The number of patient shuttles allocated to each area must be informed by the number of facilities to be covered, and the distance between facilities and district hospital, if existing. For example, the Botshabelo complex has 13 clinics feeding to the district hospital. The distance between facilities is reasonable, the roads between these facilities are drivable and the district hospital is central to most of these facilities. To operate a functional patient shuttle one would need a maximum of three vehicles and three drivers operating at scheduled times. This means of the total patients carriers bought under the programme, five can be used elsewhere.
- The training of Advance Midwives must continue, so as to ensure that the 24-hour clinics operating maternity units are well staffed. Presently these units are staffed by one midwife who is also responsible for MCH activities in the facility. During the day, the midwife cannot manage MCH activities and attend to maternity cases at the same time.
- The activities planned for the 2005-2007 need to be aligned with the recommendations made in the review:
  - The objective of implementing a clinic supervisory manual must focus on (i) strengthening support systems and processes for supervisors in the complex; (ii) developing and implementing a plan for roll-out of the manual to the province. This process must also include developing standard provincial tools to monitor the implementation of PHC core package and well functioning of all community health complexes in the province; and (iii) training of all supervisors in the province on the use of the manual.
  - The objective of integrating Bosthabelo community health complex to Mangaung municipality must focus on building capacity in the whole district to properly manage community health complexes in the whole district. Activities must include training of managers in the municipality on managing the complex, establishing and supporting joint meetings for planning, developing service standards, quality assurance systems, monitoring and evaluation tools and systems, reporting and feedback systems. The piloting of the patient electronic information system should be used as a forum for this integration in the district. This system must add other PHC activities on it, not just ARVs, as all clinics in the Botshabelo complex have computers.

- The objective of replicating and strengthening the referral system must focus on properly planning, implementing, monitoring and evaluating the patient shuttle system. This must include developing a policy on the shuttle system, educating communities about the shuttle system, and developing operational guidelines and indicators for monitoring the system. The activities of producing name and service package boards, and developing and distributing referral pamphlets must be phased out and be absorbed by the provincial budget, as this has proven to work and is a good investment for the province.
- It may be of good practice for the province to develop a provincial manual on planning, implementation, monitoring and evaluation of PHC community health complexes, which would be used to train managers of these complexes and which can be a guide for other provinces in the country on how to establish and manage this approach to the delivery of integrated PHC services.

Capacity building for NGOs

- As a matter of priority for this programme, a complete evaluation of the component must be conducted with the view to:
  - providing the province with clear guidelines on how to work with NGOs. This must include defining the role of regional/district HIV and AIDS coordinators, support, supervision and mentoring of NGOs, assessment of quality of NGOs services, and sharing of lessons amongst NGOs in the province.
  - revising the present NGO policy so that it details issues relating to funding criteria, contracts, payments, reporting, and role of provincial and district authorities.
  - developing a monitoring and evaluation framework for NGO support in the province which will include a set of indicators, tools for collecting and reporting information, and a plan for building M & E capacity for NGOs funded by the province.

  This activity would require the province to appoint an institution or consultant who can conduct this evaluation. The institution or consultant must have the following technical experience: (i) conducting evaluations of NGOs working on HIV and AIDS, especially in South Africa; (ii) extensive experience in policy development in the public sector; (iii) expertise in monitoring and evaluation, especially developing M & E frameworks, developing indicators, and generating M & E reports. This activity can be funded from the uncommitted funds in the present DCI funding cycle.
- The present structure of this component can not cope with the demand of the activities. The component manager alone is not in a position to plan, implement and monitor effectively the implementation of this component. A decision must be taken to actively involve the regional and district HIV and

AIDS coordinators in this programme. These coordinators need to be in charge of the implementation. They must be responsible for supporting and managing NGOs funded by the province and for ensuring that NGOs are adhering to provincial policies and are reporting properly; they must monitor training and mentoring of NGOs by service providers contracted by the province; and they must meet regularly with NGOs as part of supportive supervision. This will reduce the workload of the component manager, who must be responsible for coordination and providing strategic support to the coordinators.

- There must training on NGO management and monitoring and evaluation provided to coordinators as matter of urgency. This will enable them to provide quality support to the NGOs. This activity must be included in the 2005-2007 plan. The training course must cover management issues for non-profit organisations, principles of monitoring and evaluation, indicator development, data collection for monitoring purposes, reporting, and report writing.
- The NGO support programme must adopt a two-tiered approach to training, working first with the more established, funded NGOs, and then rolling out a modified version of the training to smaller, unfunded or newly established organisations
- Training for NGO capacity building should use face-to-face instruction as opposed to iCAM or distance learning approaches. This is because most of the operational staff of NGOs have different educational levels and backgrounds requiring physical interaction to make teaching and learning effective.
- Where training requires members of NGOs to travel and sleep over, the budget should cover the accommodation and travel expenses of NGO participants – particularly those from non-funded organisations.
- The mentoring visits to NGOs should occur over a shorter period of time to encourage regular attendance and participation. This is important to build confidence and commitment from NGO staff. We also recommend that there be a follow-on visit 4-6 months after the completion of mentoring. This visit would provide organisations with a chance to have emerging questions addressed.
- The component must continue with the quarterly reporting meetings for NGOs. These may be organised at sub-district level and be run by the coordinators. They must focus on sharing lessons, appraising one another and updating each other on new developments and emerging issues on HIV and AIDS and community responses to HIV and AIDS.
- The training manual for NGOs is a very useful tool; NGOs have found it to be useful and of value. This manual need to be translated into SeSotho as a matter of priority. This can increase the usefulness of the manual to NGOs and trainers who have been selected to roll out the training.

- The trainers already being trained need to be closely monitored and supported to enhance their competencies. There must also be trained on supervision and M & E so as to provide the needed capacity at community level to support NGOs responses to HIV and AIDS.
- Establish clear indicators for evaluating programme success, including expected levels of competence by organisations participating in the programme
- The proposed activity plan for 2005-2007 on this component may also need to be aligned to the recommendations made in this review. All the objectives listed in the draft plan under this component are useful for continuity and expansion of NGOs support in the province. However, some of the activities may need to be re-focused. For example:

    - Objective 1, on training of HIV and AIDS & TB district coordinators and lay counsellors – the activities needs to be split. The training for coordinators must focus on principles of managing NGOs, supervision, mentoring and monitoring and evaluation. The training for lay counsellors can focus on the technical programmatic issues of HIV and AIDS, STIs and VCCT. This training must cover the whole province and will allow the province to standardise the management of NGOs supported by the Department in the province.
    - Objective 4, on mentoring of NGOs – this activity needs to be part of district coordinators' role after they have undergone the training indicated on Objective 1. We would suggest that the objective should focus on developing systems and tools for monitoring the mentoring and support process for NGOs by coordinators.
    - Objective 6 and 7 – we would suggest this should focus on building a pool of trained trainers across the province, not just in one district. This pool of trainers can then cascade training in all districts and would be supported by coordinators in the training and providing supportive visits to NGOs in the province.

Lessons that can be learned from programme implementation

Lessons from this programme for Development Cooperation Ireland and the Free State Department of Health can be categorised into four broad areas, although there may be other specific areas that would be relevant and useful.

1. **Overall programme timing**: Programmes of this nature require the Department and the donor to allow for and invest resources during the inception phase. This ensures that:
   - Programme activities introduced to already existing programmes and systems are gradually absorbed.
   - Public sector (Department of Health) systems are properly adjusted to accommodate requirements for donor funding and the alignment of systems is done with a minimum of disruption.
   - Time is given to assess the Department's capacity and ability to respond to the donor programme framework and activities within the agreed upon programme timeframe. This is important when deciding or selecting Department personnel who will play lead role(s) in the programme.
   - Flexibility is agreed upon in the programme framework and activities planned so that it is possible to address emerging needs over time. The public sector environment changes and new priorities emerge as they plan on year to year basis and new areas of support are identified. Donor support programme must be able to respond to these areas as long as they are within the programme framework mandate.

2. **Planning of donor programmes**: Planning can be enhanced by using a programme framework tool - for example, a logical framework. The planning tool may enhance the focus, identify risks and set clear targets for the programme. In the future, DCI and the Department may opt to start with a planning session where a SWOT analysis is done, and a plan is developed using a planning tool to guide programme activities, outputs and time frames. This approach may allow for the identification of challenges prior to implementation and allow planners to develop interventions to meet the challenges.

3. **Monitoring progress** – Identifying indicators at the beginning of the programme is part of good planning practice. Although all the component activities had activities, targets and inputs, there were no process indicators in the plans. Effective monitoring for programmes of this nature, which also requires assessing quality, effect and impact, needs to have input, process, output and outcome indicators. Perhaps in future, there needs to be detailed planning at component level, with focused processes and outcomes. This may be done through:
   - Small planning groups for each component, comprising of key stakeholders in implementation, can benefit by having agreement on

processes to be used, the set of indicators for the component against activities, outputs expected against timeframes, and outcome indicators for the whole component.

- Stakeholders who will implement component activities can agree on the standard tools required to collect monitoring data, the types of data to be collected, and where data will be stored and analysed.
- They must agree on a reporting format and types of reports to be generated for service providers, managers and donors.

4. **Documenting lessons** – This can be best achieved if evaluative activities are built into the programme plan. Documenting lessons requires a systematic approach to understanding what makes a programme work or not work. The programme would have benefited if this was built into the programme framework. The review has identified successful and not so successful interventions across the three components, but can not provide analytical reasons for success or failure. DCI and the Department may invest in funding evaluative processes within each component and document processes that contribute to success and those that pose challenges. This is important because donor-funded programmes:
   - Are time bound; therefore, what has worked needs to be identified and adapted to overall Department plans
   - Can be a catalyst to unlock bottlenecks and red tape associated with government programmes. These programmes can assist in identifying those bottlenecks and offer solutions or alternatives.
   - Can respond to specific needs and can operate in pilot sites to test new ideas or innovations. Outcomes from such initiatives can be useful if there is proper documentation of activities.

List of documents reviewed

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8. Customer/client service assignment outline. Regenesys School of Management, March 2005.
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29. Free State Department of Health: Development Cooperation Ireland. Report of financial performance (1st January – 30June 2005) Extension period.

30. Motivational leadership programme 18 outline. TDA Human Resource Consultants.

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32. Report on training of CBOs and NGOs: BMBM Development Services, September 2005.

33. Summary Sheet: Support to primary health care delivery in the Free State and capacity building for HIV & AIDS in the Free State, August 2001.

34. Support to primary health care delivery and capacity building for HIV & AIDS prevention in the Free State. Component 3- Annual Report, January-December 2003.

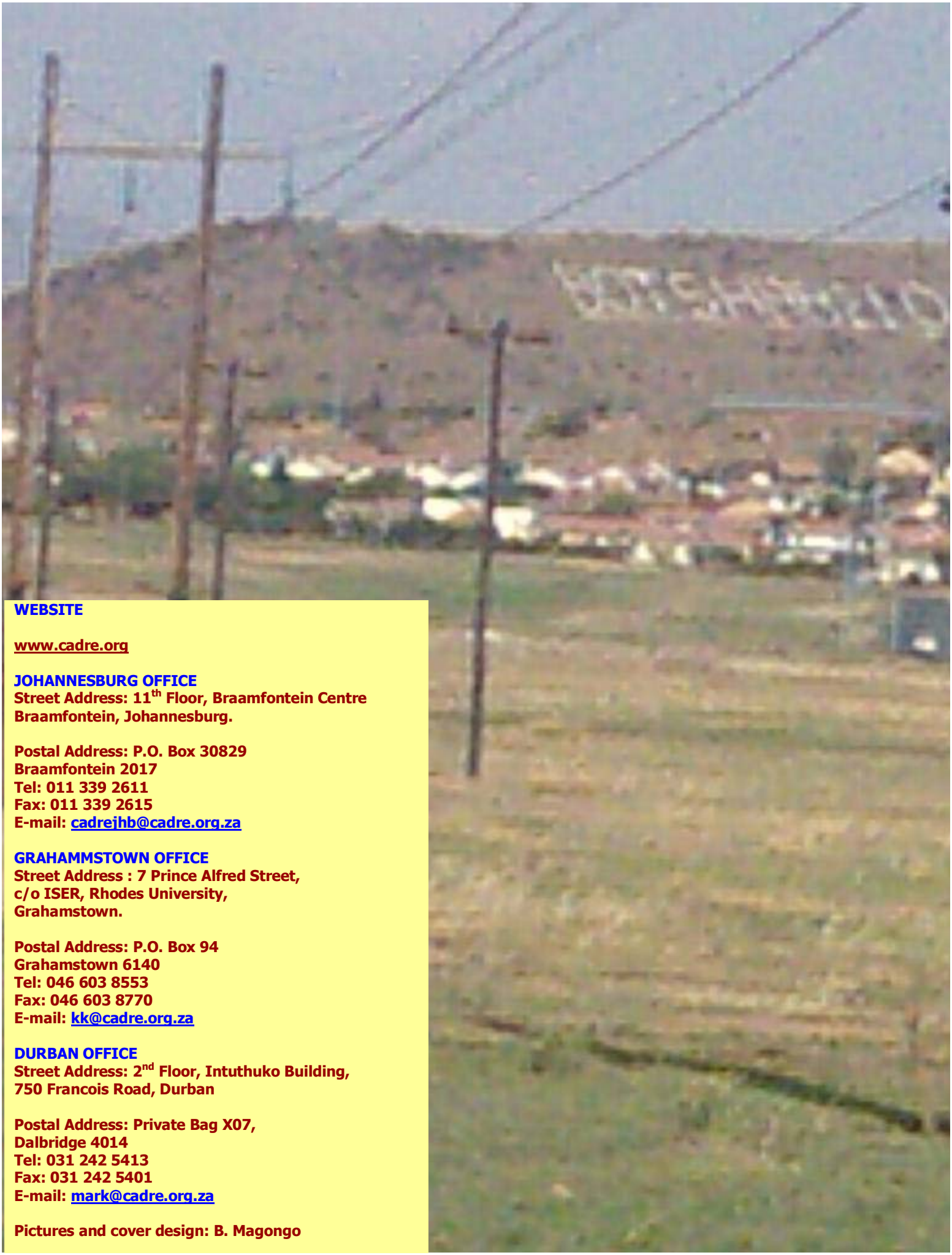
35. Support to primary health care delivery and capacity building for HIV & AIDS prevention in the Free State. Component 3 -Annual Report, January-December 2004.

36. Support to primary health care delivery and capacity building for HIV & AIDS prevention in the Free State. Component: Implementation of community health centre (CHC) complex system – Botshabelo, January-December 2003.

37. Support to primary health care delivery and capacity building for HIV & AIDS prevention in the Free State. Component: Implementation of community health centre (CHC) complex system – Botshabelo, January-October 2004.

38. Support to primary health care delivery and capacity building for HIV & AIDS prevention in the Free State. Progress report – Extended work plan January-June 2005.

39. Training the Trainer NGO. PWC & Partners, March 2005.



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