MONITORING AND EVALUATION OF THE EUROPEAN UNION 'PARTNERSHIPS FOR HEALTH' PROGRAMME, SOUTH AFRICA

OUTLINE OF FRAMEWORK FOR BASELINE STUDIES AND MONITORING AND EVALUATION - 2002

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CONTENTS

ACRONYMS

CHC - Community health clinic
CSO - Civil society organisation
DHIS – District health information system
DHS – District health system
DMDOH – District municipality department of health
DOTS - Directly observed treatment short-course
HISP - Health information systems programme
IEC – Information, education and communication
IDP – Integrated development plan
IMCI – Integrated management of childhood illnesses
INP – Integrated nutrition programme
ISRDS – Integrated rural development strategy
LG – local government
LMDOH – Local municipality department of health
M&E – Monitoring and evaluation
MCH - Maternal and child health
MCWH - Maternal, child and women's health
MOU - Materntiy and obstetrics unit
MSP – Municipal or metropole service partnerships
MTCT - Mother-to-child transmission
NDOH – National Department of Health
NFS - National PHC Facilities Survey
NGO - Non-governmental organisation
NHISSA - National health information system of South Africa
NPMU – National Programmed Management Unit (see below)
NPSC – National Programmed Steering Committee
OPD - Outpatient department
PDOH – Provincial Department of Health
PHC – Primary health care
PMU – Provincial Monitoring Unit
PPT – Provincial Task Teams (see below)
R&D – Research and development
SADHS – South African Demographic Health Survey
SETA – Sector Education and Training Authority
STD - Sexually transmitted diseases
TB -Tuberculosis
TOP - Termination of pregnancy
URS – Urban renewal strategy
VCT - Voluntary counselling and HIV testing
WHO - World Health Organisation

PROGRAMME SPECIFIC TERMS AND DEFINITIONS

AWP – Annual work plan
CSO - Civil society organisation
NPMU – National Programme Management Unit (within the NDOH) which will ensure the overall management and monitoring of the programmed)
NPO – Non-profit organisation
NPSC – National Programme Steering Committee comprised of senior management from the national and provincial departments of health, senior management representatives from the targeted district municipalities, CEOs of selected NGOs representative of the sector, and a representative from the EC Delegation in Pretoria with observer status
PHP - Partnerships for Health Programme
PMU – Provincial Monitoring Unit
PPT – Provincial Task Teams comprising representatives of PDOH, DMDOH and CSOs
PHP – Partnerships for Health Programme

UFE – Utilisation-Focused Evaluation:[1] Based on the premise that evaluations should be judged by their utility and actual use; the focus of UFE, from beginning to end is on use by intended users.
PIU – Primary intended users: A term associated with UFE. PIUs are those with a direct, identifiable stake in the programme of monitoring and evaluation, and/or who can make direct use of the data/findings that emerge.

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[1] Patton, 1997

1. INTRODUCTION: PARTNERSHIPS FOR HEALTH PROGRAMME

The European Union (EU) 'Partnerships for Health' Programme (PHP) is a six-year programme developed in collaboration with the South African Government and international partners with similar priorities. Currently these are the Government of the United Kingdom (DFID) and the United Nations Population Fund (UNFPA).

The aim of the PHP is to support the decentralisation of health services in South Africa by strengthening and supporting co-operation between non-profit health providers and government services, thereby creating formalised partnerships for the delivery of primary health care (PHC), and especially those services addressing HIV/AIDS. The PHP will, in the first instance, be conducted in five provinces (Gauteng, Limpopo, KwaZulu-Natal, Eastern Cape and Western Cape) and will actively engage with processes of decentralisation and devolution of PHC services to local government. The programme will be located in a selection of ten districts (category C municipalities) or metropoles (category A municipalities).

The PHP aims to identify gaps and under-capacity in the provision of PHC and to profile potential non-profit partners to address the same. It will provide technical assistance to develop capacity of Government and non profit organisations to engage as partners, in areas such as programme planning, management, basic accounting, monitoring, evaluation, report writing and development of career opportunities for personnel.

The PHP will be supported by a technical assistance framework (see Appendix 1) managed by a National Programme Management Unit (NPMU) which will coordinate technical assistance to national, provincial and local departments of health and civil society organisations (CSOs)[2] participating in the programme. The programme will be monitored by provincial monitoring units (PMUs) in each of the five provinces.

This document has been prepared as a preliminary step in developing a foundation for M&E of the PHP and specifically to sketch out the parameters for a baseline study. An extensive literature search was conducted to locate literature resources relevant to the PHP. Accompanying this document is a CD ROM containing most of the articles located, and listed in the bibliography at the end of this document. In addition to this there is much useful information available on the internet. Appendix 2 lists some of the more useful web-sites and a description of the relevant information which can be obtained off the internet. Some of these sites will be very useful for developing research protocols and procedures and could provide useful resources for PHP developers and managers.

2. PARTNERSHIPS FOR HEALTH IN THE DISTRICT HEALTH SYSTEM (DHS)

2.1 Partnerships for health

The term 'partnership' has been used to describe many forms of interaction between public and community-based, non-profit sectors in the area of policy formulation and implementation[3]. Partnerships may include bilateral or multi-party arrangements between such diverse groupings as government departments, volunteer agencies, national NGOs, local common interest groups and individuals. These may be pragmatic relationships involving no more intensive communication than fortnightly talks on the telephone[4], or 'elaborate' and 'extensive' arrangements linking government and the non-profit sector.[5]

The model of partnership between CSOs and Government health services in South Africa is relatively new, although in other health systems, and perhaps particularly in the United Kingdom, there is a well established history of partnerships and research and literature to support this. In South Africa, throughout the country, there are numerous relatively small scale co-operation and funding agreements which link CSOs and government. For example, Hospice branches staff and operate inpatient units in some provincial hospital facilities, and in at least one province, Hospice home-based carers are paid a stipend by the Department of Social Development and rents are paid by the Department of Health. In

[2] The type of organisations with which partnerships are likely to be formed under the umbrella of the PHP are those designated as NGOs (non-governmental organisations), CBOs (community based organisations) and NPOs (non-profit organisations). These are collectively called CSOs (Civil Society Organisations).

[3] For useful conceptual reviews see: Mellor, 1985; Kramer and Grossman, 1987; Salomen, 1987; Billis, 1993

[4] Mellor, 1985

[5] Salomen, 1987

exchange, Hospice provides training and care services in response to AIDS, which would otherwise fall to the direct responsibility of the public health sector. Such arrangements are congruent with a broad legislative framework which endorses partnerships. However, the newness of the concept of partnerships means that there are few established models for the same, and that there are significant development challenges in establishing partnerships on a large scale.

One of the most widely spoken about advantages of partnerships for health is in that it allows greater co-ordination of resources, thereby avoiding duplication and developing better economies of scale. In relation to the burgeoning of numerous small and often struggling HIV/AIDS organisations, for example, it has been said that "Small local NGOs/CBOs are providing a range of services in specific locations individually, which if coordinated together and with government services, could provide a comprehensive integrated HIV/AIDS programme, including community participation and multi-sector collaboration."[6] A number of alternative methods of service delivery[7] are available within the local government framework, one of which is partnerships with CSOs.

The Partnerships in Health Reform Project[8] identifies and pursues research topics about which there is substantial interest, but only limited hard empirical evidence to guide policymakers and policy implementers. Currently, researchers within this programme are investigating six main areas: 1) analysis of the process of health financing reform; 2) the impact of alternative provider payment systems; 3) expanded coverage of priority services through the private sector; 4) equity of health sector revenue generation and allocation patterns; 5) impact of health sector reform on public sector health worker motivation; and 6) decentralisation in relation to local level priority setting and allocation. These are some of the main international foci of research on health partnerships, although as noted, there appears to be a paucity of research which has been done in development and support of partnerships.

It has been suggested[9] in a Brazilian study of decentralised health care, that in developing understanding of decentralised management in the health sector, it is important to develop concepts and methods to evaluate not only the formal organisation and outputs of the health system, but also aspects of local social organisation and political culture "within which that local health system is embedded".[10] The implementation of reforms may be subject to vagaries which have little to do with health systems, but which influence the implementation of reforms and thereby responsivity to local needs, the quality of care provided, and the efficacy of the system. Some of the key aspects identified are: the space for autonomy; the space for local voices in political institutional life; personalised influences in the form of established managers and management styles; and professional roles and relationships. This makes it important to look at the personal, organisational, community and social arrangements involved in reform and change management.

The programme offers opportunities for greater involvement of public interest, and offers to address one of the cornerstone commitments of the Declaration of Alma Ata, a founding document for the world-wide adoption of PHC, namely broader participation of the public in the health system. There has been much written about participation in health systems and how participation might be measured[11]. The extent to which partnerships allow for public participation and agenda setting in health remains to be seen, but partnerships with CSOs are generally considered as offering possibilities for this.

Problems with partnerships

Whereas reform of health system delivery through integrating CSO services into the formal health sector promises to deliver many advantages, the research and literature warns of a few possible problem areas that the PHP M&E system will need to be closely attuned to. Amongst these are:

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[6] Gordon & Ndondo, 2002, p.7

[7] These include corporatisation, public-public partnerships (between municipalities), contracting out, leases and concessions and transfer of ownership.

[8] Much of the high quality research published by PHR (Partners for Health Reform) can be accessed via: http://www.phrproject.com/

[9] Atkinson *et al.*, 2000

[10] Atkinson *et al.,* 2000, p.619

[11] Kelly & Van Vlaenderen, 1995

- CSO activities are often conducted by committed staff and volunteers, but they often lack the resources to run existing programmes effectively, and to improve capacity and security[12]. They often operate at a local level and do not have the administrative or management skills and experience to be accountable to government, and certainly not the experience of working within government frameworks.
- Maintenance of partnerships between large and bureaucratic health services and small CSO service providers (which may be highly focused, efficient and cost effective in the way that they deal with meager resources), is likely to be fraught with challenges from both sides. Health workers in the formal health sector are accustomed to working within particular protocols of practice and there may be clashes between these 'communities of practice'. This may take place at any of a number of possible levels including: working conditions, salaries, work culture, motivation, reporting structures, referral practices, record keeping, attitudes to clients, expectations of clients, ethics and professional procedures. The programme will likely have to place much emphasis on dealing with differences at this level, to present a relatively seamless and continuous experience of engaging with the health system on the part of clients.
- Related to the above is a prevailing negative attitude towards co-operation with government on the part of CSOs. Government services are often perceived to be inefficient in terms of service delivery and administration, poorly geared for responding to development challenges, slow to adapt to new and unique circumstances and less than sensitive to staff needs.
- Many projects involving partnerships report professional rivalries and jealousies between health workers and even competition for patients, which may show in uncooperativeness and unwillingness to share and learn from each other. Mistrust about the skills of trained volunteers is frequently reported in community health worker programmes. Professionals are prone to jealously guard their hard-earned qualifications and the programme is highly likely, in some instances at least, to face difficulties around issues to do with professional competencies, standards and licenses.[13] This is especially likely to be the case in regard to the recognition of prior learning or educational equivalencies, which is a cornerstone of the PHP.
- It has been reported that "There are a lot of concerns about contracting with government and fears of privatization of health services."[14] It will be important, and indeed central to the work of the project, to find ways of 'bridging' the two sectors and building capacity in both to work as partners. "There can be no valid 'partnership' without respect, mutual capacity-building and some equality in decision-making."[15] The nature of the problems to be encountered needs to be anticipated if an understanding of the key change processes is to be monitored, documented and understood.
- CSOs are diverse in terms of culture, history, size, activity, structure and security as organisations.[16] The implications of the range of characteristics for monitoring and evaluation need to be taken into account. If the range of organisational characteristics is not taken into account, important baseline elements which will underlie the way the programme develops in practice, will be missed. It is important to bear this in mind in developing the baseline instruments.
- CSOs are usually based in towns and benefits flowing from partnership are most likely to reach relatively richly serviced environments first. The perennial problems of under-serviced rural areas (usually DMAs rather than local municipality managed) will be important to monitor. Partnerships with CSOs could be said to be no solution in respect of the problem of health delivery in under-serviced areas, as they often experience the same difficulties as do formal health services in working in remote and sparsely populated areas.
- The exact strategic inputs that will be made will be determined during the course of the programme and therefore it is difficult to lay out in precise terms what will be evaluated and how. The broad parameters for the type of inputs that will be necessary have been researched[17] and can be anticipated. These concern a strategy of engagement rather than a specific action

[12] Gordon & Ndondo, 2001
[13] Tovey & Adams, 2001
[14] Gordon & Ndondo, p.6
[15] Gordon & Ndondo, p.6
[16] Gordon & Ndondo, 2001
[17] Gordon & Ndondo, 2001

plan. This means, however, that other forms of M&E will be necessary to monitor and evaluate emerging initiatives within the context of this strategy.

- Partnerships may be easier to invoke than manage, develop and sustain. Management of partnerships requires specific mechanisms which need to be developed anew in different circumstances. Experience in the NHS system in the UK has shown[18] that the 'hype' of partnerships, which sees partnerships as unquestionably advisable, often overlooks the significant development challenges that are faced.
- Partnerships that strongly rely on the services of volunteers are not necessarily sustainable in the long-term or up-scalable unless the specific motivations of volunteers[19] are taken into account and met. These vary considerably and whereas altruistic attitudes and civic responsibility may partly account for volunteer motivation, amongst other possible reasons people may volunteer: to obtain experience and training; in the hope of future salaried employment; and because they are unemployed and have time on their hands. In such contexts the ongoing commitment of volunteers to remain volunteers is by no means certain.

Each of the above issues are likely to be central challenges faced by the PHP and, to this extent, overcoming of these problems falls within the desired outcomes of the project. Programme evaluation requires that the status quo in respect of these issues be assessed at the outset and throughout the life of the Programme. These issues have been taken into account in developing an M&E evaluation framework for the project.

Elements of successful partnerships

Some of the findings of research and reviews relating to successful partnerships are:

- A review of partnerships for health[20] concludes that: partnerships operate most effectively when built on explicit and structured planning, nurturing and maintenance; partnership building is a skilled process that requires a significant investment of time and resources; partnerships are more likely to succeed in circumstances where an open and honest discussion of the potential difficulties involved in collaborating is possible; partnerships function best in circumstances where the partners offer contributions to an agreed common goal; partnerships are maintained most effectively in circumstances where change has been brought about in an incremental and co-operative fashion.
- A study aimed at developing a tool to assess the readiness of civil society organisations to enter into partnership with municipal health departments[21] in South Africa concluded that assessment of organisational performance will only be valid if the CSOs concerned are engaged in the assessment as partners and expect benefits to flow from the process. So, if organisational performance is to be assessed at the outset (as a baseline for M&E), it needs to be tied into the promise of partnerships and this needs to be accompanied with some form of promotion of the programme. Whereas the planning of the programme is proceeding in concert with Government, it would also be important to establish a platform for buy-in for CSOs as a pretext to the baseline studies. The studies are likely to take time and opportunity on the part of CSOs and good, reliable assessment will require their co-operation. It is also important to establish the expectation that benefits will flow from involvement if there is to be ownership of changes in terms of organisational development.[22]
- Partnerships are not in all circumstances the preferred way of delivering health services and development must be based on understanding the problem that requires a partnerships approach. It should be clear why a partnership approach is the best response to the perceived need or problem.[23]

[18] HEBS, 2000
[19] The work of Senekal *et al.* (2001) provides important insights into the motivations of volunteer DOTS supporters in the rural Eastern Cape.
[20] HEBS, 2000
[21] Gordon & Ndondo, 2001
[22] Gordon & Ndondo, 2001
[23] HEBS, 2000

- A review of partnerships[24] suggests that the shape of partnerships should be crafted according to specific needs and circumstances rather than based on a prototype of a partnership ideal. This means that whilst models are useful, a successful large-scale programme of partnerships will need to have strong capacities for developing partnerships-to-fit, rather than work through applying formulae or prototypes. However, both elements are clearly necessary to accommodate the dual and somewhat contradictory needs of specificity and efficiency.
- Partnerships will vary in their rationale, scope, scale, lifespan and formality[25] and the partnership 'type' chosen needs to be "appropriate to the circumstances within which a partnership exists and the associated expectation".[26]
- In a review of large scale contracting of NGOs for HIV/AIDS response in Brazil and Gautemala[27] it was found that a combination of 'assistance' and 'expectations' of accountability in financial monitoring worked most successfully in improving NGO performance. Qualities of successful administration include a single administrative unit and consistent systems and procedures. An analysis of the relative merits of 'contracting' and 'grants' suggests that contracting may be a more favourable approach as it places the onus on NGOs to deliver, focuses on measurable outputs, creates a greater accountability for how funds are spent and opens the way for legal remedies. Unanswered questions include whether NGOs are cheaper and in what situations, how to operationalise performance contracting and whether NGOs and government have the capacity for this.
- Service agreement contracts at PHC level do not have a strong history of success in South Africa[28] and principles and processes need to be carefully spelled out. Recommendations[29] for contracts between provincial and local governments point to the need for PHC contracting to be based on: sound policy frameworks and strategic planning; trust and a shared vision between the contracting parties; flexible contract specifications which stress constructive M&E procedures; and the need to start slowly and build capacity. These principles would as well apply to LG and CSO contract agreements.
- "It seems more helpful to find ways of supporting a group of smaller CSOs in a catchment area, perhaps coordinated and supported by a larger, more established NGO, than selecting one or two NGOs with a higher level of organisational performance based on conventional measures."[30] This suggests that the highest gearing for change may come about through working with small or forming NGOs which may have an insignificant funding base, if any funding at all. It would be easy to overlook such organisations in conducting an audit of existing CSO initiatives, as they might not even be integrated into CSO networks or be recognised by other organisations in the area.
- The greater the level of local community involvement in setting agendas for action, the larger the impact. Volunteer activities, peer programmes, civic activities and involvement of local committees have been shown to increase the benefits that flow from alliances and partnerships for health promotion.[31]

[24] HEBS, 2000
[25] HEBS, 2000
[26] HEBS, 2000, p. 4.
[27] Connor & Barnett, 2001
[28] McCoy *et al.*, 2000
[29] McCoy *et al.*, 2000. This publication also contains a useful annotated bibliography of key readings on contracting for health care.
[30] Gordon & Ndondo, 2001, p.7
[31] Gillies, 1998

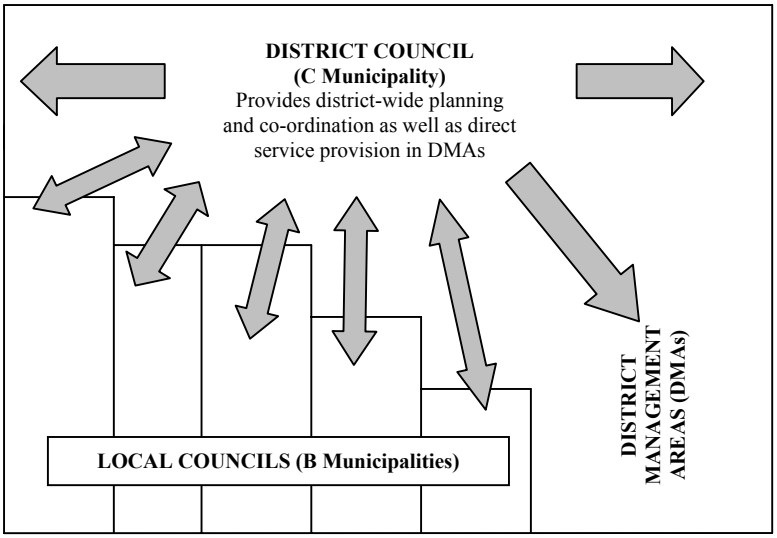
2.2 District health systems and local government structure

Recent legislative changes have resulted in a move towards responsibility for the delivery of PHC services increasingly being shifted from provincial government to municipal level.[32] In principle, the idea is that municipalities would take responsibility for PHC services within municipal boundaries and the co-ordination of these services would be devolved to local government (LG) structures. This is seen to be consistent with a vision of participatory democracy and is also intended to lead to better quality health services, services which are more attuned to local needs and conditions, better access to health services and better coverage of areas not well served by centralised health systems.

Unfortunately there has been little research which has demonstrated the success of such developments on a large scale, or for that matter, the lack of success. In many respects these shifts are in uncharted terrain. It could be argued that certain sectors of government, notably professional services, are best not devolved too 'close to the ground' where capacities to manage such services are, at best, uncertain. Concerns about this, and also the practical difficulties involved in devolving health services to municipal level, have given rise to uncertainty about direction. Certainly at the level of implementation, but also at the level of policy, there is indecision about how certain kinds of services should be devolved to municipalities. In order to understand the difficulties involved it is necessary to appreciate the structure[33] of LG in South Africa.

A local government district is governed by a district council (C Municipality). Such district municipalities incorporate a number of local municipalities (B Municipalities) and also areas of the district which are not directly governed by local municipalities. These are called district management areas (DMAs), which are generally those areas where capacity or population size do not warrant formation of a B municipality. Rural areas without towns and farming areas tend to be managed at the level of the district. The following figure depicts these structures.

The two types of structure within a local government district



The existence of metropolitan areas also needs to be considered in understanding the LG context, as at least one metropolitan area will be included in the ten primary sites of the PHP. In 6 metropolitan areas of the country there are no district and local councils but a metropolitan council (A municipality) which is an independent authority with the same status as a district from the perspective of provincial authorities. Metropoles are governed by metro councils and there may be metro sub-councils and wards which have variable functions attached to them.

[32] For an excellent review to the changing role of local government as a service provider see Durban Unicity Committee (2000). Barron & Sankar (2000) describe the developments leading to a district health system and the framework for the integration of district health and local government. For a synopsis of health policies and legislation: 1994-2000, see Pillay & Marawa (2000).

[33] As set out in the Municipal Demarcation Act (1998) and the Municipal Structures Act (1998).

It is important to realise that whilst significant steps have been taken to implement the Municipal Structures Act, the ways in which the system will ultimately work are largely 'in the making'. This is partly because certain aspects of how the system will work have not been determined yet, and partly because the system has been designed to accommodate a degree of flexibility.

There is still some uncertainty about how health will be managed in the new local government framework. The transformation of earlier district health management systems to fit into municipal structures under the new dispensation is particularly complicated, especially since there are strong provincial differences in how the system previously functioned. Very often staff within DHSs are at a loss to explain 'the big picture' of how local and district municipalities function in relation to each other in the health field. There is much still to be resolved and it appears that local and practical options may prevail over national or provincial master plans, to accommodate the complexities of how systems currently function, and to keep systems running whilst they are overhauled.

In most cases district councils have not assumed their full roles and authority. Local councils may be considerably larger than district councils in terms of staff numbers and capacity, and there is there is much uncertainty about how district and local municipalities should interact. There is also lack of clarity about how decision-making and co-ordinating functions can be transferred to districts. Clearly, a good deal of effort of the PHP will need to be expended in extending the capacity to develop this system, so that the district councils can assume their statutory role. However, such efforts are likely to be made in a context of uncertainty about the co-ordination of PHC resources in DHSs[34]. Whereas a municipal based DHS[35] seems to be congruent with the general thinking around devolution of service provision to municipal level, current proposed changes to the National Health Bill 2001[36] suggest a reversion in thinking to provincial based DHSs with only select health care functions, such as environmental health, devolving to local municipalities. However, uncertainty about the decentralization of PHC to local government and the financing of PHC clinics within local municipalities looks unlikely to be resolved in the near future, and even after the broad policy framework is concluded, the arrangements in different provinces and districts will need to be worked out in detail to suit local circumstances. This will most likely take a number of years.

One of the largest areas of inequity, and one of the biggest challenges, is the delivery of health services to rural areas. Large municipalities based in cities usually have a relatively well developed health infrastructure and they have the funds from municipal revenues to operate such systems. They are also sometimes richly endowed with CSOs that provide a back-up in the areas where municipal health services are less than adequate. District councils, on the other hand, face the challenge of meeting health needs in DMAs where there is usually a very poorly developed health infrastructure and district health managers face the challenge of developing services in these areas with no real infrastructure to commandeer. In this context there is some debate about the reallocation of local municipal (B type) resources (capital expenditure is supposedly determined at the district level) to districts and this possibility is a source of concern in local municipalities. It is estimated that district municipalities will only be fully operational by 2004 and the PHP will therefore be started in this climate of uncertainty. However, the uncertainty is alleviated to a certain extent by the flexibility that is built into the local government system as a whole. Local arrangements between the different authorities are an intended feature of a LG system which has to be flexible in order to accommodate *ad hoc* arrangements which have been put in place over time and to accommodate the need to continue to deliver services to areas which are well resourced, whilst spreading resources to under-resourced areas.

A further issue of relevance to PHP is the management of health budgets. In some provinces, it appears that C municipalities allocate capital budgets to B municipalities, but not operational budgets, which are intended to come from local municipality revenues. But this system is disadvantageous to poorer municipalities which do not generate sufficient revenue to run good quality health services. The concept of district municipalities is that they are planning and integrating structures and one of their primary functions is to resolve this type of problem. Their function, in this respect, is currently best characterised by the development of integrated development plans (IDPs) for the district, which is achieved by bringing together the IDPs of local municipalities into a form which works for the district as a whole.

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[34] This is partly addressed in National Policy on DHS (1996) and the 1997 'White paper on transformation of the national health system', but these issues are very much still to be resolved.
[35] Consistent with the Municipal Structures Amendment Act (Act 33 of 2000)
[36] This bill is critically discussed by Barron & Asia, 2001

Unfortunately the capacity of district municipal structures is considerably less developed than the capacities of sometimes much larger and more established local municipalities. The capacity for planning and implementing at district level is often correspondingly less developed than local capacities and it is not altogether clear (including officials within these different structures) how the relationship between these two different kinds of structures is likely to pan out. Although documents of the Department of Provincial and Local Government refer to these as two tiers of local government, it could be argued that they are not tiered in the sense of one being a foundation on which the other is built, but they are rather parallel systems which have different functions and need to work together. Needless to say the relationships between these structures are critical to the functioning of the system as a whole and the PHP will be situated squarely at the heart of this uncertain and often contested terrain.

The relationship between provincial and district health services is another area where there is much uncertainty. In some districts it is accepted that province will continue to oversee the development and management of major treatment facilities and services and PHC (treatment of minor ailments, prevention and health promotion services) are intended to fall under the jurisdiction of districts. There is uncertainty about how B and C municipalities will resolve areas of jurisdiction, especially over services that fall within urban areas of B municipalities, but there is also some uncertainty about small inpatient units and day-hospitals (level one) facilities which have been under local municipality (B) jurisdiction. Again, the development of partnerships in this context will be subject to ongoing lack of clarity about how facilities and services are classified and under which administration they fall. Recent developments suggest that municipal health (B) will deliver those health services which fall under the heading of 'environmental health' and that all other health services will fall under provincial administration. This development is surprising to many health managers who expected that the move to devolve all primary health services was already established policy. This characterises the uncertainty that currently exists.

A further complexity which has a bearing on the level at which PHP arrangements will need to be negotiated and entrenched lies in an uncertain distinction between types of services. The distinctions between environmental health, treatment facilities and PHC facilities and services (which includes treatment for relatively minor ailments) breaks down in many cases, especially in respect of the ancillary health professions. Purely medical procedures are relatively easily classified. But the same cannot be said of some of the services likely to be offered under partnership agreements. For example, partnerships with an organisation offering home-based care may involve setting up a 'respite unit' in a hospital facility as part of the service, even though the greater part of the work of this organisation may be done in partnership with clinic services classified as PHC. Voluntary counselling and HIV testing would be another type of service which could potentially be offered by a CSO partner and which falls across boundaries which traditionally define the types of health service and administrative level. These cross-cutting arrangements are currently conducted on an *ad hoc* basis and in some respects the lack of formalisation has allowed developments to occur which would prove more problematic or complicated in a system where lines of authority and jurisdiction are more clearly defined. The municipal framework of governance was intended to be flexible, but the flexibility that currently exists – witnessed, for example, in the variety of service provision arrangements that Hospice Association of South Africa has been able to make with provinces and municipalities – may, ironically, be compromised by attempts to formalise systems for establishment of health partnerships in a health system which is, in many respects, not yet matched in structure or function to the municipal demarcation framework.

The complexities described above mean that the PHP is going to need to penetrate and function at all levels of the provincial and DHSs. National frameworks and decisions relating to the functioning of the DHS will also impact at the level of policies and guidelines about the relation between districts and provinces and within districts. This means that understanding of the achievements and challenges of the PHP is going to require understanding of the relationships between these different agencies.

The NDOH does not have a clear, coherent, unambiguous policy on service delivery through CSOs, although there are many cases co-operation between CSOs and different levels of government.

3. FOUNDATIONS OF M&E PROGRAMME

Statements about the importance of evaluation are frequently made in the partnerships for health literature. One such call is for "the development of frameworks that will inform the evaluation of

partnerships and for this work to be a central feature of partnership formation, development and maintenance".[37] However, there is a dearth of work on the evaluation of partnerships and few examples of how evaluation can assist partnership development.

One suggestion for evaluating partnerships[38] involves three contrasting, though related, components: the preparatory work of assessing potential; the process of joint working and monitoring thereof; and an assessment of the extent to which achievements have been fulfilled. The preparatory work is seen as having the process function of fostering critical and evaluative skills within each particular partnership and within the programme as a whole. This means that each partnership needs to begin with an evaluative process, as does the entire PHP programme. The first stage of this would respond to the need to assess the capacity of the system to develop and accommodate partnerships, the capacity of CSOs to enter into partnerships and the needs of the public which stand to benefit from such partnerships.

In the process of implementation decentralisation and partnerships programmes tend to be shaped by local baseline conditions (for example, local political conditions) that were not evident prior to implementation.[39] It is difficult to anticipate the nature of partnerships from this programme and it is likely that the PHP will give rise to a range of novel arrangements between partners, which will be unique in some cases. The challenge here is to develop a methodology for the baseline study and an M&E framework in a context where the activities which will be the substance of the programme are by nature not specifically definable.

Certain key health development areas can be expected to be strong areas of activity because these are priority areas widely recognized as needing input. These will almost certainly include a strong orientation to HIV/AIDS (prevention, treatment, care), but will also include other areas such as TB and maternal and child health programmes. However, understanding of what will happen at what sites and towards what ends will be a product of the PHP development process rather than something that can be spelled out at this time. This poses a significant M&E challenge, and specifically a challenge for baseline studies.

One way of dealing with this challenge is to establish indicators of change that are not overly specific and are which are based on an understanding of partnership processes rather than specific health outcomes in particular areas of practice. This may ultimately lead to evaluation outcomes which show how the character of the health delivery system has changed but leaves us none the wiser as to whether the new arrangements have made an appreciable differences to the lives of people and specifically to their health status.

It is an assumption that this will happen and there is a sense in which this assumption does not need to be questioned although the degree to which better health systems lead to better health is of course an open and complex question. There are many determinants of health that have nothing to do with health systems, not least poverty and social conditions. If the focus of the M&E programme were to attempt to measure the impact on health status there would be a strong risk of showing only weak effects in the short term. This would be the case even in a scenario where the PHP makes a significant contribution to developing health systems which make a difference to the quality of life of people, and where the work of the PHP is an important contribution to a broad front of developments which make a difference in concert.

For these reasons the M&E framework has a focus on outcomes that are directly imputed in the rationale of the PHP. These naturally concern an understanding of the nature of partnerships formed and the impact of such partnerships in terms of the functioning of the health system. The functioning of the health system in this context is of interest in respect of the range and scope of services offered, access to such services, the quality and efficiency of such services, the sensitivity of such services to the needs of the public, the culture of service delivery, the public relationship to and perception of such services and the management of such services including the management of the integration of the health system and the continuum of care.

In order for the PHP to be of more general value than it may be in the 10 contexts where it is located it will be important that the M&E programme contribute to understanding of the models of partnership arrangements that arise. The emphasis on devolution and tailor-made solutions will need to be balanced by a strong M&E programme which binds the parts together into the whole that is the PHP. The

[37] HEBS, 2000, p.7
[38] Douglas, 1998
[39] Atkinson *et al.*, 2000

challenge in setting out a framework for the M&E programme is to develop areas of M&E focus that are most likely to reflect the concepts which will be important across the diverse localities of the programme. Towards this end the review of literature has made a start in outlining what some of these more general issues are likely to be. The M&E elements which have been extrapolated from this conceptual base are presented following.

Proviso: The details of programme targets for the PHP have not been determined and to a large extent will be determined *en route*, through participatory processes involving partners representing the different types and levels of programme domain. For this reason an M&E framework has had to be devised which focuses on the broadest parameters of the PHP rather than on specific interventions. A macro-orientation has been adopted, recognizing that baseline studies, formative evaluations, and niche research are a necessary and important feature of programme development as the shape of projects becomes apparent. Furthermore, specific disease conditions have not been identified as the particular province of the PHP although HIV/AIDS, TB and maternal and child health, as current priority areas in public health, may well deserve to be the focus of attention.[40] But the disciplines to be involved, the foci of partnerships and the targets are at this point can only be speculated about. Therefore the M&E framework presented here is largely oriented around understanding the broad parameters of partnership and service delivery which the programme is intended to bring about, rather than specific impacts in terms of disease profiles.

3.1 Aim and objectives

Aim

To provide a conceptual and operational framework to support the PHP, with particular emphasis on utilisation of data, process, and the outcomes, impact and cost-effectiveness of programme interventions (especially those associated with Municipal (or Metropolitan) Service Partnerships (MSPs)).

Objectives

1. To complete baseline studies in selected District Municipalities or Metropoles which will participate in the PHP, that will form a benchmark against which change (positive, negative, intended or unintended) can be measured, with particular emphasis on key societal, organisational and 'individual' indicators.
2. To develop an innovative programme of monitoring that supports programme stakeholders in active learning and increasing programme effectiveness. Emphasis will be on 'reflective practice', sharing of successes, early identification of problems, problem solving and lesson learning.
3. To evaluate the process, outcomes and impact of the EU 'Partnerships for Health' Programme and thereby address the key operational question: 'Are MSPs a useful, cost-effective and sustainable way to extend and improve PHC services at the district / local government level in South Africa?'

3.2 Principles of programme monitoring and evaluation

Basic principles of M&E that have informed the development of the M&E framework include:

- The need to develop a monitoring and evaluation culture within the PHP that sees M&E as integral to programme activities.
- To develop a framework which closely ties M&E to programme development and specifically to adopt a utilisation-based approach to programme monitoring which is explicitly designed not only to serve the needs of evaluation, but also of programme development by actively addressing the needs of primary intended users.
- To develop a cost-effective system of M&E which uses existing data sources/information systems and avoids the establishment of unsustainable, parallel information systems. Further, to develop an M&E system that generates essential data, but not too much data.

3.3 Indicator development

Indicators should be developed with the following criteria in mind:

[40] Peter Barron, feedback on proposal.

Validity: Measures what it is supposed to measure. Is closely related to the underlying observed fact.

Precision: Must be clearly and unambiguously defined, with parameters and definitions of what is measured clearly defined in terms of data source features.

Sensitivity: Indicators should be sensitive to the changes the programme intends to bring about.

Reliability: Accuracy and replicability of measurement.

Timeliness: Availability of the indicator at the point it is needed.

Comparability: Does the indicator measure the same thing across different contexts?

Additivity: Can the indicator be applied to population sub-groups?

Interpretability: Does a higher value imply that a health system performs better?

Cost: Does cost of measuring an indicator compare favourably with cost of measuring other indicators, and what is the cost relative to the value of the indicator?

Utility: Is the measurement of the indicator of value for programme development? (see table below)

The last of these criteria is particularly important if the M&E process is to enhance programme development. M&E may be a formative as well as summative and evaluative process. The utilisation focused evaluation (UFE) approach to evaluation purposefully enhances the contribution of M&E to programme development, and towards this end has endorsed a number of additional criteria for indicator development.

Utilisation focused indicators

Some evaluators working within a UFE framework recommend a **SPICED** approach to indicator development and assessment:[41]

Subjective: Indicators are developed and negotiated by primary intended users based on their perspectives and intended use of data.

Participatory: Indicators should be developed with those best placed to assess them; i.e. primary intended users (or representatives thereof).

Interpreted and communicable: Locally defined indicators may not mean much to other stakeholders, so they need to be explained.

Cross-checked and compared: The validity of the assessment needs to be cross-checked by comparing different indicators and progress, and by using different informants, methods and researchers.

Empowering: The process of setting and assessing indicators should be empowering in itself and allow groups and individuals to reflect critically on their changing position.

Diverse and disaggregated: There should be a deliberate effort to seek out different indicators from a range of stakeholders/intended users, especially men and women.

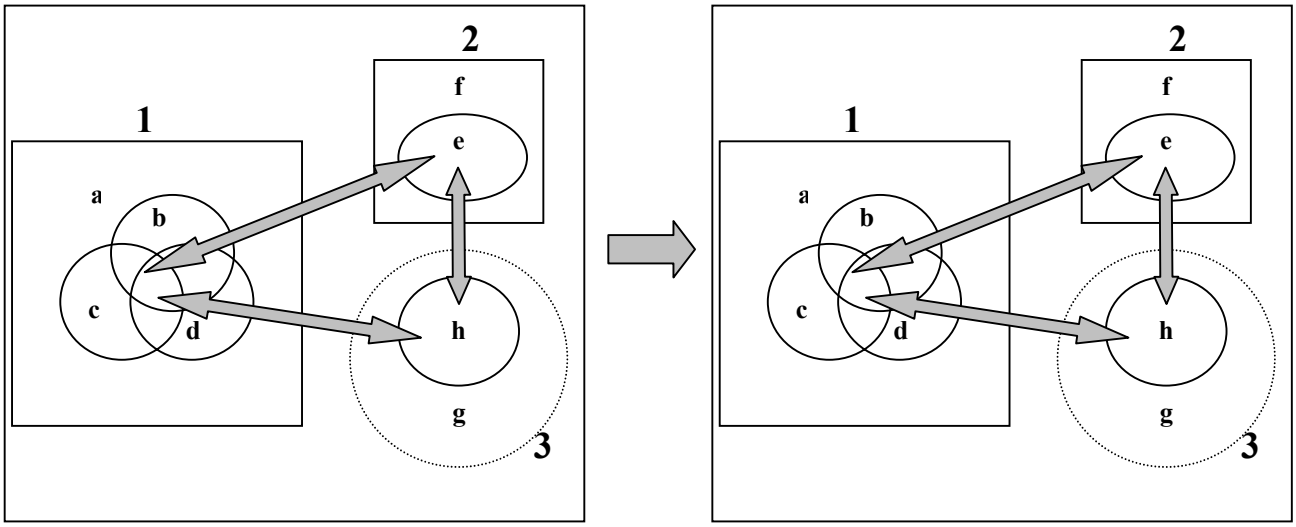
Other important issues to bear in mind when developing indicator measures are:

- It is generally regarded as better to present indicator measures in relative terms (percentages or ratios instead of raw numbers) to facilitate comparability.
- The total number of indicators must be as small as possible, so as to reflect the key dimensions of performance.
- Indicators are never directional. Targets are directional.
- Whether the data is already accessible in a widely available secondary data source or whether primary data has to be collected through health care consumer surveys, household surveys and provider surveys.

[41] Roche, 1999

3.4 Programme domains

BASELINE – T1 **EVALUATION – T2**



DOMAIN	CONSTITUENT AGENCIES
1. GOVERNMENT HEALTH SERVICE	**a. National government** **b. Provincial government** **c. District municipality (C municipality)** **d. Local municipality (B municipality)**
2. CSOs	**e. Local CSO** **f. Parent body of local CSO (district, national or provincial)**
3. PUBLIC CONSTITUENCY	**g. Health service users** **h. Informal health service providers /contributors / volunteers / participants**

The PHP involves support for development of sustainable partnerships between CSO service delivery agents and the formal health sector for the improvement and extension of public health services. Within this framework there are three broad stakeholder groups (domains), each comprised of a number of constituent agencies.

Domain 1: Government health framework

Constituent a. The role of National Government in determining local health delivery is through establishment of statutory and regulatory frameworks, policies, guidelines and priorities. Provincial budgets are allocated at the level of national government, although specific budget allocations are determined provincially.

Constituent b. Provincial government is responsible for allocation of a health budget and setting priorities within the province. Activities at the level of district municipalities and metropoles are guided by provincial allocations and strategic frameworks. Provinces are responsible for planning and monitoring of service delivery frameworks.

Constituent c. District municipalities are responsible for co-ordinating and planning for health in the district as a whole, for integrating development plans of municipalities into district IDPs and for managing service delivery in district management areas. Proportional representation councillors and officials interact in running the affairs of district councils.

Constituent d. Local municipalities are responsible for health services within municipalities. Larger and wealthier municipalities fund their own health services and generally make decisions about allocations of operational budgets. Capital budgets are allocated at district level. Ward councillors, proportional representation councillors and officials interact in running the affairs of the B Municipality.

Domain 2: CSOs

Constituent e. CSOs are represented by local level offices, or organisations within districts and metropoles. These may raise their own funds, or may be community self-help or volunteer organisations with little funding support.

Constituent f. Whilst many CSOs are only locally based, some are part of a larger group which have national and/or provincial offices which to varying extents determine the parameters of their operations and often raise funds for local branches. Partnerships and alliances at local level may be mediated by provincial or national strategic frameworks.

Domain 3: Public constituency

Constituent g. The public is a user and beneficiary of health services but is, in some respects, a contributor through payment for certain services. The public may also contribute through participation in health facility committees, through volunteer services and through CSO organisation membership and service. The public should be characterised as an active user of health services, rather than a passive recipient, as members of the public exercise choices about how they engage with health services. These choices may, in direct and indirect ways, influence the shape of health services. The public may also provide health services to other members of the public and towards this end may be organised into informally constituted associations (e.g. women's support groups, church health visitors, alternative and complementary health groups (traditional healers, herbalists, lay counsellors, etc.)). Health service contributors may also be individuals with particular skills or experience, for example, people with personal experience of particular illnesses who assist others to cope. Health service contributors include volunteers, such as DOTS supporters, lay counsellors, Hospice care givers and emergency service volunteers. This domain also includes community members who are active advocates for particular health issues, for example, those who campaign for the rights of the disabled or intellectually handicapped.

Constituent h. The public constituency of health service users.

Inter-domain

Although the concept of partnership has been defined as partnership between CSOs and local government agencies, the concept requires co-ordination of efforts within domains as well. It is anticipated that the initial work of the project will largely be targeted at co-ordinating and building capacity for the co-operation of different levels *within* each domain. In this respect the PHP will involve partnerships within domains, for example, between provincial government and local municipalities in the provision of specified PHC services. As the programme develops and the actual establishment of partnerships becomes central, it is anticipated that inter-domain (as opposed to intra-domain) work will become the focus. However, initially in order to facilitate the development of such partnerships efforts may need to focus on developing inter-domain partnerships, and notably between provinces and the three types of LG.

Implicit to the concept of partnership is that the relationship is mutually beneficial, and it is important in establishing sustainable partnerships for each partner both to benefit from the partnership and to have leverage to influence the scope and terms of the partnership. The sustainability of partnerships, a subject of much discussion in the literature, rests on mutual benefit through a shared vision, and recognition of this in decision-making arrangements. It will be important to understand the conditions of sustainable partnerships as the programme develops and development of models for successful partnerships will require a close monitoring of the contexts of partnership at all levels including the expectations, challenges and obstacles involved in partnership.

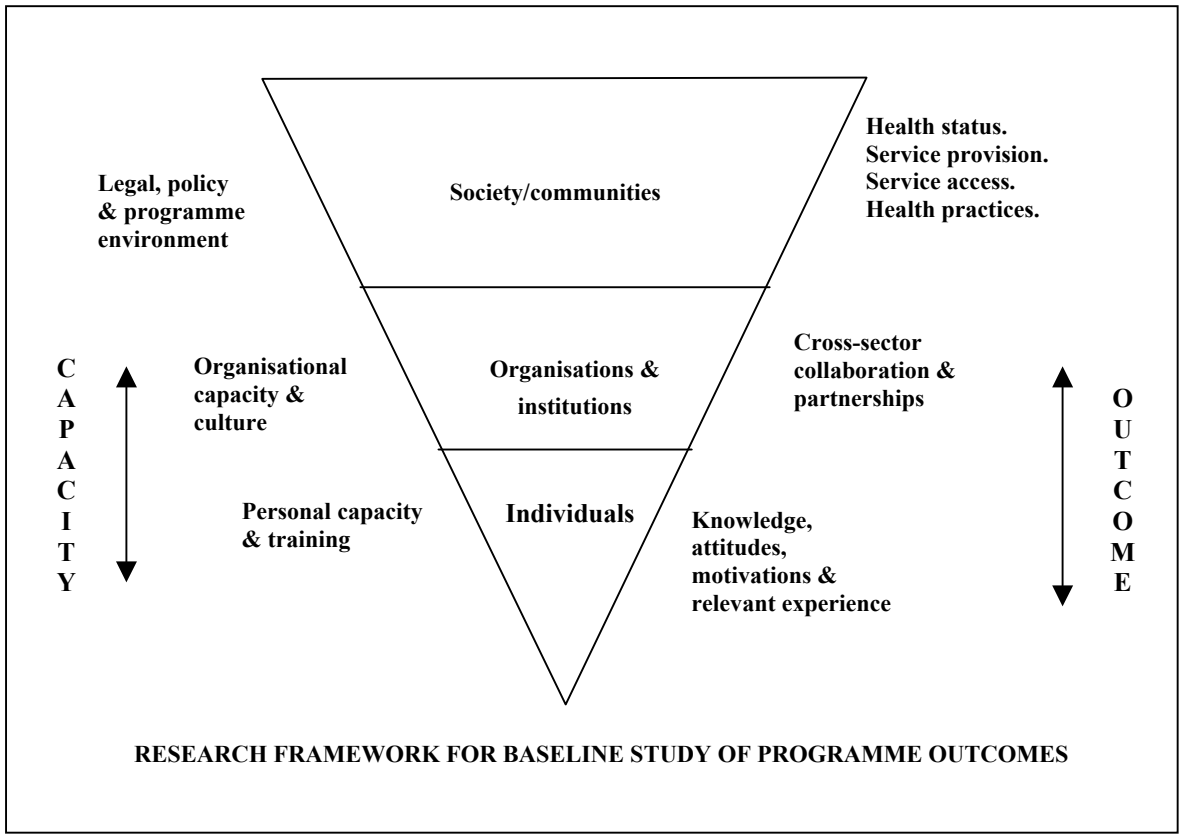
The need to understand relationships between and within domains is also important in developing an understanding of causality with respect to programme outcomes and impacts. If we are to understand an impact such as a decrease in syphilis prevalence in a community, and understand the activities that have led to this impact, it is important to be able to identify these activities. Because the activities essentially involve the transformation of the relationships within and between domains and the development of partnerships within the context of these relationships, we need to know 'what matters' about these partnerships. If there is to be any causal attribution it needs to be based on an understanding

of how partnerships mediate particular outcomes. Following the syphilis example, the provision of SRH services on the part of a MSP may be of benefit because it offers a service that wasn't there before, because it offers a better service in terms of being more sensitive to user needs and concerns, or because it presents a more congenial public interface to potential users. The point is, we need to know which of these options are of particular importance, and the M&E approach needs to be sensitive to these issues at the outset.

Towards this end the literature reviewed on problem areas and ingredients of successful partnerships, needs to be thoroughly considered in developing baseline research instruments.

3.5 Programme activity dimensions

Effective outcome evaluation of cross-sector partnership programmes requires data (including baseline data) to be collected at three levels of analysis, namely at the level of individuals, organisations and society.[42] The figure below shows the three levels of analysis and indicates some broad themes for investigation. These levels of analysis refer to different levels of *capacity* through which PHP *outcomes*



RESEARCH FRAMEWORK FOR BASELINE STUDY OF PROGRAMME OUTCOMES

will be mediated. Note that any dimension of activity can be represented in any service provision location. For instance, the societal level of activity is reflected at the level of a rural clinic in functioning of the drug supply chain, the organisational level is reflected in the relationship of the clinic to the local community, and the individual level is reflected in the motivation of staff.

It is assumed that all programme outcomes will require personal, organisational and societal capacities and support. Accordingly, each of the programme activities needs to be examined in terms of each of these dimensions.

4. M&E PLAN AND INDICATORS

To the extent that formative evaluation processes are used in securing a research-based approach to programme development, evaluation should be seen as integral to all stages of programme implementation. The continuum of development and evaluation is operationalised through monitoring. Monitoring is depicted below as an activity which takes place in collecting data relating to *inputs,*

[42] Adapted from Tennyson, 1998.

activities and *outputs*. It concerns key programme *processes* rather than outcomes or impacts. Evaluation involves measuring the *outcomes* and *impacts* of the programme.

M & E ELEMENTS

Inputs refer to resources which are committed to specific activities. These can be quantified at a cost level and are directly related to the core activities of the project.

Activities of the project include planning, training, managing and other core constituent of programme outputs.

Outputs are intended units of programme delivery; for example, CSO managers trained in M&E and District Management Teams that have established a Partnership Programme plan.

Outcomes are those effects which are brought about directly or indirectly by the programme.

Impact refers to the outcome of the programme over a longer period in terms of the broad rationale of the programme to improve access to health resources.

The baseline study which this document is principally concerned with involves the outcome/impact level of monitoring and evaluation. Because the programme is limited in scale, impacts are measured not at the level of improvement of health status and other ultimate impact measures of health programmes. Rather the domain of impact is the functioning of the health system itself, and specifically the functioning of the partnership relationships, in facilitating access to quality comprehensive health services.

The focus of the document at this level should not detract from the importance of lower level M&E activities which are outlined in the following table under the heading of 'monitoring'. There is further need for development of assessment tools to be used within the programme, in recruiting NGOs and assessing their suitability for partnership arrangements, for understanding preparedness for partnerships within government health structures and for monitoring the functioning of important inputs which will be made as part of the programme in developing capacity for partnerships.

Whilst in the following table the measurement of outcomes and impacts is depicted as an evaluation activity, and the measurement of inputs, activities and outputs is depicted as a monitoring activity, it may be better to depict these two sets of activities on an M&E continuum. Attributing outcomes and impacts to the PHP requires a sound understanding of how the chain of association between inputs-activities-outputs-outcomes-impacts works.

An M&E framework needs to be developed to accommodate the different phases of the 'Partnerships for Health' Programme throughout its intended six year duration. As well as a baseline study and ongoing programme monitoring activity, it will be necessary to periodically review aspects of the programme and the progress of the programme as a whole at shorter intervals. It is suggested that two-year reviews of the programme be conducted; i.e. at two and four years. Such reviews should be conceived as 'formative evaluations'; that is, they will focus on ways of improving and enhancing the programme and increasing its effectiveness. These should involve collation of the PHP outputs in the preceding two years, and would essentially be a consolidation of monitoring data into a review of progress to date. Such a review would ideally be conducted at PMU level (provincial) and the results in each province explored at a workshop of PMUs and then consolidated at the level of the NPMU.

Outcomes and impacts will be measured against baseline study conditions. It is suggested that a mid-term outcome evaluation be conducted at three years and that impacts be measured at the conclusion of the PHP after six years. The measure of outcomes at three years will involve a selective look at specific areas of programme activity, focusing on selected components of the baseline study, and conducted only in those areas where there has been programme activity, rather than at district level. The impact study in six years will involve a repeat of the baseline study at district level. The baseline to six year comparison will used as the foundation for a summative evaluation focusing on impacts, although it will also be necessary to consider formative aspects relating to sustainability.

The following table provides an outline of the suggested M&E plan. It is followed by a more detailed description of key outcome/impact indicators. It must be reiterated, however, that the precise monitoring indicators of relevance are not outlined below except in very broad terms, as there is still considerable uncertainty about how exactly the programme will roll out.

4.1 Overview of M&E framework

The following table provides a broad overview of the types and levels of M&E that will need to be applied. The indicators described in the PHP logframe (Appendix 3) have been expanded and incorporated in this and following (4.2) tables. The indicators are described in general terms only, and the outcome/impact indicators are described in more detail in the following section. Further details relating to development of research instruments and procedures for the baseline and impact studies are described in Section 5.

TYPE	LEVEL	Principal questions	Secondary questions	Objectively verifiable indicators (OVI)	Means of verification (MOV)	Instruments	Agency	Time interval
MONITORING	INPUTS	▪ What resources has the PHP programme committed to what programme activities per time period?	▪ What are the relative allocations to different programme areas? ▪ What are the shifts in resource allocation corresponding to development of the PHP?	▪ Human and material resources committed to particular activities (including training)	▪ Ongoing financial management activities ▪ Training and consulting activity register	▪ Accounting practices ▪ Expenditure records ▪ Training records	▪ PMU ▪ Project managers	▪ Monthly
	ACTIVITIES	▪ What have been the main programme activities over the last 'n' time period?	▪ How do the activities correspond to the annual work plan? ▪ How do the activities correspond to the programme objectives? ▪ What do the activities intend as outputs and outcomes? ▪ Are activities being appropriately planned, tracked, managed and evaluated?	▪ Detailed records of the type, quantity and quality of primary programme activities	▪ Record keeping ▪ Report writing ▪ Formative evaluations of value of activities ▪ Understanding of value of activities in context of PHP	▪ Programme management protocols ▪ Project tracking tools / journals/ records / minutes / activity check-lists/ workshop and activity evaluations	▪ PMU ▪ Project managers ▪ Project implementers	▪ Monthly
	OUTPUTS	▪ Have all programme activities been completed in accordance with the programme log-frame and provincial workplans? ▪ Has design, implementation, monitoring and review of the programme been fully participatory? ▪ Is there evidence of ongoing 'reflective practice' and lesson learning – if so, what, by whom, when where? ▪ Have programme resources (material, human, technical) been appropriately managed and dispersed? ▪ Have all programme management structures been established within agreed time frames? ▪ Are these structures operational, functional, effective? ▪ Is required programme documentation in place, accessible and up to date?	▪ Are programme logframes/workplans accessible to relevant role-players? Are they understood, used? ▪ What record keeping is required to establish what activities have been completed, when where, how and by whom? ▪ Who are the key stakeholders / PIU who are participating in and contributing to the programme? ▪ How are various stakeholder interests being expressed through the PHP? ▪ How is the programme being managed at the levels of domains A and 2 and by whom? ▪ Are relevant procedures accessible, understood, adhered to? ▪ Are programme monitoring activities being turned into accessible and useful reports? ▪ What is the cost-effectiveness of specific outputs across districts? ▪ Do programme outputs have any negative, unintended outputs which need to be mitigated?	▪ Specified programme outputs as defined by annual work plan ▪ Frameworks, protocols, agreements and systems developed ▪ Assessments, training programmes, monitoring and evaluation activities completed ▪ Other defined programme activities completed/not completed by appropriate role player in defined location within required time frame	▪ Project monitoring protocols	▪ Output monitoring protocol ▪ Project journals ▪ Records ▪ Activity check-lists ▪ Provincial workshops ▪ National workshops	▪ PMU ▪ Project managers	▪ Monthly collation ▪ Yearly report ▪ Biannual review at 2 years and 4 years with provincial and national workshops

TYPE	LEVEL	Principal questions	Secondary questions	Objectively verifiable indicators (OVI)	Means of verification (MOV)	Instruments	Agency	Time interval
EVALUATION	OUTCOMES	▪ To what extent has the programme made progress to achieving its purpose; i.e. district health service delivery strengthened through partnerships? ▪ To what extent are district managers able to operate integrated DHSs with partnership components? ▪ What is the increase in number of CSOs with improved capacity to form partnerships with provinces? ▪ What is the change in CSOs providing services in DHSs? ▪ What changes have there been at the level of the DHS able to support CSOs in PHC delivery and evaluation? ▪ What negative or positive unintended outcomes of the programme and for whom?	▪ How is service delivery being strengthened? ▪ How is the relationship between strengthening of service delivery and cross-sector partnerships being established? ▪ What components of an integrated DHS are proving to be more difficult and easier to change? ▪ What management capacities are proving more and less difficult to develop? ▪ What forms of community participation are present in partnerships? ▪ Which CSO types have become involved and what criteria seem to be driving inclusion and exclusion? ▪ What constitutes organisational capacity to form partnerships with government, within provincial and DHSs and within CSOs? ▪ What personal knowledge, attitudes and skills contribute to capacity for partnerships? ▪ How is the SETA initiative being employed in the PHP?	▪ Capacity of Provincial and Municipal Government to develop a framework for operation of an integrated DHS which incorporates partnerships with CSOs ▪ Capacity of CSOs to be incorporated as MSPs in DHS ▪ Operation of integrated district health system with partnerships component ▪ PHC service delivery within defined districts ▪ Number of partnerships formed within defined sphere of government over defined time. ▪ Prevalence of required knowledge, attitudes, skills among defined managers in defined spheres of government ▪ Cost-effectiveness of establishing partnerships as way of meeting health needs	▪ Baseline to 3 year repeat-study using selected outcome indicators ▪ Integration of input, activity and output monitoring activities	▪ District audit ▪ Domain 1 survey ▪ Domain 2 audit ▪ Domain 3 survey ▪ Monitoring records	▪ Evaluation research consultants ▪ PMU ▪ NPMU	▪ Baseline - 3 years
	IMPACTS	▪ Has the programme achieved its overall objective; i.e. more accessible, affordable quality PHC services for the poorest communities in 5 target provinces? ▪ Are the PHC services that have been established/developed within the context of the programme cost-effective and sustainable? ▪ Has the PHP led to a lasting improvement of the context for engagement of CSOs as service providers within the framework of government health services? ▪ Can improvements in PHC services at the intervention sites be attributed to programme outcomes? ▪ Have there been any negative/unintended impacts of the programme –if so, what, for whom, where and why?	▪ To what extent has the programme changed the climate for partnerships between CSOs and public services in other sectors? ▪ Have improvements in PHC services at intervention sites led to improvements in the health status of the local population?	▪ Existence of health partnerships ▪ Changes in access, comprehensivity and quality of health services ▪ Perceptions relating to the above ▪ Use of health services ▪ Reported unmet health needs ▪ Cost per unit of improved service or supporting service ▪ Cost-benefit per units of improvement ▪ Attitudes to partnerships ▪ Sustainability of partnerships in terms of lasting framework for supporting partnership arrangements	▪ Baseline - impact summative evaluation	▪ Baseline – impact evaluation protocol including District audit, Domain 1 survey, Domain 2 audit, Domain 3 survey	▪ Evaluation research consultants ▪ PMU ▪ NPMU	▪ Baseline – 6 years

Summary of M&E framework								
			Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Process	**Level**	**Agency**						
Ongoing monitoring of inputs and activities	Inputs and activities	PMUs and district level PHP managers	monthly	monthly	monthly	monthly	monthly	monthly
District level review	Outputs	PMUs	X	X	X	X	X	X
National PHP review	Outputs	NPMU		X		X		X
Outcome evaluation	Outcomes	NPMU	X		X (select baseline indicators)			
Baseline-final evaluation	Impact	NPMU	X					X

4.2 Key outcome/ impact indicators

The following tables provide a key list of key indicators of the outcome/impact of the PHP on each of the three target domains of the PHP: 'government health services framework', 'CSOs' and 'the public – health service users'. In each instance, in keeping with the model of looking at each of these domains through the lens of activity dimensions ('society/community', 'organisation/institution', 'individual'), for each domain the activity dimensions are used as categories in relation to which indicators are described.

The development of instruments for measuring these indicators is described in Section 5.

4.2.1 *Domain 1: Key outcome indicators – government health response to PHP*

IMPACT OF THE PHP ON SCOPE AND QUALITY OF GOVERNMENT HEALTH SERVICES (DOMAIN 1) AS A RESULT OF PARTNERSHIPS WITH CSOs (DOMAIN 2)

System/community

- Referral of clients to CSO services and facilities
- Sharing of facilities
- Implemented partnership agreements (percentage average annual growth in number of partner agreements implemented over 'n' time period)

Organisation/institution (capacity for partnerships)

- Existence of protocols and frameworks for development and implementation of partnership agreements
- Evidence of a district plan relating to PHP
- Evidence of implementation of a district plan relating to PHP
- Existence of organisation communication conduits or co-ordinating functions between statutory authorities and CSOs at provincial and district Level
- Evidence of skills/competencies (administration, financial management, planning, information use) on part of district and local municipal management team members to support cross-sector partnerships
- Existence of an integrated administrative system for PHP at provincial, district and local levels
- Evidence of use of DHIS monthly data in planning and co-ordinating district services and partnerships
- Evidence of protocols for CSO MSPs to record and feed essential health data into DHIS
- Existence of a monitoring system for partnership agreements at district level
- Integration of partnership activities into DHIS routine collection of patient data
- Evidence of municipal planning documents with CSO inputs
- Communication channels with and protocols for referral to CSOs in evidence
- Existence of co-ordinating meetings between municipal DOH and CSO MSPs
- Recognition of educational equivalencies of CSO workers or progress towards this
- Staffing levels adequate for accommodating CSO partnerships at all levels
- Evidence of appropriate training to support partnerships at all levels

Individual

- Evidence of motivation and incentives for DOH personnel to support partnerships
- Knowledge of expectations relating to partnerships
- Knowledge of the existence of PHP and relevant guidelines developed, at all levels
- Perception by clinic managers of support for partnerships on part of district management
- Existence of conflict or dissension about the PHP
- Support amongst staff at different levels for partnership development
- Knowledge on part of municipal of institutional implications (burdens and advantages) of partnerships.
- Knowledge of referral procedure for CSO referral
- Attitudes towards cross-sector partnerships (motivations and concerns)
- Personal experience of successful participation in cross-sector partnerships
- Attitude of DOH health workers to CSO workers
- Attitude of DOH health workers to referral to CSOs
- Perceived competency of CSO MSPs in particular areas

IMPACT OF THE PHP ON THE RESPONSIVENESS OF GOVERNMENT HEALTH SERVICES (DOMAIN 1) TO PUBLIC HEALTH NEEDS (DOMAIN 3)

System/community

- Existence of partnerships for service provision or service support in the following areas: HIV/AIDS prevention; HIV/AIDS continuum of care and support; antenatal care; home-based care for chronic illness; DOTS; IMCI; syndromic management of STIs; INP; confidential counselling services; VCT services; environmental health; school health; workplace health programmes; remedial and rehabilitation services; mental health; welfare-health functional integration; and other intersectoral collaborations which include health.
- Evidence of proactive attempts in relation to each of the above for: monitoring of community response; promotion of community participation
- Monthly statistics of illness profile from all PHC facilities collected and analysed in relation to services provided
- Evidence of partnership innovations to increase access to PHC services to vulnerable, immobile or isolated members of communities

Organisation/institutions

- Evidence of district management efforts to improve accountability of PHC services to communities through partnership
- Evidence of promotion of Batho Pele principles
- Existence of facility-community committee (clinic committee, hospital board)

Individual

- DOH worker attitude towards working for community
- Health workers who are courteous, empathetic and tolerant
- Knowledge of Patient's Rights Charter principles

4.2.2 Domain 2: Key outcome indicators – CSO engagement through PHP

IMPACT OF THE PHP ON CSOs (DOMAIN 2) ENGAGING WITH GOVERNMENT HEALTH SERVICES (DOMAIN 1)

System/community

- Referral of clients from public health sector and services
- Referral of clients to different types of CSO services.
- Sharing of facilities with local government services
- Implemented partnership agreements as percentage of CSOs working in the health field (Alternatively, percentage average annual growth in number of partner agreements implemented over 'n' time period)
- Evidence of CSO MSPs working to minimum service standards adopted by agreement between CSOs and DHS
- Existence of accredited training programmes in areas of operation of CSOs

Organisation/institutions

- Existence of involvement of CSOs in district level co-ordination of areas of service in which CSOs are involved
- Existence of a policy of engagement of parent body of CSOs in facilitating engagement in partnership arrangements.
- Existence of organisation communication conduits for co-ordinating function between CSOs and appropriate levels of DHS
- Existence of district level data-base of health-related CSOs updated in the last year
- Evidence of linkages between CSO services provided in context of DHS
- Knowledge of management and institutional implications of cross-sector partnerships
- Evidence of skills/competencies to support cross-sector partnerships in terms of administration, management training, planning, financial management and accountability, human resources development, monitoring and evaluation
- Evidence of recent training or updates in the above
- Evidence of CSOs planning to engage in formal arrangements for delivery of services within context of DHS
- Evidence of CSOs engaging with municipal health priority setting and integrated development plan implementation
- Evidence of readily available contact details and referral protocols between services
- Use of agreed upon referral protocols.
- Existence of co-ordinating meetings with local level DOH managers
- Evidence of use of methods for assessing quality of service delivery
- Clear job expectations relating to partnership services
- Adequate physical environment, including proper tools, supplies and workspace for services implemented through PHP
- Evidence of formal monitoring and evaluation activity in the past two years
- In relation to partnerships: existence of written service development and management plans; access to relevant acts and regulations; written records of meetings; regular co-ordination meetings; formal procedures for appointment and hiring; code of ethics; confidential information management; clear lines of referral; case management records and statistics
- Recognition of educational equivalencies of CSO workers
- Evidence of Government funded CSO activities in specific domains of CSO service delivery including: HIV/AIDS prevention; HIV/AIDS continuum of care and support; antenatal care; home-based care for chronic illness; DOTS; IMCI; syndromic management of STIs; INP; confidential counselling services; VCT services; environmental health; school health; workplace health programmes; remedial and rehabilitation services; mental health; welfare-health functional integration; and other intersectoral collaborations which include health.

Individual

- Attitude of CSO health workers to government health system.
- CSO managers in sampled areas with knowledge of relevant legislation and policies relating to partnerships
- Positive attitudes towards cross-sector partnerships (motivations and concerns)
- Nature of experience of participation in PHP
- Knowledge of opportunities associated with the Health & Welfare
- Access to training opportunities accredited by SAQA
- Perception of being encouraged to gain accreditation for equivalent experience
- Management trust in competency of low level workers in relation to work demands

IMPACT OF THE PHP ON THE INVOLVEMENT OF CSOs (DOMAIN 2) IN EXTENDING AND IMPROVING PUBLIC HEALTH SERVICE PROVISION (DOMAIN 3)

System/community

- Existence of partnerships for service provision or service support in the following areas of PHC: HIV/AIDS prevention; HIV/AIDS continuum of care and support; antenatal care; home-based care for chronic illness; DOTS; IMCI; syndromic management of STIs; INP; confidential counselling services; VCT services; environmental health; school health; workplace health programmes; remedial and rehabilitation services; mental health; welfare-health functional integration; and other intersectoral collaborations which include health.
- Evidence of proactive attempts in relation to each of the above for: monitoring of community response; promotion of community participation
- Monthly statistics of illness profile from all CSO facilities collected and analysed in relation to services provided
- Evidence of partnership innovations to increase access to PHC services to vulnerable, immobile or isolated members of communities
- Evidence of extension of CSO services to disadvantaged communities
- Evidence of change in orientation of CSO providers to better service needs of most disadvantaged communities

Organisation/institutions

- Evidence of engagement of CSOs with community structures
- Evidence of monitoring activities in CSOs to assess the relevance of services to community needs
- Use of volunteers in CSOs
- Training of community members in health provision
- Involvement of members of disadvantaged communities in CSO committees

Individual

- Attitude of CSO health workers to community

- Knowledge of CSO service providers of community health needs
- Ability of CSO service providers to speak the home languages of their clients
- CSO managers in sampled areas with knowledge of relevant legislation and policies relating to partnerships
- Positive attitudes towards community orientation of CSOs

4.2.3 Domain 3: Key outcome indicators – impact of PHP on health service users

IMPACT OF THE PHP ON ACCESS TO AND USE OF HEALTH SERVICES - THROUGH EITHER GOVERNMENT HEALTH SERVICES (DOMAIN 1) OR CSOs (DOMAIN 2)

System/community

- Use of local health facility by community (clinic attendance)
- Ease of access to services provided by clinic
- Access to essential health services
- Access to comprehensive health services
- Type of services provided which disadvantaged communities have ready access to
- Use of local health facility by different sectors of the community (age, gender, mobility, SES, marital status, education level, household type)
- Perception of quality of service on part of local community
- Average wait to be attended at health service
- Health status indicators: individual; family members; women; children
- Knowledge of availability of: essential health services; ancillary health services; social support services
- Major health concerns of those attending / accessing services
- Increases/decreases in symptom profiles: Most common reasons for clinic attendance
- Awareness of the following services offered at community level (within ward boundaries): HIV/AIDS prevention; HIV/AIDS continuum of care and support; antenatal care; home-based care for chronic illness; DOTS; IMCI; syndromic management of STIs; INP; confidential counselling services; VCT services; environmental health; school health; workplace health programmes; remedial and rehabilitation services; mental health; welfare services for health care.
- Households with chronically ill that have received home visits.

Organisation/institutions

- Community based organisations represented on district management committees and PHC committees
- Community health organisations with a knowledge of opportunities in PHP
- Availability of training for community members in health care
- Evidence of knowledge of possibilities for recognition of educational equivalencies
- Members of community organisations being trained by CSO partners
- Evidence of community organisations being engaged in functional integration of services with community based organisations
- Evidence of mechanisms for co-ordination of community welfare and development organisations with DHS
- Opportunities for engagement of community agencies and advocacy groups in PHP

Individual

- Understanding of range and type of services provided and to be expected from clinic
- Trust in health system
- Attitude to health services and providers
- Levels of possibilities for involvement in committees
- Knowledge of possibilities for redress and advocacy in cases of dissatisfaction with functioning of health system
- Satisfaction with health services
- Perception of health service availability
- Knowledge of referral system
- Perception of sensitivity of formal health system to cultural and psychological needs of clients
- Personal orientation to health service use
- Perceptions of commitment of health services and CSO services to Batho Pele principles
- Selective indicators of health behaviour and understanding of disease and illness

5. BASELINE STUDY

5.1 General principles of baseline research design

Research design

It is difficult, and arguably not possible, to conduct evaluations of large scale programmes such as this one over a long period of time, using randomised control trials. It is highly likely that success stories in one district in a province will lead to adoption of the intervention in other contexts. That this should happen is an intended outcome of the PHP which makes the use of control groups both practically and conceptually inappropriate.

There are four possible problems[43] in assessing attributable project impacts:

- Co-interventions: similar projects might be promoted by other parties.[44]
- Contamination: other factors might be affecting measured parameters.
- Compliance: project parties might introduce variations, which is likely, since the project concept involves adaptation to the different contexts in which the PHP will be implemented, through participatory processes.
- Clock: the time may not be long enough to detect changes.

The difficulties involved in overcoming these problems rule out a rigorous control-group design. As an alternative a simple pre-post intervention design is suggested, that has a strong element of process measurement so that changes and differences may be linked to activities of the programme. The attribution of effects to the programme will need to be made through a weight of evidence approach that needs as a base of evidence, systematic monitoring and documentation of inputs, activities and outputs throughout programme development. By understanding the relationship between indicators at each of these levels, and presuming that the districts will vary in respect of such variables, it will be possible to associate outcomes and impacts with programme inputs, activities and outputs.

An M&E framework and baseline studies will need to be developed for component projects as well as the PHP as a whole. 'Micro' evaluations can be used to complement the 'macro' M&E process which this document is primarily concerned with. This approach is necessary because the programme will have a staggered introduction and the exact foci, targets and locations of specific projects are not determinable at this stage. To this extent the PHP will be monitored and evaluated not through a single study but through an active programme for monitoring and evaluation that cannot be designed at the outset. This will be implemented by provincial monitoring units (PMUs) coordinated by a National Programme Steering Committee that promotes ongoing monitoring, formative evaluation and niche evaluation as an integral part of programme development.

Use of existing data sources

Commentary on the use of specific data sources is included below. In principle, where existing data is of good quality and relevant it should be used. However, in summary there is very little existing data which is of any direct use in the baseline studies, other than that which will be accessed in scoping and doing basic district audits. The emphasis of this programme necessitates the collection of specific types of data which is for the most part not available.

The same is not necessarily true for the many smaller M&E projects which will be part of the PHP. In some instances it is likely that data which is routinely captured at district and local municipality level will indeed be useful. On a smaller scale it will be possible to improve the quality of specific data collection procedures in the interest of M&E, but this may prove to be too onerous for its value at the level of the PHP as a whole.

Data collection domains

The following framework requires three different research instruments and procedures designed to capture essential baseline data relating to the outcomes and impacts of the PHP. Many of the indicators to be measured have been operationalised in existing instruments used for DHS research in South

[43] Suggestions made by Dr Erich Buch, Monitoring and Evaluation Reference Group Meeting, 24 July 2002, Gauteng.

[44] For instance an attributable parameter that may be useful for the PHP given its emphasis on technical assistance may be whether CSOs can write funding proposals. It is conceivable and even likely that other initiatives and inputs relating to this could be introduced during the life of the PHP.

Africa. However, other indicators relating to the unique context of the PHP will need to be developed into appropriate measures.

The three instruments correspond to the three programme domains described above. They involve collection of data about programme activities from each of these perspectives. Indicators from each of these domains relating to specific programme activities will need to be grouped together in developing M&E reports.

Sampling

Details of proposed sampling methodologies for each of the domains are presented below. The general approach is based on a mixture of selective sampling and systematic random sampling procedures. Types of sites will be selected and within this, systematic probability sampling and possibly random sampling procedures[45] will be employed for specific site, organisation or household selection. The sites and sampling procedures used in each of these domains will need to be carefully recorded so that the study can be repeated. The sampling frames used are not specifically designed to capture the universe of each of the districts, so much as to capture particular kinds of data which will be useful to measure through repeat surveys.

In summary, the sampling framework takes, as its primary domain of analysis, the interface of the public and the health system. The sampling frame is primarily oriented around selection of health delivery sites (Domain 1). The public (Domain C) in the vicinity of these sites will be systematically sampled after selection of health delivery sites is made, and CSO (Domain B) presence in each of these sites will be audited. The baseline study universe is, however, not limited to the encounter of the public with the health system. Within each domain but also the societal, organisational and individual characteristics which mediate this will be captured. Whereas the sampling frame is geographically located the M&E methodology is to search for 'upstream' mediators of local conditions, in the form of indicators of preparedness of PDOH, DDOH and CSO agencies for effective and sustainable partnerships, as well as for engagement with the public in this process.

In addition to collecting data in the three domains, it will be necessary to conduct a more macro level of audit of the PHC facilities and services available and of the CSO domain in each district. Procedures for this are described below.

5.2 Development of research instruments and procedures

In developing the instruments and procedures for the baseline study it will be necessary to balance the need for contextual sensitivity and standardisation. Research tools will have to be sensitive to the different localities in which the PHP is to be conducted, but also standardised, so that meaningful comparisons can be made across sites and conclusions can be reached about the achievements of the PHP as a whole, at outcome and impact levels. Issues which will be particularly challenging to deal with: sampling and generalisation to the district; sensitivity to the different types of organisations and health programmes involved; and sensitivity to the different types of processes and activities which will be involved in the PHP programme and their baseline conditions, when the types of activities are not predetermined.

It has been suggested that "CSO staff and community members have good ideas on indicators and how to measure them and the tool would benefit from their inputs in further development".[46] It has also been shown that in partnership programmes[47] it is important to use the process of developing indicators as a preliminary 'buy-in' process for all involved. Groundwork for this can be done through a first stage of the baseline study, involving developing and testing research instruments. It is important that this process be conducted at the different programme domain levels including national, provincial and local levels.

Research instruments and procedures will need to be developed and tested in sample contexts in most of the districts, not only so that they are suitable for the contexts in which the baseline study will be conducted, but also by way of laying the foundation for access to the facilities and populations in the district. This process will need to be done carefully, as it will be the first contact of most of the stakeholders with the PHP, and the way it is managed will have implications for how the programme is initially perceived. These could be negative or positive.

[45] To the extent that it is possible or practical to use lists of potential participants.
[46] Gordon & Ndondo, 2001, p.6
[47] HEBS, 2000

In the first instance it is necessary to engage provincial, district and local municipal stakeholders in obtaining support and authority for the baseline research, and for development of the research instruments. It will be important that all local municipalities are also approached directly, as chains of authority and management do not necessarily flow unimpeded from province to district to local municipalities. Chains of authority between district and local municipalities are often not strong or clearly defined. Furthermore, local municipalities may operate services independently of province and districts, and authority for conducting research in these should be obtained through an independent process.

In this process it is necessary to obtain blanket authority to work in clinics and to obtain the necessary documentation to assure this at all levels of the PHC system. It is important to ensure that authority for the study is communicated through District Management Structures to all levels of DOH service provision.

It is also necessary to use local media channels and existing CSO networks, including national newsletters and relevant listserves, to publicise the forthcoming audit and to inform organisations of the Partnership Programme and baseline study. National CSO bodies should be approached as well, to ensure maximum support and they should be asked to communicate such support to their branches.

Fortunately the relatively small scale and unintrusive process of developing the research instruments will break the ground for the more intensive process of engagement involved in the baseline studies. This process will involve speaking to relevant stakeholders about the programme and exploring key indicators in a workshop[48] to be held in each of the districts, involving key stakeholders from each of the domains. This would not need to be done 'from scratch', as a preliminary set of indicators as set out in this document may be used as a basic framework. In addition to this, a basic questionnaire will need to be developed to be sent to CSOs in the research phase, and which will be used to record services offered and basic information pertaining to participation in the project, led by the indicator list which will be developed.

Procedures and sampling frameworks will also need to be developed which suit the conditions of each district. The same workshop could be used to develop an understanding of the challenges that will be faced in doing an audit of the district. A preliminary list of the larger CSOs involved in the district will need to be obtained, as will district information about health services and facilities. This information will need to be drafted into a format that will be readily useful in the baseline studies when an audit will be done of CSOs, services and facilities, and access of the public to quality health services.

After developing draft instruments and procedures, developers will need to test these instruments in at least one randomly sampled health facility, CSO and community in each district.

Finally, the developer will need to draw a sample of the facilities to be used in the baseline study. This will need to be done in respect of each of the three research domains described below.

The outcome of this initial phase will be tested, field-ready research instruments and procedures. The protocols will need to contain notes on analysis for each indicator, and the specific numerators and denominators to be used for each indicator measure. In addition to this, a preliminary audit of key organisations and personnel should be included and made available to the baseline researchers. This will need to include addresses and up-to-date contact numbers.

5.3 District audit

In each of the 10 districts a basic macro level audit of all three domains will need to be done.

For *Domain 1* the work described in point two under key resources below, provides a broad methodology and an appropriate level of address. In addition to the broad areas looked at in this study, the following indicators will need to be looked at: existence of partnerships at district level; existence of protocols and procedures for managing partnerships at district and provincial level; and management capacity at district level to manage partnerships. These indicators are included in the table under Domain 1 below. This information can be collected thorough existing District Health Information Systems (DHIS) data collection procedures (see 4.4) and through interviews with key officials and managers in the district including Municipal Managers and health portfolio managers of all local municipalities in the district. In addition, provincial health officials will need to be interviewed.

[48] A useful model for this is the work reported in Buch n.d.(a) which involved engaging regional managers in developing management performance indicators.

For *Domain 2* a comprehensive list of CSOs offering health services in the district will need to be compiled. The methodology for this should follow a snowballing technique, until it becomes apparent that further enquiry does not turn up new cases. Such organisations are frequently known to other organisations and it is likely that a comprehensive list will be obtained in this way. A preliminary list will be available from the instrument development processes and the researchers will need to ensure that this is indeed comprehensive. All of these CSOs will need to be visited or sent postal questionnaires for completion by senior management. The development of this basic questionnaire has been described above as part of the process of development of tools and procedures for the baseline study.

For D*omain 3* there does not need to be a district level audit. Domain 3 data collection will be limited to the catchment areas of facilities that are selected for inclusion in the facilities and services survey described below.

5.4 Domain 1: DOH partnership preparedness - Management, facilities and services survey

Partnerships with CSOs will be operationalised at provincial, district and local levels. For these partnerships to be transformed into practical arrangements at the level of PHC clinic practice, preparedness will have to devolve to the level of these clinics. This component of the M&E framework considers DHS PHC preparedness, and meeting of programme objectives primarily from the perspective of the health system.

Key resources[49]

1. The 2000 'National PHC facilities survey'[50] is a valuable resource for understanding the methodological challenges in conducting health facility surveys. Also, the 1997 and 1998 surveys of PHC services in the Eastern Cape Province are a valuable source of information, particularly because they define the key indicators that they use. A 2001 survey is currently being analysed, which will provide usable data for the two health districts in the Eastern Cape, possibly making formal health facilities surveys redundant. However, it is suggested that specific data relating to partnerships will need to be collected, possibly necessitating repeating a health facilities survey tailored to the needs of the programme even in this province.

2. 'Fitting functionality into boundaries'[51] analyses the health service rendering features of two district councils in the Southern Free State Health Complex. The study documents the results of an audit of health services in district and local municipalities. Health system features and characteristics were described for a district council and its constituent local municipalities. The study is useful for conducting an audit on a district level. Organisational, managerial and resource requirements for the provision of an effective service, were considered. The categories for data collection per district were: demographic and geographic features; primary level facilities per local municipality; hospitals and medical resources; clinical support services; paramedical services (including physiotherapy, oral health, dietics services, environmental health officers and community liaison officers); and emergency medical services, transport and vehicles. In respect of each of these the implications for the organisation and management of health care were considered. The study provides an excellent model for a district wide audit of existing services. Such an audit can be conducted on the basis of existing records.

3. 'Health Care in the Free State. Implications for planning – 1996',[52]has GIS maps of every region showing clinics and Health Centres with 5 km and 10 km radii around them. The document also includes mobile clinics or service points and from these maps it is easy to see the areas not covered. 'Mapping for primary health care'[53] describes the use of district maps, clinic catchment areas and community mapping in the Eastern Cape province of South Africa, and includes a field guide to using the method. This document points out that cartographic depictions of coverage, without community mapping, do not give a full picture of where clients come from and which facility people consider "our health care provider", which is the true catchment of a health facility. A methodology is described for mapping areas where the population lives which needs access, through referral, to a higher level of care and where the health centre and clinics are which need support. Different types of maps can be created

[49] A useful review of health and related indicators is provided by Day & Gray (2001). Williamson and Stoops (2001) provide further information on common data sets and their application to the health sector.
[50] Viljoen *et al.*, 2000
[51] Schuping & McCoy, 2000
[52] Health Systems Trust, 1996
[53] Bennett & Rohde, 1999

relating to patient care and community support functions of health facilties. A clinic catchment area map shows where the population is, which has access to the services, and where the communities are which need support in improving their own health. A hospital catchment area shows where the population live who need access, through referral, to a higher level of care and where the health centre and clinics are which need support.

4. Pillay *et al.* (1998) includes a clinic and CHC manager's checklist, relating to areas of clinic management, and is useful for generating indicators around clinic CHC management, especially relating to quality of care.

5. Atkinson *et al.* (2000) describe indicators for assessing the personal, organisational and socio-political elements of decentralisation.

6. A report and handbook of indicators for measuring results of health sector reform relating to system performance,[54] provides valuable conceptual grounding for development of system indicators and indicators relating to access, equity, quality, efficiency and sustainability.

7. Work in the area of performance management of health managers[55] is potentially useful for generating indicators for management of partnership arrangements. A draft list of indicators provides some of the key areas of performance for regional managers. This work stresses the importance of involving stakeholders in the process of generating indicators.

8. Pillay *et al.* (2001) 'Developing and implementing an HIV/AIDS plan at district level' is based on work done in the Eastern Cape by The Equity Project but also reviews work done in other provinces of South Africa and internationally. It is a useful resource book on the elements of a comprehensive HIV/AIDS plan at district level.

9. There are a number of internationally developed indicator sets[56] for second generation HIV surveillance, which consider, amongst other things the preparedness of health systems to deal with aspects of the HIV/AIDS health crisis.

10. A number of indicator sets exist for assessing the functioning of health districts. These include: national districts competition indicators; 'well functioning districts' indicators; national reporting format indicators; supervisory checklists and their indicators; core package and expected outputs; PFMA reporting requirements. 'The Primary Health Care Package for South Africa: A set of norms and standards'[57] is also an important resource for developing this part of the baseline study.

Available data[58]

Much available research data, for example, data from previous health facilities surveys, is not based on current district demarcations. This means that it is not readily useable as baseline data for the PHP programme. A notable exception is the Eastern Cape where a survey of PHC facilities has recently been undertaken and which uses current District boundaries. The National Primary Health Care Facilities Survey,[59] last conducted in 2000, does not disaggregate data to district level, and the sampling frame was not such that a valid and useful picture can be obtained for the 10 district involved in the PHP programme.

Initiatives to develop an integrated DHS system[60] driven by an integrated health and management information system (DHIS) have been facilitated by the Health Information Systems Programme (HISP) of the University of the Western Cape. This has led to a coordinated national strategy for DHIS. It is reported[61] that good progress has been made and in most provinces Primary Health Care Monthly Clinic Reports on key PHC indicators are presented. In 1999 a national Primary Health Care Essential Data Set consisting of 49 data elements was approved. Subsequently, all provinces have developed data sets for PHC. There is not strong consistency or standardisation between provinces and districts with respect to what data elements are collected. Further, whilst good progress has been made, it is reported

[54] Knowles *et al.*, 1997
[55] Buch n.d. (a, b, c)
[56] UNAIDS, 2000; USAID, 2000
[57] Department of Health, 1999
[58] Williamson & Stoops (2001) provide a useful table of common data sets and their application to the health sector.
[59] Viljoen *et al.*, 2000
[60] Muschel, 1999
[61] Williamson & Stoops, 2001

that provinces are grappling with the development of coordinated systems and structures to support data handling at district level. There are also some concerns about the quality of some of this data[62] and a sound baseline study requires more reliable data than can be guaranteed by this routine data collection.[63] Furthermore, although the data is expected to be routinely submitted to the National Department of Health, it was reported in 2001 that there were poor mechanisms in place to facilitate sharing of this data between national and provincial health departments. Mechanisms at provincial and national level to analyse the data and to provide a clear picture of health status are still in development.[64]

Population data is available on population for each of districts and local municipalities, including age grouped population data, extrapolated from the 1996 Census to estimated 2002 demographics.[65] Data from the 2001 Census will only be available in 2003. Detailed countrywide 1996 census data is also available at the level of ward constituencies in each of the newly demarcated local (B) municipalities and district management areas per province.[66] This can readily be collated at the level of district (C) municipalities. This includes: population demographics, employment status, basic facilities, type of dwellings, population by age, marital status, gender, literacy, language group, population density maps, electricity and water distribution. Similar data from the 2001 Census will become available in 2003. The way that this data is organised and presented makes it useful for survey planning.

The latest October Household Survey was completed in 1999, and given that the PHP has a six year lifespan only, the age of this data would prove problematic as a foundation for the baseline study. Furthermore the 'timeliness' of available data for the follow-up survey could prove problematic.

Procedures

Sampling

The model is based on a probability sample of facilities within the health district. Sampled health facilities would be revisited for the follow-up outcome and impact surveys, allowing for evaluation of specific changes at the level of particular facilities and which would pick up particular changes and partnership arrangements that are made.

Clinics

- All clinics within the geographical boundaries of each district municipality (or metropole) to be listed from existing databases, categorized as fixed, satellite or mobile clinics (visiting points). Random selection will be used to select 20% of each type of clinic or a minimum of 4 of each type per district.
- Where districts comprise a mix of urban and rural clinics, proportional random sampling will be used to ensure that both types of setting are represented in the final sample.
- Since the number of B municipalities differs across C municipalities (districts) the number of clinics selected in each C municipality will differ.

District hospitals

It is questionable whether hospitals should be included in the survey since the programme focuses specifically on PHC services. However, some PHC service providers will also need to work in treatment facilities other than PHC clinics, so it may be advisable to include hospitals. However, this will increase the cost of the study and may not be warranted in terms of the PHC focus of the PHP.

- In each of the districts, hospitals will need to be listed as falling into each of the following 3 categories: up to 100 beds (small); between 101 and 200 beds (medium); and more than 200 beds (large hospitals).

[62] Although the correspondence between data captured in the district health infomatics system in the Eastern Cape showed a good similarity with the 1998 DHS data when this was disaggregated to the same district boundaries.
[63] This is also confirmed by Moodley (2000) who outlines a number of problems in the Western Cape, at the level of collection and interpretation of a set of standard RH indicators.
[64] This is confirmed by a study by Mbananga and Sekokotla (2002) in Mpumalanga Province.
[65] http://www.hst.org.za/local/docs/popdata.htm
[66] http://www.statssa.gov.za/default3.asp

- One hospital from each of these categories will need to be randomly selected, or if there is no larger hospital category, facilities of smaller hospitals should be selected, totaling 500 hospital beds selected.

Fieldwork procedures

The exact procedures will need to be worked out in the preparation of baseline instruments and procedures. It will be necessary to interview facility managers in person. It may also be advisable to interview at least one lower level staff member per facility.

Key indicators

A draft table of suggested indicators is presented in Section 4.2.1.

Indicators potentially cover the full range of PHC health service and facility indicators. However, the data collection process should concentrate on those indicators which relate most directly to the partnership programme. Of particular interest are areas of integrated services where CSO service providers are most likely to be brought in as partners.

Problem areas

- Lists (names and locations) of different categories of facilities are obtainable from respective provincial health authorities. In the National PHC Facilities Survey[67] it was found that with the exception of Limpopo Province, lists obtained from provincial health authorities were found largely to correspond with facilities on the ground. Therefore they can be used for sampling frameworks. If it is found that they don't correspond, lists can be updated at district level.
- Authorisation for the National PHC Facilities Survey [68] was problematic, leading to costly delays. Authorisation for data collection will need to be obtained from national and provincial health authorities, district and local authority managers, as well as from managers of the sampled PHC facilities and hospitals. It would be preferable if authorisation were to be obtained by the National Programme Steering Committee at a provincial and district level to obviate problems. Authorisation will need to be obtained on a case by case basis for selected facilities. The agency for obtaining such authorisation will need to rest with the research team, armed with appropriate authorisation at Provincial and District level.
- Differentiation between categories of PHC facilities is not clearcut and this was a problem in the 2000 National PHC Facilities Survey.[69] It is suggested in the report on this study that a mechanism for troubleshooting in this area needs to be set in place. Hopefully, the time spent on development of tools and procedures will iron out these problems on a district basis.
- Some clinics operate on certain days of the week only and as proved to be the case in the National PHC Facilities Survey, this made data collection problematic.
- The research will interfere with service provision procedures and adequate forewarning of the research is necessary, but difficult to operationalise.

5.5 Domain 2: Audit of health services and readiness for partnerships of CSOs

Key resources

1. Perhaps the most notable resource of direct relevance to the PHP is a report[70] on development of a tool to assess the readiness of civil society organisations to enter into partnership with municipal health departments in South Africa. Methods discussed include: document review; self-administered questionnaires; individual and group interviews; observation; and participatory learning processes which bring stakeholders and non-profit organisations together.

2. Another useful resource is a list of indicators[71] of aspects of social organisation and political culture in the context of the Brazilian health system reform.

[67] Viljoen *et al.*, 2000
[68] Viljoen *et al.*, 2000
[69] Viljoen *et al.*, 2000
[70] See Gordon & Ndondo, 2001.
[71] Atkinson *et al.*, 2000

3. Also useful is a document on the development of tools to measure the determinants and consequences of health worker motivation in developing countries.[72]

4. Tools for mapping of catchment areas mentioned above are potentially useable in Domain 2 as well. It would be of value to understand the reach of CSO services to different geographical areas, and the range and types of CSO services could be mapped much like public sector PHC services.

5. The National AIDS Directory will provide a useful resource for beginning the process of mapping CSOs.

Available data

There is little to no data available in this domain at district level. National organisations would, however, be able to provide basic information about their offices and branches in the ten districts of the PHP.

Procedures

Sampling

An audit needs to be done of all CSOs working in the health field within the district. This has been described above under 'District audit'. As well as organisations directly providing health services – e.g. VCT, antenatal care, health education, HIV prevention, women's health – organisations which could become MSPs of ancillary health services will need to be included. This could include, for example, organisations which provide family and marital support, health development organisations, research organisations, rights advocacy groups, development support organisations, organisational development agencies and many others.

At this level the entire universe of CSOs in the district will need to be included and described.

Fieldwork procedures

During and following the 'district audit' managers or representatives of CSOs will need to be contacted and administered interview-based questionnaires. Information gathered will need to include: nature of services; number and type of clients to whom services offered over last year; nature of co-operative agreements with formal health sector; administrative and management capacities; mechanism and nature of payment offered for services rendered; type of legal entity; numbers and qualifications of employees; vision for the next few years; perceptions of the public health sector; and other questions which address the indicators described in Appendix 4.

Where these exist it may be necessary telephonically to interview provincial managers of CSOs who will not necessarily be located in the district. In some instances it may happen that local CSOs may not have provincial offices, but report directly to national offices, in which case key personnel within these offices will need to be interviewed. Such interviews will be necessary in cases where district level representatives are not able to provide the necessary information and detail.

Key indicators

A table of suggested key indicators is presented in Section 4.2.2.

Problem areas

- The process of listing CSOs will be relatively easily conducted for the larger and more prominent CSOs, but the smaller CBOs which are less linked into health networks could be overlooked.
- Smaller CSOs are likely to be difficult to contact.
- The definition of 'CSOs in the health' field may prove problematic. CSOs predominantly identified with other sectors like education, welfare, social development, education and agriculture may well become partners but not presently be involved in health programmes.

5.6 Domain 3: Health access and context of engagement with health system

Domains 1 and 2 primarily represent the supply side of health system transformation and performance. In researching domain 3 a baseline understanding will be provided for understanding how supply side

[72] Bennett *et al.*, 2000

changes affect demand for health services, health-related behaviour change, health maintenance behaviour and health status.

Key resources

1. The South African Demographic Health Survey conducted in 1998 is an internationally standardised population-based health survey which measures a range of health outcomes.

4. Client knowledge of and satisfaction with the health system are often measured using exit surveys, as these provide an easy access to health users. However, such survey approaches do not access those for whom the services are inaccessible or those who for other reasons do not use these services. For this reason a household survey approach is preferable.

Available data

1. The annual antenatal HIV survey provides a measure of HIV prevalence amongst pregnant women. Unfortunately this cannot be meaningfully disaggregated to local municipality level without losing statistical significance, although district level data can be used.

2. The October Household Survey includes health related indicators, but the last year for which data is available at the moment is 1999. This lag means that the survey is of limited value in the context of the baseline study.

3. Data available through DHIS has been described above as too inconsistent and possibly unreliable for inclusion in the baseline study. However, improvements in standards of DHIS suggest that within a few years this data could reliably be used for M&E purposes.

Other than this there is little standardised, accessible, high quality, district denominated data available for use in the baseline study. Furthermore, available data does not address the partnership issues that are critical to the PHP.

Procedures

Sampling

It would be important for the PHP to employ a population sampling expert familiar with the Census Enumerator Area system, to assist in fine tuning a sampling procedure. As a start it is suggested that a random sample of PHC facilities sampled for Domain 1 baseline research be used to establish location points for a household survey. For the ward in which that facility is located a sample of census enumerator areas (EA) within the ward will need to be drawn. If ward boundaries are not to be used enumerator areas within a radius of 3 km from the facility could be used. The number of EAs to be used will depend on a range of factors including the size and types of EAs in the vicinity as EA household numbers can range from 80 to 250. Random selection of one male and one female adult (over 18 years) participant from each of 20 primary dwelling units per 25 randomly selected census enumerator areas per District Municipality (n =1000) would seem a suitable approximate framework to work within.

If it is necessary to sample only those within a particular area who are likely to be users of the public health system, this can easily be done by selection of certain EA types for the study based on lists available through Statistics South Africa.

Fieldwork procedures

Standard procedures for household surveys would be used.

Key indicators

A suggested list of key indicators is presented in Section 4.2.3. Measures will need to cover: health service access; perceptions of the standards and qualities of service provision; health needs; and health problems.

Possible problem areas

Apart from usual fieldwork challenges this part of the study is fairly standard. It will be important to ensure that the sample size is sufficient for a statistically robust analysis from baseline to impact.

5.7 Time frame and reports

The following recommendations are made, based on the baseline study being contracted out to one agency.

Report

- Report to be presented on a per district basis, detailing findings for each indicator level.
- Report on 10 districts to be collated by NPMU.

Time frame

- Two months required per district for data collection.
- Two months required per district for data analysis and report writing.
- Districts to be done simultaneously.
- Process to be completed in six months, given two months for planning, authorisation and pre-fieldwork data gathering.

6. SUGGESTED ADDITIONAL PROGRAMME RESEARCH ACTIVITIES

The M&E process will be driven at provincial level in each of the five provinces by a PMU, but there is additionally a need to consider the PHP at a national level as the study area. In particular there will be a need to develop conceptual understanding of models for partnership, but this is one of a number of possible study areas which may be worth examining in depth across the provinces, in order to understand innovations at a conceptual level for purposes of model building. Because the PHP strongly promotes local level innovation in the forming of partnerships there will be need throughout the life of the programme to consolidate general learnings, audit and understand models of practice and to keep track of the nature and type of innovations which are taking place. It will be of value to learn through induction, by developing conceptual and operational models on the basis of what is developed in the field.

This is a kind of second order, conceptual process, which could easily be overlooked were the PHP programme only to concentrate on development of operational systems. The learnings need to be extracted from the day-to-day operations of the project, not only to drive operations development, but to inform conceptual and model development.

The PHP programme has the possibility of contributing significantly to the understanding of partnerships, their implementation, development, maintenance and monitoring and evaluation. This will require a task group within the NPMU that specifically allocates resources to researching key issues and develops partnerships with research institutions and universities for this purpose. Commissioning of research projects that would complement and extend the programme influence would need to be made at regular, perhaps yearly intervals. Part of this research activity would be case studies and best practice studies of successful innovations. This would be most useful in groundbreaking areas, where there are few well established models to go by; for example: integrated care; referral networks and protocols; organisational culture at the partnership interface; the development of M&E systems for evaluating partnership programmes; the integration of volunteers into government health services through partnerships of CSOs; and any of the problem areas discussed earlier.

7. SUGGESTED STRATEGY FOR COMMISSIONING BASELINE STUDIES

A two-stage process is envisaged, beginning with development of standard research instruments and procedures, and followed by the actual studies in each of ten districts.

Development of research instruments and procedures

- It is suggested that the broad framework spelled out in this document be reviewed by a panel of experts and by potential MSPs to ensure that it is sensitive to the most important programme delivery components.
- Following this, it is suggested that this document be reworked to accommodate suggestions and to act as a guide to the research organisation/s that will undertake the baseline studies.

- It is suggested that one agency be recruited to develop and test specific research instruments in all five provinces and ten districts. This agency needs to have specific expertise in health systems research and preferably a record of research in the area of local government and organisational transformation. A single research instrument which has the flexibility to accommodate differences across districts would be important for reasons of comparison, and to obtain an understanding of the outcomes and impact of the PHP as a whole.
- The call for expression of interest (EOI) in developing the instrument, should be accompanied by the call for EOI in conducting the study so that should one agency emerge as the best agency for both contracts, these could be regarded as a single contract. However, allowance may need to be made for two separate contracts.
- The protocol must describe the measures for each of the indicators, and the specific numerators and denominators to be used for each measure.
- The research protocol developer should deliver the complete set of instruments in a field-ready and ready to print format, including sets of instructions for research coordinators, provincial research managers and fieldworkers. These should include measurement definitions for indicators.
- It is suggested that a research consultant be recruited to provide up to four days of specialized consultancy to the research agency involved. This consultant would need to be specialized in district level and population sampling, and especially familiar with enumerator areas, wards and district demarcation issues.
- This agency should be expected to deliver all instruments with a report on their development and suggested operational procedures for each district.
- The product should be delivered within a period of not more than three months of commencement.
- The cost of the contract for this portion of the study would best be estimated at a meeting of the expert reference group.

Baseline study

- It would be preferable for reasons of consistency, speed and cost-effectiveness for one research agency to undertake the entire study. It should be legitimate for the agency to sub-contract fieldwork to other agencies, but training, quality control and reporting should proceed through the contracted agency.
- An initial expression of interest (EOI) should be put out which includes a call for EOIs in conducting the study at provincial or district level only. The successful agency for the entire study, should be provided with the names of the agencies interested in conducting the research at provincial level or district level only. They should be encouraged to use research and M&E agencies at provincial level to develop capacity at this level, although it is possible that they would be capable of conducting the study without such assistance. There are research groups at provincial level, for instance universities, which have good capacity for undertaking provincial level research, but are not necessarily geared for, or interested in, undertaking national research.
- The agency responsible for developing the research instruments should be eligible for this contract and it would be preferable for this agency to undertake the fieldwork.
- The agency must have a history of experience in health systems research and preferably in research with government agencies. Experience in multi-site survey research should be a prerequisite. Experience in quantitative and qualitative data analysis and reporting would be expected.
- The fieldwork should be conducted over a period of not more than 4 months and delivery of a final report should be done within 6 months of commencement.
- The cost of the contract for this portion of the study would best be estimated at a meeting of the expert reference group.

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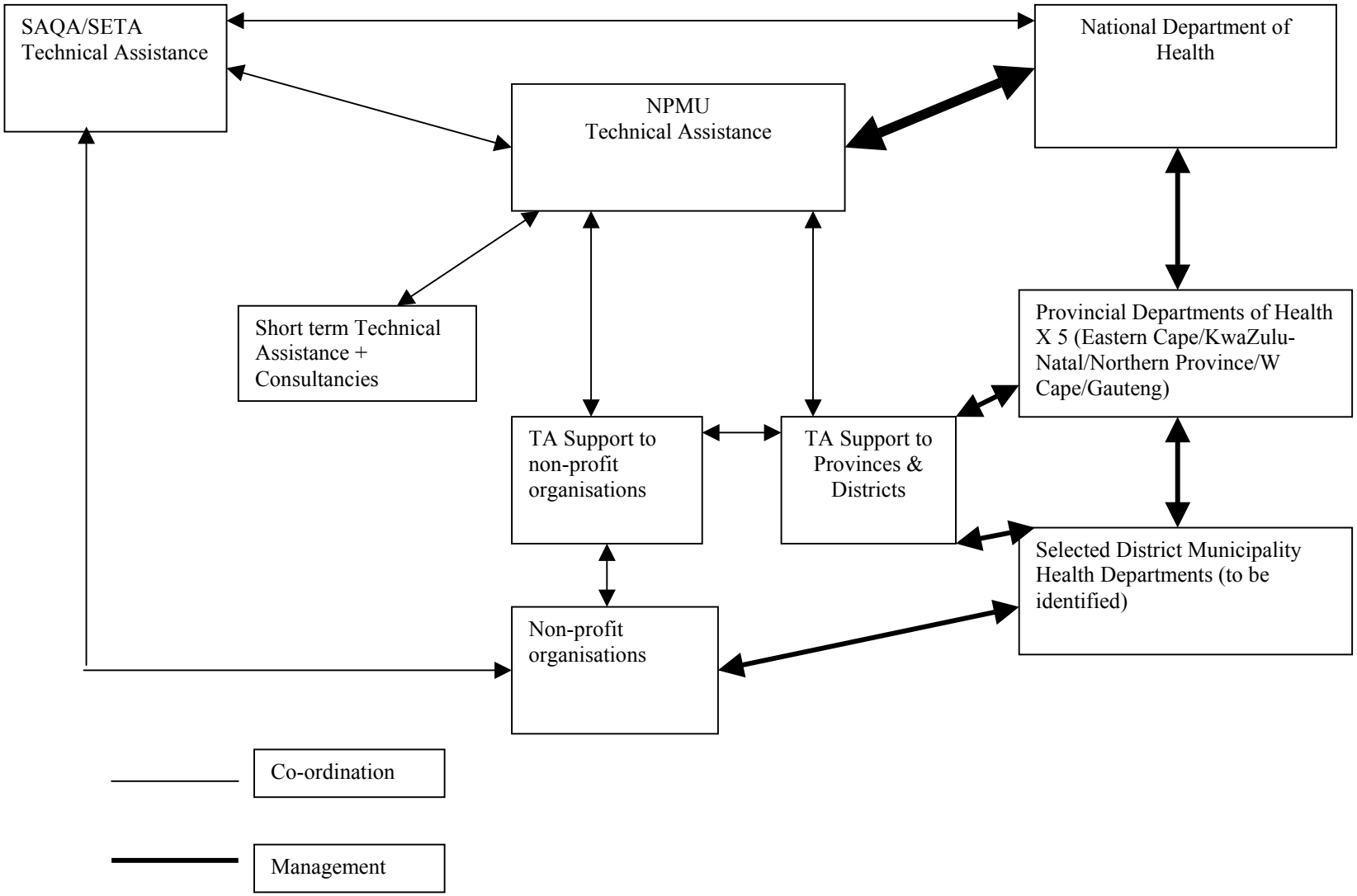
APPENDIX 1. Technical Assistance (TA) Framework



APPENDIX 2

WEB RESOURCES FOR DISTRICT HEALTH SYSTEMS RESEARCH

Domain	Web-site	URL	Content
Local government and district health systems	Health Systems Trust – Local government	http://www.hst.org.za/local/	Wide range of highly relevant contributions on local government and DHS; Bills and acts; research; South African Health Review
	Department of Provincial and Local Government (DPLG)	http://www.local.gov.za	Publications relating to Integrated Development Planning, Local Government Policy and Legislation, Municipal Partnerships, Masakhane case studies.
	South Africa Government Online: Local Government	http://www.gov.za/structure/local-gov.htm	Legislation on demarcation and municipal structures
	South African Local Government Association (SALGA)	http://www.salga.org.za/	Municipal profiles, maps, population density and demographic information; municipal contact information; Municipal legislation; IDP guidelines.
	Institute of Municipal Finance Officers (IMFO)	http://www.imfo.co.za/	IMFO Journal, skills development and training information; financial management and LG; Legislation documents on municipal finance and structures; IMFO handbook on accounting practices; information on forthcoming 'Key performance indicators of a financially viable municipality' conference.
	South Africa Government Online	http://www.gov.za/	Up-to-date news through Government Communication and Information Services; speeches; NCOP news; portal to government departments and information
	National Council of Provinces Online	http://www.parliament.gov.za/ncop/	Provincial and local government frameworks, information, current information and news of provincial and local government interest; draft legislation and opportunity to comment
	Municipal Infrastructure Investment Unit	http://www.miiu.org.za/MIIUIndex.htm	Municipal public private partnerships; municipal infrastructure development
	NPPHCN PHILA Programme; (Public Health Intervention through Legislative Advocacy Work)	http://www.hst.org.za/pphc/Phila/default.asp	Lists of and links to health related legislation
	IDASA Local Government Centre	http://www.idasa.org.za/logic	Information on projects and research relating to community participation in LG; municipal capacity building; economic development and LG; LG and Budget.
CSOs	South African National NGO Coalition	http://www.sangoco.org.za/progs/enabling/index.html	Information on framework for involvement of NGOs in development; the Not-for-Profit Act; information on establishment of the national development agency (NAD); information on development financing
	National AIDS Directory	http://www.aidsdirectory.co.za	Information and contact details on per province basis of all organisations working within HIV/AIDS and SRH field

(…cont)

Educational equivalencies	South African Qualifications Authority	http://www.saqa.org.za	Information on National Qualifications Framework; Education and Training Quality Assurance Bodies; information on Recognition of Prior Learning legislation; Qualifications and Standards Database
	ETDP.SETA homepage	http://www.etdpseta.org.za	Education, Training and Development Quality Assurance; Sector Education and Training Authority links.
	SETA website	http://www.minfosys.com/ Glossary/glossary.htm	Glossary of terms; unit standards information; lists of SETAs; SETA legislation
	Council for Health Service Accreditation of Southern Africa (COHSASA)	http://www.cohsasa.co.za	Information on quality assurance improvement programme for SA health institutions; information on health care management and patient care standards for SA following international guidelines.
	National Standards Bodies	http://www.saqa.org.za/nsb /index.htm	Standards Generation Bodies information and documentation, including legislation; criteria for the generation and evaluation of standards within the NQF
District data	District Demarcation Board	http://www.demarcation.org.za/	District demarcation boundaries; legislation relating to demarcation; municipal maps and profiles; municipal boundary data.
	Statistics South Africa	http://www.statssa.gov.za/ default3.asp	Country wide information per ward constituency in each of the newly demarcated local municipalities and district management area per province. Collatable for districts municipalities. Based on Census 1996, it includes: Population demographics, employment status, basic facilities, type of dwellings, population by age, marital status, gender, literacy, language group, population density maps, electricity and water distribution.
	HISP Health Information Systems Programme, School of Public Health, UWC	http://www.hst.org.za/local /docs/popdata.htm	Census 1996 population data per B and C municipality, modeled to 2002

APPENDIX 3: PHP LOGFRAME

PARTNERSHIPS FOR PRIMARY HEALTH CARE INCLUDING HIV/AIDS PROGRAMME LOGFRAME		
Overall Objective: More accessible, affordable quality primary health care for the poorest communities in 5 target provinces (Northern Province, Eastern Cape, KwaZulu-Natal, Western Cape and Gauteng) **Programme Purpose:** District health service delivery strengthened through primary health care partnerships between government and non-profit providers (Non-Governmental Organisations "NGOs" and Community Based Organisations "CBOs") in 5 target Provinces especially including HIV/AIDS within the global structure of the primary health care system		
Objectively Verifiable Indicators: More people use primary health care services in the target provinces and municipalities Primary health care indicators significantly improved in the five provinces and ten target district municipalities HIV/AIDS prevention and care services available throughout at least ten target district municipalities Decline in the rate of new infections	**Means of Verification:** National, provincial and municipality programme reports Quality management programme reports Workplans Non-profit organisation Annual Reports Baseline and ongoing survey reports Provincial health statistical reports Reports of programme studies ISRDS and URS reports	**Assumptions and Risks:** Implementation of the Local Government Act Availability of non-profit providers with sufficient capacity Quantity and quality of technical assistance available

Results & Activities	**Objectively verifiable indicators (OVI)**	**Means of verification (MOV)**	**Assumptions and risks**
Result 1. **The 5 target provincial departments of health and selected district municipalities together able to operate an integrated district health system including a component of partnerships with non-profit organisations**.	Joint health services management structures in five provinces Selection processes agreed in five provinces Increased numbers of people accessing PHC Number of municipality supported extra clinical health interventions e.g. VCT	National Programme reports Provincial and district municipality reports Memoranda of understanding Contracts: Technical assistance Service agreements Financing agreements NGO reports Clinic statistics Selection policies Minutes of management committee meetings	New municipalities sufficiently skilled, managed and resourced Consensus on services and responsibilities and priorities Sufficient suitable non-profit organisations available Supportive legal framework Local corruption prevented

Activities: Result 1 1. A skills analysis strategy for the programme will be developed with the objective to strengthen capacities in the areas of partnership development for the national and provincial departments of health and a capacity building programme will be implemented with the support of external expertise.	Skills profile and training schedule	Workplans and national and Provincial reports Monitoring and evaluation reports Technical assistance reports	Willingness and availability of personnel to participate
2. Provincial task teams will be established comprising representatives from provincial and district health departments and non-profit organisations to ensure the participation of all stakeholders in this partnership development. The teams will be fully trained.	Regular meetings Training programme	Minutes of meetings Training records and reports	Attendance by stakeholders at meetings and training sessions. Funding and transport available to attend meetings and training sessions.
3. Initially 2 districts will be identified by Provinces, according to pre-determined criteria within each of the 5 target provinces, for programme development (linked, as appropriate, with the ISRDS & URS).	Target District identified within Provinces	Published selection criteria and procedures Provincial reports and selection recommendations	Inter-district competition for participation Ability and willingness of Districts to participate in the programme
4. Provincial departments of health and district authority responsibilities for various health functions and services will be clarified and documented both in terms of the legislative requirements and in terms of local efficiencies and best practice with the support of adequate external expertise where appropriate.	Documented legal and operational framework for health functions at each sphere of government	Guidelines and reports from National and provincial health departments Technical assistance reports	Lack of clarity in district and provincial roles and responsibilities
5. Needs analysis contracted-out and conducted for each district in order to elaborate and implement a technical assistance and training programme.	District development plans Technical assistance/consultants appointed	District/provincial reports	Availability of suitable technical assistants Timeframe for recruitment of TAs
6. Technical Support to provinces and districts will be provided for medium-term expenditure planning aiming at the integration and sub-contracting of non-profit providers in order ensure sustainability of the partnership.	Non-profit PHC partners incorporated into MTEF	Financial reports MTEF budgets Service agreements.	Availability of fiscal resources

Result 2 **An increased number of non-profit organisations in the 5 target provinces better able to identify and define their role and negotiate and implement service partnerships with provincial health departments and district municipalities for the delivery of PHC services, especially related to HIV/AIDS**	Numbers of non-profit organisations eligible for municipal and provincial agreements Agreements with providers	Registry of non-profit providers Number of agreements Evaluation reports Provincial and municipality reports Annual reports of providers	Political acceptance of partnerships at local level Sufficient suitable non-profit providers Organisations able to retain trained staff
Activities: Result 2 1. During Phase 1 of the programme, non-profit organisation identification and consultation processes will be undertaken in each province on the basis of the DFID study to profile potential programme partners and identify gaps and under-capacity.	Data base of potential service providers established	Data base reports	Availability and willingness of non-profit partners to engage with Government
2. A programme of technical assistance for non-profit organisations, in areas such as programme planning, management, basic accounting, monitoring, evaluation and report writing will be developed in partnership with the Provincial Task Teams, together with systems for monitoring the impact and implementation of non-profit providers by the NPMU.	Training programme for non-profit organisations established in each province/district Organisational and personal development plans Impact/implementation assessment criteria and monitoring system developed	Technical assistance reports Training records Provincial reports Detailed criteria and monitoring system delivered and/or published	Availability of suitable Technical assistance availability of personnel to attend training sessions
3. Research and development of a career development framework for personnel working in non-profit organisations will be undertaken and implemented.	Career development framework Personal Development plans for health care workers Applications by non-profit providers to skills development fund for financial support for training	Organisational reports	
4. Technical Assistance will be provided to support the health Sector Education and Training Authority (SETA), in the development of standards and access to education 'equivalencies' for health workers in non-profit organisations to enhance career development in conjunction with the National Department of Health and non-profit providers.	Work “eqivalencies” identified Career development pathways established	Reports and accreditation of work and training experience	Participation of SETA and South African Qualifications Authority Agreement and participation of other government departments

Result 3 **Provincial departments of health and selected district municipalities in the 5 target provinces able to identify and to support the role of non-profit organisations in PHC service delivery and evaluation, especially related to HIV/AIDS**	Number of non-profit organisations with service agreements Percentage of MTEF budget awarded to non-profit providers Number of performance management/evaluation criteria established Number of provincial planning documents incorporating non-profit provider inputs	Service agreements MTEF and budgets Selection and appointment procedures Provincial and local organograms Provincial and municipality management meeting minutes Policy and planning documents Provider annual reports Evaluation reports	Local political support for engagement and partnership Adequate management arrangements in place in provincial and municipal departments of health Public service and non-profit organisation cultures can work together Local corruption prevented
Activities: Result 3 1. Calls for proposals will be prepared with detailed criteria for the identification and selection of a number and range of non-profit providers for PHC services.	Number of applying organisations	Evaluation reports by Programme Steering Committee	Ability of organisations to develop applications
2. A framework for collaboration between Government and non-profit providers, including: • Legal aspects (in line with municipal system); • Quality Assurance measures; • Fiscal aspects; and • Enforcement measures will be developed by the PMU and be developed by the PMU in conjunction with the Department of Health and Provincial Task Teams.	Service level agreements/contracts	Provincial and national reports	Enabling legislation
3. Research & analysis of the HIV/AIDS Continuum of Care within the PHC context will be undertaken.	Care profiles and protocols identified	Published care profiles and protocols Revised prevention strategies	
4. Packages for the HIV/AIDS Continuum of Care within the PHC package will be reviewed by Provincial Task Teams and local profiles developed with the support of appropriate external expertise.	Care profiles incorporated into PHC package	Published PHC protocols	Consistent government policy
5. Baseline studies/household surveys will be undertaken in identified districts & provinces in Year 1 under the responsibility of the NPMU. Further ongoing surveys & data reviews will be made throughout the programme.	Demographic profiles and statistical data available	Provincial reports	

6. Plans will be agreed and contracts awarded for HIV/AIDS Continuum of Care partnerships within the PHC package between government and non-profit organisations in each of 5 target provinces.	Non-profit organisation contracts with Provinces/districts in relation to AIDS continuum of care protocols	NPMU/provincial/district reports Number of contracts issued/funds disbursed	Availability of organisations to support continuum of care
7. Cost benefit analyses and performance audits undertaken to ascertain and ensure the cost effectiveness and sustainability of services provided by non-profit providers	Financial surveys	NPU/provincial and district reports	