TECHNICAL & FINANCIAL FILE

CAPACITY BUILDING IN THE DEPARTMENT OF HEALTH OF THE REPUBLIC OF SOUTH AFRICA – PHASE II

SOUTH AFRICA

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ART	Anti-Retroviral Treatment
BTC	Belgian Technical Cooperation
CB	Capacity Building
CDC	Centres for Disease Control and Prevention
CEO	Chief Executive Officer
DFID	Department for International Development (of the United Kingdom)
DMT	District Management Team
EC	European Commission
FE	Final Evaluation
FET	Final Evaluation Team
HIV	Human Immunodeficiency Virus
GDP	Gross Domestic Product
HR	Human Resources
HRD	Human Resources Development
HRH	Human Resources for Health
HRMIS	Human Resources Management Information System
HRP	Human Resource Planning
ICD10	International Classification of Disease (version 10)
JLCB	Joint Local Consultative Body
KZN	KwaZulu Natal Province
MDG	Millennium Development Goal
MTR	Mid-Term Review
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework (of Government)
NDOH	National Department of Health
NSF	National Skills Fund
ODA	Official Development Assistance
PEFA	Public Expenditure Financial Assessment
PEPFAR	(The US) President's Emergency Plan for AIDS Relief
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMGCCA	Paymaster General Cost-Centre Account
PMT	Provincial Management Team
PMTCT	Prevention of Mother to Child Transmission (of HIV/AIDS)
PMU	Programme Management Unit
PPP	Purchasing Power Parity
RA	Result Area
RDP	Reconstruction and Development Programme
SA	South Africa/African
SADC	Southern Africa Development Cooperation
SANAC	South Africa National AIDS Council
SAQA	South African Qualifications Authority
SDF	Skills Development Facilitator
SWOT	Strengths Weakness Opportunities Threats
SETA	Sector Education and Training Authority
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFF	Technical and Financial Fiche (the Project Description)
UK	United Kingdom
UNDP	United Nations Development Programme
WHO	World Health Organization

Executive summary

South Africa remains a country challenged by the legacy of the apartheid era. For decades the majority of the population was deprived of (or had limited access to) basic human rights, including healthcare. Whilst considerable advances have been made since 1994 to address the inequalities of the past, serious challenges remain. South Africa has a high Gini Coefficient, which denotes deep and substantial income inequalities in society. Indeed, South Africa, with a Gini Index of 57.8 (according to the United Nations Development Programme (UNDP) Human Development Report 2009) ranks 7th in the world in terms of national income inequality. Consequently, successive post-apartheid governments, which have all been led by the African National Congress (ANC), have given priority to the pressing need to address social inequality. Access to social service delivery – health, education and welfare - has been a central pillar to post apartheid government policy.

Within this context, the South African National Health System has identified ten key priorities, including the strengthening of human resources and, in particular, the management of hospitals and human resource practitioners.

In addition, in order to meet the United Nations Millennium Goals, South Africa has identified 18 of its 52 health districts[1] as "*priority districts*" where progress towards the achievement of the Millennium Development Goals is particularly lacking. Special attention is thus to be given to the development of these 18 priority districts.

This current project on Capacity Building represents a second phase of intervention. In 2004, Belgium signed a Specific Agreement with South Africa for Capacity Building within the Public Health Sector for a total amount of €3,500,000 over five years. Both the Mid-Term Review and Final Evaluations of the project were broadly positive and both recommended an expansion and consolidation phase (although some modification of the project design was deemed desirable). A further phase of the project was therefore proposed **which fully supports the National Department of Health's strategic objectives**. The new phase/project was identified and formulated as follows:

- The Project will operate for 36 months, with a Belgian contribution of €2,000, 000.
- The overall objective is ***"To increase the efficiency, effectiveness and quality of care in the Republic of South Africa's health sector".***
- The specific objective is ***"To improve the management capacity of Government hospitals"***.
- Three expected results have been developed: Results 1 and 2 focus on the operational level, whilst Result 3 places emphasis on the central level:

  1. Building the capacity of hospital management teams.
  2. Building the capacity of the Skills Development Facilitators in the Department of Health.
  3. The programme is to be implemented in a well-coordinated, fully integrated, sustainable process.

In keeping with the Department of Health's policy on providing extra support to the 18 priority districts and in view of the expanded nature of the programme (i.e. the inclusion of District Management Teams) and limited resources, the Project will focus on three provinces – Eastern Cape, KwaZulu Natal and North West, which between them contain 12 priority districts (although only 10 districts will be targeted for reasons elaborated

[1] In contrast with other partner countries of Belgian Cooperation, health districts and administrative districts have the same geographical coverage.

later).

A number of international development partners are implementing programmes or are in the process of developing new programmes. However at this time the BTC Project is unique in its focus on developing hospital teams and supporting the development of human resources for health. It will be necessary to maintain links established as other partners further develop programmes to maximise impact, avoid duplication and develop synergies and joint working, where appropriate.

Monitoring of the Project will be through systems in place or being developed by the National Department of Health with particular emphasis on the hospital accreditation system currently being piloted. To this end it will be necessary for the Department to develop cross-functional relationships within the context of the Project with other directorates and with provinces.

Analytical record of the intervention

Partner country	Republic of South Africa
Code DGCD	3008323
Navision Code BTC	SAF 09 018 01
Partner institute	National Department of Health
Total duration of the Project	36 months
Expected starting date	2010
Partner contribution	*In-Kind contribution*
Belgian contribution	€ 2, 000,000
Sector code	*CAD 12110*
Global objective	*To increase the efficiency, effectiveness and quality of care in the Republic of South Africa's health sector*
Specific objective	*To improve the management capacity of Government hospitals*
Expected Results	1. Building the capacity of Hospital Management Teams 2. Building the capacity of the Skills Development Facilitators in the Department of Health 3. The programme is implemented in a well coordinated, fully integrated, sustainable process

1 Analysis of the situation

1.1. South Africa: general context

South Africa remains a country challenged by the legacy of the apartheid era. For decades the majority of the population was deprived of (or had limited access to) basic rights including healthcare. Considerable advances have been made since 1994 to address the inequalities of the past however significant challenges remain. South Africa has a high Gini Coefficient, which denotes deep and substantial income inequalities in society. Indeed, South Africa, with a Gini Index of 57.8 (according to the UNDP Human Development Report 2009) ranks 7th in the world in terms of national income inequality[2]. Consequently, successive post-apartheid governments, which have all been led by the African National Congress (ANC), have recognised as a priority the pressing need to address social inequality. Access to social service delivery – health, education and welfare - has been a central pillar of post apartheid government policy.

Within this context, the grossly distorted effects of the past remain profound: high unemployment, a highly mobile and migrant workforce, substantial levels of poverty, high crime rates (including domestic violence) and an increasing burden of disease. Improved access to basic, quality assured, healthcare has been a key component of the social agenda. As shown in Table 1, overall Gross Domestic Product (GDP) expenditure on health is relatively high for a developing country at 8.6%. However, as with other sectors, social inequality disguises a starker reality - 5% of GDP expenditure on health is directed at 14% of the population (7 million people) through private healthcare schemes whilst a mere 3.6% is directed at 86% of the population (42 million people). Thus, the strengthening of the public health care system is a fundamental necessity. South Africa faces a quadruple burden of diseases consisting of HIV and AIDS; other communicable diseases; non-communicable diseases; and violence and injuries. The consequence of this is a high level of mortality and morbidity. In 2009, Statistics South Africa (STATSSA) estimated the life expectancy of South Africans to be 53.5 years for males and 57.2 years for females.

The Government White Paper on the Transformation of the Health System, released in 1997, accentuated the need to:

- Decentralise the management of health services;
- Establish the District Health System to facilitate the implementation of Primary Health Care (PHC);
- Increase access to services for citizens;
- Ensure the availability of good quality, essential drugs in health facilities;
- Strengthen disease prevention and health promotion in areas such as HIV and AIDS, and maternal, child and women's health;
- Implement the Integrated Nutrition Programme to give added focus on sustainable food security for the needy;
- Rationalise health financing through budget reprioritization.

The National Department of Health's Strategic Plan has stressed that the health sector must return to these aims and the BTC Project is crosscutting in its support of that vision. The Strategic Plan further details that the Department will also accelerate delivery in the four key objectives expected from the health sector in the revised outcome-based

[2] According to the United Nations Human Development Report 2009, South Africa ranks behind, in order of the highest Gini Coefficient : Namibia (74.3), Comoros (64.3), Botswana (61.0), Haiti (59.5), Angola (58.6), Bolivia (58.2). The current CIA World Fact Book, on the other hand, ranks South Africa as the highest in the world terms of national income inequality, with a Gini Coefficient of 65.

Medium-Term Strategic Framework (MTSF) for 2009-2014:

- Increasing life expectancy;
- Combating HIV and AIDS;
- Decreasing the burden of diseases from Tuberculosis (TB);
- Improving Health Systems Effectiveness and 20 deliverables (detailed below).

The National Department of Health will ensure over the next 5 years that the health system is overhauled and managed by appropriately trained and qualified managers. Initial focus will be on Chief Executive Officers (CEOs) and managers. Their skills and competencies will be assessed independently and, where skills gaps are identified, appropriate training will be provided. Appropriate delegation will also be given to eligible hospital managers. One of the Department's key objectives for 2010/11 is to improve budget and expenditure monitoring, and the provision of support to Provinces. The BTC project therefore fully supports this objective through hospital management team capacity building.

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During 2010/11-2012/13, the National Department of Health will strengthen Human Resources (HR) Planning, Development and Management. The review of the current Framework for HR Planning will be completed, and a revised and updated HR Plan will be produced. This will be informed by the needs of the country, as well as the capacity to produce health professionals. The Department will also continue to support all Provinces to finalise and implement their HR Plans in line with the National Plan. The BTC Project fully supports this objective through the strengthening of Skills Development Facilitators (SDFs).

Table 1 : country data for the Republic of South Africa

Total population	49.68 million
Gross national income per capita	PPP International $ 8,900
Life expectancy at birth m/f (years)	53.5/57.2
Healthy life expectancy at birth m/f (years)	43/45
Probability of dying under five years of age (per 1000 population)	69
Probability of dying between 15-60 years of age m/f (per 1000 population)	598/531
Total expenditure of health (Intl $)	869
Total expenditure on health as a percentage of GDP	8.6%
Estimated overall HIV prevalence rate	10.6%[1]
Estimated HIV prevalence amongst adults aged 15 to49	17%[1]
Estimated number of HIV infected individuals	5.21 million[1]
Incidence of TB (all forms) 2002/2008 (per 100,000 population)	2002: 493.7 2008: 948/100,00[2]

Source: 1 Statistics South Africa 2009 2 WHO Estimate 2008

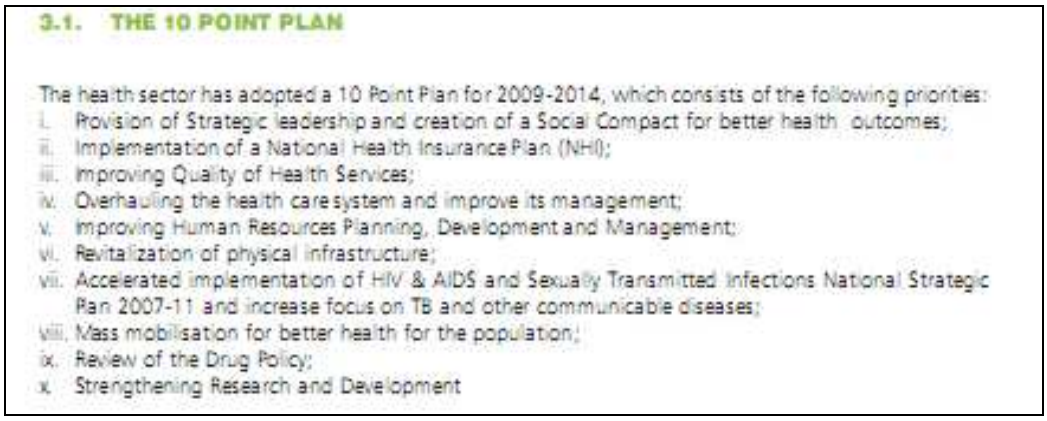
1.2. The South African Health Sector Policies And Strategies

1.2.1 National Health Sector Priorities

As South Africa is designated a middle-income country, there is no Poverty Reduction Strategic Paper *per se*, since such strategic papers are an instrument aimed a low income countries seeking concessional assistance from the World Bank and the International Monetary Fund[3].

The national priorities for the health sector are extensively developed in the National Department of Health Strategic Plan 2010/11-2012/13. This strategic framework is developed around 10 priorities, more commonly known as the 10 Point Plan.

The 10 key points can be summarised as follows: [4]



3.1. THE 10 POINT PLAN

The health sector has adopted a 10 Point Plan for 2009-2014, which consists of the following priorities:

i. Provision of Strategic leadership and creation of a Social Compact for better health outcomes;
ii. Implementation of a National Health Insurance Plan (NHI);
iii. Improving Quality of Health Services;
iv. Overhauling the health care system and improve its management;
v. Improving Human Resources Planning, Development and Management;
vi. Revitalization of physical infrastructure;
vii. Accelerated implementation of HIV & AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11 and increase focus on TB and other communicable diseases;
viii. Mass mobilisation for better health for the population;
ix. Review of the Drug Policy;
x. Strengthening Research and Development

Figure 1 : the 10 point plan of the NDOH Strategic Plan 2010/11 - 2012/13

To accelerate the achievement of the objectives outlined in the Medium Term Strategic Framework (MTSF) 2009-2014, in January 2010 the Government adopted a new **outcome-based approach**.

In keeping with this new approach, the health sector will devote particular attention to four key areas outlined above (increasing life expectancy; combating HIV and AIDS; decreasing the burden of diseases from Tuberculosis and improving Health Systems effectiveness).

[3] Poverty Reduction Strategy Papers were initiated by the World Bank and the International Monetary Fund for low-income countries seeking concessional financing, particularly with regard to debt relief. They are prepared by the government in question, civil society, the IMF and the World Bank. Although South Africa qualifies as a middle income country on the basis of its Gross Domestic Product, this instrument, as can be seen from the Gini Coefficient, often masks inequalities within countries.

[4] Source: http://www.doh.gov.za/docs/misc/stratplan/201011-201213a/index.html

Focusing on these areas, the health sector must produce twenty deliverables over the next five years:

1. Increased life expectancy at birth
2. Reduced child mortality
3. Decreased maternal mortality ratio
4. Managing HIV prevalence
5. Reduced HIV incidence
6. Expanded access to the Prevention of Mother to Child Transmission (of HIV/AIDS) (PMTCT) Programme
7. Improved TB case finding
8. Improved TB outcomes
9. Improved access to antiretroviral treatment for HIV-TB co-infected patients
10. Decreased prevalence of drug resistant TB
11. Revitalisation of Primary Health Care
12. Improved physical infrastructure for healthcare delivery
13. Improved patient care and satisfaction
14. Accreditation of health facilities for quality
15. **Enhanced operational management of health facilities**
16. **Improved access to human resources for health**
17. Improved health care financing
18. Strengthened health information systems
19. Improved health services for youth
20. Expanded access to home based care and Community Health Workers.

The 10 Point Plan of the Health Sector for 2009-2014 incorporates the 20 priority areas of the outcome-based MTSF, as well as the Millennium Development Goals. These linkages are reflected in detail in the Strategic Plan. Focused and systematic implementation of the 10 Point Plan must yield the results desired by these priorities.

With specific reference to the health sector, President Zuma, in his State of the Nation Address on 3 June 2009, said:

> *"We are seriously concerned about the deterioration of the quality of health care, aggravated by the steady increase in the burden of disease in the past decade and a half.*
>
> *We have set ourselves the goals of further reducing inequalities in health care provision, to boost human resource capacity, revitalise hospitals and clinics and step up the fight against the scourge of HIV and AIDS, TB and other diseases.*
>
> *We must work together to improve the implementation of the Comprehensive Plan for the Treatment, Management and Care of HIV and AIDS so as to reduce the rate of new HIV infections by 50% by the year 2011. We want to reach 80% of those in need of ARV treatment also by 2011.*
>
> *Working together let us do more to promote quality health care, in line with the United Nations Millennium Development Goals to halve poverty by 2014."*

1.2.2 Health capacity building in the context of the HIV and TB expansion programme

In 2009 the Government made a renewed commitment to dramatically to increase the national HIV and TB response. It was decided that the scale of the epidemic required an urgent approach characterized as "business unusual". A series of events in the build up to World AIDS Day in 2009 laid the foundation for this paradigm shift and included Cabinet endorsement of the need for a national HIV Counselling and Testing campaign. On World AIDS day, 1st December 2009, the President announced that the following directives to address the HIV and TB epidemics in South Africa which would be launched on the 1st April 2010:

1. A massive campaign to mobilise all South Africans to undergo testing for HIV and to ensure that every South African knows their HIV status. The initial target is 15 million South Africans to be tested by June 2011.

2. Increased access to antiretroviral treatment for children under one year of age who test positive for HIV. This will contribute significantly both to the quality of life for infected children and the reduction of infant mortality

3. Patients presenting with both TB and HIV infection will be started on Anti-Retroviral Treatment (ART) if their CD4 count is 350 or less[5]. TB and HIV will be treated under one roof. 1% of the population has TB and co-infection with TB and HIV is 73%.

4. All pregnant HIV positive women with a CD4 count of 350 or with symptoms - regardless of their CD4 count - will have access to treatment. This represents a major shift from previous eligibility for treatment which only kicked in when the CD4 count was less than 200. All other HIV positive, pregnant women with higher CD4 counts will be given treatment at fourteen weeks of pregnancy to prevent mother to child transmission of HIV.

5. All the health institutions in the country should be able to provide HIV counselling, testing and antiretroviral treatment.

The imperative of expanding the number of clients counselled and tested for HIV comes as a result of the magnitude of South Africa's epidemic**. Every day over 1,200 people become infected with HIV in South Africa. This staggering number has contributed to an epidemic where today 5.2 million South Africans (10.9% of the total population) are living with HIV**.

The health system is being assessed for its readiness to implement these directives and the key stakeholders have been consulted to assist them. While the campaign will start in one district in each province, it is expected that 500 additional facilities will be identified every quarter to provide Anti-Retroviral Treatment until all facilities are covered.

These ambitious targets require a unique response and will necessitate the involvement of all levels of caregivers and stakeholders. Capacity building will be needed at individual level as well as at institutional level. It is therefore anticipated that this project will make a significant contribution to addressing the needs of the HIV/TB expansion programme in the 10 priority districts.

[5] CD4 or T-cell count are cells targeted by the HIV virus leading to weakening of the body's immune system, making those with a depleted CD4 count vulnerable to opportunistic diseases.

1.2.3 Priority on achieving the Millennium Development Goals.

The eight MDGs and 21 targets are measured, in health terms, according to 14 health indicators. Whilst the Project does not directly target specific MDG health targets (which contain no human resources development indicators for health), it cannot be overemphasised that the improved management of health services and the improved utilisation of qualified human resources is a pre-requisite for the achievement of the Millennium Development Goals.

Concerned with achieving the MDGs, within South Africa 18 Districts have been identified as "Priority Districts" progress towards the achievement of the Millennium Development Goals is particularly lacking. These health priority districts are detailed in Table 2.

Table 2 : List of Health Priority Districts

Province	District
Eastern Cape	Amathole
	Alfred Nzo
	Ukhahlamba
	Cacadu
	OR Tambo
	Chris Hani
Free State	Thabo Mofutsanyane
Gauteng	Metsweding
KwaZulu Natal	Zululand
	Ilembe
	Umkhanyakude
	Amajuba
North West	Bojanala
	Bophirima
Northern Cape	Kgalagadi
Western Cape	City of Cape Town

Speaking of the 18 districts at the **Annual Development Partners Consultation Forum** on 9 December 2009 the late Deputy Minister of Health, Dr. Molefi Sefularo, said:

> *"We have identified eighteen (18) Priority Health Districts for intensive work. These districts were chosen because they have poor health status, health service delivery and poor access to health services. These districts have been ranked using key indicators, data on which are readily available, mostly through the District Health Information system. These are: deprivation index, as reported in the District Health Barometer, percentage of pregnant women tested for HIV, immunization coverage at one year of age, percentage of deliveries which take place in a health facility and Vitamin A supplementation coverage in the 1-5 years old children.*
>
> *The fourteen worst performing districts are located within five provinces, namely the Eastern Cape, Kwazulu-Natal, North West, Limpopo and Mpumalanga. For the Free State and Gauteng, the districts with the highest ranking were chosen. Within each of the districts, the sub-districts with the highest deprivation index were identified using information from the 2007 Community Survey."*

National and international efforts are to be brought together in order to address this situation in the “critical” districts.

1.2.4 “Human Resources for Health” in South Africa

Human resource issues within the health sector manifest a complex inter-relationship between multiple government departments at national and provincial levels (Health, Public Service and Administration, Education and Treasury), with academic institutions, professional bodies and associations and with the private sector. Within this context South Africa, supported by the first phase of the BTC Project, introduced a **National Human Resources Planning Framework - the “Human Resources Plan”**[6]

The eleven core principles of the framework are:

1. Stewardship for health care lies with the National Department of Health;
2. South Africans must enjoy a reliable supply of skilled and competent health professionals for self-sufficiency;
3. Planning and development of human resources linked to the needs and demands of the health system must be strengthened;
4. The optimal balance, equitable distribution and use of skilled health professionals to promote access to health services must be developed;
5. Health workers must have the capacity and appropriate skills to render accessible, appropriate and high quality care at all levels;
6. Work environments must be conducive to good management practice in order to maximize the potential for the health workforce to deliver good quality health services;
7. South Africa’s role in international health issues contributing to leadership, scientific advances and global health professions is critical;
8. South Africa’s contribution, in the short to medium term, to the global health market must be managed in such a way that it contributes to the skills development of health professionals;
9. Mobilization of funding to ensure successful implementation of the Plan;
10. The Department of Health must ensure that it has the technical expertise necessary to lead health workforce planning;
11. There must be reasonable remuneration of health professionals and attractive working conditions to enable them to regard the public health sector as an employer of choice.

There is an extensive legislative framework for employment and skills development in South Africa. Amongst these are Skills Development Act and the Skills Development Levies Act - the latter of which prescribes that an amount equal to 1% of any employee’s annual salary must be made available by the employer (including the public sector) for skills development activities.

[6] Full details are available at http://www.doh.gov.za/docs/facts-f.html under the chapter AIDS and HIV Related: A National Human Resources Plan for Health - 2006[6]

Others bodies regulating employment and HR practice and conditions include, but are not limited to, the following:

1. National Economic, Development and Labour Council
2. Commission for Conciliation, Mediation and Arbitration
3. Advisory Council for Occupational Health and Safety
4. Commission for Employment Equity
5. Compensation Board
6. Employment Conditions Commission
7. National Productivity Institute
8. National Skills Authority
9. Unemployment Insurance Board.

Certain categories of staff (currently doctors, dentists and pharmacists) must also adhere to continuing professional development requirements for professional/clinical registration.

Whilst, in theory, extensive training/educational public sector funding is available, for many participants of phase 1 the BTC Project had provided the only training they had received within the previous eighteen months. For almost all it was the only management training. Moreover, it was the only team-orientated training provided to hospital management teams.

A South African Institute of Health Care Managers exists but does not provide any clear training, direction or regulation of health service managers. Currently consideration is being given to proposals advanced by the late South African Deputy Minister of Health for the creation of a Health Academy of Leadership. Planning for the Academy is at an embryonic stage and further consideration is needed in relation to the financing of the Academy, the identification of an appropriate faculty to instruct and train and also to curriculum development.

The following extract from the National Human Resources Plan for Health aptly encapsulates the pressing need for high quality training and professional development at all levels in the health care system.

Human Resources Development Priorities

The objective of Human Resource Development is to provide programmes, which orientate, train, and develop employees by improving the skills, knowledge, abilities and competencies necessary for individual and organisational efficiency. These include productivity as well as personal career growth. While career development and the acquisition of job skills after employment are the joint responsibility of the employee and the employing unit, the Department is obligated to provide a programme of training and development which improves organisational effectiveness and productivity by enhancing the skills, knowledge, abilities, and competencies brought to the position by the employee and which are necessary for work-related success, individual growth, and career development. Human Resource Development units in all the provinces must provide such programmes and make every effort to balance the needs of the individual and the needs, goals and objectives of the Department of Health.

In helping the Department fulfil its goals of providing good services, HR Development units are committed to delivering high quality training programmes designed to promote personal, professional and organisational development. To entrench this culture, the National Department of Health is spearheading the harmonisation of development training

programmes. This means developing or improving expertise in areas such as Organisational Development, Executive Development, and Skills Development. Such programmes will assist in enriching the capabilities of individuals and work teams while improving organisational systems and processes.

Because the quality of health service delivery depends to a large extent on the availability of qualified personnel and their performance, enabled by the availability of sufficient equipment, drugs and other facilities, it is most important that employees are well qualified to manage these factors. Health managers can influence the performance of personnel in various ways; this matter requires carefully formulated and implemented Human Resources Development policies, developed in consultation with stakeholders. The knowledge and skills of the health managers, needed to perform human resource development tasks, will therefore be developed with a view to setting minimum national standards.

Building people management skills is an area of focus for the output of human resource development programmes. The average amount spent on human resources comprises about 65% of the health annual budgets. People management skills for managers will therefore be honed over an accelerated period of time to benefit patient care and the health workforce, in line with Batho Pele[7] principles.

Well-planned workforce management improves efficiency by means of a culture that supports and develops the organisation's staff, allowing the health workforce to share in the organisation's objectives. Highly qualified, motivated staff comprises the heart of any high-quality health system and this has been well illustrated by many efforts, which have nevertheless failed to generate the intended benefits in spite of significant investments in infrastructure and procedures.

Training programmes for senior managers and all supervisors in the health sector, which inculcate both technical and managerial competencies, are crucial to improving the quality of the health system.

The Department of Health at both national and provincial level will support training at facilities in the health sector by means of capacity building measures, such as curriculum design programmes, or measures regarding the introduction of modern methods of instruction and teaching materials.

Figure 2: A National Human Resources Plan for Health to provide skilled human resources for healthcare adequate to take care of all South Africans (pages 96/97) FINAL DRAFT (2006)

1.3. The Belgian support to Capacity Development in the Health Sector in South Africa

1.3.1 The capacity building Project - phase 1

In 2004, Belgium signed a Specific Agreement with South Africa for Capacity Building within the Public Health Sector for a total amount of € 3,500,000 over five years. The Project was initially divided into 5 key expected results:

[7] Batho Pele – "putting people [service users] first" through 8 core principles: consultation, setting service standards, increasing access, ensuring courtesy, providing information, redress and value for money

- Result Area 1: Improved Human Resource Management Tools
- Result Area 2: National & Four Provincial Plans Developed & Disseminated
- Result Area 3: Improved Skills amongst Human Resource Practitioners at all levels
- Result Area 4: Developed leadership in Human Resources Planning
- Result Area 5: Capacity Created Within Provinces to Access SETA and NSF Finances for Training.

In July 2008 a Mid Term Review (MTR) was conducted. This MTR led to an extensive remodelling of the logical framework of the phase 1 Project and the reformulation of some expected results. This MTR also recommended a consolidation phase: "**Approve an extension of the Project as a consolidation of the Project interventions in RA 2-5. Without extension it is very likely that the interventions would not only not progress, but the achievements gained so far would be lost."**[8]

In December 2009 the final evaluation of the Project was conducted. The main conclusions of this evaluation are:

Key priorities identified for this Project were the need for a database to map human resources skills within the health system and also the need to build capacity amongst managers especially at the hospital level and amongst human resource practitioners. Five result areas were identified to support these key focal areas of intervention and focussed on supporting the establishment of the HR database, improving skills and coordination amongst hospital managers and human resources practitioners including the establishment and use of country exchanges.

A number of challenges affected implementation. These were cross-cutting across all health sector interventions (also affecting other ODA support) and included (but were not limited to):

1. The availability of additional funding (both South African funding and ODA) to support the focal areas identified (most notably in the creation of the health human resources database) but which has also impacted upon general service delivery aspects; and
2. High levels of staff turnover and vacancy rates within the public health system, which has resulted in the movement of staff within the Project's focal areas and also upon the capacity of the Department of Health to manage certain aspects of the Project's implementation.

Notwithstanding the complexities and sometimes difficult challenges, BTC and the Department of Health have pursued a flexible and adaptive approach to Project implementation. Although the Project had to be extended by one year it is anticipated that at its conclusion ninety-eight percent of funds will have been utilised for the Project purpose.

Considerable success has been noted particularly in the capacity development of hospital management teams and the improved coordination and communication between the National Department of Health and provincial Skills Development Facilitators. In other areas, most notably the creation, expansion and implementation of the health human resources database, the benefits have yet to be fully realised. The development of the HR database was severely affected by the lack of additional financial resources from outside the BTC Project and remains dependent upon funds being made available to be fully functioning.

[8] Recommendations for BTC Brussels, point 8.2.4.1 of the MTR-report

The work, undertaken to-date, provides a sound basis for consolidation, expansion and further development. A further Project phase is therefore recommended to consolidate the considerable achievements made.

Figure 3 : Extract of the Executive Summary of the Final Evaluation

1.3.2 The capacity building Project – phase 2

Following the MTR of 2008, in June 2009 the National Treasury of the Republic of South Africa officially transmitted to the Belgian authorities in South Africa the identification file for the second phase.

On the 13th of October 2009 the special committee on development cooperation between the Kingdom of Belgium and the Republic of South Africa meeting in Brussels agreed on the start of the formulation of a phase II – a consolidation phase of the first Project on capacity building within the health sector.

The following expected results were proposed to be consolidated in the next phase[9]:

- Result 1 focuses on developing a Human Resource Information Management System (HRIMS), which will enhance health workforce planning. The consolidation for this result area would focus on system support.

- Results 2 and 3 focused on capacity building at hospital management team level. Innovative in its approach, the Project had triggered the introduction of important elements in the capacity of hospital management and, following lessons learned during the Project period, the training interventions would be consolidated in terms of the target groups and in terms of the synchronisation of the capacity building efforts in “soft” and “hard” skills. In the consolidation phase it is recommended that the current results 2 and 3 be merged into Result Area 2 under the title: “Capacity building in managing hospitals”.

- A further element will be the extension of the proposed result area 5, capacity building of the Skills Development Facilitators within the National and Provincial Departments of Health. This will be known as Result Area 3 under “Capacity Building of Skills Development Facilitators in the Public Health Sector.

On the 9th December 2009, the Joint Local Consultative Body (JLCB) adopted the Terms of Reference and the mission schedule for the present formulation (see annex 3)

A recruitment procedure was initiated to form a team of consultants to formulate the Project in close collaboration with a formulation manager appointed by BTC Headquarters.

The formulation mission’s work began at the end of February 2010.

[9] Revised identification file, transmitted on the 11th June 2009.

1.4. The International Development Partners in the Health Sector in South Africa

According to the audited National Health Accounts 2008/09 (Annexure 1N), the National Department of Health received ZAR 220 million in external assistance. However the reported income only relates to direct cash transfers to the National Department of Health. Considerable resources are also made available through non-cash transfers with the United States providing some US $580 million in development aid through the US President' Emergency Programme for Aids Relief (PEPFAR) alone. Yet the phase 1 Project represented the only support project of its kind and was unique in providing support to the development of hospital management teams and skills development facilitators.

However, in clear recognition of the evolving priorities and increased collaboration with international partners, a number of donors are currently developing or recently implementing new support programmes. These donors include the EC (€100m sector budget support programme), the UK's Department for International Development (DFID), the United States (through, *inter alia*. PEPFAR, USAID/Centres for Disease Control and Prevention (CDC), Germany and Ireland. These programmes have some linkages to the BTC phase II Project. Most notable amongst these are the proposed CDC intervention to support Amathole district in the Eastern Cape Province and the proposed EC sector budget support which, it is intended, will target districts/primary health care services (although this has yet to be fully elaborated). Clear linkages will need to be established during the implementation of the Project to avoid overlaps and to establish strategic partnerships to maximize the synergies that exist between the various interventions. Most other ODA, whether through the Departments of Health structures (National and Provincial) target HIV/AIDS/TB specific interventions and although not directly linked to the BTC Project may have some overlaps particularly in the context of supporting District AIDS Committees. Furthermore significant levels of training and capacity building in the field of HIV/AIDS/TB are being undertaken together with Department of Health funded management development interventions especially at the district level. It will therefore be critical to ensure adequate planning of BTC capacity building within the broader scope of training and capacity building to ensure that the timings of trainings and capacity building do not overlap or coincide with other initiatives underway and thereby maximize potential attendance.

The formulation team, in consultation with the Department of Health, visited other key players operating in the health sector. From of these meetings the information, outline below, was gathered. This proved particularly valuable since a complete mapping of development partners in South Africa does not as yet exist.

A number of donors support health interventions in South Africa. There is a current strong focus on supporting HIV and AIDS interventions with the bulk of resources being directed accordingly. Following sections give a short overview of other development partners, their activities and the potential for synergy.

1.4.1 United States Centres for Disease Control and Prevention (CDC)

The CDC has previously collaborated with BTC/Department of Health within the context of the BTC funded TB/HIV integration Project. However, this collaboration was not formalised through any structured agreement or coordination mechanisms. The CDC indicated that requests had been made by the National Department of Health for more "vertical training" and that the CDC had supported this through the Sustainable Management Development Programme (SMDP). The CDC acknowledged that the

optimal approach to strengthening districts was unclear and that the current emphasis was away from training individuals to training whole district teams. Within this context, the CDC is currently giving consideration to strengthening Amathole District in Eastern Cape (one of the priority districts and also defined as a "TB crisis district"). It was suggested that the District Health Barometer - a tool developed by the Health Systems Trust (a South African NGO) – be used as the measuring instrument. The SMDP approach would also involve partnering with local universities (the University of Witwatersrand in Johannesburg and the University of Pretoria). No clear planning has yet taken place and the CDC expressed a strong interest in working with BTC within the context of the current proposed programme to maximise collaboration and synergy.

1.4.2 United States President's Emergency Plan For AIDS Relief (PEPFAR)

PEPFAR II (2009) moves away from concentrating on solely emergency relief to a broader focus on sustainability10. In South Africa, funding will focus on TB and HIV interventions within the context of human capacity development at the provincial and district levels. Within the context of South Africa, support will be provided to train a further 140,000 health care personnel. Training will focus largely on clinical staff and patient management. There is a recognition of the need to work more closely with the National Department of Health (not undertaken during PEPFAR I) to ensure an improved and coordinated response to provincial needs. There are no current plans to fund the National Department of Health but to enter into a National PEPFAR Coordination Agreement/Partnership Framework with Government (to be agreed). Current annual PEPFAR disbursement in South Africa is US $580 million per annum and this level of funding is expected to continue. The bulk of funding is used to supply anti-retroviral treatment.

Each province has a PEPFAR coordinating group and BTC has been invited to participate in forthcoming meetings.

Despite the scale of the PEPFAR programme, there are no overlaps with the proposed BTC Project. However, given the large scale training underway, there is a clear need for greater and improved coordination of training activities at provincial and district levels.

1.4.3 European Commission

The European Commission currently operates a targeted sector budget support programme which addresses home-based care. This support will end in April 2011 and the costs of the programme are included into the medium-term expenditure framework of provinces and, as such, the intervention is planned to continue and be fully financed by Government. No direct synergies or overlaps are anticipated with the BTC programme, given the different healthcare levels targeted.

A new sector budget support programme (€ 126,000,000 over 4 years) is expected to commence in 2011, which is still at the planning stages. The new proposed support programme will target primary health care and as such it is envisaged that support will be provided to District Management Teams. There is therefore the possibility of collaboration at this level. The EC is fully aware of the proposed BTC Project and has expressed the wish for collaboration and will take into account the proposed Project during the forthcoming phases of planning the EC intervention. The EC is the largest donor to the Department of Health (US financial assistance to the sector is larger but it has provided limited support to Government). At the time of the BTC Formulation Mission, no clear indicators for district level support/variable tranche indicators had been identified.

[10] Launched in 2003 with a single focus on AIDS, PEPFAR was signed into law on July 30 2008 and authorised US $48 billion over the next five years to combat HIV/AIDS, Tuberculosis and Malaria.

There will be a clear need for BTC Project staff to engage with the European Union Delegation in the implementation stages of both the EC and proposed BTC Project. Opportunities for synergies and joint working clearly exist but need to be explored further as the EC and BTC processes evolve.

1.4.4 United Kingdom Department For International Development (DFID)

The UK's Department for International Development (DFID) programme is valued at £25 million over 4 years and commenced in November 2009. The programme aims to support the 10 point plan of the Department of Health through a number of targeted interventions:

- Parliamentary oversight
- Direct institutional support to the South African National AIDS Committee (SANAC)
- Support to the SANAC monitoring and evaluation processes
- Support to the Department of Health
    - To the Medicines Control Council
    - To support Prevention of Mother-to-Child Transmission (PMTCT) of HIV, with a particular focus on maternal health and Tuberculosis.
- Support to civil society.

Whilst no direct linkages to the proposed BTC Project are foreseen, strengthening synergies will exist within the context of overall health systems.

1.4.5 The Global Fund to fight AIDS, Tuberculosis and Malaria

The Global Fund[11] is not represented in South Africa since its resources are largely channelled through SANAC. Five grants are currently at different stages of operation or to be applied for:

- Round 2 – to support TB/HIV Integration.
- Round 3 – HIV/AIDS grant to Western Cape for treatment, care and support.
- Round 6 – HIV Prevention – phase 1 has been completed and an application for phase 2 has been submitted
- Round 9 – (Awarded but not formally notified) – HIV/AIDS support to the Department of Health for monitoring and evaluation and to the Department of Social Development for care and support, together with support to two faith-based umbrella organisations.
- Round 10 – to be formulated and applied for – will focus on anti-retroviral treatment and TB

None of the Global fund grants include support for the capacity building of hospital management or strengthening human resources planning. No direct linkages to the

[11] The Global Fund to Fight AIDS, Tuberculosis and Malaria, established in 2002 is a public/private partnership with approved funding of US $19.3 billions for more than 572 programmes in 144 countries.

proposed BTC Project are, therefore, foreseen. However, within the context of overall health systems, increasing synergies will exist.

1.4.6 France

France previously supported a hospital management development programme through twinning with French institutions. The programme ended in 2008 and there are currently no plans for a further phase of support. The previous programme focussed on management training for individual Chief Executive Officers. Current support focuses on the EC Erasmus Mundus programme[12] and collaborative laboratory research. France would be willing to consider future hospital twinning-type support. However, the current problem is to find French hospitals that would be willing to participate. There are, therefore, no clear established links between the proposed BTC support and French Development Cooperation to South Africa.

1.4.7 Sweden

Sweden chairs the EU+ working group of donors for Health, HIV and AIDS (Belgium, Canada, EC, Germany, Ireland, Italy, Japan, Netherlands, Sweden, UK, UNAIDS, USA). Through the EU+, three seats have been allocated (EU Member States, Non-EU and Multilateral) on the Resource Mobilisation Committee (RMC) of SANAC. A recent study has sought to map EU+ donor activities in the health and HIV arenas in South Africa. The study has yet to be completed but has identified that, between 2007-2009, some ZAR 3 billion was donated to the South African Government's National Strategic Plan for HIV and AIDS and towards general health objectives. Key priority areas of support were treatment, care and support for people living with HIV. The donor working group has acknowledged that there is "*a great disparity between what development partners can do and actually do*". There is a need for greater and continuous donor coordination on the part of the national authorities.

As a bilateral donor, Sweden is providing support to civil society organisations, start-up and medium-term support to the SANAC Secretariat and to the development and support of HIV/AIDS programmes in the workplace. At the bilateral level, within the context of overall health systems, increased synergy will exist but there are currently no clear opportunities for joint intervention.

1.4.8 Germany (DED/GTZ)

German development programmes are implemented by a number of agencies (GTZ, KFW, DSD, Invent) and South African partners (Department of Health and non-governmental organisations). Within the "sector" programmes/Projects are entirely related to HIV/AIDS interventions. A new programme, in the early stages of formulation, seeks to integrate and consolidate current programmes. The proposed new German programme will seek to:

- Reduce the incidence of HIV infection in selected provinces and districts; and
- Ensure the improved coordination of HIV/AIDS interventions.

The proposed new German programme will not include direct support to health systems capacity building/strengthening. However, its proposed support to provincial and district AIDS councils for improved management and coordination will necessitate working with provincial and district health structures. Future support for the new programme is envisaged to be through the provision of technical assistance. Target provinces have yet to be finalised but are likely to be selected from Eastern Cape, Mpumalanga, KwaZulu

[12] The Erasmus Mundus programme of the EC is a cooperation and mobility programme in the field of higher education.

Natal and Limpopo provinces.

Given the HIV/AIDS focus of the proposed German programme, no direct overlaps with the proposed BTC programme are foreseen. However, given the multiple development partner interventions at district health system level, which require coordination, synergies between the respective programmes are envisaged.

1.4.9 Ireland

Ireland has a five-year aid programme of support to South Africa valued at € 6,500,000 of which 70% is directed to support to Limpopo Province – the balance being directed to the South African National AIDS Council and others. Priorities for Irish development assistance are to:

- improve service delivery in health and education;
- respond to HIV and AIDS especially in the context of women and children;
- focus on gender-based violence.

Due to the economic recession, budget cuts are being experienced in Ireland's aid support (a 57% cut in 2009). € 420,000 has been allocated to health in Limpopo Province of which € 120,000 was disbursed in 2008 but, owing to transfer delays in the South African public finance system, was subject to a 7 month delay in reaching the beneficiary. The key focus at district level is to strengthen District AIDS Councils through capacity building to develop work plans and activity-based budgets. No activities are undertaken within the broader context of strengthening the health system. Skills development facilitators in the province play an important role in coordinating training together with the Limpopo provincial human resources unit which together were successful in bringing different role players together.

There is currently no intention of broadening the scope of the Ireland's support to other provinces or to broaden the strengthening of health systems at the district level. No direct overlaps or collaboration are, therefore, foreseen within the context of the proposed BTC Project.

1.5. Strengths, Weaknesses, Opportunities, threats Analysis (SWOT)

The following SWOT analysis was presented to and discussed in the Joint Local Consultative Body (JCLB) in Pretoria, in the context of the Aid Memoire. The following SWOT list was garnered from the various exchanges and discussions with all stakeholders at local, district, provincial, national and international level.

In the context of the consolidation of the previous Project, the SWOT analysis does not address the health sector as a whole but is confined to human resources for health and, specifically, capacity building issues.

1.5.1 Strengths

- An established capacity building programme with well developed modules
- Focus on a mix of hard skills and soft skills
- Focus on team building and strengthening
- Adopted a needs-based approach
- Availability of phase 1 impact assessment data
- BTC adopted a flexible approach

- Nationally led Project

1.5.2 Weaknesses

- Poor participation of skills development facilitators in Phase 1
- Lack of sustainable and additional funding
- Service delivery by private providers
- No elected national institutional partner institute
- Low involvement of district management teams and provincial management teams
- Overlap of modules
- Little shared knowledge of module content
- No accreditation/certification of modules
- Parallel implementation/little ownership
- Dilution as a result of broad geographical coverage
- Inefficient overall setup with consequent weak cost-benefit ratio

1.5.3 Opportunities

- Priority districts identified
- Hospital management capacity is a Ministerial priority
- Demand to expand district management teams
- Presence of 2010-2013 Strategic Plan with human resources development priorities and Government commitment
- Existence of skills development facilitators
- Regional Training Centres on course to be established
- Training Facility Basket Funds by BTC
- Willingness of ODA partners to collaborate
- Good private sector service providers

1.5.4 Threats

- Poor communication
- Staff retention problems: brain drain/staff turnover /migration / transfers
- Staff bound by training contracts leading to resistance in following the training
- Vertical programme destabilise systems
- Funding constraints

This SWOT analysis will be a valuable tool for the consolidation phase of this current BTC project and which are elaborated further in the following section.

2 Strategic Orientations

2.1. Identification of problems

The new Project is a consolidation of the Project that was successfully implemented since 2005 under the auspices of the Department of Health, and in which 66 hospital management teams were trained in both soft and hard skills.
Successive midterm reviews and the final evaluation ensured a thorough assessment of the Project and enabled the team to learn lessons and to identify challenges and recommendations.
The first phase covered 66 Hospital Management teams; the second phase will focus on approximately 50 new District Hospitals. During the implementation, however, the problems that arose in the previous Project (see Final Evaluation Report and also point 1.5.2), will be appropriately tackled and new emphases defined and executed.

2.2. Intervention strategies

2.2.1. Aligning with national plans.

With the Paris Declaration[13] in mind, the principles of alignment are high on the agenda.
It is indeed of utmost importance for Belgian cooperation to work within the framework of a national strategic plan. In this specific case, the key reference strategic plan is the Strategic Plan 2009/2010 – 2011/2012, published by the Department of Health, and available on electronically. [14]

SUB-PROGRAMME	NATIONAL DOH MEASURABLE OBJECTIVES FOR 2009/10-2011/12	EXPECTED OUTCOMES	PROGRAMME OUTPUTS	INDICATOR	TARGET (2009-2010)	TARGET (2010-2011)	TARGET (2011-2012)
HUMAN RESOURCES MANAGEMENT AND DEVELOPMENT	Community Care Giver (CCGs) policy finalised	Improved working conditions for CCGs	CCG Policy finalized and implemented by March 2012	CCG Policy finalized	Policy finalised by March 2010	CCG Policy implemented by NPOs in 18 districts	CCG Policy implemented by NPOs in 52districts
	Strengthening of hospital management teams	Competent hospital management teams	Consolidate the existing programme and expand the model to additional hospitals	Number of hospitals teams assessed and trained.	Consolidate 64	76 new Hospital teams	88 new Hospital teams
	Strengthen human resource capacity in district hospitals	Improved clinical skills mix in support of family physicians	Increased number of Clinical Associates in district hospitals.	Number of clinical associates entering the degree programme[1]	75 new (focusing on 18 priority districts)	100	150
	Strengthen human resource capacity for the delivery of emergency care services	Critical mass of Emergency Care Technicians in the health workforce	Increase production of ECTs in provincial colleges	Number of colleges offering ECT	8	8	8
				Number of employees entering the programme (including RPL)	300	400	250
				Number of school-leavers entering the programme	250	250	250

[13] The Organisation for Economic Co-operation and Development (OECD) Paris Declaration on Aid Effectiveness of 2005 stresses, *inter alia,* that donors should align their development assistance policies with the partner government's national development policies.
[14] Full version available on *www.**health**-e.co.za/uploaded/78c7201744fb7defb26801abdea98db2.pdf*

Figure 4 : the Strategic Plan 2009/2010 – 2011/2012 – p 86.

Although Belgian cooperation cannot hope to cover the entire gamut of hospital management, a substantial portion of it will indeed be covered – and this is fully consistent with the current priorities of the National Department of Health Strategic Plan.

A needs analysis at each targeted hospital was undertaken for the hospital management capacity building during phase 1. Key needs identified and subsequently developed into training modules were:

- Team Building
- Change Management (together with conflict management in some instances)
- Leadership
- Labour relations
- Project management
- Stress management
- Diversity management
- People management
- Change management
- Financial management
- Strategic planning
- Corporate governance
- Performance management
- Monitoring and evaluation.

Thus the training comprised a mixture of “hard” and “soft” skills for the management of the hospitals. It is envisaged that the bulk of the phase 2 training will focus on broadly similar activities, although some new modules may be required to reflect emerging needs, for example, the integration of new policies on HIV and AIDS management. A needs analysis and baseline study will therefore be conducted in each newly targeted hospital to assess specific institutional requirements.

Wherever possible the baseline will be undertaken on the basis of the hospital accreditation tools that are currently being developed by the National Department of Health and which are based on 5 core standards:

1. Improved values and attitudes amongst health care workers
2. Improved patient safety
3. Infection prevention and control
4. Improved facility cleanliness
5. Reduced waiting times.

An assessment of the project intervention will also be based upon the hospital accreditation system.

2.2.2. Double anchorage: Focus on the strategic level and on the operational level.

The first phase of the Project can be viewed as a laboratory phase, with a high operational positive impact at the hospital management level.

However, some major weaknesses were recognized: weak participation of the skills development facilitators; questionable assessment tools to monitor the progress of team skills; insufficient strengthening, at the regulatory and policy levels, in the National Department of Health and the Provincial Department of Health.

A double anchorage of the intervention, both at local and central levels, has been proposed. On the one hand, the national level must be strengthened in its role of regulator, coordinator, developing the skills frameworks and training modules and subsequent assessment tools. This will be the core of Result Area 3.

On the other, the operational level will be assisted in a more complete, integrated way, not only focussing on isolated teams, but on the full set of all those involved in hospital management: the district teams, the skills development facilitators and so on.

2.2.3. Implementing Belgian Policies And Strategy In The Health Sector - Belgian Policy Note The Right to Health and Health care

The Belgian Minister, Charles Michel, on 24th of November 2008, officially approved the policy Note The Right to Health and Healthcare. This note identifies, as a first challenge for the healthcare system, the quantitative and qualitative human resources deficiencies that exist in developing country settings. [15]

Under the main components of the response from Belgian cooperation, under chapter 5, specific support to the capacity building of human resources in terms of both quantity and quantity is highlighted.

5.2 *The healthcare system: specific support*

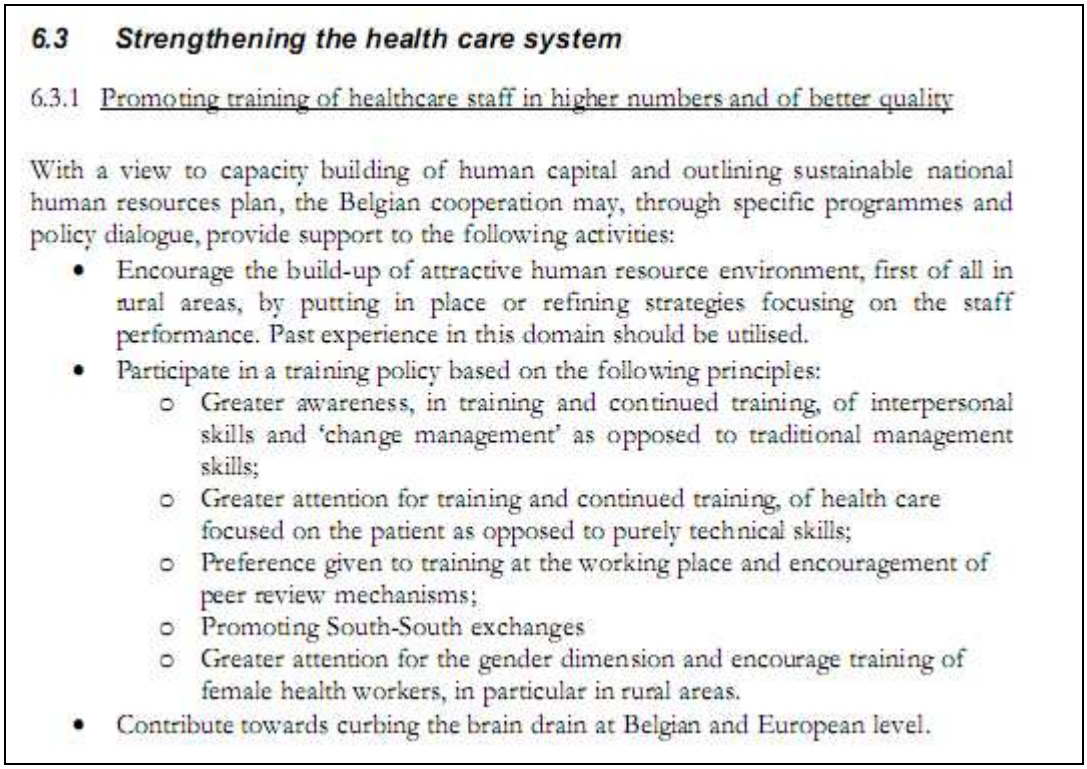
1. Capacity building of human resources in terms of quantity and quality

The gaps in terms of quantity and quality (technical and relational competence, sense of responsibility, motivation) of personnel, in the administration as well as in the provision of healthcare in the stricter sense, seriously impede the development of healthcare services. This is why interventions must make a structured contribution to the creation and maintenance of a sufficient number of healthcare providers who are both competent and motivated. This comprises a consistent package of measures: improved training, increased financing (including salaries), improvement of working conditions, activities aimed at fostering motivation (career planning, guidance, and housing) which can be added to structural measures aimed at reducing the brain drain. When considering these measures, it is essential to take gender aspects into account. Thus, the presence of properly trained female personnel seems to increase use of the services available among women and young people. Training and retraining also place the emphasis firmly on the quality of dialogue between users and the community. The patient should be in the centre. The emphasis lies not only on technical quality but also on the quality of healthcare provision. In other words, it is a question of striking a better balance between "care" and "cure". Coordination with other ministries (education, finance) and dialogue with healthcare providers are also indispensable.

Figure 5 : The Belgian policy note: Support to Capacity Building

Further down the policy note, special attention is paid to the training of healthcare staff as documented in figure 7 below. [16]

[15] Belgian Policy Note The Right to Health and Health Care, p 11.
[16] The full Belgian Policy Note is available on www.dgcd.be.



6.3 Strengthening the health care system

6.3.1 Promoting training of healthcare staff in higher numbers and of better quality

With a view to capacity building of human capital and outlining sustainable national human resources plan, the Belgian cooperation may, through specific programmes and policy dialogue, provide support to the following activities:

- Encourage the build-up of attractive human resource environment, first of all in rural areas, by putting in place or refining strategies focusing on the staff performance. Past experience in this domain should be utilised.
- Participate in a training policy based on the following principles:
  - Greater awareness, in training and continued training, of interpersonal skills and 'change management' as opposed to traditional management skills;
  - Greater attention for training and continued training, of health care focused on the patient as opposed to purely technical skills;
  - Preference given to training at the working place and encouragement of peer review mechanisms;
  - Promoting South-South exchanges
  - Greater attention for the gender dimension and encourage training of female health workers, in particular in rural areas.
- Contribute towards curbing the brain drain at Belgian and European level.

Figure 6: the Belgian Policy Note and the promotion of training of healthcare staff.

2.3. Description of beneficiaries

First-line (direct) beneficiaries will be hospital management teams, district management teams and skills development facilitators in the selected provinces, who will benefit directly from the offered training.

Second-line (indirect) beneficiaries will be the staff of health facilities, principally hospital staff, which will benefit from improved and better management of staff and services.

Third-line (indirect) beneficiaries will be the public health care system service users who will benefit from improved service delivery as a result of the improved management of health care facilities. 86% of the population is reliant upon the public health care system for the delivery of health care services.

2.4. Synergies with other stakeholders

When the Project was being formulated, potential partnerships with other stakeholders and partners were discussed. The proposed assistance by the CDC to the district of Amathole in Eastern Cape, focussing on HRH development, illustrates significant similarities with the BTC Project. The suggested approach of strengthening a local training institute through a partnership with an international institute is highly seductive.

The BTC Project will, during its implementation, work closely with other potential stakeholders in such kinds of innovative interventions.

2.5. Geographical coverage of the intervention

The Government of South Africa has identified eighteen health districts as priority districts (c.f. section 5.2.3) and targeted them for service delivery improvements. Twelve (12) of the districts are contained within three provinces – Eastern Cape, KwaZulu Natal and North West. It was therefore proposed, and agreed by the Joint Local Consultative Body (JLCB), that the Project should target these three provinces (with special attention to the priority districts) both to avoid the dilution effects of trying to service all provinces and to maximize the return on investments made.

Amathole district in Eastern Cape is covered by a CDC programme and, for that reason, not included in the BTC Project. However, synergies will be developed and, wherever possible, common activities can be envisaged. Amajuba's Dannhauser sub-district in KwaZulu Natal does not have a hospital. The number of covered districts by the BTC Project is therefore 10.

Table 3 : 10 priority districts to be covered by the second phase

Province	Districts
Eastern Cape	1. Alfred Nzo
	2. Ukhahlamba
	3. Cacadu
	4. OR Tambo
	5. Chris Hani
KwaZulu Natal	6. Zululand
	7. Ilembe
	8. Umkhanyakude
North West	9. Bojanala
	10. Bophirima

3 Intervention framework

3.1. Global objective

To increase the efficiency, effectiveness and quality of care in South Africa's health sector

The Project is foreseen to contribute towards improving capacity to deliver health care in the targeted districts with potential long-term spin offs to the overall health sector.

3.2. Specific objective

To improve the management capacity of Government hospitals

The Project aims to build capacity at different levels of hospital management teams within a health facility and, in order to ensure sustainability; this will include district management teams. These are the teams that provide the link between the hospitals and are accountable to the Provincial Department of Health. In addition, a needs assessment of skills development facilitators within the overall health sector will be identified and appropriate capacity building provided. A further pillar of the Project is to embody the ownership of the interventions by the beneficiaries through a) underscoring dedicated leadership; b) participatory coordination and c) promoting information sharing to ensure the Project's full integration into the National Department of Health. This will ensure sustainability after the end of BTC funding.

3.3. Expected results

In order to realise the objective of the Project, three expected results were developed. The first focuses on the hospital management teams, the second focuses on the crucial skills development facilitators. Thirdly, emphasis is placed on sustainability - developing the capacity development programme in an integrated and optimally coordinated way by the National Department of Health.

Result 1
Capacity of hospital management teams built at all levels.
Result 2
Capacity of skills development facilitators in the Department of Health is built at national and provincial levels.
Result 3
The programme is implemented in a well coordinated, fully integrated and sustainable process.

Table 4 : Expected results

To achieve these results, various activities and sub-activities will be implemented. These activities are presented in the following section.

3.4. Activities

The design of the Project's implementation is anchored in achieving the expected three results, with specific activities and sub-activities for each result area which, when implemented, will contribute to the achievement of the overall as well as the specific objectives of the Project. The result areas are inextricably interrelated and the activities, therefore, will need to be carried out progressively in order comprehensively to reach the specific objective and expected results.

To ensure a coherent methodology of executing the Project, a detailed ***Implementation plan*** of the activities, including the proposed time frame for the completion of the Project, is contained in *Annex 4* of this report. An outline of activities and sub-activities for each result area is set out below.

Result 1: Capacity of hospital management teams built at all levels.

The key proposed activities and sub-activities to be implemented under this result area are the following;

1.1 Conduct a needs analysis in identified hospitals and priority districts within 3 provinces and develop specific interventions.

- The Programme Management Unit (PMU), in collaboration with skills development facilitators, will identify hospitals that will be the beneficiaries of this Project, within the 10[17] targeted priority districts in the three provinces of Eastern Cape, KwaZulu Natal and North West.
- The skills development facilitators will be engaged to conduct a review of the capacity needs/deficiencies of the targeted health facilities as well as among the district management teams. This exercise is expected to build on and strengthen the existing human resources development plans of the requisite health facilities. This, in turn, would be channelled into the formation of an up-to-date district human resources development plan.
- The outcome of this exercise will be a comprehensive *Synthesis Report on the Health Facilities and District Management Teams Capacity Needs/Deficiencies Analysis* with a clearly defined SWOT analysis for each health facility and district management team..
- Through a similar consultative process between the National Department of Health and Provincial Departments of Health, including the skills development facilitators, hospital and district specific interventions will be developed.

17 & 17 These numbers of 10* priority districts & 50* hospitals are proposed for the purposes of planning & budgeting, otherwise the actual numbers can be decided after determining the real cost of capacity building interventions.

- The PMU is to engage the services of a short-term expert to undertake a baseline survey of selected beneficiaries for the purpose of measuring intervention outcomes as well as to edit and synthesize intervention reports and produce a final work plan for implementation.

1.2 Conduct capacity building interventions for hospital management teams in identified 50[18] hospitals.

Similarly short-term South Africa Qualifications Authority (SAQA) accredited training consultancies will be identified, through an open tender system, to undertake an integrated training in soft and hard skills based on identified needs/deficiencies analysis for each facility in order to improve the delivery of quality health care.

1.3 Conduct capacity building interventions for district managers in 10 districts

The same service provider that will undertake capacity building for the hospital management teams will also conduct capacity building (integrated soft and hard skills packages) for the district management teams in the specified locations.

1.4 Conduct an impact and quality assurance assessment of hospital management teams and district management teams.

An impact assessment among the beneficiary Hospitals and District Management Teams will be conducted after an agreed feasible timeline to gauge the uptake of the training and identify improvements or lack thereof. It is recommended that, this exercise be conducted through short-term consultancies after agreeing on the methodology and tools[19] to be used in the assessment and re-assessment.

Due consideration should be given to utilising the existing relevant tools within the National Department of Health to avoid duplication and parallel exercises. Some of the suggested tools whose suitability can be explored further for possible use are *Core Standards for Health Facilities, Six sigma, Kirkpatrick and ROI or ROE methodologies*. In the event that structured questionnaires will be used to conduct impact and quality assurance assessments, it is advised that they be developed and submitted to the Human Science Research Council (HSRC) of South Africa for approval. This will not only ensure their compliance with the required ethical standards, but, bearing the seal of approval of HSRC, will be a reliable and accredited tool that the National Department of Health can continue using in future assessments.

1.5 Service Excellence Awards to hospitals and district management teams

The concept of Service Excellence Awards to hospitals and district management teams is to reward **teams** that put the service-user's needs first, set and achieve high standards, respect the rights of service-users, use public resources carefully and effectively, and dare to do things differently. All of which are designed to

[19] The recommended methodology and tools should be easy to administer and well understood by the participants, be compliant to HSRC ethics and, more importantly, provide reliable results.

reward efforts/progress in elevating their health facilities and the district in general from the low ranks of deprivation to a higher level.

This is foreseen as a Team award and not for front-line workers who deal face-to-face with patients and clients. It should include all those workers behind the scenes who make a real difference to the overall services which the patient or client receives. The introduction of such an award would not only highly motivate the participants to focus health care delivery beyond the "business as usual" attitude, but will also enhance the sustainability of this capacity building approach. Depending on the agreed award, especially if it involves prize money, it would contribute towards identified improvements that will have an impact on the quality of service within the institution/district where the winning team is based. The selection of the assessment tools for determining those who qualify for the awards should be based on an agreed methodology and tools as discussed in section 1.4 above.

The inputs towards such an initiative would be consultative meetings between the PMU and the Provincial Departments of Health to agree on the modalities of, for instance; the entry procedures; how to enter; criteria for short listing the participants; the judging process; the award – (prize money or otherwise) based on award category for hospitals and for district offices; and finally hosting of the award ceremony at the provincial level.

Result 2: Capacity of skills development facilitators in the Department of Health is built at national and provincial levels.

Under this Result area, the Project will support training of skills development facilitators at all levels within the Department of Health. A thorough analysis of needs/deficiencies must be undertaken prior to defining the SDF's training needs to inform the modules to be offered. Taking care not to duplicate what the National Department of Health is implementing or recycle previous beneficiaries, the training interventions should offer practical, operational and work place skills, within the domain of human resources, for health planning and development. Broadly, it would be expected that, by the end of the training, the SDF's will have been enabled in a mix of any of the following skills:

- General human resources management concepts;
- Acquire basic research skills to enable the collection and analysis of human resource data within the scope of their work;
- Understand the process of developing a human resources for health plan for either a facility, district or provincial structure;
- Learn how to interpret the national human resource development (HRD) strategy and therefore align and implement the district and provincial HRD plans in accordance with the national HRD strategy;
- Be fully compliant with the relevant Skills Development Act of South Africa;

- Manage skills demands of requisite infrastructures and be able to advise and implement learnerships and other available skills programmes.

It must be underscored that the training modules provided must conform to the approved skills development curricula and, therefore, the participants who successfully complete and pass the training can be awarded an equivalent of 120 credits or more. This would not only ensure dedicated participation, but also commitment to perform by the participants.

The inputs into realising these activities are the hosting of a two-day national workshop by the National Department of Health for SDF's and other relevant players from the Provincial Departments of Health. The purpose of the workshop will be to agree and harmonize the training modules based on an overarching needs analysis. Capacity building interventions will subsequently be conducted through a short-term consultancy, followed by an evaluations and impact assessment.

Result 3: The programme is implemented in a well coordinated, fully integrated and sustainable process.

Without a dedicated Programme Management Unit (PMU) to guide and provide leadership and coordination in the context of this Project, the efforts would be in danger of being *ad hoc*, isolated, and non-complementary. They could even run counter to other directorates' work plans and lose the benefit of synergies of development partners working to improve the same sector.

Therefore, the activities to be implemented under this result area are expected to ensure that the objective of the initiative is realised in a well coordinated process; the programme is fully integrated into human resources development frameworks of the National Department of Health; and that best practices are embedded to ensure sustainability.

The proposed inputs towards these efforts are for the PMU to host regular working group meetings that will bring together key players from the National and Provincial Departments of Health and donors working in this sector. The PMU will also undertake regularly to update capacity building strategic frameworks, guidelines, modules and assessment tools to ensure they conform to skills development requirements. Another proposed task for the PMU is to develop a Memorandum of Understanding to drive the implementation of HRD strategy by skills development facilitators.

3.5. Indicators and means of verification

The Project Log frame presents in greater detail a description of the above result areas with their specific activities, the Indicators and the Means of Verification. Since this is a capacity building programme, the intervention activities will be measured by a mix of process indicators, result-based indicators as well as outcome/impact indicators. As no similar Project has ever been implemented in the health sector in South Africa, comparative baseline indicators do not exist. Consequently, the proposed indicators will continually be refined as the implementation process unfolds and more lessons are learned and documented.

At the start of the intervention, the Joint Local Consultative Body will determine the need to organise a baseline study in order to document the situation at the inception of the Project. The baseline study will also assess whether there is a need to realign the expected results with the HR health sector national strategy. If needed, the LFM will be

updated with regards to the objectively verifiable indicators. The conclusions and recommendations of the baseline study will be presented to the steering committee and all modifications submitted for approval by the Steering Committee. During the mid-term review, the value of and progress on the indicators will be addressed in depth.

4 Resources

This section addresses the resource requirements for the proposed Project. The resources are divided into three broad components: financial resources, human resources and material resources.

4.1. Financial resources

The budget available for this phase of the Project is € 2,000,000 (to be provided by Belgium) will be spread across the foreseen three-year implementation period (2011 - 2013).

Budget code	Description of Budget Items		Mode	Total Cost €
Part A	Result 1	Building the capacity of hospital management teams	Direct Management	€ 1 475 000
	Result 2	Building the capacity of skills development facilitators in the Department of Health	Joint Management	€ 95 000
	Result 3	The programme is implemented in a well coordinated, fully integrated and sustainable process	Joint Management	€ 45 000
Part X	X 01	Reserve	Joint Management	€ 8 000
	X 02	Reserve	Direct Management	€ 32600
Part Z	Z 01	Staff expenses	Direct Management	€ 126 000
	Z 02	Investments	Direct Management	€ 15 000
	Z 03	Operational expenses	Direct Management	€ 108400
	Z 04	Audit, monitoring and evaluation	Direct Management	€ 95 000
		Sub - Total	Joint Management	**€ 148 000**
		Sub - Total	Direct Management	**€ 1 852 000**
		TOTAL COST		**€ 2 000 000**

Table 5 : Summary of Budget Components

The budget has been premised on the logical framework. This approach allows each result area -including their respective activities as well as general means (*i.e. human resources, material resources, operation costs and monitoring costs*) - to be allocated specific financial estimates. In addition, it will enable planning and monitoring of expenditures during implementation. The allocated estimates provides a framework for financial planning, otherwise actual budget lines will be nailed down to each activity prior to commencing implementation. Perdiem will not be covered by the budget.

An indicative detailed budget is found in *(Annex 2)* of this report, while the following table

3, presents a summary of the overall components of the budget.

4.2. Human resources

One of the challenges worth noting and particularly relevant to this Project is the shortage of human resources at HR Directorate of the National Department of Health. There is a clear lack of capacity and requisite skills among some of the staff involved in the implementation of this Project. There is thus a perceived need for BTC to second an Assistant Manager to strengthen human resources capacity at the HR Directorate and, more specifically, to provide overall support in the implementation of this Project. An overview of the profile of such an Assistant Manager is presented in 7.3 of this report. The efforts of the resulting team will be regularly complemented by out sourced services of short-term consultants to conduct specific activities according to Project needs.

In addition, through regular contacts, BTC national and head office will support the implementation of the Project by making available a backstopping team (consisting of a public health medical doctor from BTC headquarters and administrative staff – an accountant and administrator) as and when required, which together with the team at the National Department of Health will ensure the successful implementation of this Project.

5 Implementation modalities

5.1. Legal framework and administrative responsibilities

The Government of South Africa has designated the National Department of Health as the administrative entity responsible for executing the Project. The National Department of Health will appoint the Project Manager. The Project Manager will report to the Joint Local Consultative Body (JLCB).

The Project Manager will actively monitor all activities to ensure optimal implementation. He/She shall be responsible for the technical, administrative, budgetary and accounting management of the Project. He/She will also coordinate with other clusters and Directorates within the National Department of Health, Provincial Departments of Health and other Government institutions and offices as may be required on all aspects affecting the Project. He/She will be responsible for ensuring that the Project activities are congruent with South African Government policies and objectives.

A long-term local senior resource person, appointed by BTC in conjunction with the National Department of Health, will be based in the HR Department of the National Department of Health and will serve as the Project Assistant Manager. The Assistant Manager will be responsible to the Project Manager and will act as the day-to-day coordinator of the Project on behalf of the Project Manager, with specific responsibility for supporting the implementation modalities of the Project. The Assistant Manager will also be responsible for the transfer of skills, knowledge and information gained during the life time of the Project and during phase I of the Project to officials within the National and Provincial Departments of Health to ensure that, at the conclusion of the Project, institutional capacity for implementation has been enhanced and maximised.

5.2. Financial Mechanisms

As shown in Table 5 : Summary of Budget Components, € 1 852 000 will be managed under direct management by BTC, as requested by the partner. All these expenditures under direct management shall be managed directly by BTC and will therefore not follow the same financial mechanisms for co-managed budget lines. For funds administered directly, BTC is financially and technically responsible. Belgian rules and regulations regarding public procurement shall apply.

The remaining € 148 000 will be under joint management. Budget shall be transferred to a separate Project account opened at a local commercial bank (the Project account). This account shall be jointly administered by the BTC resident country representative and the president of the JLCB. For all expenditures on this account, partner country regulations regarding public procurement shall apply. The funds shall be transferred to the Reconstruction and Development Programme (RDP) account held by the National Treasury of South Africa at the National Reserve Bank of South Africa. In accordance with National Treasury rules and in compliance with the Public Finance Management Act (PFMA), funds will then be transferred to the National Department of Health Paymaster General Cost Centre Account (PMGCCA) designated for the Project where they will be held and disbursed under the instruction of the Project Manager (or his/her designated deputy) in full accordance with PFMA rules. Transfers from the RDP account to the PMGCCA can only be made after approval by the JLCB of the business plan for the prescribed period of the Project to be implemented by the National Department of Health.

No transfers are foreseen from the RDP account to Provincial Departments of Health owing to the complexity of the transfer methodology. However, this will be subject to review at all times. In the event that transfers are made to provincial departments, PFMA rules, regulations and procedures will apply.

Annual financial audits of the Project account, RDP account and revenue accounts shall be organised by, and discussed in detail by, the JLCB. If needed, *ad hoc* audits can be arranged at any time.

The Project Manager, the BTC country representative and the responsible Belgian Development Cooperation representative shall each receive copies of the bank statements of transfers from the Project account to the RDP account and of transfers from the RDP account to the Department of Health PMGCCA as and when the bank issues them or upon request.

5.3. Technical responsibilities

The National Department of Health shall be responsible for the technical oversight and management supported as necessary by the use of short-term consultancies. No long-term *technical* assistance is foreseen as the knowledge, skill and know-how have been built during phase 1 of the Project.

However implementation capacity gaps exist and to this end a long-term resource person will be locally engaged to facilitate implementation and support the Programme Manager (c.f. section 7.3).

5.4. Implementation and follow-up structures

5.4.1 The Joint Local Consultative Body (JLCB)

The JLCB, established after the signing of the Specific Agreement, is the highest level of decision-making with regard to the implementation of the Project and is responsible for the follow-up, monitoring and controlling the Project implementation. The Specific Agreement determines the composition and responsibilities of the JLCB.
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The JLCB shall meet as prescribed, normally every six months, in the Specific Agreement or more frequently as necessary.

For the purposes of approving minutes, these shall be circulated by the PMU to all members of the JLCB within 7 days of the meeting. In the absence of comments within 10 days after circulation, the minutes will be duly signed by the chair of the JLCB and the BTC country representative.

To further enhance coordination and linkages with other operations, the JLCB may co-opt additional members as may be required and may include, but is not limited to, other directorates/clusters in the National Department of Health (Districts and Development, Quality Assurance etc), provincial representatives and other donors. Co-opted members will be in addition to any representation outlined in the Specific Agreement.

If there are overlapping areas with other donors' interventions or with other coordination mechanisms that may be established within the Department of Health, and if reorientation turns out to be necessary to improve complementarities, the JLCB will have to review and approve and new structures proposed.

The JLCB will have to approve any changes deemed necessary, provided that such proposed changes do not alter the Projects global or specific objectives or overall budget.

The Project Manager and Assistant Manager shall attend the JLCB as observers. The Project Management Unit will provide secretarial support to the JLCB and will propose the agenda and present reports. The proposed agenda shall be agreed by the full JLCB. The PMU will be appointed by the JLCB.

Within the limitations imposed by the Specific Agreement of the Project, the JLCB shall lay down its own internal rules and take decisions by consensus.

5.4.2 Project Management Unit (PMU)

The PMU will be managed by the Project Manager assisted by the Assistant Manager. Responsibility for Project implementation rests with the staff within the HR Cluster: Directorate Human Resources Development. HR staff within that cluster will implement the activities on behalf of Provincial Health Departments.

The PMU is responsible for the coordination and day-to-day management of the Project. Its role is to guarantee the Project results are realised in order to reach the specific objectives. It will be responsible for:

- Coordinating the overall planning of objectives
- Organising, coordinating and supervising the implementation of Project activities (including those activities undertaken by consultants and for the management of their contracts)
- Monitoring the Project's progress based on the indicators
- Giving technical advice and guidance on Project methodology and strategy
- Guaranteeing financial management, accounting and compilation of reports
- Assuring timely compilation of progress reports and budgeted work plans for consideration by the JLCB
- Acting as the secretariat of the JLCB
- Coordinating and networking with other partners including other donors and structures within the Departments of Health.

5.5. Reporting

Reports are expected to control the financial and technical implementation of the activities and reflect upon, refine and propose improvements to the log frame. The Mid-Term Review (MTR), in particular, is expected to revisit both the relevance and design of the Project if deemed necessary, and will scrutinise the indicators used and ensure their amendment or update (c.f. item 3.5).

Table 6: Scheduled Reports, contents and responsibilities

Report	Content	Responsibility
Biannual progress report and business plan	Format to be agreed upon by the JLCB: ▪ Report on previous 6 months (technical and financial) ▪ Major achievements, problems and highlights ▪ Progress on results and activities ▪ Statement of expenditure ▪ Business plan and budget for the next 2 quarters	PMU
Annual progress report and business plan for the coming financial year	Format to be agreed upon by the JLCB: ▪ Technical and financial report of the previous year ▪ Major achievements, problems and highlights ▪ Progress on results, activities and specific objective ▪ Statement of expenditure ▪ Review of the assumptions and risks of the results and specific objective ▪ Recommendations on redesign/reorientation ▪ Degree of integration into departmental systems and processes ▪ Business plan for t the following year	PMU
Mid-Term Review (MTR)	Based on BTC Standards ▪ 18 months after the beginning of the Project, the MTR will evaluate the	PMU/Independent Consultants

	progress towards the expected results and the specific objective based on defined indicators and will formulate recommendations to reach this objective. The recommendations can imply a need to reorient the Project if it is advised to modify some of the results and activities	
Annual Audit	Annual Audits based upon international auditing standards	Independent Auditors
Final Report	Based on BTC Standards ▪ Account of the progress, achievements and problems ▪ Recommendations regarding future support	PMU/Independent Consultants
Financial reporting: monthly and quarterly	Monthly: financial execution reports to BTC representative Quarterly: financial planning to be presented to BTC representative	PMU

For the evaluation of reports and business plans the PMU will consolidate information and report from various sources. Relevant Directorates/Clusters in the National Department of Health and Provincial Officers will assist by preparing activity reports and helping in measuring indicators.

5.6. Modification of the project description (TFF)

The Project description (TFF) may be modified by the JLCB with the exception of the overall and strategic objectives, the overall budget and the project duration. Results and activities and the reallocation of budgets between budget lines is permitted and may be undertaken for the purposes of optimising the attainment of the specific objective and adapting to local changes. It must be recognised that the National and Provincial Departments of Health operate in a fluid and evolving developmental state and, as such, maximum flexibility should be afforded to the JLCB to reorient the Project as necessary.

Changes to the overall budget, the overall objective and the specific objective may not be made without prior approval of Head Offices of partner and DGD and must be confirmed by Exchange of Letters between the parties.

5.7. Monitoring and evaluation (M&E)

The organisation and content of the monitoring and evaluation seek to institutionalize results-based management within the context of the Project and to link and associate these within the M&E structures of the National and Provincial Departments of Health. To this end, various reports and reviews will emphasise content corresponding to different levels and aspects of the log frame so that management decisions concentrate on the pursuit of Project results, the specific objective and on the broader contribution of the Project to the strategic objectives of the National Department of Health.

5.7.1 Baseline study

At the inception of the Project, the JLCB will decide on the need for a baseline survey in order to define clearly the baseline values for all result and process indicators of the project. Funding of the Baseline will be on the budget line A0101

5.7.2 Mid Term Review

At the end of the second year, a mid term review will be organized. This review will focus particularly on the achievements of the Project made in regards of the 3 result areas. An external assessor, contracted after public tender procedure by BTC headquarters, will conduct this MTR.

5.7.3 Final Evaluation

As foreseen for all Projects, a final evaluation will take place at the end of the 3rd year. An external assessor, contracted after public tender procedure by BTC headquarters, will conduct this final evaluation.

5.7.4 Backstopping missions

Once a year, an expert from BTC will perform a backstopping mission in order to give advice, support, revise the implementation of the Project (c.f. item 4.2).

5.8. Closure of the project

Final Report
The responsibility for drafting the final report rests with the PMU. The PMU will submit a draft final report to the JLCB one month after the conclusion of the Final Evaluation.

Project finalisation responsibilities by both parties
The JLCB is responsible for the final closure of the Project. On completion, all Project assets will be handed over to the National Department of Health in accordance with the general processes stipulated in the Specific Agreement. The last JLCB meeting shall decide on the destination of the Project equipment transferred.

6 Cross cutting themes

6.1. Environment

No environmental aspects, either positive or negative, are expected as a result of the Project.

6.2. Gender

South Africa has strict equity rules, which include gender and race, relating to employment and service delivery. The Project is expected to conform to these rules and regulations. Gender issues will be addressed through the existing equity machinery of government. Training will target men and women equally and will be subject to the participant's employment/occupation. Gender disaggregated collection of data is a requirement of all training interventions undertaken by or through government departments.

6.3. Social economy

The Project aims to contribute to poverty reduction by ultimately improving the efficiency, effectiveness and quality of public health care services and especially in the targeted priority districts. Multiple level interventions to improve access to and the quality of service provision are underway. The Project will ensure synergy with these interventions within the broader context of service delivery reform. Since 86% of the population is reliant upon the public health care system, improvements in service delivery have a direct and major impact upon South African society.

6.4. Children's Rights

Similar to the Project's impact on the social economy, children's rights will be indirectly enhanced. Poverty reduction and access to basic services, including health care, are a basic right and, as such, service delivery improvements enhance the social protection of children. With respect to the Convention on the Rights of the Child, its four core principles will apply. The four core principles of the Convention are a) non-discrimination; b) commitment to the best interests of the child; c) the right to life, survival and development; and d) respect for the views of the child. Every right spelled out in the Convention is inherent in the concept of human dignity and the harmonious development of every child. The Convention protects children's rights by setting standards in health care, education, and legal, civil and social services.

6.5. HIV / AIDS

The Project does not target HIV and AIDS interventions directly. However, there is a clear recognition on the part of the South African authorities that the strengthening of human resources management and health systems in general are a prerequisite for an adequate response to the HIV and AIDS crisis in South Africa. On 1 December 2009, the State President announced a number of new measures that South Africa intends to take to accelerate the pace of HIV/AIDS care, management, treatment and support. These measures include treatment for all children under one year of age who test positive for HIV. The CD4 count will therefore not determine initiating treatment. This initiative will contribute significantly towards the reduction of infant mortality over time.

All patients with both tuberculosis (TB) and HIV will get treatment with anti-retrovirals if their CD4 count is 350 or less. At present treatment is only available when the CD4 count

is less than 200. TB and HIV/AIDS will now be treated under one roof. This policy change will address early reported deaths arising from undetected TB infection among those who are HIV positive. South Africa has taken this step on learning that approximately 1% of the population has TB and that the co-infection between TB and HIV is 73%.

All pregnant HIV positive women with a CD4 count of 350 or with symptoms regardless of CD4 count will have access to treatment. At present HIV positive pregnant women are eligible for treatment if their CD4 count is less than 200. All other pregnant women not falling into this category, but who are HIV positive, will be put on treatment at fourteen weeks of pregnancy to obviate mother-to-child transmission. Previously treatment was only started during the last term of pregnancy.

In order to meet the need for testing and treatment, South Africa will work to ensure that all the health institutions in the country are ready to receive and assist patients (not just a few accredited ARV centres). Any citizen should be able to move into any health centre and ask for counselling, testing and treatment if needed.

The implementation of these policy changes is effective from April 2010. Institutions are hard at work to ensure that systems are in place by the 31st of March.

These new measures represent a major challenge to the public health care system and especially in terms of human and financial resources. The proposed Project will therefore greatly assist South Africa in the broader context of human and financial resources management and in so doing indirectly - but crucially - support the HIV and AIDS response.

7 Annexes

Annex 1 The Logical Framework
Annex 2 The Budget
Annex 3 Terms of Reference for the Programme Assistant Manager
Annex 4 Implementation Plan

7.1. Log-frame

Overall Objective				
To increase the efficiency, effectiveness and quality of care in South Africa's health sector				
Specific Objective	**Indicators**	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
To improve the management capacity of Government hospitals	• Total number of hospitals that has completed capacity building interventions. • Number of participating hospitals accredited by achieving Core Standards for Health Facilities. • % completion of District Managers training per district. • % completion of SDF's training per province. • Project coordinating working group operational. • Agreed Memorandum of Understanding and guidelines for implementation of HRD strategy /plan by SDF's. • Number of hospitals with sound strategic plans • Number of hospitals with good monitoring and evaluation of clinical outcomes • Number of hospitals with Quality Improvement strategies	• National & Provincial skills training statistics & reports. • Core Standards for Health Facilities Appraisal reports[20] and accreditation. • Random Interviews / Questionnaires with local service beneficiaries. • Frequency of meetings, quorum & minutes of meetings. • Report on implementation of the National Department of Health HRD strategy at National & Provincial levels.	• External and internal brain drain due to high staff turn-over & mobility. • Impact of factors such as AIDS on HR Workforce	• External and internal brain drain due to various reasons controlled. • Impact of other factors such as AIDS on HR Workforce controlled. • Local high staff turn-over & mobility reduced. • Acquired skills are retained within the sector.

[20] CSHF - Core Standards for Health Facilities : The National 1000-Health Facility Quality Improvement Plan (October 2009), identified five crucial pillars for improving quality

Result Area 1	Indicators	Means of Verification	Risks	Assumptions (Hypothesis)
Capacity of Hospital management teams built at all levels.	• % of high, middle and low-level management teams trained within a facility. • % of trained staff in post at Project conclusion. • % realisation of Core Standards for Health Facilities. • % individual completion of District Managers training. • % completion of District Managers training per district. • Service Excellence Awards granted[21].	• Hospital, Provincial & National skills training statistics & reports. • Activity reports. • EQi & Psychometric evaluations • Random Interviews / Questionnaires with service beneficiaries. • Staff perception of institutional management (by structured Interviews & questionnaires). • Core Standards for Health Facilities Appraisal report & accreditation. • PMDS[22] reports.	• External and internal brain drains due to due to high staff turn-over & mobility. • Impact of other factors such as AIDS on HR Workforce. • Overall loss of acquired skills from the beneficiary Institutions • Unavailability of whole teams during training intervention.	• External and internal brain drain due to various reasons controlled. • Impact of other factors such as AIDS on HR Workforce controlled. • Local high staff turn-over & mobility reduced. • Acquired skills are retained within hospitals & in the sector • Consistent availability of whole teams during training intervention.

of care as: *i) Improved values & attitudes among health care workers; ii) Improved patient safety; iii) Infection prevention & control; iv) Improved facility cleanliness; v) reduced waiting times.*

[21] Service Excellence Awards – [To Hospitals & District Management Teams]: To be awarded in recognition of overall performance of management teams that put the service-user's needs first, have evidence based overall improvements in management of the health facility including effective resource management.

[22] PMDS – Performance Management & District Surveys

Result Area 2	Indicators	Means of Verification	Risks	Assumptions (Hypothesis)
Capacity of Skills Development Facilitators in the Department of Health is built at national and provincial level.	• Number of SDF's trained. • Level of individual completion of SDF's training. • % completion of SDF's training per province. • Level of implementation of national and provincial HRD plans by mid term review and final evaluation. • Level of aligning institutional skills development to Provincial/National skills development strategy by mid term review and final evaluation.	• National & Provincial SDF's training statistics & reports. • Activity reports. • Evaluation reports. • Random Interviews / Questionnaires with training beneficiaries. • Report on implementation of National Department of Health HRD strategy at national & provincial levels.	• Unavailability of targeted SDF's during training interventions. • Financial constraints such as lack of or insufficient National & Provincial budgets to allow the implementation of the HRD plans. • Administrative constraints such as the unavailability of adequate staffing at all levels to monitor & ensure development & implementation of HRD plans.	• Consistent availability of targeted SDF's during training interventions. • Availability of national & provincial budgets to allow implementation of the HRD plans. • Staff availability at all levels to monitor & ensure development & implementation of HRD plans.

Result Area 3	Indicators	Means of Verification	Risks	Assumptions (Hypothesis)
The programme is implemented in a well coordinated, fully integrated and sustainable process.	• Project coordinating working group operational – [With co-opted representatives from other relevant departments from National and Provincial Departments of Health, hospitals & development partners]. • Strengthened capacity & skills at the National Department of Health specific to this Project. • Agreed Memorandum of Understanding and guidelines for the implementation of HRD strategy /plan by SDF's. • Degree of programme integration into National Department of Health. • Participation & Inputs into relevant development partners consultative meetings.	• List of co-opted members of the working group. • Frequency of meetings, quorum & minutes of meetings. • Technical assistance from BTC deployed at the National Department of Health to strengthen capacity & transfer skills in the management of this Project. • Fully integrated programme into National Department of Health HRD frameworks at end of BTC Project • Developed implementation plans for HRD strategy & their execution. • Recognition of programme within the National Department of Health & Provincial MTEF. • Relevant development partners meetings reports. • Monitoring & Evaluation reports.	• Non-functional Steering Committees at some levels of the health structure. • Poor or lack of effective communication with relevant stakeholders. • Over looking complimentarity of actions of National Department of Health, BTC and other partners/donors implementing similar Projects such as CDC, EC etc • Lack of an appropriate & sustainable exit strategy as it relates to the end of BTC funding for the Project.	• Functional Steering Committees at all levels primarily providing strategic leadership, guidance, oversight, and coordination on Project operation. • Improved & sustained communication networking all relevant stakeholders. • Actions of National Department of Health and BTC are complementary with a firm handle on embodiment & a premium on ownership. • Partnerships with other donors implementing similar Projects such as CDC, EC are pursued & harmonized. • National Department of Health in collaboration with BTC & relevant stakeholders develop an appropriate & sustainable exit strategy as it relates to the end of BTC funding for the Project[23].

[23] It is important to recognise that an exit strategy should not only address securing local financial resources for the Project, but will also have to deal with matters such as staffing and further roll-out of Project implementation into other deserving districts and health facilities. It is imperative that this activity should commence immediately so as not to result in an extended interruption in expanded implementation when the BTC funding comes to an end.

ACTIVITIES PER RESULT AREA					
Result Area 1		**Activities**	**Sub Activities**	**Input / Means**	**Total Costs in €**
Capacity of Hospital management teams built	1.1	Conduct a needs analysis in identified hospitals and priority districts within 3 provinces and develop specific interventions.	Identify the targeted hospitals and beneficiaries	PMU Meeting/Workshop to identify hospitals	€ 0.00
				Official letter from National Department of Health to Province / hospitals	€ 0.00
			Conduct a needs analysis & Baseline survey (BSS)	Conducted by SDF's in 3 provinces x 50* identified hospitals.	€ 0.00
				Possible ST- Expert to undertake BSS & aid in improved skills development plans	€ 55 000.00[24]
			Develop hospital specific interventions	PMU Meeting in coordination with SDF's to decide on specific interventions	€ 0.00
	1.2	Conduct capacity building interventions (Integrated training in soft skills & hard skills) for hospital management teams in identified 50*[25] hospitals.	Integrated soft skills package	Short-term consultancy (3days training 50* hospitals)	€ 250 000.00
			Hard skills based on identified gaps to improve quality of care	Short-term consultancy (3 - 5 days training 50* hospitals)	€ 900 000.00
	1.3	Conduct capacity building interventions for District Managers in 10* districts	Integrated soft skills package	Short-term consultancy (3days training 10* districts)	€ 55 000.00
			Hard skills based on identified gaps	Short-term consultancy (3 - 5 days training 10* districts)	€ 165 000.00
	1.4	Conduct impact and quality assurance assessment of Hospital management teams and District management teams.	Assess beneficiary Hospitals & Management Teams	Short term consultancy to conduct impact and quality assurance assessment - (Based on agreed tools)	€ 40 000.00
			Assess beneficiary Districts & District Managers		

[24] In case this budget line (€ 55 000.00) is not utilized as indicated, it can be re-allocated into expansion of further capacity building as need arises.
[25] These numbers of 50* hospitals &10*districts are proposed for purposes of planning & budgeting, otherwise the actual numbers can be decided after determination of real cost of capacity building interventions.

	1.5	Service excellence award for hospital and district management teams	Meetings - PMU & Provincial Departments of Health to agree on Awards + modalities	PMU and Provincial Departments of Health meetings	€ 0.00
			Hosting Awards ceremony	Awards – (Prize money or otherwise)	€ 10 000.00
					€ 1 475 000.00

Result Area 2		Activities	Sub Activities	Input / Means	Total Costs in €
Capacity of Skills Development Facilitators in the Department of Health is built.	2.1	Agree and harmonize the training modules based on needs analysis	Hosting of a National Workshop	2 days National workshop and Provincial Departments of Health (Travel, accommodation & catering for 25 people)	€ 15 000.00
	2.2	Conduct capacity building interventions by training in the standardized modules.	Skills training based on identified gaps	Short-term consultancy (3 - 5 days training x10 workshops)	€ 70 000.00
	2.3	Conduct evaluations & impact assessment.	Assess beneficiary SDF's	Short term consultancy to conduct evaluations & impact assessment (Based on agreed tools)	€ 10 000.00
					€ 95 000.00
Result Area 3		**Activities**	**Sub Activities**	**Input / Means**	**Total Costs in €**
The programme is implemented in a well coordinated, fully integrated and sustainable process.	3.1	Conduct working group meetings (National Department of Health, Provincial Departments of Health and other donors).	Hosting working group meetings	2 per year: Travel, accommodation & catering.	€ 15 000.00
	3.2	Update capacity building strategic frameworks, guidelines, modules and assessment tools.		Short term consultancy (60 days)	€ 30 000.00
	3.3	Develop a memorandum of understanding for implementation of HRD strategy by SDF's.		Meeting: National Department of Health Provincial Departments of Health, SDF's	€ 0.00
					€ 45 000.00
				GRAND TOTAL FOR (RA 1+2+3)	**€ 1 615 000.00**

7.2. Budget

BUDGET TOTAL				Execution mode	BUDGET TOTAL	%	YEAR 1	YEAR 2	YEAR 3
A			**Specific objective (part) 1**		**1.615.000,00**	**81%**	**138.000,00**	**1.443.000,00**	**34.000,00**
A	*01*		*result 1 : capacity of Hospital Management teams built*		*1.475.000,00*	*74%*	*58.000,00*	*1.393.000,00*	*24.000,00*
A	01	01	need analysis of selected districts and hospitals in 3 provinces	REGIE	55.000,00		55.000,00	0,00	0,00
A	01	02	capacity building interventions in 50 hospitals	REGIE	1.150.000,00		0,00	1.150.000,00	0,00
A	01	03	capacity building interventions in 10 districts	REGIE	220.000,00		0,00	220.000,00	0,00
A	01	04	impact assesment and evaluations	REGIE	40.000,00		0,00	20.000,00	20.000,00
A	01	05	service excellence award for hospital and district managment teams	REGIE	10.000,00		3.000,00	3.000,00	4.000,00
A	*02*		*Result 2 : capacity of Skills Development Facilitators in the Department of Health is built.*		*95.000,00*	*5%*	*45.000,00*	*45.000,00*	*5.000,00*
A	02	01	Agree and harmonize the training modules based on needs analysis	Co-management	15.000,00		15.000,00	0,00	0,00
A	02	02	Agree and harmonize the training modules based on needs analysis	Co-management	70.000,00		30.000,00	40.000,00	0,00
A	02	03	Conduct evaluations & impact assessment.	Co-management	10.000,00		0,00	5.000,00	5.000,00
A	*03*		*Result 3: The programme is implemented in a well coordinated, fully integrated and sustainable process*		*45.000,00*	*2%*	*35.000,00*	*5.000,00*	*5.000,00*
A	03	01	Hosting working group meetings (NDOH, PDOH and other donors).	Co-management	15.000,00		5.000,00	5.000,00	5.000,00
A	03	02	Update capacity building strategic frameworks, guidelines, modules and assessment tools .	Co-management	30.000,00		30.000,00	0,00	0,00
A	03	03	Develop a memorandum of understanding for implementation of HRD strategy by SDF's.	Co-management	0,00		0,00	0,00	0,00
X			**Budgetary reserve (max 5% * total activities)**		**40.600,00**	**2%**	**0,00**	**0,00**	**40.600,00**
X	*01*		*Budgetary reserve*		*40.600,00*	*2%*	*0,00*	*0,00*	*40.600,00*
X	01	01	Budgetary reserve CO-MANAGEMENT	Co-management	8.000,00		0,00	0,00	8.000,00
X	01	02	Budgetary reserve STATE MANAGEMENT	REGIE	32.600,00		0,00	0,00	32.600,00

Z			**General means**		**344.400,00**	**17%**	**108.300,00**	**118.300,00**	**117.800,00**
Z	*01*		*Staff expenses*		*126.000,00*	*6%*	*42.000,00*	*42.000,00*	*42.000,00*
Z	01	02	National manager	REGIE	126.000,00		42.000,00	42.000,00	42.000,00
Z	01	03	Finance and administration team	REGIE	0,00		0,00	0,00	0,00
Z	*02*		*Investments*		*15.000,00*	*1%*	*15.000,00*	*0,00*	*0,00*
Z	02	02	Office equipment	REGIE	8.000,00		8.000,00	0,00	0,00
Z	02	03	IT equipment	REGIE	7.000,00		7.000,00	0,00	0,00
Z	*03*		*Operational expenses*		*108.400,00*	*5%*	*36.300,00*	*36.300,00*	*35.800,00*
Z	03	01	Office rent						
Z	03	02	Services and maintenance costs	REGIE	6.000,00		2.000,00	2.000,00	2.000,00
Z	03	03	Vehicle running costs	REGIE	12.000,00		4.000,00	4.000,00	4.000,00
Z	03	04	Telecommunications	REGIE	3.600,00		1.200,00	1.200,00	1.200,00
Z	03	05	Office supplies	REGIE	1.800,00		600,00	600,00	600,00
Z	03	06	Missions	REGIE	82.500,00		27.500,00	27.500,00	27.500,00
Z	03	07	Representation and external communication costs	REGIE	2.500,00		1.000,00	1.000,00	500,00
Z	03	08	Training	REGIE	0,00				
Z	03	09	Consultancy costs	REGIE	0,00				
Z	03	10	Financial costs	REGIE	0,00				
Z	03	11	VAT costs	REGIE	0,00				
Z	03	12	Other operational expenses	REGIE	0,00				
Z	*04*		Audit and *Monitoring and Evaluation*		*95.000,00*	*5%*	*15.000,00*	*40.000,00*	*40.000,00*
Z	04	01	mid term review	REGIE	25.000,00			25.000,00	
Z	04	02	final evaluation	REGIE	25.000,00				25.000,00
Z	04	03	external audit	REGIE	30.000,00		10.000,00	10.000,00	10.000,00
Z	04	04	Backstopping	REGIE	15.000,00		5.000,00	5.000,00	5.000,00
TOTAL					**2.000.000,00**	*100%*	**246.300,00**	**1.561.300,00**	**192.400,00**

7.3. ToR Long-Term Personnel

Project Assistant Manager

Role Overview:

The long-term local resource person will provide insights and guidance for the Project implementation in close collaboration with the Project Manager. He/She will actively stimulate coordination with other donor agencies working in the same field.

He/She will act as the Project Assistant Manager and will also be co-responsible for the Belgian contribution and will facilitate the administrative and financial execution of the Project, as well as the monitoring of its evolution through Project specific indicators.

The Assistant Manager will be part of the Project Management Unit (PMU) that will be established at the inception of the Project and consist of the Project Manager, the Assistant Manager and any staff seconded by the Project Manager from the HR Directorate of the National Department of Health. The PMU is responsible for the coordination and day-to-day management of the whole Project. Its role is to guarantee the Project intermediary results are realised in order to reach the specific objective.

The Assistant Manager will be appointed by BTC Representation in South Africa and will be based, as agreed with the Department of Health, in the Department. Salary will be aligned on NDOH.[26]

Specific Responsibilities and activities:

- Contribute to the content of training packages specific for every level of HRM
- Coordinate the overall planning of Project activities
- Organize, coordinate and supervise the implementation of Project activities (including activities carried out by consultants hired for specific tasks and the management of their contracts)
- Elaborate the terms of reference and manage the procurement processes of national or international consultants to be hired for specific pieces of work
- Follow the Project progress based on indicators defined
- Prepare the timely compilation of the following documentation:
    - Quarterly progress reports and budgeted work plans for consideration by the JLCB
    - Compilation of consolidated technical and financial reports for the previous period (quarterly/annual)
    - Annual business plans and budgets
    - Any other reports, both technical and financial, as may be required.
- Assist in the organisation and the JLCB meetings including the preparation of the draft agenda, dissemination of reports and the drafting of minutes of the JLCB
- Create linkages and networks with other national and international partners related to the Project
- Prepare and participate in meetings with institutional partners both nationally and in the provinces
- Be responsible for the financial management, accounting and timely and accurate

[26] Salary scales of the BTC staff delegated to the NDOH will be aligned with their salary scales. A person with the required profile would fall in the category 11 or 12. This corresponds with a gross annual salary level of 375.000 to 410.000 ZAR

compilation of financial reports
- Prepare and coordinate the budget and financial planning and implementation of the project activities at the financial level
- Supervise the call for tender processes and the tendering with suppliers
- Prepare all the requested financial and accounting documents, set-up the payments and expenditures follow-up and analyse the costs
- Prepare, update and follow up closely the accounting of the project
- Under the supervision of the Programme Manager, ensure that all the aspects of financial management are under control
- Ensure all the tasks related to the procurement and the use of equipment and supervise the logistics
- Undertake periodic analyses of the administrative, financial and accounting procedures and propose improvement if necessary
- Prepare detailed and compete financial reports respecting the relevant procedures;
- Ensure correct, timely and accurate input of financial data in the FIT system;
- Ensure the proper financial closing of the project.

Profile:

- ❑ A relevant university honours degree
- ❑ A minimum of five years work experience in a developing country context
- ❑ Experience of managing or working with health systems management within the context of human resources development/human resources for health
- ❑ Knowledge and experience of managing Belgian procurement rules and procedures is essential
- ❑ Knowledge of South Africa procurement processes
- ❑ Experience of networking with international and national stakeholders related to the Project
- ❑ Fluency in written and oral English
- ❑ Capacity to work in a diverse multicultural and multi-disciplinary team
- ❑ Excellent report writing and budgetary management skills
- ❑ Excellent Project planning skills

7.4. Implementation Plan