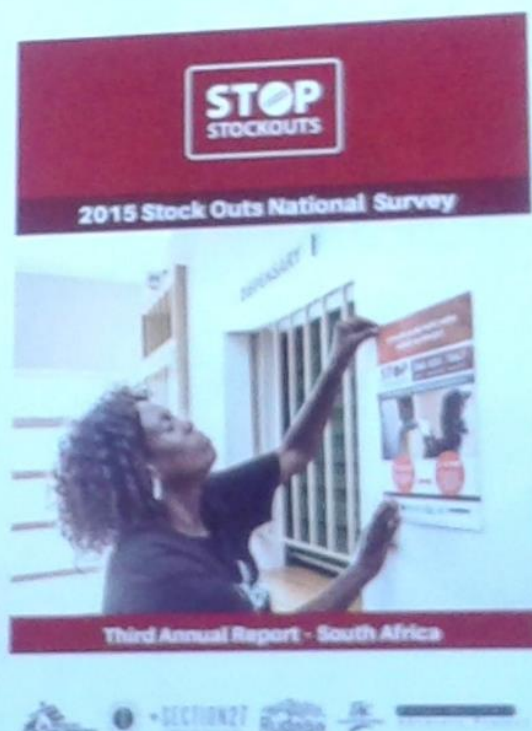


What if the medicines are missing?



EVALUATION OF THE STOP STOCK OUTS PROJECT (SSP), SOUTH AFRICA

November 2016

This publication was produced at the request of MSF on behalf of the SSP. It was prepared independently by **Andrew McKenzie** (independent evaluator) and **Tim McCann** (SEU)

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARO	Annual Review of Operations
ARV	Anti Retro Viral
BAS	Basic Accounting System
CCMDD	Central Chronic Medicine Dispensing and Distribution programme
CDC	Community Development Centre
CHAI	Clinton Health Access Initiative
CHC	Community Health Centre
CSO	Civil Society Organisation
DHIS	District Health Information System
DoH	Department of Health
DRC	Democratic Republic of the Congo
EC	Eastern Cape
EDL	Essential Drug List
ESMS	Electronic Stock Monitoring System
EU	European Union
FDC	Fixed Drug Combination
FS	Free State
GF	Global Fund
GP	Gauteng Province
Hb1ac	Glycated haemoglobin
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resource
HST	Health Systems Trust
KZN	KwaZulu Natal
LP	Limpopo
LPV/r	Lopinavir/ritonavir
MAVC	Making All Voices Count
MEDSAS	Medical Stores Administration System
MoH	Minister of Health
MOU	Memorandum of Understanding
MP	Mpumalanga
MPP	Medicines Patent Pool
MSF	Médecins Sans Frontières
NC	Northern Cape
NDoH	National Department of Health
NHI	National Health Insurance
NHIRD	National Health Information Repository and Data warehouse
NW	North West
OTIF	On Time and In Full

PAT	Pipeline Analysis Tool
PDoH	Provincial Department of Health
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
RHAP	Rural Health Advocacy Programme
RUDASA	Rural Doctors Association of South Africa
SA	South Africa
SCM	Supply Chain Management
SSO	Stop Stock Outs
SSP	Stop Stock out Programme
SVS	Stock Visibility System
TAC	Treatment Action Campaign
TB	Tuberculosis
ToR	Terms of Reference
VAN	Visual and Analytics Network
WC	Western Cape
WHA	World Health Assembly
ZAR	South Africa Rand



EXECUTIVE SUMMARY

The Stop Stock Outs programme (SSP) was formed in the aftermath of the 2012/13 Mthatha depot crisis. Six organisations who were already dealing with drug stock outs joined forces to tackle the issue. They included Section27, Médecins Sans Frontières (MSF), Southern African HIV Clinicians Society, Rural Doctors Association of South Africa (RUDASA), Rural Health Advocacy Project (RHAP) and Treatment Action Campaign (TAC). The different organisations brought different skills to the table. The objectives were twofold 1) to advocate largely to the National Department of Health (NDoH) to ensure policy and supply chain management (SCM) system changes that would ensure sustainable delivery of medicines to patients, largely focused on anti-retrovirals (ARVs) and TB medication, and 2) to mobilise civil society organisations (CSOs) and clients to address stock out problems on the ground. From the beginning the SSP has tasked itself to hold government accountable, to perform a watchdog role and to present the patient view on stock outs.

Two key approaches have been used. The first is a community mobilisation strategy largely led by TAC that includes health rights workshops (including access to drugs), communication initiatives (e.g. community radio and newspapers, posters and leaflets) and a hotline where health care workers and patients can report drug stock outs. SSP has negotiated an escalation protocol with the NDoH that prescribes how the process after receiving a stock out report on the hotline should proceed. The second is an evidence based advocacy approach at the NDoH level to lead to policy and systems changes to address drug stockouts. A key component of this approach has been the annual SSP survey which has provided evidence from all facilities across the country.

The evaluation comes at a time when the SSP has secured sufficient funding for the next three years and at a time when the SSP is reflecting on where it has come from and what it has achieved and making plans to strengthen the project in the years going forward. Parallel to this evaluation has been an organisational assessment.

The overall objective of the evaluation was to evaluate the impact and effectiveness of the SSP and specific objectives included evaluating the SSP's impact on provincial/national government policy and reform, on community mobilisation to address stock outs, on creating an effective advocacy consortium on health and HIV, on strengthening a regional stop stock outs movement and on assessing replicability regionally and in other service areas.

The evaluation used a mixed methods approach of document review, interviews/focus group discussions and observation. The field visit was over two weeks and included time in two provinces (Limpopo and the Eastern Cape), at the NDoH and with the consortium members and other key parties. In addition, regional and global parties were interviewed telephonically.

The findings were that the project has been enormously successful in changing the mindset at NDoH level and has led to the NDoH introducing, or fast tracking, policy and systems reforms (e.g. the stock visibility system - SVS; visual and analytics network - VAN, direct delivery, buffer stock, an advisory forum and the Central Chronic Medicine Dispensing and Distribution programme - CCMDD). This has largely been due to evidence based advocacy based mainly on the annual survey and to a lesser extent from the narratives from the ground. The mindset has changed from denial to a fixation on shortages and finally to realising that stock outs are a significant contributor to patients not receiving medicines and that SCM system issues need to be addressed. However, the jury is still out on whether these policy and systems reforms will have long lasting effects on reducing stock outs across the whole country. But, they definitely seem to be steps in the right direction.

On the ground, the SSP has had success within the limited footprint offered by TAC in mobilising CSOs and patients to address stock outs locally. This has been both formally through such mechanisms as the hotline and informally through CSOs and community members negotiating with health care workers at different levels. In addition, the hotline has ensured that reported problems have been dealt with through the escalation protocol.

The SSP has also had success in transferring the model to other regional countries (e.g. DRC, Mozambique and Malawi). This has been driven by MSF. These counties have adopted aspects of the SSP, in particular the focus on evidence based advocacy, the need for the patient view to be paramount and the emphasis on stock outs and allied SCM system challenges as opposed to shortages.

The consortium has worked really well together. Some challenges in the consortium have included the more adversarial advocacy strategy adopted with the NDoH, the focus of stock outs on HIV/TB or on whether this should be broadened to other drugs/diseases and whether the role should be merely as a watchdog or expanded into identifying and assisting in resolving SCM system challenges, especially last mile challenges. However, all consortium members acknowledge the strength that the different parties bring to the table and this is seen as a model for replicability.

SSP has not been good on packaging and costing what is needed for replicability. As mentioned the community mobilisation has not been as widespread as anticipated and thus this has limited the potential to mine the hotline data as a source for real time advocacy purposes. While the impact at NDoH level has been substantial, the impact at PDoH and lower levels has not been as dramatic. The consortium has been powerful on addressing direct HIV issues but not broader health systems issues (e.g. HR and budgetary concerns, poor management and supervision) and other disease concerns.

The findings are aligned with the specific objectives of the evaluation ToR. The findings are based on the interviews, reports and observations. Early findings were presented at three feedback sessions and this feedback is also included in the evaluation report. The conclusions are linked to the seven key criteria identified in the evaluation ToR: relevance, appropriateness, effectiveness, efficiency, impact, replicability and sustainability of the SSP.

The recommendations are based on the understanding that the context within which SSP is operating has changed. As identified the NDoH has responded to the high level advocacy advanced by SSP and its partners with policy and system changes. This has not been complemented by significant changes in last mile delivery beyond what is promised in the system changes introduced by the NDoH.

Key recommendations include:

- *Continue with advocacy at the national level to ensure that the policy and systems reforms are effectively implemented. Consider changes to the annual survey*
- *Strengthen advocacy at provincial and local levels with a particular focus on last mile delivery*
- *Increase community footprint/patient view as no one else provides this view through broadening the number and type of CSOs active on the ground and increase the use of the hotline*
- *Negotiate an MOU with government*
- *Support replication both geographically and for other service areas by packaging/costing the model*
- *Continue with the regional work in spreading the SSP model*
- *Strengthen the institutional structure of the SSP*

In summary, the SSP has had an impact on individuals; on policy and practice at national, provincial and district levels; and regionally and internationally. This was verified by a number of different sources. Three key issues need to be highlighted 1) the annual survey provides data/evidence for advocacy purposes both locally and internationally 2) SSP articulates the patient view, last mile SCM system challenges, and the missing 20% and 3) SSP has added Stock outs to the lexicon (not shortages) nationally and internationally.

PROJECT BACKGROUND

With ever larger numbers of patients dependent on continuity of life-long treatment, the monitoring, prevention and resolution of medicine supply problems is critical. The voice of ordinary citizens is key to holding government to account over the availability of essential medicines as access to medicine is a basic human right.

The Stop Stock outs Programme (SSP) was formed against a background of several organisations repeatedly being informed of drug stock outs (particularly ARVs) at the point of service. This had been going on for several years prior to the Mthatha Depot crisis. In late 2012, the Mthatha Depot in the Eastern Cape was under exceptional stress due to a prolonged strike. MSF, TAC and Section 27 entered into an agreement with the Eastern Cape Department of Health to assist so as to ensure that patients received their drugs during this period. This was the stimulus that led to the formation of the Stop Stock Outs Project (SSP).

The SSP is a concerted effort by a consortium of six civil society actors from a range of related disciplines [law and governance (Section27), health care (Médecins Sans Frontières, Southern African HIV Clinicians Society, Rural Doctors Association of South Africa), advocacy (Rural Health Advocacy Project), and community empowerment (Treatment Action Campaign)] to sensitise patients, healthcare workers and communities to their role in monitoring the obligations of the state to provide health care, and in particular drugs. Thus, the SSP was formed to monitor essential medicines and address medication stock outs and shortages in South Africa through gathering data and using citizen voices and multi-sectoral civil society coalitions to play a crucial role in assessing gaps in service delivery, informing solutions and advancing development of, and reforms in, policy from decision-makers.

The overall objective of the SSP is to improve the right to health, which in this case means access to essential medicines, of citizens reliant on the public healthcare system in South Africa. The specific objectives are:

- To improve access to information and capacitate communities on legal and constitutional rights related to the right to medicines
- To co-ordinate and develop a country-wide network of citizens/civil society collecting information through a platform to improve access to health and medicines.

Activities fall under 3 Pillars:

- **Voice** - Patients and health care workers empowered to hold their health system accountable and report on stock outs → **through hotline reporting, community mobilisation activities**
- **Influence** - Civil society pressurises government and others to respond to stock outs and drug supply challenges → **through the annual survey, and other advocacy mechanisms at national and local levels**
- **Sustain** - Develop a long term sustainable programme to represent patients and healthcare workers in securing access to medicines → **evaluation, organizational development**

To address the objectives, the SSP has developed, tested and implemented an innovative model to crowdsource reports of stock outs from patients, health workers, volunteers and sentinel surveyors. Stock outs are reported to the SSP via a hotline and communities are made aware of, and mobilised through, a community mobilisation approach in targeted districts. The SSP attempts to resolve stock outs on an ongoing basis, as and when they happen, by using an escalation protocol, agreed with the Department of Health, to address problems reported through the hotline. The protocol is more about who is responsible/accountable for each reported problem and less about what to do to solve the problems on an ongoing basis. For example, the reported problems are not collated and analysed to track trends or areas of significant problems in order to propose solutions to ongoing problems. To mobilise patients and communities, the SSP has initiated a trainer of trainers (TOTs) programme with the purpose of establishing a network of community mobilizers that understand patient rights, raise social awareness in reporting the stock outs and build the capacity of beneficiaries in using the tools and resources inherent in the SSP approach and model.

The hotline/community mobilisation activities have been complemented by an annual stop stock out survey to quantify across the country at a point in time the extent of the stock out problem faced by patients. Three surveys have been completed with the first in 2013.

The overall objective of the evaluation was to evaluate the impact and effectiveness of the SSP from inception to 2016 at the local, national and regional level, identifying successes and areas for improvement, whilst identifying lessons learned and assessing the replicability of the project in other areas and locations relevant to MSF.

Specific objectives included:

- To evaluate and describe the effectiveness of the project in achieving its objectives, identifying lessons learned to be carried forward for future similar interventions

- To evaluate and describe the project's impact on:
 - provincial and national government policy and reform on availability of medicines
 - mobilizing patients on stock outs and rights to medicine at a community level in South Africa
 - mobilizing groups of civil society organizations (the project's consortium members) within South Africa to work together, galvanize activism in Health and HIV in South Africa
 - a Stop Stock Outs movement and using the Stop Stock Outs model/activities in the region (Mozambique, Malawi, DRC)
- To assess the prospects for replicability of this project in other settings and/or other service delivery areas

The evaluation comes at a time when the SSP has secured sufficient funding for the next three years from the MAVC and the EU (logframe for the EU project attached as annex iv). Parallel to this evaluation has been an organisational assessment. Thus, the evaluation comes at a time when the SSP is reflecting on where it has come from and what it has achieved and making plans to strengthen the project in the years going forward.

EVALUATION METHODS & LIMITATIONS

To meet the objectives of the SSP evaluation, the ToR lists a number of questions and areas that must be addressed in the evaluation relating to seven key criteria: 1) Relevance i.e. were strategies/activities aligned with identified needs 2) Appropriateness i.e. were strategies adopted appropriate for the set objectives, and sensitive to contextual changes 3) Effectiveness i.e. did the strategies/activities achieve the objectives and if not, why not and what should be changed 4) Impact i.e. did the SSP improve availability of medicines at the point of service for patients, and specifically, what difference has the project made in terms of policy/practice both nationally and internationally, in terms of mobilising patients and CSOs to advocate for their rights to access medicines, and in terms of contributing to a regional SSO movement; the proportion of the target population reached and the perceived effects by them and other stakeholders 5) Replicability i.e. identifying activities/processes necessary for transferring to other geographical and functional areas 6) Efficiency i.e. were activities/strategies implemented with the best use of available financial resources and time and 7) Continuity i.e. will the project be sustainable.

The Evaluation Matrix (annex v) is used to document the approach taken in the evaluation and will utilise the questions specified in the ToR and add other questions related to the relevance, appropriateness, effectiveness, efficiency, impact, replicability and sustainability of the SSP. The Evaluation Matrix will address the major questions and challenges raised in the ToR related to the expected results of the SSP. On the basis of the Evaluation Matrix, specific evaluation and analysis tools and guidelines were developed and implemented in the field visit/interview phase of the project (example in annex vi). This was a dynamic process and the tools were adapted throughout the evaluation process.

The primary information will be analysed in combination with the document review to assess the input (activities) – output (deliverables) – result (effect) chain of the project and, hence, be able to measure the achievement and progress made to date. Special importance will be given to obtain ownership of the evaluation approach and methodology, thus findings, and the main conclusions and lessons learnt, were shared with the main stakeholders of the SSP during the three structured briefings framing the evaluation: inception report, restitution and presentation of outcomes. The presentations were highly interactive to ensure that discussions and critical review took place with the input of all invitees. This was essential to ensure that the final conclusions and recommendations with concrete actions and timeline inputs are appropriate and adequate.

Underpinning the evaluation and analysis is a Complex Adaptive Systems lens which is a critical theoretical approach in understanding how health systems work, how the different components interact and how innovations or changes are institutionalised.¹

The SSP is a strategy to enable clients and CSOs to hold government structures and systems accountable for ensuring the availability of essential medicines at the point of service. The health system can be seen as a complex adaptive system. Complex adaptive systems are complex in that they are diverse and made up of multiple interconnected elements and are adaptive in that they have the capacity to change and learn from experience. The complex adaptive

¹ Paina L, Peters DH. Understanding Pathways for Scaling up Health Services Through the Lens of Complex Adaptive Systems. *Health Policy and Planning* 2012; 27: 365–373; Adam T. Advancing the application of systems thinking in health. *Health Research Policy and Systems* 2014; 12:50; Peters DH. The application of systems thinking in health: why use systems thinking? *Health Research Policy and Systems* 2014, 12:51

systems lens will aid and frame the analysis of the data/information from the interviews, document review, focus group discussions and observations.

In summary the evaluation used a mixed methods approach combining interviews with reviewing reports and data and observations of community mobilisation workshops and a quarterly pharmacy meeting. Interviews included:

- NDoH, PDoH (Limpopo, Eastern Cape), depot, district, sub-district, clinic, clients
- Consortium partners
- Regional and other interested parties

A full list of those interviewed is in annex ii.

Three limitations to the evaluation were identified:

- Limited time

There was some concern initially that given the short time between finalising the evaluation and the field work that some of the interviewees might not be available. As it turned out, only one of the planned interviews did not take place.

- Limited sample/limited coverage

Given only two weeks for the field work, decisions were taken on which provinces and people to interview and visit. The national department and two provinces were included (Eastern Cape and Limpopo). The findings, conclusions and recommendations are thus based on this sample.

- Limited ability to evaluate SSP impact in non-SA contexts

Part of the evaluation was to assess and describe the project's impact on a Stop Stock Outs movement and using the Stop Stock Outs model/activities in the region (Mozambique, Malawi, DRC). None of these countries could be visited in the time available. Thus, telephonic interviews were conducted.

FINDINGS

The findings are framed by the three specific objectives as identified in the evaluation ToR. The second specific objective is discussed first. The findings are based on the interviews, reports and observations. In addition, early findings were presented at three feedback sessions: MSF restitution meeting in Cape Town, the MSF annual review of operations (ARO) meeting and the SSP steering committee meeting both in Johannesburg. Observations and discussions from these meetings are included in the report.

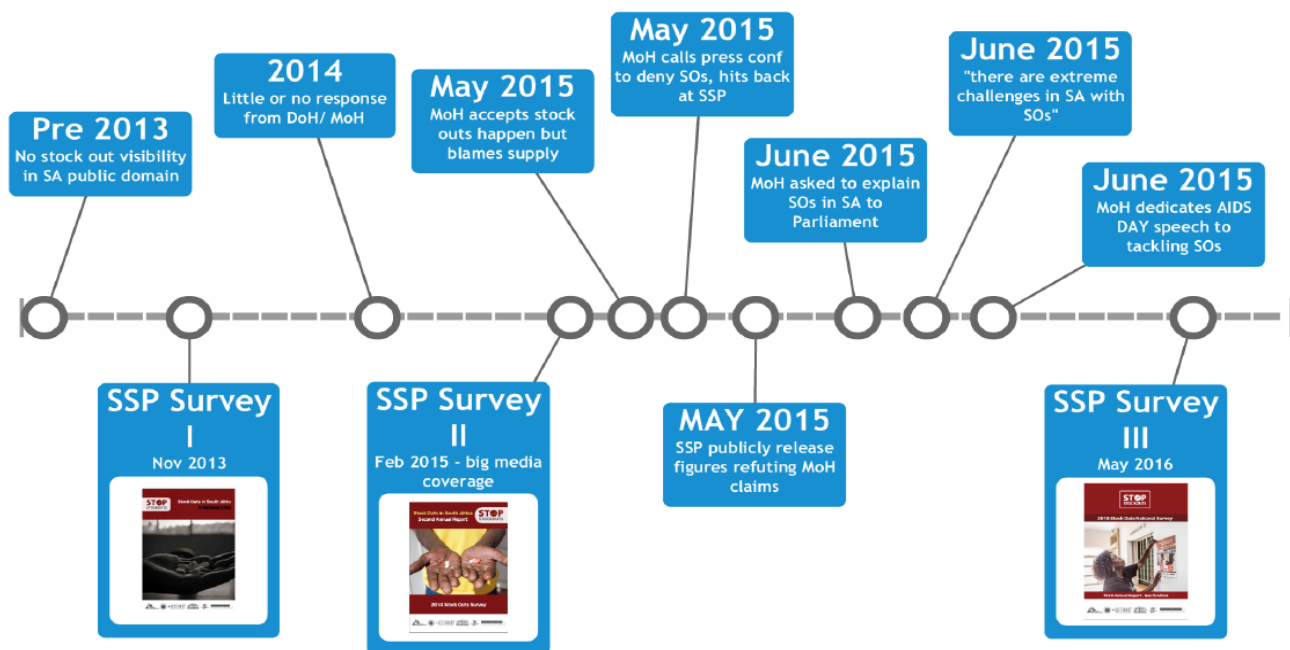
IMPACT ON PROVINCIAL AND NATIONAL GOVERNMENT POLICY AND REFORM ON AVAILABILITY OF MEDICINES

National Level

Linked to policy changes and supply chain management (SCM) reforms at national level, there has been a changing mindset at the National Department of Health level, and causality can be relatively easily drawn to the efforts of SSP and specifically to the impact of the national surveys. In the late 2013 joint NDoH and WHO HIV-TB-PMTCT review of the programme in South Africa it was stated:

"No significant stock-outs of tracer drugs were reported during the last 12 months"

This was the mindset of the NDoH and of many organisations in South Africa. The mindset has shifted from denial (or even complete aversion)² to partial acceptance³, and very quickly to stock outs becoming a key priority of the Minister of Health and the department^{4,5} (see timeline below).



Illustrative timeline of SSP influence on MoH discourse

² No evidence of 'stock out' discourse in public communication from MoH/DoH prior to first SSP annual survey in November 2013

³ After the release of the second SSP national survey in February 2015, MoH concedes there is a stock out issue and speaks regularly about stock outs affecting patients in South Africa, but rejects a 'stock out crisis' (MoH Budget Speech May 2015, Motsoaledi: Media briefing on availability of medicines May 2015)

⁴ "The minister has also now conceded that there are extreme challenges with stock management at provincial depots and public medical facilities," – From a member of South African Parliament, where MoH is called to explain the "Stock Out" situation in the country after SSP publicly challenges the MoH's declarations that stock outs are not at crisis levels <http://www.dispatchlive.co.za/news/2015/06/08/motsoaledi-must-explain-stock-outs-to-parly-da/>

⁵ Three weeks later, the MoH dedicated his 45 minutes closing speech at SA Aids conference to the issue of Stock Outs and how DoH plans to address the problems <https://soundcloud.com/ryan-fortune-msf-org-za/sa-health-minister-aaron-motsoaledis-closing-speech-at-sa-aids-conference-2015>

By mid 2015, the issue of stock outs was acknowledged as highlighted in this newspaper report when the MoH was called to Parliament to discuss stock outs:

"Just last week, Motsoaledi denied the stock-outs," Dr Heinrich Volmink, the DA's shadow deputy minister of health, said.

"However, this week 20 essential medicines are being flown into the country on emergency flights to address the shortages."

Business Day reported on the emergency measures on Monday, and that Motsoaledi late last week had convened an urgent meeting with pharmaceutical manufacturers, the Medicines Control Council, the provincial health MECs and heads of health departments to establish the scale of the problem, the reasons for the stockouts, and how long it would take manufacturers to fulfil orders.

"The minister has also now conceded that there are extreme challenges with stock management at provincial depots and public medical facilities," said Volmink.

From Motsoaledi must explain stock-outs to Parly: DA. By Phumza Sokana - June 8, 2015
(<http://www.dispatchlive.co.za/news/2015/06/08/motsoaledi-must-explain-stock-outs-to-parly-da/>)

The attribution to the impact of the SSP on this change in mindset was first confirmed by a head of pharmaceutical services at provincial level and later cemented at the NDoH level, where it was described how the Minister demanded a response from his team that would be effective to prevent stock outs after considerable public pressure resulting from the SSP:

"after the release of the first SSP survey, the Minister demanded a system that predicts stock outs, not explains why they happened - he always said we were good at post-mortems but wanted prevention"
(NDoH Pharmacy interview)

This changing mindset is reflected in documents such as plans and policies. Examples include from the 2015-2019 strategic plan page 19:

"Medicines availability - a network of linked stock systems will be established throughout the supply chain value chain to improve availability. In order to simplify the supply chain and its responsiveness direct deliveries are being implemented to central and regional hospitals. The National Department of Health maintains a buffer stock of vital medicines at the central procurement unit for deployment in the event of stock shortages.

In order to improve access, a system of central chronic medicines dispensing and distribution service providers linked to pick up points (that) have been established in order (to) improve access through extended service hours and closer proximity to the patient's place of residence."

and from the 2015 NHI White Paper pages 14 and 77:

"Public sector facilities are regularly assessed against core quality standards. This has revealed that there are quality problems in the areas of staff attitudes, waiting times, cleanliness, drug stock outs, infection control and safety and security of staff and patients."

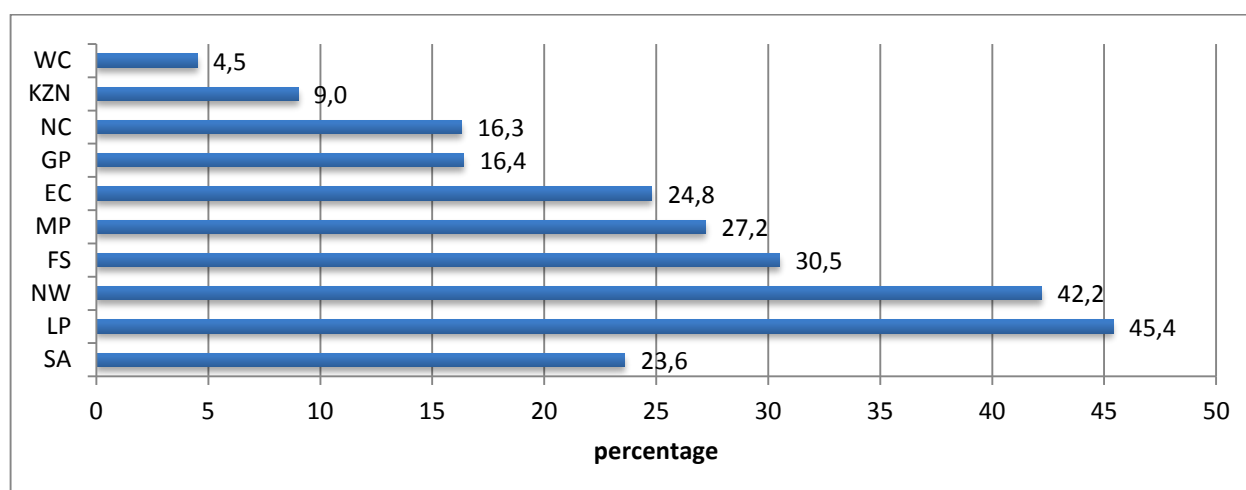
and

"The benefits of central procurement derive from leveraging the economies of scale of NHI to obtain the best possible price. The advantages of price determination could save millions of rands every year. Improving systems and processes within the procurement system will bring greater efficiencies, fewer stock outs and better access to health products for the patient."

and

"Pharmaceutical depots are no longer a preferred method for ensuring the sustainable supply of medicines because of the inherent risks of pilferage, expired stocks, lack of security of supply, drug stock outs and inefficient distribution to health care facilities. A mechanism of direct delivery of health commodities from suppliers to facilities shall be implemented."

However, although stock outs features in these documents, the NDoH still has no indicator in their plans that tracks stock outs. The DHIS2 (the national routine HMIS system) does have one indicator - tracer items stock out rate (fixed clinic/CHC/CDC) - and the data is shown below by province for the 2014/15 financial year.⁶



tracer item stock out rate by province (2014/15 financial year)

As will be seen later, this is very comparable with the SSP survey data. However, if one uses the DHIS2 data to drill down to facility level, very few facilities are reporting and thus the aggregated data by province is based on a small sample. Thus the alignment with the SSP survey data might be fortuitous. In addition, no one interviewed in government was aware of the DHIS2 indicator and data and did not access or use it. Those aware were outside government and most had not drilled down to realise the limited reporting rate.

A key nuance in the mindset change has been the acceptance of stock outs into the government lexicon. Previously, the narrative was on shortages and these shortages were caused by supplier problems. These included shortages of APIs (active pharmaceutical ingredients) which were both global and local, problems with quantification and forecasting and thus suppliers not producing adequate amounts or not having sufficient buffer stocks. Shortages of specific drugs (e.g. the LPV/r shortage in 2015) did play a role at certain times. However, the NDoH was reluctant to accept that SCM problems, especially last mile problems, could be the cause of patients not receiving medicines. But the evidence was clear. If the problem was largely due to shortages, then provinces, districts and sub-districts would all experience a similar level of shortage of drugs. However, the SSP annual survey data showed that provinces, districts and sub-districts were performing very differently. This indicates that there is large element of stock out and last mile delivery challenges within the system.

"the surveys provided the hard data that was missing" (non SSP, non government informant)

All the interviews with national and provincial people acknowledged that the SSP had had a key influence on government and on the speed of changes that have been introduced.

But the response has moved beyond a changed mindset. There has been an injection of funding from the treasury to address stock outs and a number of new initiatives introduced by the NDoH, some (not all) of which can be directly attributed to the SSP. These include:

1) SVS (VAN) stock visibility system/visual & analytics network

A major concern of the department was that they had no idea of what was happening on the ground. The joint report from the NDoH and WHO in late 2013 had not indicated any significant problem with stock outs. There was no routine information system that could provide them with accurate information. The only evidence was anecdotal reports from the ground and to some extent these could be ignored or regarded as isolated problems and not symptomatic of a wider challenge. As mentioned the DHIS data was not used, even if they were aware of it. Thus, while the government was aware that there was a problem, it had no mechanism to quantify the problem. Given this context, the results from the SSP annual survey reports came as a considerable surprise to government. Initially, they discredited the results largely based on challenging the methodology utilised. This led to a particularly acrimonious relationship between the

⁶ data from the NHIRD - National Health Information Repository and Data warehouse - managed by the NDoH

NDoH and the SSP which still lingers to this day. The DoH view that was expressed was that the criticism was not constructive and tended to be negative. Positive developments were not acknowledged.

A significant part of the response to MoH demands for a system that prevents stock outs. The system developed to give government a view from the ground was the stock visibility system.⁷ As confirmed in discussions at national level, the SVS was developed in direct response to the lack of data and the stock outs as exposed by the SSP annual survey. Initially, this was started in hospitals and PHC facilities in the NHI pilot districts. Facilities report using the electronic stock management system tool for hospitals and an app from PHC facilities. The system is now being rolled out to all facilities. The data is captured centrally at the NDoH and at this stage is only shared with those in government. There are also provincial surveillance centres which can access the data. Each PHC facility has to report weekly on an agreed set of drugs and the reporting includes quantification, drugs delivered in that week and expiry date. The system allows for the NDoH to see on an ongoing basis what is happening in terms of drug supply at each and every facility in the country.

Currently the SVS/VAN/ESMS system is used for monitoring purposes or visioning (phase 1). Phase 2 is the informed push (now being piloted). Phase 3 is closing the loop and phase 4 is demand planning. Closing the loop will be when the box barcode is scanned by the receiving nurse/pharmacist and transmitted to the cloud. The nurse/pharmacist will then be sent a proforma invoice and she/he will open the box to check. She will then get a one-time pin number which allows her/him to open a goods received voucher to confirm that all drugs are present and this will then allow payment to be made.

Linked to this is the pipeline analysis tool (PAT) which captures information from drug manufacturers and suppliers. This allows for centralised oversight of supplier performance and links up to drug availability from the SVS. Thus peaks and troughs in drug availability can be smoothed out. The NDoH has also adopted a much more stringent approach to managing contracts with drug manufacturers/suppliers. There is a dedicated unit at NDoH to do this. They meet with all suppliers at least monthly and penalties have been invoked regularly. The NDoH claims to have moved OTIF (on time and in full) drug distribution from 30% to 80%. However, provinces are not necessarily at the same level and some provinces are still using emergency tender regulations to bypass the current tender system and buy drugs that are more costly.

Weaknesses in the SVS include the time needed, often by nurses at PHC level, to fill in the app on a weekly basis. Although not quantified, people that we spoke to suggested that up to 3 hours per week would be needed. More time would be needed if the pharmacy was not organised and the bin cards were not up to date as drugs would then have to be counted. In most cases, and especially at PHC level, this would be the case. There were also some concerns at the NDoH at the accuracy of the data and the lack of any other validation system. From the staff that we spoke to at provincial level and lower, it seems that only provincial level people utilise the access pin codes to view the data and see the situation on the ground. Most staff were unaware of this availability and where they knew they stated that they had lost their pin number. The SVS was initially intended as an early warning mechanism, but has still not managed to be deployed as such because the stock levels are not matched with patient numbers. This is planned for the future. Finally, the SVS does not capture the patient view. It measures drug availability at facility level but not whether individual patients experienced stock outs i.e. went home with the wrong drugs or insufficient quantities of the right drugs. The SSP survey and hotline evaluates stock outs from the patient perspective. The survey asks questions from facility staff re drug availability and also what they did if drugs were not available. The survey does not ask patients directly. The hotline collects data from health workers, CSOs and patients.

⁷ besides the SVS, the DHIS2 and the SSP annual survey, some provinces have developed their own systems (e.g. excel based) to improve stock visibility

The VAN at the NDoH



2) Direct delivery

As highlighted in discussions at the NDoH, this has also been developed largely in response to the evidence unearthed by the SSP, particularly the annual survey.

"SSP stimulated the new systems and this has allowed the department to manage the whole system better and manage transitions better. SSP has helped increase visibility and transparency." (NDOH pharmacy interview)

For a long time, the NDoH has acknowledged that the pharmaceutical depots were a weak link in the SCM system. Drugs were delivered and unpacked/packed at multiple different levels for onward transmission to the final destination. In some cases this could happen up to 11 times as drugs passed from manufacturer to supplier to depot to sub-depot to hospital and then to facility. At each stage they would be unpacked and packed, often several times in one institution/facility. Besides being inefficient this system allowed for wastage and leakage. The NDoH response has been to introduce direct delivery from a centralised facility in Mid Rand to the whole country (Western Cape excluded). Manufacturers pack separately for each health facility. This is then sent to the cross docking facility in Mid Rand where courier services deliver all drug boxes for a health facility direct to the health facility. Packing occurs at the manufacturer side and unpacking occurs at the health facility.⁸ The plan is for 70% of drugs to be delivered in this way with the depot delivering the remaining 30% which are drugs that are not used that often and forecasting is less predictable or when shelf life is shorter. Thus, the response has been to create a very centralised distribution system that has been largely outsourced/privatised. In addition, the Mid Rand cross docking facility keeps a buffer stock of certain drugs (e.g. ARVs) that can be used to fill gaps when there are supplier shortages. At this stage direct delivery is targeted at quantity (larger facilities), and small rural areas are still left behind.

3) CCMDD

The Central Chronic Medicine Dispensing and Distribution programme was started before the SSP as a mechanism to decongest health facilities of chronic stable patients.⁹ This was linked to the development of the adherence clubs for chronic stable HIV+ve patients. The SSP, with the evidence produced on the stock outs through the annual survey, has probably played a role in speeding up the CCMDD programme. To date around 750,000 patients are on this programme with an additional 350,000 in the Western Cape on a similar programme. The national target, excluding the Western Cape, is 1.1 million patients by the end of the 2016/17 financial year.¹⁰ Chronic stable patients are given a choice of a community pickup point near to where they live. A courier service will then deliver to that point. SMSes will be used to alert the patient. If the drugs are not picked up then the packages should be returned via the courier.

The CCMDD programme has ramped up very quickly. There were several concerns expressed at whether in the rapid scale up there were sufficient checks and balances to ensure that if the programme was not working smoothly that corrective action could be taken. For example, for the courier service to deliver to a community point, there needed to be a minimum number of patients picking up from that point (250 was the number mentioned¹¹). If not, then the drugs were delivered to the nearest clinic which then had to make sure that they were sent on to the community pickup point. Similarly, there were some concerns that the necessary clinical checks were not in place. Although the patients are chronic stable patients, their clinical condition can change and side effects of medication can emerge. It is not clear that the system create adequate controls to factor this in. For example, while patients still need 6/12 checkup or clinical visits and six monthly scripting, the blood test to check adherence is done at the clinical visit (e.g. viral load, Hb1ac) and for abnormal results patients are called back. This might be easier on paper than in reality.

4) Forum

A new initiative to address stock outs is the forum to promote transparency and multi stakeholder engagement regarding medicine availability. Again, the establishment of the forum is in response to the ongoing stock out problem. The first meeting was held in September 2016. It is too early to assess how this advisory body will function. One concern expressed was that there was little community or patient representation on this body but it was largely a government and private sector dominated body. Another concerns is the confidentiality agreement. It is not clear what this means for the independence of civil society. Feedback on the draft forum ToR from SSP members has raised a number of issues to be discussed. These include indicators to track stock outs, regular reports on mechanisms to address stock outs and

⁸ Note that tender prices with suppliers is the same as for facility as for depot. Therefore, for a facility manager it makes sense to use the couriers/direct delivery as the depot adds on 5% to cover their costs.

⁹ other mechanisms include the adherence clubs and the fast lane appointments for chronic patients

¹⁰ note that recruitment rate is now 7x that of a year ago

¹¹ other interviewees mentioned 300 so not sure if we have the correct number

their impact, making information on stock outs publically available (e.g. could consider what the NDoH did once in placing the current stock out status on their website), plans to address poorly performing districts and sub-districts, early warning systems and emergency response teams and so on. Many of these issues could be discussed if the forum has been created to advise on stock outs. Some of these issues can be included in a potential MOU (see recommendation iv).

Provincial Level

As mentioned earlier in the limitations, the understanding of the evaluators is based on visits to two provinces. In South Africa's Constitution health is a concomitant responsibility shared across the three levels of government. Thus while the NDoH can set policy and frameworks, implementation is up to the two lower levels.

At provincial level, the two provinces visited were signing up patients for CCMDD. Each sub-district had their targets. In terms of direct delivery, this had not yet been implemented in the Mthatha Depot and was happening to some extent in Limpopo. Mthatha Depot management stated that they were still responsible for delivery of most drugs to facilities. In terms of SVS, neither province visited were accessing the data. Limpopo province reported that the Samsung cell phones used to transmit the data had all been removed so as to be registered in line with the PFMA. They had only recently been returned. Thus, the number of facilities reporting was poor. This was reflected at the SVS centre in the NDoH. More worrying was the reported drop off in reporting rate in Limpopo before the phones were withdrawn. In the Mopani district, it was said that the rate had dropped down to around 30% from an initial reporting rate of around 70%.

Local Level

One of the key problems identified in the two provinces from discussions at district, sub-district and facility level and at the depot was poor basic pharmacy management at facility level. Bin cards are not up to date and poor bin card management means that quantification is inaccurate. This creates a vicious cycle of poor demand forecasting and thus problems with over and under supply of drugs. Layout and systems in pharmacies and drug store rooms are not standardised even within individual provinces. Management and oversight is weak. In addition, staff at facilities and at the depot don't know their own budgets. The depot highlighted that the MEDSAS (drug system) was not linked with BAS (the financial management system). Therefore, there is no checking of an order against the available facility budget and the depot will supply if the drug is available and within reasonable parameters (i.e. they won't supply an obviously excessive amount requested or drugs that are not meant to be used at PHC level). However, the facility should not order if the budget is not available, the depot should not supply if the budget is not available and should not order from the supplier if the budget is not available.

The medicines and surgical supplies budget is under the general goods and services budget line item. Managers are allowed to move or vire funds within line items and many will spend money on other goods and services and deplete the goods and services budget line item as they know that the depot will supply drugs even if there is no budget. As mentioned budget tracking was not seen as a priority. In addition, there is little sanction for overspending. The medicines budget is thus not ring fenced.

Finally, there were several complaints of limited oversight and supervision. This was reported from clinic sisters who were dealing with medicines and the SCM system. District pharmacists interviewed confirmed that supervision was limited. One of the problems identified is that the pharmacy directorate is responsible at provincial level for SCM system issues but that clinic nurses do not fall under them.

At a local level there have been several initiatives to address drug stock outs. In Limpopo, the head of pharmacy services at provincial level has introduced a management tool that facility managers need to use. There are five key areas to review: stock levels, stock outs, stock out drivers, challenges experienced, what done. Health care workers at PHC facilities have informal networks to address stock outs. They share drugs using whatsapp groups, sub-district meetings and the clinic supervisor who will be called upon to shift drugs from those who have to those who don't. Hospitals in some provinces are responsible for a group of PHC facilities and thus these facilities get support from the hospital pharmacist. CSOs and community members try to address stock outs on the ground through working with facility and depot staff to address problems as and when they arise.

Overall there is concern whether government is adequately addressing last mile SCM issues. There seems to be insufficient training, no posts for sorely needed pharmacy assistants, specific budget adherence issues and lack of any sanction for poor performance. All these impact on the SCM system, especially last mile delivery.

Thus, the changes witnessed at national level (such as direct delivery, SVS, CCMDD) are slowly rolling out but what seems to be lacking is the attention needed on the last mile delivery problems.

IMPACT ON MOBILIZING PATIENTS ON STOCK OUTS AND RIGHTS TO MEDICINE AT A COMMUNITY LEVEL IN SOUTH AFRICA

One of the pillars of the SSP is to mobilise patients and CSOs through facilitating workshops on issues around patient rights, including discussing stock outs. The Treatment Action Campaign (TAC) has led in this area. Workshops have largely been held in areas where TAC members and groups are active. TAC has currently 45 community mobilisers while SSP has 6 community advocates. Currently, the community advocates are employed by SSP but there are negotiations to organise a contract with TAC and 'return' the community advocates to TAC. In the field, the community advocates are 'managed' by TAC and draw on TAC resources. This limits them to operating in areas where TAC has a presence. For instance 12 of the 23 TAC branches in the Eastern Cape are in the Quakeni sub-district. The SSP community advocate and the RHAP mobiliser are also based there. While this creates a strong team it does not allow for wide coverage.

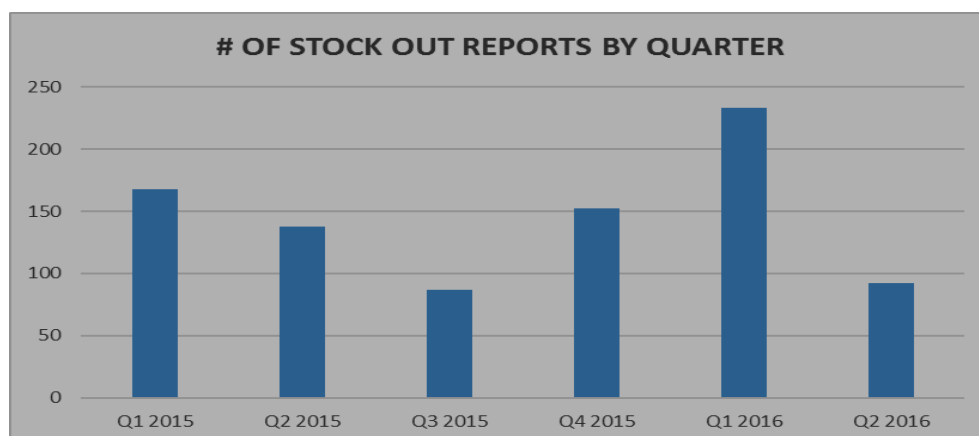
In addition to the workshops, there are other community communication tools. This includes posters and leaflets, community radio slots and community newspaper articles. The evaluation team did not have sufficient time and resources to evaluate the impact of these tools. Anecdotal evidence from the reviews suggests that in some areas the DoH allows the posters to be placed in the facilities and the leaflets to be distributed to patients. But, this was not the case throughout.

The community mobilising workshops are held jointly. In the Eastern Cape we observed two workshops where TAC, SSP and RHAP facilitated the workshop. Section 27 was meant to be there, as the Eastern Cape is one of two provinces where they have a presence, but they had another commitment.

TAC members that we spoke to at both workshops were clearly instrumental in addressing challenges experienced by patients at PHC facilities. TAC members have a certain number of clinics that they 'cover'. Stock outs are one issue that they address. Others include waiting time and staff numbers. In discussions with clinic staff and supervisors, it is clear that TAC is both respected for what they do but also seen as an annoyance. But TAC does address the issues. They try to address what they can on the ground through dialogue at facility, sub-district, district, depot and, if necessary, at provincial level. Because they are respected community members and activists they have access to politicians locally and provincially which makes their task easier.

If they cannot address the issue, they will use the hotline. The two main users of the hotline are TAC members and health care workers. The SSP has negotiated an escalation protocol with the NDoH (see annex vii). The hotline receives around 600-700 calls per annum although this is increasing. Most of these are resolved following the approach documented in the protocol. The TAC members and clients on the ground that we interviewed reported that in all but one case there was resolution and that the loop had been closed through informing the complainant of the outcome.

From the most recent SSP quarterly report, the following information can be gleaned on the hotline.



Although data fluctuates quarter by quarter, approximately 2/3rds of stock outs are reported by organisations and patients and 1/3rd by health care workers. Around 1/2 get resolved within a week and the rest within a month. The complaints are largely restricted to areas where TAC is operational. Of more concern (from the recent quarterly report page 3):

"Almost 90% of patients reported leaving their facility without any medication due to the stock out, while 97% of facilities reported providing patients with no medicine due to the stock out."

It is also clear that community members do not always know about the hotline and try to address issues locally, largely with the clinic staff. From the SSP baseline report (August 2016) between 15 and 25% of patients sampled reported problems to the SSP.

The SSP has been successful in mobilising patients around patient rights issues, in this case access to medicine. However, the coverage has been limited and this is an area that needs addressing going forward.

IMPACT ON MOBILIZING GROUPS OF CIVIL SOCIETY ORGANIZATIONS (THE PROJECT'S CONSORTIUM MEMBERS) WITHIN SOUTH AFRICA TO WORK TOGETHER, GALVANIZE ACTIVISM IN HEALTH AND HIV IN SOUTH AFRICA

The SSP was formed by the six organisations as they all realised that they were dealing with a common issue, often from different viewpoints. All six organisations have a long tradition of advocating for patient rights albeit in different ways. All six organisations reported that the consortium had on the whole worked exceptionally well together. The different organisations complemented each other. TAC was the cornerstone of the community mobilisation strategy and had the political connections which allowed them to pick up the phone to senior politicians and policy makers. RUDASA and RHAP provided the rural health worker view and were instrumental in bringing these challenges to the fore. Section 27 provided legal backup when needed and strengthened the strategic nous needed for the programme. The HIV Clinicians Society had good connections with the DoH, contributed to developing guidelines for the DoH on treatment protocols and treatment alternatives when certain drugs were not available. The HIV Clinicians Society also housed the SSP. MSF brought the global view and took the lessons learnt and the evidence gathered to global platforms. They added more strategic thinking especially in terms of advocacy and provided significant funding before the SSP secured their own funding.

Challenges were both tactical and logistical. In terms of logistics, some of the consortium partners struggled to attend the steering committee meetings (largely TAC and RUDASA). Besides logistic concerns, TAC expressed problems with the technical and medical nature of some of the discussions at the steering committee level which largely excluded them. The HIV Clinicians Society, and to a lesser extent RUDASA, expressed some concern at the adversarial advocacy strategy adopted whereas they were trying to maintain cordial relations with the NDoH. The NDoH confirmed that there had been several occasions, often at high profile conferences, where they had been 'attacked' and indicated that a more 'constructive' advocacy approach would have been welcomed. There was some indication that the NDoH had tried to block funding for the HIV Clinicians Society although this was not confirmed.

The other issue where there was disagreement was the breadth of focus. RUDASA and RHAP wanted to broaden the focus to include stock outs of other drugs (e.g. vaccines and other chronic EDL drugs). To some extent this has happened in the annual survey. But the SSP still maintains a focus on HIV and TB. The community mobilisation strategy is aligned with TAC (an HIV organisation).

But clearly, the SSP and the consortium driving it had had enormous impact on policy development, change in mindset and approaches to address stock outs at the NDoH level. Some of this had filtered down to provincial level. The consortium members all felt that it had been a worthwhile exercise; that they had learnt significant amounts from each other; that addressing an issue such as stock outs required a consortium approach; and that they felt that the relationship should continue.

Finally, the balance between organisations that represent an on-the-ground view and those that target higher levels is critical. Community activism needs to be complemented by high level advocacy and vice versa. Because it can be difficult to evaluate the impact and effectiveness of the on-the-ground activities, there is often a tendency to ignore the importance of this work. However, the on-the-ground view ensures that the focus is on the patient. This is one of the key strengths of the SSP. Some concern was expressed that if the community level activism and focus was downplayed, then the SSP might end up as a middle class civil society movement speaking on behalf of the patients on the ground.

IMPACT ON A STOP STOCK OUTS MOVEMENT AND USING THE STOP STOCK OUTS MODEL/ACTIVITIES IN THE REGION (MOZAMBIQUE, MALAWI, DRC)

One suggestion was to create a regional stock outs movement. However, in discussions with consortium members, all felt that it was not appropriate for the South African SSP to regionalise. Rather different countries needed to create their own SSO programmes based on local organisations forming a consortium.

Drug stock outs are a problem in many countries. MSF has spearheaded the regional replication of the SSP model, or of parts of it. Discussions have been held in a number of countries. The evaluation team interviewed people in Mozambique, Malawi and DRC. Although none of these countries has adopted a country wide approach to addressing stock outs, they have taken aspects and implemented locally. Top of the list is the need to produce evidence as this is seen as necessary to back up an advocacy campaign and to emphasise the patient view (the community mobilisation activities and the hotline are largely the vehicle for this in South Africa). The other key lesson transmitted is to distinguish between shortages and stock outs and thus advocate for the focus to be on the SCM system and particularly last mile

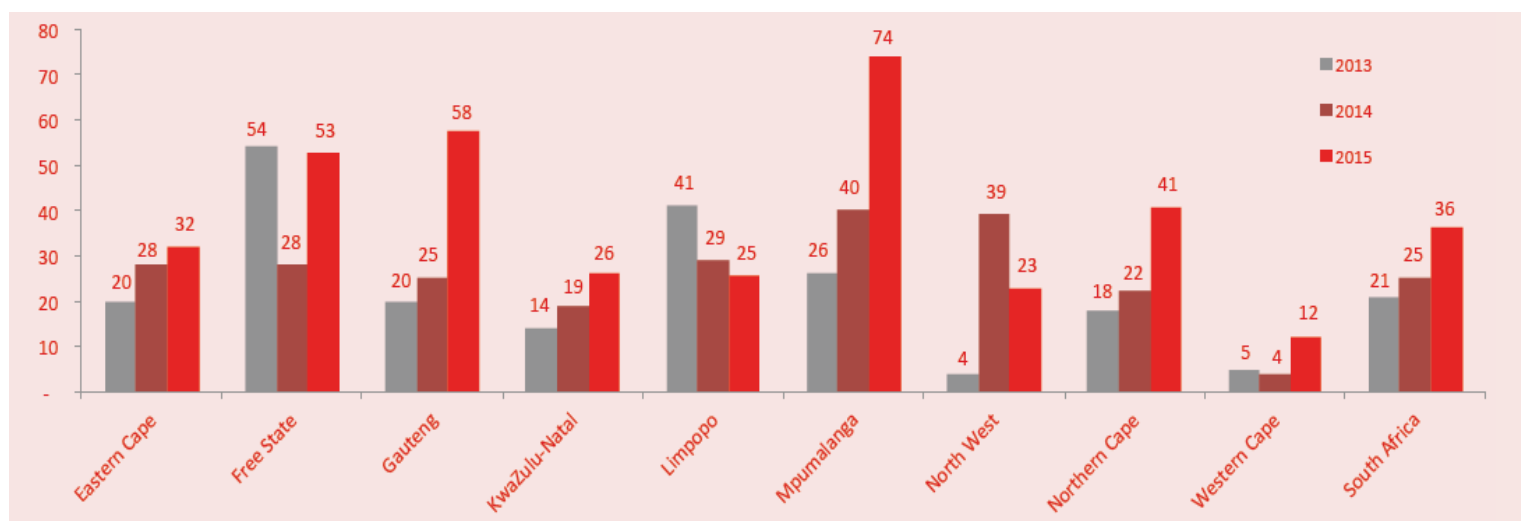
delivery. In several of the countries where MSF has shared the SSP model, the SCM system is particularly weak. In these situations, additional support has been provided to strengthen the SCM system through providing drugs or contracting suppliers to provide drugs.

At a global level, MSF has used the evidence generated from the SSP to influence global views. SSP has provided clear evidence which can be translated into clear messages. This has often been done in conjunction with the MSF Access Campaign who realised that they and SSP are targeting the same institutions and the same people. This has led to better synergy. For example, during the 2015 LPV/r shortage, MSF was alerted to the issue from data/evidence collected in South Africa (from the SSP) and confirmed regionally. In conjunction with the MSF Access Campaign they were able to lobby AbbVie and the South African government to ensure that alternative sources for the drugs could be supplied in South Africa.

The evidence generated has been utilised to bring the stock out language onto the global stage as opposed to only seeing the challenge as shortages. The May 2016 WHA resolution was mainly on drug shortages but did include some paragraphs on stock outs and SCM issues. Anecdotally the Global Fund chief procurement officer said that the SSP annual survey made them realise that the GF needed to put more resources into these issues. A report from the Inspector General and the work of the SSP contributed to the creation of a specific unit in the Global Fund to audit and strengthen SCM systems and in particular last mile challenges. In Kinshasa following the stock out snapshot (similar to the annual survey), the Global Fund added extra \$s to their grant to cover last mile delivery challenges.

THE EFFECTIVENESS OF THE PROJECT IN ACHIEVING ITS OBJECTIVES, IDENTIFYING LESSONS LEARNED TO BE CARRIED FORWARD FOR FUTURE SIMILAR INTERVENTIONS

The results from the 2015 SSP survey show a deterioration rather than an improvement. In this sense, the SSP can be regarded as not having made much progress to achieving its overall objective of improving patient access to essential medicines.



2015 SSP survey

However, the SSP survey results can be read in several ways. Firstly, the SSP survey is a snapshot in time and is not tracking stock outs in real time. This is what the NDoH SVS does. Obviously, the SSP does not have the resources and the access to track stock outs in real time. But the SSP annual survey is useful for showing trends over time and also for validating other data systems e.g. the SVS. If one unpacks the 2015 data, there has been a decrease in stock outs of FDC drugs. This has decreased from 9% of facilities to 4%. We know that around 80-90% of patients are on FDCs. This is a significant improvement. The problem lies with 2nd line drugs. Then the 2015 annual survey was done at the time of the LPV/r crisis and 24% (348/1467) of the stock outs were due to adult LPV/r stock outs which were due to international shortages and patent barriers.

However, the annual SSP survey highlights that drug stock outs are still a serious issue. The survey also documented that 25% of stock outs led to patient getting incomplete regimen or no medicines at all which is a concern both from the quality of care angle and in terms of compliance/adherence. Finally, the survey shows the large interprovincial differences, and, if you drill down, large district and sub-district differences, which are largely due to SCM system, and especially last mile, challenges.

The effectiveness of the SSP in achieving its two specific objectives

- To improve access to information and capacitate communities on legal and constitutional rights related to the right to medicines
- To co-ordinate and develop a country-wide network of citizens/civil society collecting information through a platform to improve access to health and medicines.

has been discussed above. In summary, progress has been made but coverage has been limited by resource availability and the footprint of the consortium partners in the country (especially TAC and RHAP).

THE REPLICABILITY OF THIS PROJECT IN OTHER SETTINGS AND/OR OTHER SERVICE DELIVERY AREAS

As mentioned in the earlier section, MSF has been spearheading the transference of the SSP model to other regional countries. Section 27 have adapted the model for use in the education section to address stock outs of textbooks.

However, what has not been determined by SSP is what the package is that is to be transferred. Key approaches and tools for replicability include:

- *the need for evidence to inform advocacy.* Governments respond to evidence. Most of the evidence is provided by the survey. However, as mentioned before this is a snapshot in time. It also represents the view from the lowest level in the DoH (the PHC facility usually). The community mobilisation and hotline provide evidence and the view of stock outs from the patient level. It is important that this narrative is available to complement the health service narrative. The SSP has not as yet worked out how to extract sufficient evidence from the community mobilisation/hotline activities. Partly this is due to the limited coverage of these activities.
- *the emphasis on stock outs as opposed to shortages.* This shifts the emphasis from supplier and global issues to the SCM, last mile and local issues. This is an important part of the package and the evidence generated from the survey is used to make this point. It means that the DoH cannot relinquish their responsibilities as they are responsible for SCM system issues. As can be seen from the South African example, there has been to date little focus on the lower levels in addressing the stock out issues.
- *the importance of community mobilisation.* The TAC members we interviewed were proud of what they had achieved on the ground and in their communities. This is difficult to quantify but is a key component of the SSP. Without it the view from the patient will be lost. In the SSP this is rolled up into the community mobilisation activities, the local communication aspects (radio, posters/leaflets, newspapers) and the hotline. These components are more difficult to transfer because they are resource intensive and their effectiveness and impact is difficult to quantify. Thus, they can be at risk of being dropped. Some have suggested that a consortium such as SSP can be used to strengthen CSOs such as TAC and others and even raise seed funding for CSOs.
- *the need for a broad based consortium.* The SSP consortium had a mix of health organisations, community activist organisations and members who were skilled in advocacy and the law. All these are necessary for a successful SSP. Most of these need to be local organisations or at least have a local base. A number of the respondents mentioned that the consortium approach and composition was one of the key strengths of the SSP.
- *the tools necessary.* The SSP has committed significant resources to key tools - the survey, the hotline, the community mobilisation approach, the advocacy strategy, the escalation protocol, the consortium model. These are not clearly documented. Rather than expecting other settings (either geographic or service delivery areas) to reinvent the wheel, it should be incumbent on the SSP to package these tools in a way that is easily transferable.

Part of the documentation process needs to include costing of the different elements.

Summary

"our power is our voice" (consortium member)

All consortium respondents expressed that the SSP was an advocacy organisation, a watchdog, that it was set up to represent the patient view and address stock outs as experienced by patients. Evidence based advocacy is what SSP does well. They were not there to address SCM issues. In a sense, this is the core of the debate about future directions. There is a fine line between advocacy, being a watchdog and trying to hold government to account on one side and on the other getting your hands dirty and venturing into problem identification and resolution. In a sense, the SSP has already crossed this line by working in the Mthatha depot during the crisis, by utilising the escalation protocol to address individual stock out problems, through TAC members addressing problems on the ground on multiple occasions and

potentially by joining the newly established forum. In other countries, MSF has clearly gone beyond being a watchdog and ventured into SCM system areas.

In a sense it is easier to be a watchdog at the national level as there is not much that a project can do at that level besides advocating for change. With SSP this has been successful. However, it is more difficult to only be a watchdog on the ground. This is why many of the problem identification and problem resolution activities are more on the ground (Mthatha depot, escalation protocol and TAC work). As identified the key problems are shifting to the last mile SCM system challenges and some of the proposed recommendations are to focus more at the lower levels. This is likely to lead to more engagement with problem identification and resolution activities.

The SSP needs to make a critical decision that they will move beyond the watchdog role, in what circumstances they will do this and what this means. This is probably the most critical debate that the SSP needs to have and a debate that needs to be on the agenda of each meeting.

CONCLUSIONS

The conclusions are drafted around the seven key criteria identified in the ToR: relevance, appropriateness, effectiveness, efficiency, impact, replicability and sustainability of the SSP.

Before highlighting the conclusions it is important to realise that the context within which SSP is operating has changed. As identified the NDoH has responded to the high level advocacy advanced by SSP and its partners with policy and system changes (e.g. SVS, direct delivery, CCMDD). This has not been complemented by significant changes in last mile delivery beyond what is promised in the system changes introduced by the NDoH. As will be discussed in the recommendations section it is important for the SSP to take cognisance of the changed context and build their response based on this.

Relevance *i.e. were strategies/activities aligned with identified needs*

The key strategies adopted were evidence-based advocacy to change government policy and systems, community mobilisation to address last mile SCM challenges. The key objective was to prevent stock outs and ensure patient access to medicines. What has been particularly relevant has been the high level evidence based advocacy. Of less relevance has been the community mobilisation strategy in that it has only been relevant in the limited areas it is operational. Neither the formal component (hotline) nor the informal component (TAC advocacy at ground level) of the community mobilisation strategy has been successfully mined to produce real time data to utilise for local level advocacy so as to prevent localised stock outs. In a sense, the strategies/activities have been relevant for high level needs but not as relevant for local needs or only for local needs where the strategies/activities have been implemented.

Appropriateness *i.e. were strategies adopted appropriate for the set objectives, and sensitive to contextual changes*

There is no doubt that the strategies adopted were appropriate in the context in which the SSP was started. There were stock outs but no one knew the extent of the problem. By quantifying the problem through the first annual survey, this was the first time that evidence of the extent of the problem surfaced. This led to the change in mindset of the NDoH and the new policies and strategies adopted. It also led to the acknowledgement that the problem was more than shortages and it was SCM system challenges that were contributing to stock outs. However, the activities to mobilise clients and community based organisations to tackle stockouts have not been as successful largely because of three issues. Firstly, the coverage or footprint has not been that extensive. Secondly, the SSP has not created a mechanism to quantify the stock out problem in real terms. The survey is a point in time survey and the hotline has not generated enough data to address real time stock out tracking. Thirdly, the SSP has not explicitly focussed its advocacy efforts at last mile delivery problems that have been identified (e.g. lack of pharmacy assistant posts, problems around using the budget, supervision and training at the lower levels). When this happens the SSP will have responded to the contextual changes and adopt strategies that are more appropriate to address last mile challenges.

Effectiveness *i.e. did the strategies/activities achieve the objectives and if not, why not and what should be changed*

The strategies and activities adopted have led to some improvements in access to drugs, especially first line ARV drugs. They have also prompted a response from the NDoH in developing and implementing new policies and systems. They have been less successful at influencing last mile challenges and affecting a broad based country wide community mobilisation response to addressing local stock out challenges. Changes are highlighted in the recommendations.

Impact *i.e. did the SSP improve availability of medicines at the point of service for patients, and specifically, what difference has the project made in terms of policy/practice both nationally and internationally, in terms of mobilising patients and CSOs to advocate for their rights to access medicines, and in terms of contributing to a regional SSO movement; the proportion of the target population reached and the perceived effects by them and other stakeholders*

The strategies adopted have been necessary, and by catalysing the South African media, sufficient to bring about significant policy and systems changes and have impacted on availability of drugs, especially first line ARV drugs. However, there is still much to be done. But, it can be argued that the policy and system reforms initiated by the NDoH still need more time to show impact. Further impact will be influenced by increasing focus on SCM system issues, particularly last mile challenges.

There has also been important international impact in that the SSP has contributed to a change of mindset in patient centered advocacy. Concretely In December 2015, the Medicines Patent Pool (MPP) and AbbVie signed a new licence

agreement to increase access to LPV/r in South Africa and across Africa. The 2016 WHA resolution is also partly attributable to the SSP.

In terms of mobilising patients and CSOs this has happened but not to the extent envisaged. This is largely due to the limited footprint or coverage of the SSP due to alignment with only one CSO, TAC. Thus the proportion of the targeted population reached with community mobilisation activities is small. In addition, the SSP only tracks problems that are raised through the hotline. It does not track stock out challenges that are addressed or raised locally by clients or CSOs with facility or other health staff.

Changes in access to and availability of drugs are due to the more high level advocacy initiatives that have stimulated the policy and system reforms. If these are not backed up by extending the community mobilisation coverage then it is possible that last mile inequities will persist.

Replicability *i.e. identifying activities/processes necessary for transferring to other geographical and functional areas*

As indicated, five activities/processes were identified in terms of replicability. These include the need for evidence to inform advocacy, the emphasis on stock outs as opposed to shortages, the importance of community mobilisation, the need for a broad based consortium and the tools necessary. However, these have not been clearly documented, costed and packaged. This needs to be done if the model is to be 'sold' on.

Efficiency *i.e. were activities/strategies implemented with the best use of available financial resources and time*

No formal evaluation of efficiency was conducted. The recent study by Quentin Baglione "Cost-analysis of Stop Stock-Out Project" has some data on the costs of the different elements.

But it can be asserted that the SSP has made excellent use of the consortium members' resources. This includes being housed in, and managed by the HIV Clinicians Society, using TAC resources as a base for the community mobilisation activities and TAC staff to push the SSP profile, utilising MSF resources to assist with the advocacy strategy and provide major resource support for the annual survey. This has meant that the SSP has not been required to raise significant resources on its own. The new situation of increased SSP resources has led to this evaluation and the organisational review.

The annual survey has provided an invaluable source of evidence for advocacy both within South Africa but also regionally and globally. MSF has liberally used the data generated for other equally important purposes and all the countries where it is spreading the SSP message to have adopted as a starting point the need for evidence generation to fuel the advocacy activities.

The consortium is still divided on two issues. First, although the initial focus has been on ARVs and TB drugs it was agreed from the beginning that vaccines and other essential drugs would be tracked in the annual surveys. Vaccines were included from the 2013 survey. However, there has never been complete agreement on the inclusion of a wider set of essential drugs. In the 2015 annual survey, 5 vaccines and 7 essential drugs were assessed. However, in terms of efficiency if the model (inclusive of the survey, the community mobilisation and the hotline) was fully extended to, or replicated for, other diseases and drugs (e.g. mental health, diabetic, hypertensive drugs), this might make the SSP model more efficient. This would also mean engaging with other organisations that deal with these diseases. The second issue is the community mobilisation strategy. Some consortium members argue that the costs involved in the community mobilisation strategy have not produced startling results in terms of clients and CSOs addressing stock out issues and achieving their health rights. For example, the provisional results from the Baglione study estimate that the average cost per reported and escalated stock out amounted to ZAR 2,465. While this seems excessive, the report does not benchmark this. In addition, in this evaluation it is clear that the SSP is not tracking mechanisms (types and frequency) that clients and CSOs adopt when addressing stock outs and other health issues. The SSP is only tracking hotline raised issues. Thus it is difficult to determine whether the most efficient strategies and activities have been adopted. In addition, because of the limited footprint and the 'confinement' to the TAC areas, the community mobilisation strategy and activities are not necessarily targeted at the districts and sub-districts most in need. This is addressed further in the recommendations.

Continuity *i.e. will the project be sustainable*

In terms of continuity/sustainability three issues need consideration. In terms of organisational continuity/sustainability, the SSP has commissioned organisational development experts to review the organisational structure and propose mechanisms to ensure that the SSP remains organisationally sustainable. The key concern here is the relationship between the SSP and the six consortium members and the need to enable the SSP to stand firmly on its own two feet.

The second issue concerns resources. Initially, the SSP was largely dependent on the consortium members for financial and other resources (e.g. expertise in the design, implementation and analysis of the annual survey). SSP has secured funding from the beginning to 2016 from MAVC and the EU which will take it through to August 2019. Thus there is some degree of financial security and sustainability. The organisational development assessment is also looking at what is needed in terms of staffing and capability to ensure that the SSP becomes more sustainable. The third issue concerns strategic sustainability. Initially, SSP efforts were targeted at changing the policy and systems to ensure that the DoH acknowledged the problems of stock outs and designed systems to address these issues. This was largely successful. In terms of strategic continuity and sustainability it is essential for the SSP to review their strategies and activities to ensure that they meet the emerging context. This is discussed further in the recommendations.

RECOMMENDATIONS

⇒ **Recommendation 1: Continue with evidence-based advocacy at the national level.** SSP needs to continue to 'rattle the cage' using evidence generated from the annual surveys and, if possible, from a more extensive hotline system (see recommendation 3). Although the NDoH has changed mindset and introduced new policies and systems to address stock outs, these are not embedded and need to be monitored. There are some concerns re the technical fix approach adopted by the NDoH and whether this is feasible across all areas in South Africa. Thus SSP needs to ensure that NDoH strategic and annual plans include indicators and targets¹² on stock outs and that these are tracked using the SVS system. The extended hotline would add an independent view to this. Other issues impacting on stock outs (e.g. HR issues, budget issues) could be added to the advocacy slate.

A key tool to validate the NDoH SVS data is the annual survey as it is the only independent survey and provides the evidence base for advocacy both nationally and internationally. This needs to be retained. However, SSP should consider the following changes to the annual survey:

- Previous surveys, the hotline data and the SVS have identified hotspots or poorly performing districts and sub-districts. In the design of future annual surveys ensure that the telephonic interviews are supplemented by visits to some of these hotspots. Consider the possibility of exploring HR and budget issues and supervision in these areas to identify root causes of the problems. One consideration is to consider using other data sets (e.g. the DHIS2 data, ideal clinic data, the HST district barometer data) to cross triangulate with the stock out data.
- With the NDoH strategy and systems response to stock outs, it is critical that the annual survey also include the newer delivery models in the design. For example CCMDD is delivering drugs to community pick up points. The current survey will not measure stock outs at these points.
- Consider sampling patients to get a more detailed patient view. This could be from a random sample of CCMDD patients (the CCMDD system works on sending SMSes) or combining with the active surveillance proposed in recommendation 2.
- Significant problems with the methodology are continuously raised by the NDoH after the survey has been completed. This often distracts from the results as the debate centres on the methodology rather than the results. Key issues raised by the NDoH relate to respondent bias, definitions of stock outs and shortages, drug selection, who to interview and whether drugs kept in other areas than pharmacy (e.g. in consulting rooms) are included. Without discussing the merits of the methodological objections it is critical to agree the methodology with the NDoH prior to survey. If agreement is not possible, at least acknowledgement and documentation of the discussions and points of agreement/disagreement. This could be part of the MOU (see recommendation 4).¹³
- Consider extending the survey to include other priority diseases and drugs. With the increasing emphasis on NCDS, drugs for mental health, diabetes and hypertension should be high on the list. Although some of these drugs are included in the survey it is important to ensure that a more representative sample of these drugs is included. To be effective, it is also critical that CSOs that deal with these diseases are included as the consortium is not set up to deal with other conditions. Thus what drugs are included might depend on what CSOs are included. The SSP needs to consider whether it includes this within the existing survey or replicates the survey methodology to accommodate other diseases and drugs.
- Consider the frequency of the survey. Already the 2016 annual survey is to be held in 2017. The SVS will provide real time data that the MOU (recommendation 4) might allow the SSP to access. If recommendations 2 and 3 are adopted, more real time data might be available through the hotline. Thus the annual survey can be seen as validating the real time data. The SSP should consider doing the survey every two years.

⇒ **Recommendation 2: Strengthen advocacy at provincial and local levels.** At provincial level use the same approach as used at NDoH level. Given resource requirements, it might make sense to pilot this in one province. Key advocacy areas would be on shifting provincial mindset to acknowledge stock outs as a problem, advocacy to implement and use the NDoH systems (e.g. SVS, direct delivery, CCMDD, buffer stocks), tackling SCM system

¹² a new 90:90:90 was suggested - 90% of facilities with 90% of drugs 90% of the time

¹³ there are strong views that the NDoH is objecting to the methodology because it does not like the results. While this is probably true, the point is not to get into an endless debate re methodology. Rather, the two 'sides' need to agree to disagree and then move on to look at the results. The disagreement might impact on the extent of the stock out problem but not on the fact that there is a problem.

issues such as procurement and tenders, and ensuring that provincial plans include stock out indicators and targets and that these are tracked using the SVS system. Linked to the advocacy would be monitoring of their performance in implementation of these activities. In addition, data generated from the hotline, and especially how problems have been addressed using the escalation protocol in the province, should be used to inform responses from the provincial DoH to address SCM system challenges. It is not enough for the SSP to continue to tackle individual problems identified by the hotline. The provincial DoH needs to include these challenges in training, supervision and mentoring activities. Given the rocky relationship experienced between the SSP and the NDoH, it would make sense for the SSP to develop a clear advocacy/communication strategy for its engagement with the province or provinces.

At local level, the SSP should strengthen the capacity of CSOs (TAC and others) to advocate to health staff at facility level to address stock outs. At all three levels SSP should increase advocacy on the need for pharmacy assistants, better training and supervision and more effective management and control of budgets for drugs.

⇒ **Recommendation 3: Increase community footprint/patient view as no one else provides this view and it focuses on last mile delivery.** This is where the key challenges of the SCM system are experienced and there is a need to strengthen CSO role in government accountability. However, consider the following changes to the community mobilisation strategy and the hotline:

- Involve CSOs other than TAC. Initially, one can start with other HIV CSOs e.g. TB/HIV care. This will allow for a broader footprint. Clarify outputs (deliverables, indicators and targets) expected from the CSOs. Consider signing MOUs with the CSOs.
- As with the annual survey, consider extending the community mobilisation activities to include other priority diseases and drugs (see recommendation 1)
- consider other methods of creating mass awareness about stock outs such as:
 - Increased use of community radio/newspapers
 - Using testimonies from patients in the community newspapers and radio slots and in advocacy activities in general
 - Promote marketing materials (posters, business cards, T-shirts, drug containers, pillboxes) and ensuring that access to health facilities for these purposes is part of the MOU (recommendation 4)
- As health workers are already using the hotline to report stock outs, try to increase this capability through consortium members (e.g. RUDASA, RHAP and HIV Clinicians Society) and consider using the ward based outreach team members as agents who can monitor and report stock outs. Consider including this in the MOU (recommendation 4)
- Utilise knowledge from the annual surveys, the hotline and the SVS, if access is given, to target hotspots. To do this consider the use of mobile teams that could be sent to these areas to mobilise clients and CSOs in these hotspots to address stock outs.
- Another consideration would be to move from passive surveillance which is the current mode to active surveillance in these hotspots through contracting CSOs or clients (e.g. in adherence clubs) to regularly monitor drug availability in these hotspots. Community mobilisers and advocates could also be used for this purpose and also to investigate the causes of the stock outs.
- Consider using active surveillance or mobile teams to monitor the CCMDD roll out.
- Consider how to mine the hotline data more effectively, especially if the community mobilisation strategy increases the footprint and the number of calls received.

Recommendations 2 and 3 need to lead to:

- Addressing the last mile/SCM system weak point
- Ensuring that both sides are telling the story (health workers and patients)
- Increased awareness of stock outs and reporting mechanisms
- Increased use of the hotline
- Increased use of informal resolution mechanisms (health worker networks, clients/CSOs resolving challenges with health workers). But it is not clear how SSP could track these informal resolution mechanisms. The recent costing study only dealt with formal mechanisms. The SSP needs to think through how it can quantify the effect of SSP on informal mechanisms.

- ⇒ **Recommendation 4: Negotiate an MOU with government.** Government is currently receptive to this and is particularly interested in getting the view from the ground and having an independent validation mechanism. They are not convinced that the data received through the SVS is necessarily of the highest quality. The suggestion is for the SSP and the NDoH to pilot an approach in a sub-district. The SSP already has an escalation protocol with government and the MOU would add to this. The pilot, and possible wider MOU, could be used to focus on last mile delivery, the missing 20% of facilities that routinely don't report, the patient view, stock outs (not shortages), management capacity at facility and sub-district levels and forecasting. All these have been identified as key aspects of the SSP mandate. Another approach would be to validate SVS results with data collected in the field in the next SSP survey. As highlighted earlier, the use of WBOT members in reporting stock outs should be considered as should the appropriate use of marketing materials. Additional considerations for the SSP to include in the MOU are advocating for an indicator or indicators measuring stock outs to be included in all strategic and annual plans, for the SVS to be used as an early warning system and for an emergency response team to address stock outs which is something NDoH is reluctant to consider. The on-the-ground coping mechanisms to address stock outs mentioned before are an embryonic emergency response team. The MOU must ensure that the SSP has access to the SVS. One consideration is whether the MOU should be with the NDoH or the PDoH, or both.
- ⇒ **Recommendation 5a: Support replication¹⁴ both geographically and for other service areas** through packaging the SSP and provide support as needed and within resources. As mentioned in the findings section, this is already occurring and parts of the model have been transferred to other countries. Support would be welcomed as identified in discussions with some of the regional countries. Areas for packaging are indicated previously and the importance of costing the different elements needs to be stressed again. Linked to this is for the SSP to consider forming or becoming part of a regional network where interested parties can share approaches, tools, successes and challenges and learn from each other.
- ⇒ **Recommendation 5b (for MSF): Continue with the regional work in spreading the SSP model** but ensure that this work is shared with SSP. Document lessons learnt and share with SSP and other countries. There were some suggestions that MSF could use the SSP model and the evidence generated to further influence such bodies as the Global Fund, CHAI and the Gates Foundation. In South Africa, the SSP should also engage more with these actors as part of their advocacy.
- **Recommendation 6: Strengthen the institutional structure of the SSP**, which is the work of the other organisational development team. It is critical to develop a strategic plan and a revised advocacy strategy; to have clear indicators and targets, inclusive of outcome and impact indicators; to consider staffing/resources in the light of this and to empower staff to lead the SSP into a new era.

¹⁴ It is important to note that the recommendation is not about regionalisation of the SSP, rather that the SSP supports other countries in developing SSO programmes

ANNEXES

ANNEX I: TERMS OF REFERENCE

TERMS OF REFERENCE Subject/Mission	Stop Stock Outs Project of MSF OCB South Africa mission
Evaluation Sponsor/ Owner	Marc Biot, CO Cell 5, OCB
Evaluation Focal Point (HoM?)	Andrew Mews (HOM) – +27 21 4481058 or +27 716031628 or Bella Hwang (Project Co-ordinator) +27 79 897 8518
Primary Stakeholders/ Evaluation Communication Group	<i>To be completed by evaluator/ evaluation team</i>
Starting Date	As soon as possible
Duration	6-8 weeks
Time period to be evaluated	From Mthatha intervention and denial that stock outs exist in South Africa in 2012 to stock out interventions described in the 2015 and 2016 Minister of Health's Budget Speech

CONTEXT AND BACKGROUND

South Africa is currently facing a chronic crisis of national stock outs in a crippled health system as thousands of HIV&TB patients lives remain at risk. To form a longer term strategy in addressing medication stock outs and shortages in South Africa, a consortium of concerned organisations met in November 2012 to discuss the development of a project to monitor essential medicines and address medication stock outs when they occur. All organisations routinely receive reports of stock outs from health care workers and patients and are asked to intervene.

The core of the Stop Stock Out Project and intervention is to develop, test and implement an innovative model to crowdsource reports of stock outs from patients, health workers, volunteers and sentinels surveyors, map reported stock outs and shortages publicly, track and trace selected case reports, escalate reports through the supply chain and advocate for resolution by pressuring accountable government individuals and entities. Data collected is analysed to understand the root causes of stock outs and what further intervention and advocacy needs to take place. The system aims to bring visibility and transparency to a struggling health system. To achieve this the project will aim for a robust and safe integrated electronic platform. The intention is that the platform developed may serve as a model to be reproduced in other operational countries in the region. The project also aims to set a system of trainer of trainers (TOTs) with the purpose to establish a network of community mobilizers that raise social awareness in reporting the stock outs and build the capacity of beneficiaries in using the model.

REASON FOR EVALUATION / RATIONALE

MSF works in countries with weak health systems often hampered with financial and human resource deficits, a growing burden of disease, lack of accountability and poor transparency, resulting in poor provision of health services including the availability of essential medicines.

One of the ways to hold governments accountable to providing healthcare for their citizens is through civil society. MSF often steps in when governments aren't able to provide medical care to their citizens and should find innovative ways in ensuring citizens receive health services. Strengthening patient's voices and local community's ability to respond to stock outs and health issues can be key in holding government accountable. Strong civil society/NGOs have a critical role to play in 'redynamising' and empowering them. However, NGOs are fighting for financial survival and being corporatized and co-opted, thus muting independent criticism of government.

Partnerships and relationships between NGOs community activists and enlightened individuals in government have played a critical role in the initial response to HIV in the face of denialism, stigma, and lack of funding. As access increases the perception of urgency and emergency have diminished and activism around HIV has waned even as funding reduces. With ever larger numbers of patients dependent on continuity of life-long treatment the monitoring,

prevention, and resolution of supply problems is critical and our experience has shown the potential of civil society partners to continue to pressure government into responding.

The SSP is an attempt to gather data and use citizen voices and multi-sectoral civil society coalitions to play a crucial role in advancing development and policy reforms. The project tests a model to see how and if linking communities together, using project generated and crowdsourced data will ensure citizens and civil society co-operate to collect the necessary evidence in a standardised manner that results in robust and reliable data that can be used to inform solutions from decision-makers and provide evidence for civil society's change and advocacy strategy. And also determine if transparent and accessible information can be used both by citizens and decision-makers to assess gaps in service delivery and resource allocation, determine the magnitude of a specific problem when no public information exists on health service delivery and identify facilities where there is no medication or poor health services.

Evaluating and documenting the effectiveness of this project can lead to enabling a replication of the model in other contexts where a parallel civil society monitoring system can provide checks and balances to internal government monitoring mechanisms, thus ensuring transparency and accountability in the delivery of various services, not only health.

OVERALL OBJECTIVE and PURPOSE

Evaluate the impact and effectiveness of the SSO project from inception to 2016 at the local, national and regional level, identifying successes and areas for improvement, whilst identifying lessons learned and assessing the replicability of the project in other areas and locations relevant to MSF.

SPECIFIC OBJECTIVES / Evaluation questions

The overall objective can be seen as three specific objectives:

1. To evaluate and describe the effectiveness of the project in achieving its objectives, identifying lessons learned to be carried forward for future similar interventions
2. To evaluate and describe the project's impact on:
 - provincial and national government policy and reform on availability of medicines
 - mobilizing patients on stock outs and rights to medicine at a community level in South Africa
 - mobilizing groups of civil society organizations (the project's consortium members) within South Africa to work together, galvanize activism in Health and HIV in South Africa
 - a Stop Stock Outs *movement* and using the Stop Stock Outs model/activities in the region (Mozambique, Malawi, DRC)
3. To assess the prospects for replicability of this project in other settings and/ or other service delivery areas under-provided by the government of MoH of medical humanitarian concern?

The following evaluation questions can be used by the evaluation team in order to respond to the specific objectives:

Relevance:

- *Does the project correspond with identified needs?*
- *Are the objectives coherent with the expressed needs of the organisation?*

Appropriateness:

- *Is the strategy appropriate in order to achieve the objectives?*
- *Were appropriate and timely adaptations made in response to changes in the environment?*
- *What are the limitations/opportunities inherent in the approach?*

Effectiveness:

- *To what extent have the defined objectives been achieved?*
- *What were reasons for achievement or non-achievement of objectives?*
- *Were the activities carried out as originally planned?*
- *What can be done to make the project more effective?*

Impact:

- *Does the project make a difference? What kind of difference and in what way?*
 - *Can (contributions to) changes in government or WHO policy or practice be reasonably attributed to the project?*
 - *Can (contributions to) changes mobilizing patients on stock outs and rights to medicine at a community level in South Africa be reasonably attributed to the project?*

- *Can (contributions to) changes mobilizing groups of civil society organizations (the project's consortium members) within South Africa to work together, galvanize activism in Health and HIV in South Africa be reasonably attributed to the project?*
- *Can (contributions to) changes to a stop stock outs movement and using the Stop Stock Outs model/activities in the region (Mozambique, Malawi, DRC) be reasonably attributed to the project?*
- *What proportion of the target population have been affected by the project?*
- *What do beneficiaries and other stakeholders affected by the intervention perceive to be the effects of the project?*
- *Does the project have any unforeseen positive or negative consequences?*

Replicability:

- *What are the prospects for replicability of this project in other settings and/ or other service delivery areas under-provided by the government of MoH of medical humanitarian concern?*
 - *What factors (conditions) are necessary for the success of future similar projects?*

Efficiency:

- *Were activities cost-efficient?*
- *Were objectives achieved on time?*
- *Was the programme or project implemented in the most efficient way compared to alternatives?*

Continuity:

- *To what extent is it likely that the benefits of the project will continue after MSF's withdrawal?*
 - *What MSF measures are likely to improve the prospect of benefit continuity?*

EXPECTED RESULTS

- An inception report (based on the SEU standard) prior to field visit phase
- An initial restitution with the mission prior to the completion of the field visit
- A presentation of the main evaluation outcomes (specifics to be decided at a later stage)
- Dissemination of the evaluation in MSF channels as per normal procedure. Mission will be responsible for further dissemination externally (to be discussed further).
- A professional, publishable final report (based on the SEU standard) that can be shared externally of maximum 25 pages including:
 - A summary of the evolution of the project from 2012 to 2016
 - A response to the specific objectives of the evaluation
 - Documentation of Lessons learned for future similar projects, specifically focused on replicability of the approach in other settings

TOOLS AND METHODOLOGY PROPOSED

- Review and analysis of project documents
- Meeting/discussion/interviews with key-team members at co-ordination, project and external to MSF NGO partners
- Meeting/discussion/interviews with key-authorities – National Department of Health and 2 or 3 selected provincial department of health
- Meeting/discussion/interviews with patients and healthcare workers and community mobilizers
- Natural group discussions or focus groups with workshop/community participants
- Observation of mobilization workshops and activities

Suggested timeline:

The evaluation should take place primarily in Johannesburg, with interviews with co-ordination in Cape Town and two or three day visits each to 2 other provinces to attend community workshops and interview community participants and community mobilizers and MoH.

1. Johannesburg/Pretoria (7 days total)

- a. 3 days – interview project staff, and consortium partners
- b. 1 day – interview National Department of Health
- c. ½ day – interview Gauteng Department of Health
- d. 1 day – attend community workshop with participants, group interview on impact of project

- e. 1 day – interview patients/healthcare workers who report to the hotline
 - f. ½ day – interviews with Co-ordination in Cape Town via telecon and MSF Joburg office advocacy and communications team
2. Field visit to two provinces x 2 (4-6 days total)
- a. 1 day – attend community workshop with participants, group interview on impact of project
 - b. 1 - 2 days (2nd day needed if workshop is not located where the provincial MoH is and travel is required) – meet with community mobilizer and interview and MoH (may need to drive to another city if workshops is not where the provincial MoH is)

RECOMMENDED DOCUMENTATION:

Project Document, Sit Reps, Stock Out Survey Reports, Stock outs.org, Funding proposals to external funders

PRACTICAL IMPLEMENTATION OF THE EVALUATION Number of evaluators	1 (plus SEU contribution)
Timing of the evaluation	As soon as possible
Required amount of time (Days);	
▪ For preparation (Days)	5
▪ For field visits (Days)	Max 20 including travel days @ 0.5 contract days per day travelled
▪ For interviews (Days)	Included in field visit days
▪ For writing up report (Days)	5
Total time required (Days)	30

ANNEX II: LIST OF INTERVIEWEES

Name	Organisation	Name	Organisation
Marc Biot	MSF	Bella Hwang	MSF
Tinne Gils	MSF	Sue Tafeni	SSP
Indira Govender	RUDASA	Lauren Jankelowitz	HIV Clinicians Society
John Stephens	Section 27	Sasha Stevenson	Section 27
Robert Setshedi	HOPS Limpopo	Gaza Shivambu	District pharmacy, Mopani District
Miyelani Maringa	District pharmacy, Mopani District	Gavin Steel	NDoH
Anban Pillay	NDoH	Marije Versteeg	RHAP
Amukelani Maluleke	TAC	Anele Yawa	TAC
Andrew Mews	MSF	Amir Shroufi	MSF
TAC members	East London workshop	TAC, SSP and RHAP Eastern Cape co-ordinators	East London Workshop
Mncedisi Dlova	Mthatha Depot	Mathanda	Mthatha Depot
TAC organiser	Lusikisiki	Clinic supervisor	Quakeni sub district
Gateway clinic Manager	Lusikisiki	TAC members	Lusikisiki workshop
Helen Chorlton	OD consultant	Ingrid Obery	OD consultant
Andy Gray	Pharmacist, KZN	Rohit Malpani	MSF Access Campaign
Martin Ewert	Gates Foundation	Kerstin Akerfelt	MSF
Ilse Casteels	MSF	Mark McCaul	MSF
Carlota Silva	MSF	Omega Machechera	MSF
Ben Chinsakaso	MSF		

ANNEX III: INFORMATION SOURCES

Documents from SSP including quarterly reports; MAVC baseline reports; provisional findings of the SSP cost analysis; SSP SC ToR; SSP annual surveys 2013, 2014, 2015; escalation protocol; forum ToR.

Documents from the NDoH - strategic and operational plans, annual performance plans, NHI white paper

Other documents including Klugman and Jassat report 'Enhancing Funders' and Advocates' Effectiveness: The Processes Shaping Collaborative Advocacy for Health System Accountability in South Africa'; Global approaches to addressing shortages of essential medicines in health systems, WHO Drug Information Vol. 30, No. 2, 2016; presentation by Gavin Steel at the HIV Clinicians Conference: Supply vs. Demand: Managing Medicine Shortages, April 2016; Joint report by WHO and NDoH on HIV-TB-PMTCT programme, 2013; Empty shelves Come back tomorrow ARV Stock Outs Undermine Efforts to Fight HIV, MSF December 2015; MSF Briefing Note: Technical Consultation on Preventing and Managing Global Stock Outs of Medicines, March 2016; WHO resolution: Addressing the global shortage of medicines and vaccines, May 2016.

Timeline and media information sources

- 2010 SSP consortium members regularly engaging DoH on medication supply
- 2010 SSP consortium members started collecting stock out/shortage reports on an ad-hoc basis
- 2012 (September) Section 27 contacted MSF with a request to intervene at Mthatha depot
- 2012 (November) Consortium members met to form the Stop Stock Out Consortium and project concept
- 2012 (December) MSF and TAC intervene at Mthatha depot to respond to failing medicine supply in the Eastern Cape
- 2013 (January) MSF withdraw from Eastern Cape Stock Out Crisis
- 2013 (March) Consortium forms HR plan for Stop Stock Out Project
- 2013 (April) National DoH engaged on consortium and Stop Stock Out Project
 - National DoH informed of details of project
- 2013 (September) Stop Stock Outs National Hotline launched
- 2014 First stock outs annual survey and media campaign
- 2014 (February) Patient workshops initiated; Decentralized dispensing pilot launched by NDOH
- 2014 (April) Engagement with Unions initiated
- 2014 (July) Stock outs escalation protocol developed and presented to NDOH
- 2014 (September) Training of Trainers/TAC programme launched
- 2014 (December) Second Annual Stock Outs Survey completed
- 2015 (Feb) Survey II Report Released
- 2015 (Q1) Engagement with Heads of Departments and/or Member of the Executive Council of Health in Gauteng, Free State, Kwazulu-Natal Limpopo, Northern Cape, North West and Western Cape Provinces. Engagement with OR Tambo District DoH (Mthatha Depot area).
- 2015 (Feb) Letter of introduction for the project signed by Gauteng Province
- 2015 (May) National Minister of Health's 2015 budget speech including provisions for fixing the supply chain <http://www.gov.za/speeches/minister-aaron-motsoaledi-health-dept-budget-vote-201516-5-may-2015-0000>
 - <https://soundcloud.com/ryan-fortune-msf-org-za/sa-health-minister-aaron-motsoaledis-closing-speech-at-sa-aids-conference-2015>
- 2015 (April) NDoH Annual Performance plan for 2015-2018 incorporating supply chain indicators and components of the SSP model for stock out surveillance:
- 2015 (May) Meetings with the National Minister of Health, Deputy Minister, and Director Generals on stock out crisis in South Africa
- 2015 (May 24) Minister Aaron Motsoaledi: Media briefing on availability of medicines – denying a stock out crisis and hitting back at TAC (focusing on FDC)
- 2015 (June) 2014 Stock Outs Survey results launched with action plans from Gauteng, Limpopo, Northern Cape, North West and Western Cape Provinces.

- 2015 (June) Minister of Health's closing speech at SA AIDS focused on stock outs
 - <https://soundcloud.com/ryan-fortune-msf-org-za/sa-health-minister-aaron-motsoaledis-closing-speech-at-sa-aids-conference-2015>
- 2015 (July 30) MEC Sibongiseni Dhlomo: Statement on shortage of essential medicines (blaming international supply issues)
 - <http://www.gov.za/speeches/executive-statement-kzn-health-mec-dr-sibongiseni-dhlomo-kzn-legislature-shortage-essential>
- 2015 (September) Initial meeting with South African Pharmacy Council to increase flexibilities in regulations to allow for alternative models of drug distribution
- 2015 (September) After intense SSP pressure over 2015, Ministerial Task team set up at National level to address stock outs (includes WHO, international and local actors)
- 2015 (October) Third annual stock outs survey launched with the addition of University of Cape town and MSF ERB approvals.
- 2016 (May) Survey III Report Released

PRINT

- *Star* – 'Medicine supply crisis'
- *Citizen* – 'Stock Outs can mean death'
- *Witness* – SA
- *Citizen* – 'Medicine out of stock'
- *Polokwane Observer* – 'Lim drug stock outs'

BROADCAST

- *Channel Africa* – 'The cost of not providing ARVs on time' – Interview with Martha, MSF SA and Willy Madisha, COSATU
- *Talk Radio 702 / Cape Talk Simulcast* – Midday report – 'Hospitals running out of medicines' – Interview with Anele Yawa, TAC
- *MFM 92.6* – Lunch – 'Department of Health working with pharmaceuticals to relieve the country's medicine shortage'
- *Highveld Stereo* – News @ 19:00 – 'Hospitals running out of medicines'
- *North West FM* – View Point – 'Focus on drug shortages' – Interview with Bella Hwang, Stop Stock Outs Project
- *Munghana Lonene* – Current Affairs – 'Shortage of drugs in the rural areas' – Interview with Jaackson Chuma, Malamulele Home Based Care Forum
- *ANN7* – Game on Extra – 'Shortage of medicine a challenge in SA' – Interview with Maria Mokhesi, Living with HIV/Aids, Tinne Gils, MSF SA, Joe Maila, Department of Health
- *Radio Islam* – Yaseen – 'Drug shortages at government hospitals continue to be a major concern' – Interview with Bella Hwang, Stop Stockouts Project
- *Tshwane TV* – News round-up – 'Patients suffer as provinces struggle to manage medicine orders'
- *SABC* – 9 AM News Interview with Bella Hwang, Stop Stock Outs Project

ONLINE

- *EWN* – 'Health Minister meets suppliers to tackle drug shortages'. Read article [HERE](#)
- *East Coast Radio* – 'Joint effort tackle drug shortages in SA'. Read article [HERE](#)
- *ENCA* – 'Penicillin and heart failure meds in low supply'. Read article [HERE](#)
- *SABC* – 'Activists lash out at State over ARV treatment shortfalls'. Read article [HERE](#)
- *NSP Review* – 'Drug stock outs: the crisis continues'. Read article [HERE](#)
- *Mail & Guardian* – 'Survey uncovers shortage of critical medication'. Read article
- *Health-e* – 'More than one in 10 health facilities hit by drug stock outs'. Read article [HERE](#)
- *Health-e* – 'Report: 2014 Stock Outs Survey'. Read report [HERE](#)

- BD Live – ‘Weak public health systems factor in medicine shortage’. Read article [HERE](#)
- ENCA – ‘Patients suffer as provinces struggle to manage medicine orders’. Read article [HERE](#)
- BD Live – ‘Medicines council targets sourcing of active ingredients to relieve shortage’. Read article [HERE](#)
- Eye Witness – ‘Health Dept. working to replenish medicine stocks’. Read article [HERE](#)
- IOL – ‘SA’s medicine supply crisis’. Read article [HERE](#)
- Citizen – ‘HIV/Aids: Stockouts can mean death’. Read article [HERE](#)
- Politics Web – ‘Chronic drug stock-outs threaten gains of ART programme – SSOP’. Read article [HERE](#)
- SABC – ‘Aids activists protest over drug shortage’. Read article [HERE](#)
- All Africa News – ‘South Africa – Drug shortages threaten progress made in the world’s largest HIV programme’. Read article [HERE](#)
- New Age – ‘Drug shortage puts patients at risk’. Read article [HERE](#)
- New Age – ‘Aids activists protest over drug shortage’. Read article [HERE](#)
- World News – ‘South Africa: Drug shortages threaten progress made in the world’s largest HIV programme: MSF’. Read article [HERE](#)
- Emlak Haberleri – ‘South Africa: Drug shortages threaten progress made in the world’s largest HIV programme: MSF’. Read article [HERE](#)
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- Mail & Guardian – ‘Drug shortages ‘imperil NHI plan’. Read article [HERE](#)
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- Press Reader – ‘Survey reveals drug shortages’. Read article [HERE](#)
- Health-e – ‘Staff shortages contribute to stock outs’. Read article [HERE](#)
- News Informer – ‘South Africa – Drug Shortages Threaten Progress Made’. Read article [HERE](#)
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- Health-e – ‘Drug stockouts cast long shadow over the Aids conference’. Read article [HERE](#)
- <http://bhekisisa.org/article/2015-05-25-motsoaledi-refutes-claims-sa-faces-drug-shortages>
- <http://www.timeslive.co.za/thetimes/2015/05/18/Dying-for-drugs>
- <http://www.dispatchlive.co.za/news/2015/06/08/motsoaledi-must-explain-stock-outs-to-parly-da/>
- <http://www.dailymaverick.co.za/article/2015-07-01-groundup-theres-no-excuse-for-medicine-stockouts-minister-heres-the-proof/>
- <https://www.health-e.org.za/2015/11/23/south-africa-launches-worlds-first-early-drug-stock-out-warning-system/>
- <https://www.health-e.org.za/2015/11/23/4-things-south-africa-is-doing-to-safeguard-medicines/>
- <http://we-care.co.za/department-of-health-will-electronically-track-medicine-stockouts/>
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- <https://www.health-e.org.za/2016/04/16/quarter-surveyed-health-facilities-report-stock-outs/>
- <https://www.pressreader.com/>
- <https://issuu.com/hmpg/docs/hc-1607>

ANNEX IV: LOGFRAME FOR EU PROJECT

CTR: DCI-AFS/2016/ 374-479 "Stop Stock outs" Project							
IMPACT:	Intervention logic	Indicators	Baseline	Current Value	Targets	Sources and means of verification	Assumptions
Overall objective	To improve the right to health, including access to timely, acceptable, and quality healthcare (including essential medicines), of citizens reliant on the public healthcare system in South Africa.	# Provinces and National Department of Health with clean (unqualified) financial audit (2015)	3/9 provinces & NDoH	Same as baseline	5/9 provinces & NDoH	NDoH annual performance plan	Patients receiving their medication and high quality health services will have better health outcomes and live longer lives
		Health facilities' compliance scores on vital measures in the six ministerial priority areas: Positive and Caring Staff (2012)	30% - national score	Same as baseline	40%	Office Health Standards and Compliance National Health facilities Audit	
		Health facilities' compliance scores on vital measures in the six ministerial priority areas: Medicine Availability (2012)	54% - national score	Same as baseline	65%	Office Health Standards and Compliance National Health facilities Audit	
		% of people who have accessed HIV treatment (6.4 million total in SA with HIV) (2012)	Women - 34.7%; Men 25.7%	Same as baseline	Women - 40.0%; Men 30.0%	HSRC South African National HIV Survey	
		# Hospitals with electronic medicine supply monitoring systems	39	Same as baseline	120	NDoH annual performance plan	
OUTCOMES:	Intervention logic	Indicators	Baseline	Current Value	Targets	Sources and means of verification	Assumptions
Specific Objectives	SO1. To improve access to information and capacitate communities on legal and constitutional rights related to the right to health	• # of health service delivery incidents reported to the project (male/female reporters)	• 201	Same as baseline - to disaggregate by male/female	• 1300(at least 65% female)	Project records	1. Funding is available from the government for medicines and healthcare 2. Citizens, patients and healthcare workers are able to make reports without repercussion s. 3. Partnerships with external stakeholders remain
		• # of medicine availability incidents reported to the project from citizens/patients (male/female reporters)	• 84	Same as baseline - to disaggregate by male/female	• 700(at least 65% female)	Project records	
		• # of medicine availability incidents reported to the project from healthcare workers (male/female reporters)	• 81	Same as baseline - to disaggregate by male/female	• 500 (at least 65% female)	Project records	
		• % of different provinces with patients and healthcare workers reporting on stock outs coverage	Eastern Cape -15%; Free State -15%; Gauteng- 20%; Kwazulu Natal 10%; Limpopo – 15%; Mpumalanga - 15%; North West -10 %; Western Cape - <1% - more even coverage based on project activities) (total 2016-2018)	Same as baseline - to disaggregate by male/female	Eastern Cape -24%; Free State -15%; Gauteng- 18%; Kwazulu Natal 16%; Limpopo – 17%; Mpumalanga -8%; North West -2 %; Western Cape - <1%	Project records	

	SO2. To co-ordinate and develop a country-wide network of citizens/civil society collecting information through a platform to improve access to health and medicines.	• % change in stock outs in each province and nationally	• 24% of facilities reporting at least 1 ARV/TB stock out during 3 month survey period	Same as baseline - to disaggregate by male/female	• 18% of facilities reporting at least 1 ARV/TB stock out during 3-month survey period	Project records Annual survey Government documents Published reports and articles	established and feedback re performance is accepted. 4. Change of government or other personnel in relevant departments continue to co-operate with the project and welcome its input. 5. Government procurement processes remain broadly the same. 6. Burden of disease remains the same or similar to what it is today, i.e. no new epidemic strikes (e.g. Ebola)
		• % of positions/titles people responsible for medicine supply provided by government	40%	Same as baseline - to disaggregate by male/female	80%	Project records Annual survey Government documents Published reports and articles	
		• % increase of escalated incidents responded to by government with feedback	29% by district; 70% by province; 16%	Same as baseline - to disaggregate by male/female	70% by district; 80% by province; 50% by national DoH	Project records Annual survey Government documents Published reports and articles	
		• # of civil society meetings with DoH and provinces engaging with project information and evidence	9	Same as baseline - to disaggregate by male/female	45	Project records	
		• # of action plans produced by DoH to address medicine availability	3 provinces	Same as baseline - to disaggregate by male/female	9 provinces	Project records Annual survey Government documents Published reports and articles	
		• Decrease in the length of time to resolve an incident (from date of report to government to resolution date)	45 days average, min 1 day – max 180 days	Same as baseline	25 days average, min 1 day – max 90 days	Project records Annual survey Government documents Published reports and articles	
OUTPUTS		Indicators	Baseline	Current Value	Targets	Sources and means of verification	Assumptions
Output 1 (VOICE): At least 6,000 community members (including healthcare workers) trained over 3 years in understanding stock outs, reporting to the hotline, on advocacy, on health care rights and on using regularly the eletronic platform to for community health surveillance.		• # patients and community activists trained in "Making your right to health a priority" workshops	720	Same as baseline - to disaggregate by male/female in future	6000 (at least 65% female)	Project records	Sufficient suitable trainers are available to run the workshops. CBOs are willing to engage.
		• # of stock outs and shortages reported	500	Same as baseline - to disaggregate by male/female in future	750 (at least 60% female reporters)	Project records	
		# of healthcare workers (sentinel surveyors) and DoH trained	200	Same as baseline - to disaggregate by	300 (at least 60% female)	Project records	

		male/female in future		
# of Community Mobiliser/ Trainers Trained and Mentored	6 (3 male/3 female)	Same as baseline - to disaggregate by male/female in future	45 (at least 50% female)	Project records
# of campaigns/workshops conducted in each of the districts targeted by the project (annually)	10	Same as baseline - to disaggregate by male/female in future	100	Project records
# of focal sentinel surveyors recruited to regularly report on stock outs	200	Same as baseline - to disaggregate by male/female in future	300	Project records
# materials distributed	300 (2015)	Same as baseline - to disaggregate by male/female in future	3000 (Total 2016 - 2018)	Project records
# patient testimonies	Not developed	Same as baseline - to disaggregate by male/female in future	Developed	Project records
#different districts with patients and healthcare workers reporting on stock outs (coverage)	4/5 (80%) districts in GP	Same as baseline - to disaggregate by male/female in future	50% of 8 districts in EC, 80% of 5 in FS, 100% of 5 in GP, 30% of 11 in KZN, 80% of 5 in LP, 100% of 3 in MP, 50% of 4 in NW (based on districts with high health burden = more impact)	Project records
Annual survey completed and report written	2015	Same as baseline - to disaggregate by male/female in future	Completed annually 2016,2017,2018	Project records
Integrated electronic platform developed	Not developed	Same as baseline - to disaggregate by male/female in future	Developed	Project records
% of incidents reported logged and tracked on case management platform from citizen report to final summary	50%	Same as baseline - to disaggregate by male/female in future	100%	Project records
# external viewers/users of incident management log	Baseline required. To be ascertained during initial 3 months of grant	Same as baseline - to disaggregate by male/female in future	21600 sessions/Page views	Project records

	# of external downloads of reports/incident management log from platform	Baseline required. To be ascertained during initial 3 months of grant	Same as baseline - to disaggregate by male/female in future	150	Project records	
Output 2 (INFLUENCE): Reliable data on drug stock outs and data on response of government officials responsible for the availability of essential medicines is available and regularly shared with government and other policy-makers to influence and inform programme and policy change	• # medicine monitoring reports produced for stakeholders (government and non-government) from the day-to-day hotline and escalation process	Not yet implemented	0	9 (3 per year), 225 (75 per year)	Published reports, project data, project reports, media	Communities and patient groups continue to be willing to engage with the project and participate in monitoring and reporting activities. No other social or political crisis emerges that absorbs the attention and efforts of activists to a greater extent, thus deflecting activism away from health.
	• # annual national stock outs survey completed and reports produced	1 per year	1 per year	3 (1 per year)	Published reports, project data, project reports, media	
	• # facilities willing to participate in the survey	2463 (88%) – 2015	Same as baseline - to disaggregate by male/female in future	2463 (88%) maintain	Published reports, project data, project reports, media	
	• # of high-level stakeholder & ministerial consultations held to share project data and influence policy (Minister, OSHC, DoH, Pharm Services, District Managers etc.)	1 per year	Same as baseline - to disaggregate by male/female in future	3 (1 per year: 2016, 2017, 2018)	Published reports, project data, project reports, media	
	• # of presentations to community radio and community-based organisations on national stock outs survey and day-to-day project activities	44	Same as baseline - to disaggregate by male/female in future	100 (33 per year)	Published reports, project data, project reports, media	
Output 3 (SUSTAIN): A sustainable civil society model and network is developed to enable South African civil society to hold government accountable in the long term	#Workshops to disseminate civil society monitoring model & # of participants at each workshop (CBOs given information and female/male attendees)	10 60 participants	Same as baseline - to disaggregate by male/female in future	100 (33 per year)	Project data and reports	Funding is sustained. Civil society remains committed to the cause. No other civil strife or crisis arises which is more pressing and diverts the attention and energy of civil
	# Survey reports produced	1	Same as baseline - to disaggregate by male/female in future	6	Project data and reports	
	# Annual reports produced	Not implemented	Same as baseline - to disaggregate by male/female in future	1	Project data and reports	
	Assessment & annual report regarding current governance and organisational model/Terms of Reference signed amongst consortium partners and	1 per year	Same as baseline - to disaggregate by	3	Project data and reports	

		SA HIV Clinician’s Society OR SSP registered as an independent NGO		male/female in future			society from health.
		# SSP steering committee strategy meetings	1	Same as baseline - to disaggregate by male/female in future	2	Project data and reports	
		# SSP steering committee meetings	4	Same as baseline - to disaggregate by male/female in future	12	Project data and reports	
		# SSP steering committee members (female/male)	At least 6 (at least 65% female)	Same as baseline - to disaggregate by male/female in future	Maintain at least 6 (at least 65% female)(total 2016-2018)	Project data and reports	
ACTIVITIES		Means and Costs (Euro)				Assumptions:	
Activities related to Ouptut 1	ACT 1.1 Develop workshop curriculum and establishment of a network of six provincial trainers (trainers of trainers programme) across the country who will be engaged to mobilise patients, communities and civil society organisations, train trainers nt the conduct of patient rights workshops and promote the model (24 workshops per year)	Means: Community mobilisation officer, project manager, campaigns officer.				Sufficient suitable trainers emerge from within relevant communities.	
	ACT 1.2 Conduct workshops with healthcare worker groups to encourage healthcare worker reporting and activism (10 workshops per year)	Means: Community mobilisation officer, project manager, deputy project manager, campaigns officer, workshop materials, travel, venue				Unions remain engaged with the project and on side and healthcare workers are not and do not <i>feel</i> threatened or frightened to report.	
	ACT 1.3 Patient Mobilisation to report on medicine availability to the project • Conduct interviews with community journalists, advertise and promote the project and hotline on community radio and newspaper • Carry out clinic to clinic campaigns to distribute project materials and promote hotline number: reaching 1,500 people per quarter • Distribute project promotional materials at community events and to other community based	Means: Community mobilisation officer, project manager, deputy project manager, campaigns officer, workshop materials, communications officer, community radio and newspaper adverts, venue for workshops, information, education & communication materials (posters, flyers, business cards etc.), bulk SMS, travel				Patients are willing to engage and stigma does not prove an obstacle to collection of phone numbers, SMS distribution or meeting attendance.	

	<p>organizations: 33,000 per quarter</p> <ul style="list-style-type: none"> • Ongoing active surveillance of stock outs at facilities: 75 facility visits per quarter • sending information to patient and healthcare worker mailing lists: 1,500 sms' per month 		
	<p>ACT 1.4 Implement the sentinel surveyor program for focal patients and healthcare workers each representing one clinic to monitor health service delivery and availability of medicines on a regular basis (once per month SMS check-ins to report if there is or is not medicine available in the clinics the attend or work at) (Increase current list of 200 sentinel surveyors by 20% annually)</p>	<p>Means: Project manager, technical advisory and policy officer, deputy project manager, campaigns officer.</p>	<p>Healthcare workers are not and do not feel threatened or frightened to report and patients do not worry that involvement may prejudice their treatment.</p>
	<p>ACT 1.5 Conduct info sessions at healthcare facilities to encourage patient reporting (120 facilities per year) as part of the community mobiliser/trainer role</p>	<p>Means: Community mobiliser/trainers, project manager, deputy project manager, campaigns officer, workshop materials</p>	<p>Facilities grant the project access to hold the workshops.</p>
	<p>ACT 1.6 Develop a 'Faces of the SSP Campaign' - Collection of patient and health care worker stories and testimonies and share stories with community journalists and in an annual report (10 faces per year)</p>	<p>Means: Project manager, deputy project manager, campaigns officer, stock out case manager</p>	<p>Patients are willing to engage and stigma does not deter them from telling their stories.</p>
	<p>ACT 1.7 Design and develop technical specifications and M&E needed for the project and by government to influence change for the integrated mobile electronic reporting and mapping platform.</p>	<p>Means: Project manager, technical advisory and policy officer, deputy project manager, case manager, server</p>	
	<p>ACT 1.8 Work with software developer to develop and maintain patient management software</p>	<p>Means: Project manager, technical advisory and policy officer, deputy project manager, case manager, community mobilisation officer</p>	<p>Government and stakeholders have equipment to access and capacity to obtain information and utilise data.</p>
<p>Activities related to Ouptut 2</p>	<p>ACT 2.1 Case management and escalation of reports to appropriate government entities of reports from the community</p>	<p>Means: Software developer, project manager, technical advisory and policy officer, deputy project manager, case manager</p>	<p>Government and stakeholders have equipment to access and capacity to obtain information and utilise data.</p>

health surveillance system for resolution (All cases. Estimated 500 reports per year)		
ACT 2.2 Promotion of the 'stock outs escalation' protocol in provinces (Work with government to determine accountable people along the supply chain and hold them to account in preventing and resolving stock out problems.)	Means: project manager, deputy project manager, stock out case manager, CEO, Technical Adviser on Policy & Implementation	
ACT 2.3 Liaise with partners to develop and distribute clinical guidelines to support health facilities and healthcare workers when medicines are out of stock (dependent on which medicines are out of stock each year; estimated 1 clinical guideline produced per year).	Means: Community mobilisation officer, deputy project manager, campaigns officer	
ACT 2.4 Community mobilisers to participate in meetings with local authorities & engagement around stock outs: 50 meetings per year	Means: Project manager, technical advisory and policy officer, deputy project manager, stock outs case manager	
ACT 2.5 Analysis of data collected through community mobilisation which will be used to develop evidence-based advocacy strategies to liaise with government and policy-makers. (monthly reports consolidated into annual report distributed to 10 stakeholders)	Means: Project manager, technical advisory and policy officer, deputy project manager, telephone interviewers stock outs survey, phone costs, communications officer	Telephonic access to facilities available; government able and willing to act on results of survey.
ACT 2.6 Annual formalised research representing the voices of the beneficiaries of the healthcare system (patients and healthcare workers) through a <u>national survey</u> contacting all 3547 health facilities across the country	Means: Project manager, technical advisory and policy officer, deputy project manager, stock outs case manager	
ACT 2.7 Annual presentation of project and survey results to NDoH and each of the provinces (10 presentations)	Means: Project manager, technical advisory and policy officer, deputy project manager, stock outs case manager	

	ACT 2.8 Document and publish reports on the use and benefits of using a citizen-based monitoring and feedback system in parallel to government systems for monitoring health service delivery. (1 report to be published towards the end of the 3 year period)	Means: Project manager, technical advisory and policy officer, deputy project manager, stock case manager	Sufficient M & E resource is available to the project; sufficient writing resource is available to develop and disseminate toolkit. Interest in model by other CBOs.
Activities related to Output 3	ACT 3.1 Develop a network of civil society organisations and hold annual seminars to capacitate civil society with regards to the SSP model and utilising monitoring models more broadly	Means: Community mobilisation officer, deputy project manager, campaigns officer	Interruptions to supply of essential medicines and other challenges with the healthcare system continue to plague the country in the long term. If the system suddenly starts to function effectively this project will no longer be necessary. There is willing and available resource to create an independent NGO and manage it, should that be the result of strategic assessment.
	ACT 3.2 Circulate survey report and annual report to civil society organisations and community leaders	Means: Project manager, technical advisory and policy officer, deputy project manager, CEO	
	ACT 3.3 Ensure Stop Stock outs Project (SSP) governance systems are in place and that SSP begins journey to becoming independent	Means: Project manager, technical advisory and policy officer, deputy project manager, CEO,	

ANNEX V: EVALUATION MATRIX

Evaluation issue	Evaluation question	Judgement criteria	Indicators	Data sources
Relevance	EQ 1: Does the overall SSP and the SSP objectives correspond with identified needs?	Extent to which the project and its objectives are aligned with identified needs	Stakeholders' perceptions of the alignment between identified needs and the SSO project and its objectives	Document review; Stakeholder interviews (national and provincial management, partner organisations, patients, health care workers, community mobilisers)
Appropriateness	EQ2: Are the SSP strategies and activities appropriate for the SSP objectives?	Extent to which the strategies and activities adopted are aligned with the objectives	Stakeholders' perceptions of the alignment between the strategies/ activities and the objectives	Document review; Stakeholder interviews (national and provincial management, partner organisations, patients, health care workers, community mobilisers)
	EQ3: Are the SSP strategies/ activities contextually appropriate?	Extent to which the strategies and activities adopted are contextually appropriate over time	Stakeholders' perceptions of whether strategies and activities adopted are contextually appropriate over time	Document review; Stakeholder interviews (national and provincial management, partner organisations, patients, health care workers, community mobilisers)
Effectiveness	EQ4: To what extent have the defined objectives been achieved? What were reasons for achievement or non-achievement of objectives?	Extent to which the activities have achieved the SSP objectives to date	Evidence demonstrating outputs / results of the SSP to date are contributing to / in line with the SSO project objectives	Project reports, other reports Stock out data/analysis from annual reports and NHIRD data
			Stakeholders' perceptions of the results achieved or not achieved so far of the activities implemented in achieving the SSO project objectives to date	Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)
	EQ5: Were the activities carried out as originally planned?	Extent to which the activities were carried out as planned	Evidence linking actual activities to planned activities	Project reports, other reports Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)
	EQ6: What can be done to make the project more effective?	Extent to which strategies/ activities have changed	Evidence linking changed strategies/ activities to contextual changes	Project reports, other reports

Evaluation issue	Evaluation question	Judgement criteria	Indicators	Data sources
		based on changing contexts or lessons learnt		Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)
Impact	EQ7: What difference has the SSP made in terms of policy/practice both nationally and internationally?	Extent to which the SSP has influenced policy/practice nationally and internationally	Evidence showing policy or practice changes	Project reports, other reports Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)
	EQ8: What difference has the SSP made in terms of mobilising patients and CSOs to advocate for their rights to access medicines?	Extent to which patients and CSOs have been mobilised	Evidence of the mobilisation of CSOs and patients	Project reports, other reports Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers) observation at patient workshops
	EQ9: What difference has the SSP made in terms of contributing to a regional SSO movement?	Extent to which a regional SSO movement is functioning and what contribution the SSP has made to this	Evidence of a regional SSO movement and SSP contribution to this	Project reports, other reports Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)
	EQ10: What is the proportion of the target population reached?	Extent to which the target audience has been reached	Evidence of the target population being defined and the percentage been reached	Project reports, other reports Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)
Efficiency	EQ11: Were activities/strategies implemented with the best use of available financial resources and time	Extent to which efficient use of resources was made	Evidence of best use of resources (financial, human, time)	Project reports, other reports Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)
Replicability	EQ12: What activities/processes are necessary for transferring the SSP to other geographical and functional areas	Extent to which core activities/processes have been identified?	Evidence of the core activities/ processes been identified/ documented	Project reports, other reports Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)
Continuity	EQ13: Will the project be sustainable	Extent of transferring the SSP to a more permanent home or base	Evidence that suggests the SSP is embedded within existing CSOs and will continue?	Project reports, other reports

Evaluation issue	Evaluation question	Judgement criteria	Indicators	Data sources
				Stakeholder interviews (national, provincial, patients, health care workers, community mobilisers)

History/Background of the model

1. Can you describe the process of how the SSP was established?
What was your role?
2. What in your view were the initial reasons for establish the SSP? What issues were the SSP meant to address?
How were these needs identified?
3. What were the key objectives of the SSP?
4. Can you describe the major milestones in the development of the SSP? (build on the timeline at the end)
5. What were the key challenges? key successes? key enablers? in the development of the SSP?
6. Were there any key points or stages when you realised that the SSP approach was accepted and had taken off?
What were these key points? Why do you think this happened?
7. From your perspective were there any aspects in the implementation of the SSP that surprised you, were not anticipated? Describe these and why you think they happened?
8. Were there any unintended consequences e.g. things that happened that were not planned for or thought of? (positive and negative) Give examples. How were they addressed?
9. Describe the relationship between the partner organisations (MSF, TAC, RUDASA, RHAP, Section 27 and Southern African HIV Clinicians Society). What has been the role of each organisation? What have been the challenges? What could have been done better?
10. Describe the composition and role of the steering committee. What has it done well? What have been the challenges? Has the role changed over time? What role do you see it playing in the future?
11. Describe the relationship between the SSP and the different levels of the public health service - national, provincial, district/facility? What has worked well? what could have worked better?

Relevance and appropriateness (were strategies/activities aligned with identified needs and were strategies adopted appropriate for the set objectives, and sensitive to contextual changes)

12. Does the overall SSP and the SSP objectives correspond with identified needs? Link to the questions above (2, 3 and 4) on their understanding of the objectives.
13. The objectives of the SSP in the logframe were:
SO1. To improve access to information and capacitate communities on legal and constitutional rights related to the right to medicines

¹⁵ there are different questionnaires for the different categories of interviewees

SO2. To co-ordinate and develop a country-wide network of citizens/civil society collecting information through a platform to improve access to health and medicines.

The expected results of the SSP are:

ER 1 (VOICE): At least 6,000 community members (including healthcare workers) trained over 3 years in understanding stock outs, reporting to the hotline, on advocacy, on health care rights and on using regularly the electronic platform to for community health surveillance.

ER 2 (INFLUENCE): Reliable data on drug stock outs and data on response of government officials responsible for the availability of essential medicines is available and regularly shared with government and other policy-makers to influence and inform programme and policy change

ER 3 (SUSTAIN): A sustainable civil society model and network is developed to enable South African civil society to hold government accountable in the long term

Do you think that the SSP has met these objectives? What is the evidence? What has been successful? What has been challenging? How have the challenges been addressed?

14. What strategies/activities were adopted/implemented to meet these objectives?

Who or what (people and institutions) was key in initiating the adoption/implementation? why? How were they identified or supported?

Were there any significant blockers? How were they addressed?

What feedback (positive or negative) was received from key stakeholders and institutions during the implementation of these strategies/activities?

15. Are the SSP strategies/activities contextually appropriate? Has the context changed over the period of the SSP? Have any changes been made to the strategies/activities?

16. The stock out rate varies across districts and provinces. Has the SSP investigated the reasons for these differences? Has the SSP adapted the strategies and activities to respond to these differences? If not, why not?

Effectiveness and impact (did the strategies/activities achieve the objectives and did the SSP improve availability of medicines at the point of service)

17. How has the SSP performed? What have been the challenges?

18. How has community access to information and understanding of health rights improved? Can you give any examples? Have communities and CSOs been mobilised to advocate to improve medicine availability? Can you give examples.

19. What coalitions have been built to collect evidence for action? what has been achieved by these coalitions? What challenges have been experienced and how have these been overcome?

20. How effective has the report crowdsourcing been in addressing stock outs? How has the escalation protocol functioned? Has medicine availability improved at the point of service? What have been the successes and what have been the challenges?

21. What effect has the SSP had on development, evolution and implementation of government policy and practice on drug supplies and stock outs? At national level? at provincial level? at district/facility level?
22. Has there been any influence at regional or international levels?
23. The stock out rate, as measured in the annual survey, has stayed the same. Why is this so? Has this influenced the strategy/activities of the SSP? if not, why not?
24. Have the activities been implemented as planned? What changes have been made since starting? Why did this happen – give examples?
25. What could be done to make the SSP more effective?
26. Does a regional SSO movement exist? can you describe how it functions? Has the SSP contributed to this regional SSO movement?
27. How was the target population for the SSP defined? Has this been reached? What mechanisms are in place to track this?

Efficiency (were activities/ strategies implemented with the best use of available resources, human, financial and time)

28. What resources have been utilised for the SSP? How have they been utilised? do you think they could have been used more efficiently?
29. Has the use of resources been tracked against strategies? activities? what indicators have been used?

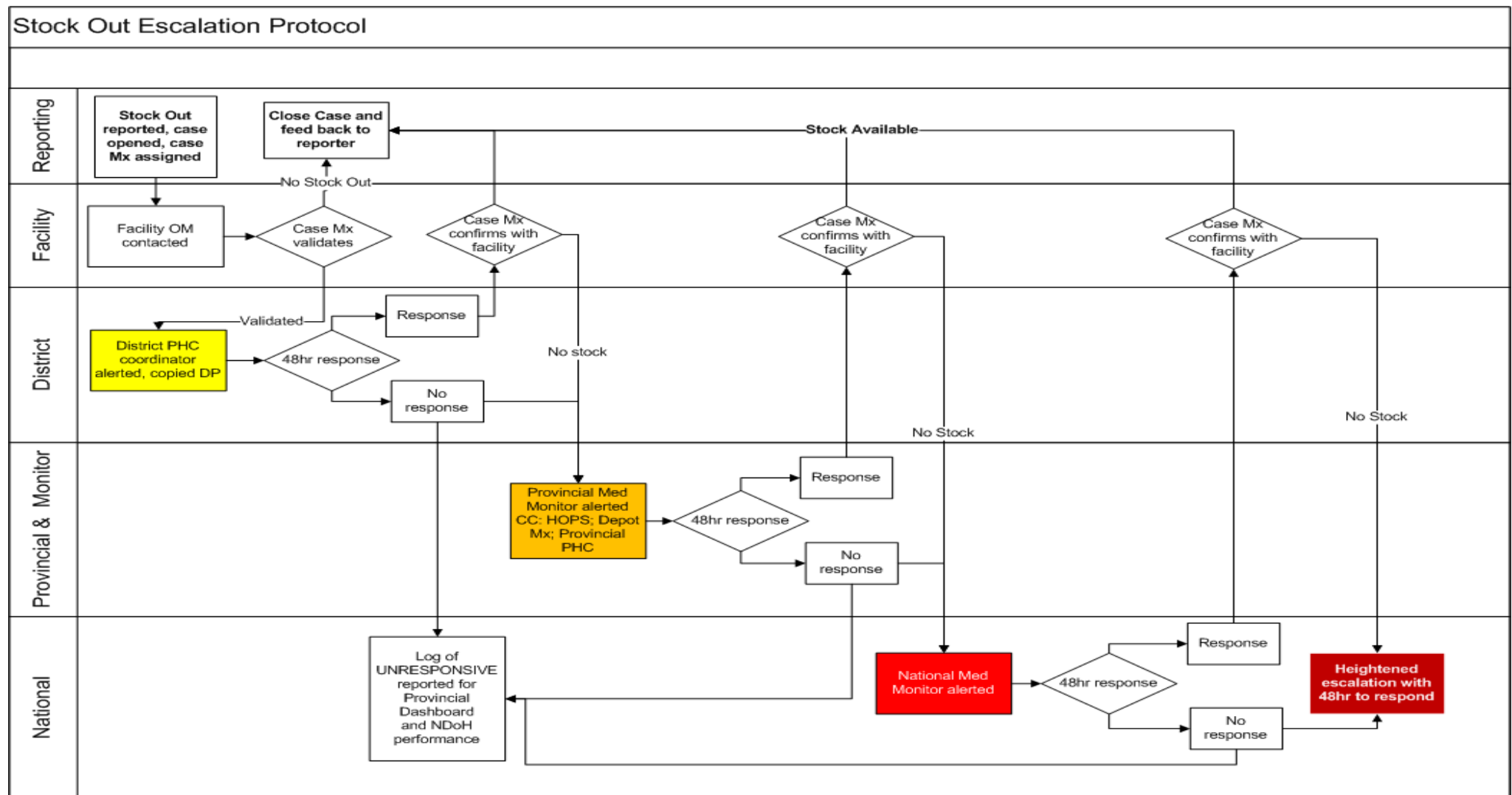
Replicability (identifying activities/processes necessary for transferring to other geographical and functional areas)

30. What are the core activities/processes needed for implementing a SSO project? Can you identify what would be needed to start a SSP in another geographical area?
31. What would be your recommendations if this model was going to be introduced elsewhere in South Africa? in another country?

Sustainability (will the project be sustainable)

32. How will the SSP continue? What issues/challenges exist in ensuring this continuity? What role will the different partners play? what role should they play?
33. What needs to happen to make the SSP sustainable?

ANNEX VII - ESCALATION PROTOCOL



Stockholm Evaluation Unit

Médecins Sans Frontières

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