

EVALUATION OF

THE EASTERN CAPE NON- COMMUNICABLE DISEASES PROJECT

South Africa

January 2023 – June 2026

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This publication was produced at the request of Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

All evaluators contracted by the SEU must adhere to the SEU Ethical Guidelines for Evaluations.

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DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of Médecins sans Frontières and the Stockholm Evaluation Unit.

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ACRONYMS

CCMDD	Central Chronic Medicines Dispensing and Distribution
CG	Consultation Group
CHW	Community Health Worker
DMOC	Differentiated Models of Care
DOH	Department of Health
EAM	Epidemiology Activity Manager
FGD	Focus Group Discussion
FHR	Facility-held Record
FRC	Field Recentralisation Programme
GDPR	General Data Protection Regulation
HSS	Health Systems Strengthening
KII	Key Informant Interview
MSF	Médecins sans Frontières
NAM	Nurse Activity Manager
NCD	Non-communicable Disease
NGO	Non-Governmental Organisation
OCB	Operational Centre Brussels
PHC	Primary Health Care
PMR	Project Medical Referent
POC	Point Of Care
PSS	Patient Support Supervisor
PUP	Pick-up Point
QOC	Quality of Care
RST	Regional Support Team
SAMU	Southern Africa Medical Unit
SEU	Stockholm Evaluation Unit
SOP	Standard Operating Procedure
TOC	Theory of Change
TOR	Terms of Reference
TOT	Training of Trainers

EXECUTIVE SUMMARY

This is an evaluation of a project by Médecins sans Frontières (MSF) Operational Centre Brussels (OCB) to improve the quality of care for non-communicable diseases (NCD) in the province of Eastern Cape, South Africa, with a focus on primary care. It covers the period from January 2023 to June 2026. The project was implemented in close collaboration with the Eastern Cape Department of Health (DOH). The evaluation aims to assess to what extent the project improved the quality of NCD care in Butterworth and identify key factors that facilitated or hindered progress towards improved NCD care quality. This includes lessons on collaborating effectively with the DOH.

CONTEXT

The Eastern Cape is one of South Africa's least well-off provinces, with high unemployment and poverty rates, and high death rates from NCDs such as hypertension and diabetes. The region suffers from underfunding, limited access to care and structural shortcomings in the health system. The DOH's national goal on NCDs is to screen 90% of adults for high blood pressure and/or elevated blood sugar, treat 60% and control 50% by 2030.

PROJECT OVERVIEW

The Eastern Cape Non-Communicable Diseases Project (EC-NCD project) aims to improve quality of care for people living with NCDs, particularly diabetes and hypertension, through capacity-building of nurses and community health workers and other health system strengthening at the primary health care level. Care is being delivered by DOH staff, and not by MSF, reason why MSF calls its approach 'hands-off'. MSF assists in building capacities of nurses and community health workers on NCDs based on a co-created and DOH-approved curriculum, based on DOH guidelines. Further support on health systems strengthening includes providing essential equipment and administrative tools (patient files) to facilitate health care delivery. The project also aimed to strengthen the expansion of differentiated models of care by setting up external pick-up points (PUPs) i.e., points where stable patients can pick up their chronic medication in the community, close to where they live. Advocacy at provincial and district level to improve NCD care quality was also part of the project.

EVALUATION FRAMEWORKS AND METHODOLOGY

Given the central role of the partnership in the project's design, the evaluation draws on a partnership framework (the Bergen Model of Partnership) to understand how collaboration between MSF and the DOH influenced implementation and results. To assess the outcome of the partnership i.e., quality of NCD care, the evaluation uses the Donabedian model which examines Structure (equipment, medicines, staff), Process (how care is delivered), and Outcomes (results of care for patients and providers).

A mixed-methods approach has been adopted. Secondary data have been collected through desk review of relevant project documents, external written sources, MSF project and DOH medical databases and patient file review. Primary data was collected using key informant interviews (KIIs), focus group discussions (FGDs), direct observation of consultations, and facility assessments.

Qualitative data were analysed using a code system based on the evaluation questions. Quantitative data were analysed aggregating and recalculating raw data from the DOH tick register.

FINDINGS

EQ1 PARTNERSHIP INPUTS

To what extent were the inputs provided by MSF and the provincial DOH sufficient to support the partnership objectives?

MSF and the DOH entered the partnership with a shared commitment to improving NCD outcomes and a common interest in strengthening NCD care through a hands-off, technical assistance model. MSF provided staff capacitation, funded and developed trainings, implemented mentorship, supported reviews, organized awareness campaigns, assisted community mobilization, funded external PUPs, and supplied equipment: blood pressure meters, point-of-care HbA1c testing equipment to assess the stability of diabetes, refrigerators and more. DOH provided access to staff, facilities, data, consumables, and endorsement of interventions, and facilitated MSF participation in reviews. Overall, these inputs were generally sufficient to support improvements in quality of care within supported facilities. However, their adequacy was constrained by significant contextual and operational challenges. Data systems lacked patient-level information, staff shortages within both partners led to delays, and high workloads at facility level limited the impact of mentorship. Logistical constraints like drug stock-outs and power outages further disrupted service provision. Political and financial instability, including the withdrawal of major US donor funding, further strained the system. While MSF's inputs were generally sufficient for strengthening quality of care within supported facilities, the relatively small scale of the project and the strained context limited its broader effects.

EQ2 PARTNERSHIP PROCESSES

To what extent did the processes established by MSF and the provincial DOH support the partnership objectives?

Partnership processes were generally effective in supporting collaboration and implementation, although communication challenges, unclear decision-making pathways, and data-sharing constraints hindered implementation and contributed to delays. The partnership relied on few formal enabling elements, mainly the MoU and regular coordination and review meetings. Regular meetings at sub-district, district, and provincial levels facilitated operational discussions, sharing of progress, and coordination of implementation. Ad-hoc meetings supported emergent needs and information exchange. Informal day-to-day interactions, regular check-ins, and MSF's efforts to blend into DOH work culture were important for maintaining relationships. Trust, open communication, and transparency were highlighted as key elements. Constraining factors included inconsistent communication across DOH levels, and uncertainty about decision-making mandates. Early

communication gaps occurred when MSF was unsure which DOH level required information, and that DOH permissions needed to be arranged through top-down processes. Data-sharing challenges and weaknesses in facility-level recording systems further constrained implementation and monitoring. MSF navigated constraints by adapting its approach, relying on experienced staff, establishing the Amathole District Partners Forum, and gaining buy-in for interventions. Despite these constraints, collaboration at district level remained strong and generally supported achievement of the partnership objectives.

EQ3 PARTNERSHIP OUTPUT

To what extent did the partnership contribute to improvements in the quality of NCD care in the supported facilities?

The partnership contributed to improvements in several structural and process dimensions of NCD quality of care. Nurse competency scores increased across supported facilities, and qualitative evidence suggests improvements in clinical decision-making, consultation practices, and medical record keeping. The partnership also strengthened key equipment-related elements of quality NCD care. Health workers reported that in particular, HbA1c testing enabled more timely treatment adjustments and patient counselling, although occasional equipment shortages and operational constraints limited optimal use. Monitoring systems remained limited, but MSF support improved register use, increasing recorded NCD patient numbers and encouraging data-driven decisions. Connectivity issues and lack of patient-level data continued to constrain outcome measurement. External pick-up points improved accessibility and reduced transport burden, though their effect on workload relief could not be demonstrated due to missing data. Evidence on outcome-level changes of quality of care is limited. While DOH aggregated data shows rising positivity rates of screening for diabetes and hypertension, suggesting increased case-finding, a continuing upward trend is not evident later in the programme. However, a comparison of positivity rates for hypertension and diabetes between facilities that received MSF-support and facilities that did not receive such support, shows that case finding is generally higher in MSF-supported facilities. The percentage of controlled diabetes patients (by HbA1c levels) shows an increasing trend. Patient experience was mixed—some appreciated medication availability and information, while others cited access barriers, inconsistent care, and poor nurse-patient interactions. Nurses expressed dissatisfaction due to severe understaffing and overwhelming workloads, compromising care quality. Conversely, CHWs reported high satisfaction with new tools but advocated for better recognition and expanded roles, like diabetes testing.

CONCLUSIONS

The partnership contributed to meaningful improvements in the quality of NCD care, particularly in the structural and process dimensions of care, including documentation and monitoring practices, availability of equipment, access to services, and the capacity of nurses and community health workers. While evidence on patient-level outcomes was not available in routine data systems, the evaluation identified indications of improved NCD case detection and early signs of better blood sugar control at facility level.

The evaluation shows that a hands-off model can contribute to quality-of-care improvements when grounded in capacity building, other health system strengthening interventions, alignment with government priorities, and strong partnership relationships. Trust, DOH ownership, and constructive dialogue were important enablers, while staffing shortages, high patient volumes, data limitations, and broader health system constraints hindered implementation and the pace of change.

The project also generated valuable lessons on working with a highly structured government partner. Effective influence required sustained engagement, understanding of decision-making hierarchies, and evidence to support advocacy. The lack of robust patient-level data limited both outcome measurement and evidence-based advocacy. At the same time, the project demonstrated the value of practical, guideline-based mentorship and training approaches that were endorsed and subsequently adopted by the DOH.

Overall, the evaluation suggests that hands-off partnerships can strengthen the foundations of quality NCD care and support sustainable system-level change. Effective collaboration and indirect influence require a nuanced understanding of the partner's context, sustained high-level engagement, and a long-term commitment. Such approaches require different staff profiles, longer implementation timeframes, adapted monitoring frameworks, and strong internal alignment on expectations. If MSF OCB intends to expand this approach, it should develop clearer guidance on suitable interventions, required competencies, support structures, monitoring approaches, implementation timelines, and the minimum conditions needed for success.

KEY RECOMMENDATIONS

FOR MSF

Partnership & Engagement

Recommendation M1: Engage at national level early and balance bottom-up and top-down approaches. This could include agreeing with DOH at higher levels on logframe targets and indicators of the project for joint monitoring and interest to achieve goals.

Project Design & Strategy

Recommendation M2: Clarify objectives and priorities upfront internally if a non-standard operational model is envisaged, including the role of medical and other pertinent advice, and manage expectations with clear communication and planning to external and partners and within MSF.

Recommendation M3: Adopt an extended project timeline, preferably amounting between 5 and 10 years.

Recommendation M4: Select pilot sites strategically (diverse types + near relevant central MoH office, depending on project and country context)

Recommendation M5: Assess baseline health system capacity before mentoring.

Recommendation M6: Read evaluation about similar projects or similar contexts, and capitalize on their lessons learned before designing and implementing an intervention.

Operational & Human Resources

Recommendation M7: Invest in experienced staff (MoH collaboration, long-term mindset)

Recommendation M8: Develop an MSF-tool with HSS-specific indicators, especially if more 'hands-off' or 'light' approaches working within the Ministry of Health is envisaged for the future.

FOR DOH

Recommendation D1: Shift expectations of NGOs and think of opportunities how partners can contribute to sustainable approaches to strengthen the health system.

Recommendation D2: Clarify expectations, roles, and responsibilities of each partner in the partnership beyond what is formally agreed in an MoU.

Recommendation D3: Secure operational support for partners and **sustain baseline capacity at pilot sites**.

Recommendation D4: Facilitate high-level engagement to create support and backing for new initiatives.

Recommendation D5: Improve internal communication to avoid misunderstanding and misalignment with the Department regarding activities implemented in the framework of a partnership.

INTRODUCTION

CONTEXT

South Africa faces a quadruple burden of disease, including HIV/AIDS, TB, NCDs, and maternal and child health issues. The Eastern Cape is among the lower-resourced provinces in South Africa's health system.¹ The whole province struggles with NCD management due to underfunding, limited healthcare access, and structural gaps in facilities. These gaps undermine integrated NCD and HIV care, leading to poor coverage, low-quality services, mistrust in clinic staff, and weak defaulter-tracing systems. South Africa's National Strategic Plan on the Prevention and Control of NCDs 2022-2027 has declared the target for its NCD care as 90-60-50: it is set to ensure that, by 2030, 90% of people over the age of 18 will know whether they have high blood pressure and/or raised blood glucose; 60% of people with raised blood pressure or blood glucose have received an intervention; and 50% of people receiving interventions will successfully bring their blood pressure or blood glucose under control.

Amathole district, though rural and economically underdeveloped, has a high population density and limited healthcare access. The majority of residents are isiXhosa-speaking and face high poverty rates.² The district faces challenges in meeting NCD targets, with high mortality rates and limited resources for diagnosis and treatment.

MSF assessed 11 health facilities in Amathole district in September 2022. In Amathole district, 43% and 36% of deaths among individuals aged 25–64 between 2012 and 2017 were NCD-related,³ and the district has the second-highest incidence of new diabetes cases (26%) in the province. This led to the design of the Eastern Cape Non-Communicable Diseases Project (EC-NCD Project) in Butterworth, Amathole district, more specifically in the sub-districts Mquma and Mbashe.

MSF-OCB EC-NCD PROJECT

The EC-NCD project, launched in 2023, aims to improve quality of care for people living with NCDs through capacity-building and health system strengthening at the primary health care level. Initially, the project medical strategy included integration with HIV and TB care. NCD care in this context has to be understood as prevention, diagnosis, treatment and monitoring of hypertension or type II diabetes. The project faced implementation delays and a one-year accelerated closure by the end of 2026 with clinical activities to finalise around July 2026, leading to an effective implementation time of approximately 1.5 years ([Figure 1](#) Project Timeline).

Care is being delivered by DOH staff. MSF assists in building capacities of nurses and communities on NCDs based on a co-created and DOH-approved curriculum, based on DOH guidelines. Patient access

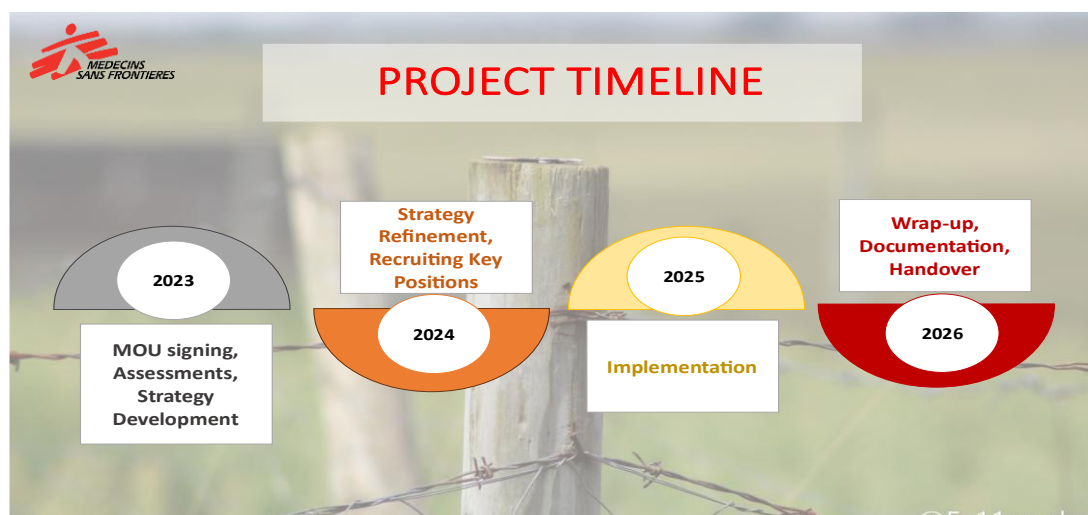
¹ Rheeder, P., Morris-Paxton, A.A., Ewing, R.-M.G., Woods, D., 2017. The noncommunicable disease outcomes of primary healthcare screening in two rural subdistricts of the Eastern Cape Province, South Africa. *African Journal of Primary Health Care & Family Medicine* 9.. <https://doi.org/10.4102/phcfm.v9i1.1466>

² Ngumbela, X.G., Khalema, E.N., Nzimakwe, T.I., 2020. Local worlds: Vulnerability and food insecurity in the Eastern Cape province of South Africa. *Jàmá: Journal of Disaster Risk Studies* 12.. <https://doi.org/10.4102/jamba.v12i1.830>

³ Médecins Sans Frontières, EXPLO, Eastern Cape, August 2022

by MSF staff only occurs during the mentoring process of nurses who underwent an NCD training. This hands-off approach to address NCDs and prioritise systemic improvements has raised concerns about how MSF can uphold medical ethical standards and ensure quality of care when only indirectly impacting patient outcomes.

Figure 1 Project Timeline



The project was structured around four **expected results (ER)**⁴:

ER1: Quality **clinical and programmatic NCD care** is available at PHC level in the selected clinics.

ER2: Patient centred care, community led activism and participatory approach are available through **community engagement** in the area of the target population.

ER3: **Differentiated Models of Care (DMOC)** are available for the target population.

ER 4: **Patient-centric policies and procedures** are adapted at all levels of DOH for better management of NCDs in the country.⁵

Table 1 (next page) shows a non-exhaustive list of planned program activities.

PURPOSE AND INTENDED USE OF THE EVALUATION

PURPOSE

As per Terms of Reference (TOR, see **ANNEX A**), the evaluation aims to assess to what extent the project improved the quality of NCD care in Butterworth and identify key factors that facilitated or hindered progress towards improved NCD care quality. The evaluation generates lessons on collaborating effectively with an institutionalised and regulated Department of Health, focusing on the opportunities and constraints of exerting indirect influence on quality of care.

⁴ Project activities are listed as originally envisaged and are not exhaustive. Some activities were deprioritised, scaled down or discarded for a variety of reasons in the course of the project, others were re-prioritised and scaled up.

⁵ Initially this expected result was: advanced screening and treatment options with a community centric operational model or improved NCD care are available and scaled up beyond Eastern cape through advocacy.

Table 1 Most important planned project activities

CLINICAL AND PROGRAMMATIC SUPPORT

- Correct documentation and recording of DOH indicators.
- Employment of data capturers to record patient-level data for MSF analysis.
- Development of a patient-level data collection-NCD database.⁶
- Implementation Research – Cohort monitoring⁶
- Training of nurses in clinical NCD management according to existing DOH Adult Primary Care (APC) Guidelines and subsequent mentorship by experienced MSF-employed nurse-mentors.
- Training of nurses to ensure adequate referral to higher levels of care and decanting to CCMDD and other DMOC.
- Training and Introduction of point of care (POC) HbA1c testing for diabetes, and a pilot of creatinine testing.
- Treatment pilots and operational research of new drugs, with single-pill combinations for hypertension, and GLP-1 receptor agonists like semaglutide for diabetes.⁶
- Integration with HIV and TB services, e.g. screening tuberculosis patients for diabetes and vice versa.⁶
- Technical and material support. This included the provision of HbA1c POC testing equipment, provision of blood pressure meters and various cuff sizes, weighing scales and height measures to calculate the Body Mass Index (BMI), provision of facility held records (patient files) and file boxes, computers and printers for data capturing at primary health care facilities and PUPs. For the latter, MSF also donated refrigerators, air conditioners and other utilities to meet the DOH requirements for PUP registration.
- Training of CHWs working at PHC facilities.
- Mental Health (MH) sensitisation and support at PHC facility level for NCD patients and nurses.

COMMUNITY ENGAGEMENT AND HEALTH PROMOTION

- Capacity-building and empowerment of a number of assessed Community-Based Organisations (CBOs).
- Conducting workshops and trainings for DOH and other district partners involved in health promotion.
- Health Promotion with wide scope (digital, radio).
- Health promotion at PHC facilities.
- Health Promotion in communities around PUPs.
- Mental health sessions in Healthy Lifestyle groups and Health Promotion activities Mental Health patient support groups.
- Support for community events and campaigns on NCDs (e.g., World Diabetes Day).
- Healthy lifestyle groups and psychosocial support groups through CBOs.
- Training of CBOs and CHWs to implement a package of NCD care at PUPs.
- CBO empowerment and sustainability: Providing training to CBOs on empowerment, sustainability, advocacy, NCD, and Mental Health facilitation.

⁶ Eventually not implemented

EXPANSION OF DIFFERENTIATED MODELS OF CARE

- Set up of external PUPs i.e., PUP that are not located on the premises of a PHC facility, but PUPs in more rural and remote settings.
- Facilitate Chronic Medication Dispensing and Distribution (CCMDD), a DOH programme that provides an alternative mechanism to facilitate access to medicines for stable patients by dispensing them at PUPs closer to their homes or workplace.
- Supporting Healthy Lifestyle groups (in selected PUPs).
- Logistical support for drug delivery in remote communities in catchment area of external PUPs.
- Training and supervision on screening and prevention of diabetes and hypertension for CHWs and CBOs working at PUPs.
- Providing CHWs that underwent training with blood pressure meters to screen for hypertension.

Advocacy and communications to support patient-centric policies and procedures at provincial, district and national level

- Development and dissemination of knowledge products and evidence (Implementation Research, Operational Research, toolkit, evaluation). 6
- Collaboration with CSOs and medical societies. 6
- Public communication through all forms of media.
- Most important advocacy themes:
 - Revision of guidelines for integrated and patient-centered care.
 - Inclusion of newer molecules and POC labs in PHC guidelines.
 - Improved patient monitoring and data systems.
 - External PUP models with less strict requirements.

INTENDED USE

This evaluation of the Eastern Cape Non-Communicable Diseases (NCD) project has been commissioned by the Southern Africa Cell of Médecins sans Frontières (MSF) Operational Centre Brussels (OCB) and was managed by MSF's Stockholm Evaluation Unit (SEU). It was overseen by a Consultation Group that included the commissioner and various advisors from the Southern Africa Medical Unit (SAMU) who were closely involved in the project, as well as key project management staff.

This final report serves as a critical knowledge product for MSF OCB and the wider movement. The evaluation findings in this report are meant to guide MSF-OCB in designing and implementing future interventions in contexts where a hands-off approach is the chosen or most appropriate option for MSF. Evaluation insights on the effectiveness of indirect influence, local-level advocacy, and capacity-building may inform strategic choices for health system strengthening, not as a primary objective in itself, but rather as a vehicle to direct quality of care improvement in resource-constrained contexts. This will be mostly applicable in settings with health systems under strong government regulations.

EVALUATION SCOPE AND FRAMEWORKS

SCOPE OF THE EVALUATION

The evaluation covers the Eastern Cape NCD project's efforts to improve the quality of hypertension and diabetes care in Butterworth. It examines both the project's contribution to changes in quality of care and its approach of working through the Department of Health to support those changes, including factors that facilitated or constrained progress.

The evaluation includes:

- Support to selected PHC facilities (including clinical mentoring, selected strengthening of health processes and systems, and donation of equipment)
- Health promotion by community health workers (CHWs) in the selected PHC facilities
- Expansion of DMOC through opening of new Pick Up Points (PUPs)
- Advocacy at provincial and district level

Given the focus of the evaluation on the partnership with DOH at provincial, district, and sub-district level, the late start of the project, and project closure earlier than planned, the evaluation of national level advocacy is scoped out because outcomes are likely to be limited. Aside from capacity-building of CBOs, other community-based and digital-based health promotion and community engagement activities have been scoped out. Only health promotion activities within PHC facilities have been included, as it directly relates to patient management.

Reflection on the ethical implications of the hands-off approach was not included in the Terms of Reference and therefore falls outside the scope of the formal evaluation. Nevertheless, given the specific nature of the Eastern Cape NCD project within MSF, and at the request of the commissioner, the evaluator considered the ethical dimensions of this operational model. These reflections are presented in Annex G.

The evaluation covers project implementation from January 2023 until June 2026.

EVALUATION FRAMEWORKS

This section describes the evaluation frameworks used to examine the project's contribution to improving the quality of hypertension and diabetes care in Butterworth, as well as the role that collaboration with the Department of Health (DOH) played in supporting or constraining these improvements.

BERGEN MODEL AND PARTNERSHIP WITH DOH

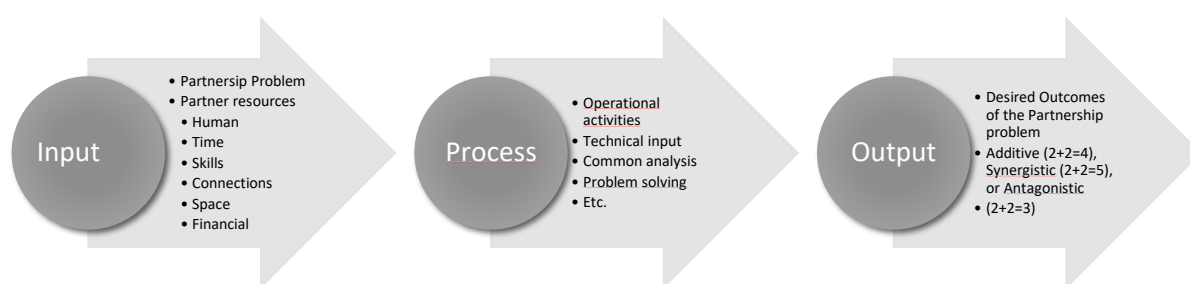
The TOR emphasises generating “lessons on collaborating effectively with a strong DOH”⁷ and “understanding the opportunities and constraints of a hands-off model”. Given the central role of the partnership in the project's design and Theory of Change, the evaluation draws on a partnership

⁷ Strong DOH in this context means: well-established policies and procedures that are standardized and rolled out nationally and provincially, however, not necessarily well implemented activities.

framework (the Bergen Model of Partnership) to understand how collaboration between MSF and the DOH influenced implementation and results.

The Bergen Model assesses partnerships through three dimensions⁸: Inputs, Process, and Outputs (Figure 2). In this evaluation, Inputs refer to the initial problem that the partnership wants to address, and the resources that each actor contributed. Process examines how the partnership functioned in practice, including relationship management and activities supporting NCD care improvement. Outputs examine the extent to which the partnership generated additive, synergistic, or antagonistic effects. The model helps explain how the project approach of working through the DOH shaped implementation and how that contributed towards improved NCD care.

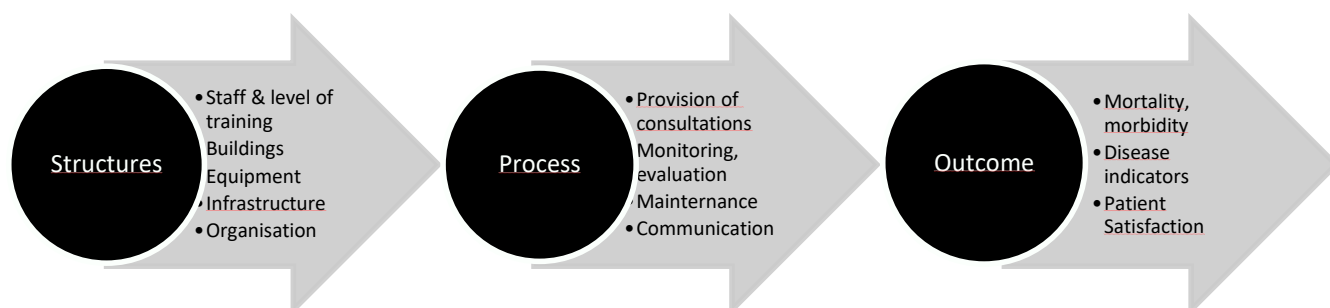
Figure 2 The Bergen Partnership Model



DONABEDIAN MODEL AND QUALITY OF CARE (QOC) FOR NCDs

To assess changes in the quality of NCD care, the evaluation uses the Donabedian Model (Figure 3), which examines Structure, Process, and Outcomes. Structure includes the availability and adequacy of facilities, equipment, medicines, and trained staff. Process assesses how care is delivered, including clinical practices and patient-provider interactions. Outcomes focus on results of care for patients and providers. This includes effects on NCD detection and diabetes control, as well as intermediate outcomes such as patient experiences and staff satisfaction. Together, these dimensions provide a systematic framework to assess the project's contribution to improvements in quality of care.

Figure 3 The Donabedian Model

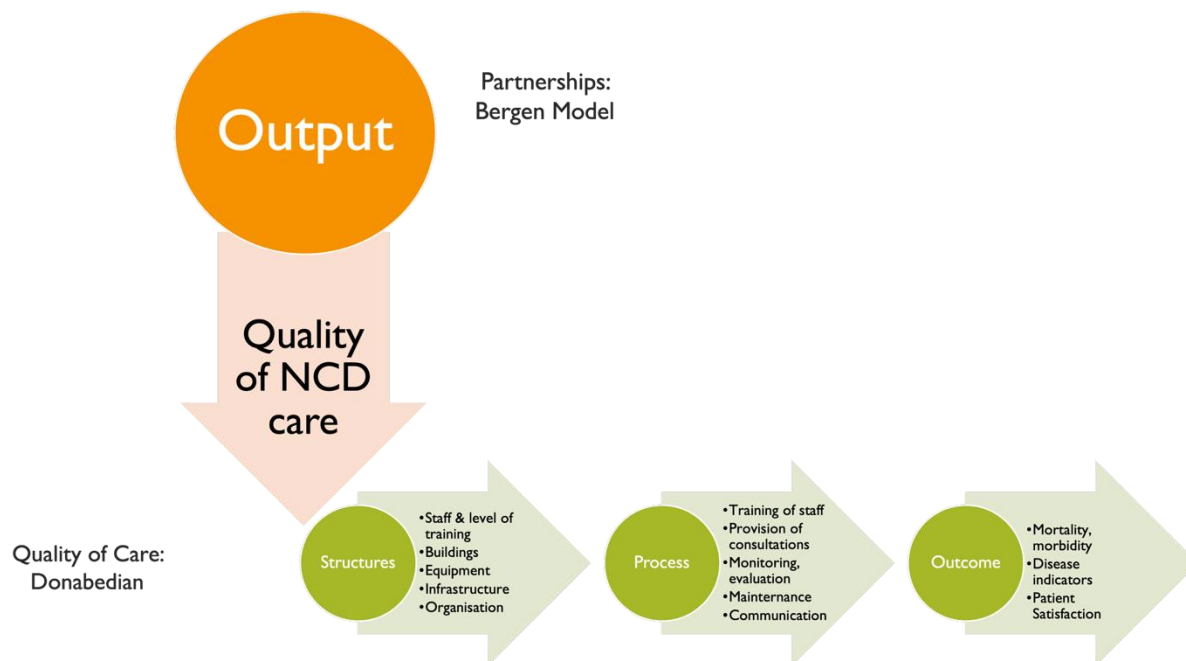


⁸ Corbin, J. H. (2006). Interactive processes in global partnership: a case study of the global programme for health promotion effectiveness.

USE OF THE TWO FRAMEWORKS

The two frameworks are used in a complementary manner. The Donabedian Model provides the primary framework for assessing changes in the quality of NCD care, while the Bergen Model helps explain how collaboration between MSF and the DOH influenced the implementation of project activities and, in turn, progress towards those changes. Together, they support an assessment of both the results achieved and the factors that facilitated or constrained them. (Figure 4).

Figure 4 The two frameworks combined



ELABORATION / RE-FRAMING OF EVALUATION QUESTIONS

The evaluation questions are based on the TOR (**ANNEX A. TERMS OF REFERENCE**), but tuned to the discussed evaluation frameworks with the Bergen Model for partnerships as the overarching framework. A cross-cutting question with sub-questions have been added. The three main evaluation questions from the TOR have been revised to comply with the Bergen Model. Detailed evaluation questions with sub-questions are included in **ANNEX B EVALUATION MATRIX**.

APPROACH AND METHODOLOGY

GENERAL EVALUATION APPROACH

A mixed-methods approach has been adopted to ensure a comprehensive, balanced, and validated evaluation process. This approach supports triangulation and enhances the credibility of findings.

EVALUATION ETHICS

Ethical Considerations. This evaluation adheres to principles like voluntary participation, informed consent, anonymity, confidentiality, and harm prevention. Participants—drawn from stakeholder groups (per Table 1)—include adults (18+) with non-communicable diseases (e.g., diabetes, hypertension). Verbal consent was obtained before interviews or focus group discussions (FGDs), with audio recording only if explicitly approved. Quotes remain unattributed, and participants were free to opt out anytime.

Process. Questions for patients focus on care experiences, while DOH staff address MSF's contributions (training, equipment) or the partnership. The consultation group (CG) reviewed all questions. An on-call MSF external FGD facilitator (not known by patients as being MSF staff) has received a briefing on informed consent and opt-out of participants.

Sampling & Approvals. Sampling took into account diversity (gender, age, vulnerability, minority status). As this is an evaluation (not research), MSF ethical clearance was not required.

Data Security. Data are stored on a GDPR-compliant, end-to-end encrypted Swiss server until the contractual evaluation expiry date for accessibility of data.

DATA COLLECTION AND ANALYSIS METHODS

The data collection methods in combination with the analytical framework, and -approaches are well suited to provide answers to the evaluation questions and allow for triangulation. The evaluation matrix (ANNEX B) summarises the approach, in which the evaluation questions and sub-questions are translated into indicators or milestones, information sources and methodologies. It is designed towards producing identifiable elements in the interventions that worked well, and clarify why, while also identifying what can be replicated beyond the context of the programme.

Secondary data have been collected through desk review of relevant project documents, external written sources and patient file review.

Primary data was collected using key informant interviews (KIIs), focus group discussions (FGDs), direct observation of consultations, and facility assessments. Part of KIIs were done remotely through video calls, while another part was collected on-site during the project visit.

The purpose of the project visit was to get a better understanding of the broader context of the project, as well as data collection through interviews and direct observation. The project visit took place from 4-20 June. It included a visit to four of the five MSF-supported sentinel clinics.

Evidence from each data source was systematically cross-checked against the other data sources. Contrast and consistency between data sources are equally informative. Where there is contrast between data sources, an explanation has been sought by further analysis, or by asking sources directly for more clarification.

DESK REVIEW OF DOCUMENTS AND OTHER AVAILABLE DATA

Desk review comprised:

- Project documents (project proposals, logical frameworks, sitreps, annual reports, project visit reports, correspondence with DOH, meeting minutes, contracts, donation certificates).
- Routinely collected monitoring data (DOH aggregated data on NCD indicators, MSF project databases, MSF project reports).
- MSF guiding documents (OCB strategy, OCB medical reports, MSF medical guidelines, MSF and OCB policies, and others).
- DOH guiding documents (e.g. guidelines and other normative documents), policies, SOPs.
- MSF and external literature and documentation of similar experiences.

KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSIONS

Key informant interviews and focus group discussions allow to delve deeper into the evaluation questions and explore the deeper mechanisms behind achieved results and observed challenges. Given the paucity of quantitative monitoring outcome data and relatively scarce project documentation in terms of MSF-DOH exchanges, this evaluation relied heavily on interviews and focus groups. **ANNEX E** contains a tabular overview of KII and FGD, participants and their stakeholder groups.

The sampling frame was purposive. Only stakeholders with good current and/or past knowledge of the project are likely to yield useful information. Gender diversity was considered in sampling, in this case paying attention to male participation. This resulted in 19% of males and 81% females participating in interviews and FGDs. The format of the interviews to collect feedback from stakeholders was semi-structured around the evaluation questions (see KII and FGD tools in **ANNEX C** and **ANNEX D**). For patients or health care providers (e.g., nurses, CHWs), an FGD was the most suitable way to collect data and retain efficiency.

Focus groups were held face-to-face in English or isiXhosa. A local translator / focus group facilitator, who participants did not associate with MSF or DOH, worked under supervision and coaching of the evaluator. The language for KIIs was English. KIIs were done online or face-to-face, depending on feasibility, location and circumstances such as internet connection. All FGDs and KIIs have been recorded, transcribed and (if applicable) translated into English for analysis.

Documents and transcribed KIIs and FGDs were analysed using a framework of codes that represent relevant keywords and themes related to the evaluation questions as well as themes emerging during analysis. Qualitative data were analysed using MAXQDA, including its AI assist module.⁹

Quantitative data from routine project monitoring data were explored to triangulate evaluation questions and, where relevant, identify trends during the project period. Data from project facilities were compared with those from non-project facilities, when the latter were available.

OTHER PROJECT-BASED DATA COLLECTION METHODS

Direct observation. Direct observation of project activities is another method used in this evaluation. This comprised observations of consultations at primary health care clinics, Chronic Medication Dispensing and Distribution (CCMDD) medicine collection at PUPs and observation of a joint DOH and MSF training of CHWs.

Facility assessment. Visits to primary health care clinics also included a brief facility assessment, including assessment of patient flow, pharmacy visit, filing rooms and facility PUPs. Checklists were used for observation of consultations, and for the assessment of facilities (see ANNEX F).

Information from direct observations and facility assessments was used to triangulate the information from KIIs and FGDs.

Facility-Held Record review. Samples of 10 patient files, known as facility-held records (FHR), have been reviewed in each of the four visited PHC facilities. Sampling frame was FHRs of patients with NCDs who had made more than one visit to the facility. Because filing systems do not have a register to identify NCD patients, a random selection could not be made, and readily available files were used. The files were then assessed to what extent the first visit information was complete, to what extent the last (most recent) visit information was complete, and to what extent they contained essential elements (like a HbA1c result, a random glucose, and blood pressure measurement).

These supplementary data collection methods offer additional insights on how NCD care in the project facilities works in practice.

LIMITATIONS

While purposive sampling is effective for targeting knowledgeable participants it can introduce selection bias. Certain perspectives may be over- or under-represented which could influence the findings and limit the extent to which they reflect the range of experiences and views of all stakeholders involved in or affected by the project. A relatively low number of patients has been interviewed about their experience. Due to long waiting times, not many patients are prepared to spend additional time in a KII or FGD. A greater number of patients would make it easier to discern common themes around access, (perceived) quality of care and patient experience in the sentinel clinics that MSF supported. It is therefore difficult to draw firm conclusions about patient experience,

⁹ VERBI Software. MAXQDA 2026. (maxqda.com)

critical outcome-level data available in this evaluation. Nonetheless, the interviews with patients contribute to triangulation with information from other stakeholders and reviewed documents.

The limited availability of individual-level outcome data is a significant limitation. While the evaluation draws on available indicators related to NCD detection and diabetes control, these data must be interpreted with caution because they may be incomplete. The assessment of the outcomes dimension of quality of care therefore also relies on patient experience and staff satisfaction as intermediate indicators. Consequently, the evaluation provides stronger evidence regarding changes in the structural and process dimensions of quality of care than regarding outcome-level changes.

The quality of routinely collected aggregated indicator data from the DOH register (the 'tick register') is a concern. For example, data are not being entered when there is a power outage. This may lead to data not entered at all, or a backlog that is hastily entered, leading to inaccuracies. The concerns over missing data in routine DOH health data in Eastern Cape has been reported elsewhere.¹⁰

Non-random selection of FHRs patient files is another limitation. Therefore, the observations coming from these FHRs are not generalisable, and can only provide a preliminary impression on the quality of record keeping and quality of care. Conclusions based on file review must be interpreted with caution.

These limitations could introduce biases influencing the evaluation's conclusions. For example, participants with positive experiences might be more inclined to participate in interviews or focus groups, potentially leading to an overly optimistic view of care quality or the DOH-MSF partnership's effectiveness. Conversely, participants might under-report challenges, resulting in an incomplete understanding of areas needing improvement. However, a safe space was always created, emphasising confidentiality to counter this underreporting.

Despite these limitations, the overall findings remain robust due to the mixed-methods strategy. This approach integrated both qualitative and quantitative data, enhancing credibility. Using diverse data sources like interviews, focus groups, site observations and quantitative metrics allowed for triangulation, mitigating potential biases from any single method or source.

¹⁰ Thabethe, S.S. & Mathews, V.E., 2024, 'Quality of routine health data in DHIS2 in South Africa: Eastern Cape province from 2017–2020', *South African Journal of Information Management* 26(1), a1903. <https://doi.org/10.4102/sajim.v26i1.1903>

FINDINGS

EQ1 PARTNERSHIP INPUTS

To what extent were the inputs provided by MSF and the provincial DOH sufficient to support the partnership objectives?¹¹

The partnership aimed to strengthen NCD care through a collaborative, hands-off technical assistance model aligned with DOH priorities. Both partners shared a strong initial interest in improving NCD outcomes, with DOH welcoming MSF's support and valuing MSF's unique focus on NCDs. This mutual interest helped solve initial communication gaps and misaligned expectations.

MSF provided staff capacitation, funded and developed trainings, implemented mentorship, supported reviews, organized awareness campaigns, assisted community mobilization, funded external PUPs, and supplied HbA1c POC equipment. DOH provided access to staff, facilities, data, consumables, and endorsement of interventions, and facilitated MSF participation in reviews.

Limitations affected the adequacy of inputs in three areas. Data, with DOH's NCD systems lacking individual-level information and MSF reporting insufficient access to data early on, contributed to initial implementation delays. Staffing shortages at DOH's side and high workload affected mentorship and daily service delivery. At MSF's side, difficulties in finding experienced project management staff also contributed to implementation delays and initial lack of strategic direction. Challenges with logistics and infrastructure, including drug stock-outs and water/electricity interruptions, hindered facility operations.

Contextual factors also influenced partnership inputs: the 2024 National Assembly elections slowed DOH decision-making and delayed formal permissions; DOH's precarious financial position led to unpaid suppliers and vacant posts; and the 2025 PEPFAR withdrawal further strained staffing, data capture, and integrated care efforts.

MSF's inputs were generally sufficient for strengthening QoC within supported facilities, but their small scale, the smaller-than-planned number of new PUPs, and limited staff support reduced broader effects.

START-UP AND CLARITY OF OBJECTIVES

MSF's primary partnership objective was to foster effective and efficient collaboration with the Eastern Cape Department of Health to strengthen healthcare services for Non-Communicable Diseases, mainly diabetes and hypertension. These services were to be integrated with care for HIV, tuberculosis, and mental health support. This collaboration aligns with the DOH's strategic plan and national health priorities, ensuring interventions were sustainable and scalable beyond the project's lifespan. MSF and DOH saw the partnership as a mutual starting point, with both partners being eager to improve NCD outcomes, particularly given the poor NCD indicators in the Eastern Cape Province.

¹¹ For the sake of clarity, the formulation of EQ1 has been slightly changed here compared to the original in the inception report and evaluation matrix.

DOH expressed a clear desire for assistance, particularly in addressing improving NCD data management. They saw MSF as a partner to help navigate crucial issues affecting their national health system and were open to collaboration.

One DOH representative highlighted that MSF's interest in NCDs was unique among NGOs, which typically focused on HIV and TB. The DOH was actively seeking solutions for NCDs and welcomed MSF's involvement, viewing it as an opportunity to improve performance indicators that they were struggling with. They appreciated MSF's approach of working within existing frameworks and integrating chronic diseases, rather than creating new, unsustainable systems. This mutual interest in improving NCD care formed a strong starting point for the partnership, with the DOH explicitly stating that they were looking for a way around their challenges and were open to MSF's support.

"I can confidently say this, there's been no other NGO that I can think of in the history of the country that has focused so intently on NCDs." (KII DOH, pos.182)

The approach MSF took for this particular project was to work completely through the DOH and provide technical assistance, rather than focusing on the delivery of health services. Project documents call this a 'hands-off' approach, which this report will use as standard term. The hands-off approach should be understood as a pragmatic response to the difficulty of operating hands-on in South Africa (e.g. regarding registration/work-permit requirements for international medical staff), not purely a deliberate partnership-design choice¹². In practice, despite 'hands-off' terminology, MSF did engage to some extent in clinical care: in the course of the project MSF negotiated a change in the MOU that allowed South African MSF nurse-mentors to assist the DOH nurse-clinicians with clinical activities, to relieve some of the heavy lifting that DOH nurses were doing on a daily basis.

It wasn't smooth sailing for the project from the start. Apart from the odd rough seas, frequent doldrums characterised the start-up phase. The project opened in January 2023 without a proper MOU and operated for 10 months before an MOU was signed in October 2023. It was also launched without permanent leadership — Project Coordinator (PC), Project Medical Referent (PMR), Human Resources manager, and logistics manager were all interim, causing a 7-month period without much direction. Political factors, such as vacant leadership positions within provincial health authorities, caused delays in implementation and decision-making. Also lack of clarity internally within MSF and misunderstandings between MSF and DOH contributed to these delays.

From the perspective of MSF, there was a lack of clarity and alignment regarding project expectations from the outset, with different individuals and organisational layers holding varying understandings. Two MSF internal factors seemed to have played a role in this, according to MSF staff interviewed: 1) OCB's programme of recentralisation, and 2) the lack of experienced MSF staff at project level.

¹² Some interviewees noted that initial discussions around the project were influenced by MSF's experience with community-based HIV models and an ambition to test community-based approaches to NCD care. However, MSF soon recognized that strengthening clinical skills and improving quality of care at facility level were necessary prerequisites for many community-based interventions to be effective. This led to a greater emphasis on clinical capacity building within primary health care facilities. As MSF sought to strengthen these aspects more directly, it encountered regulatory and operational constraints that limited its involvement in direct service delivery.

Recentralisation. The OCB Field Recentralisation Programme (FRC), initiated in 2020 in Southern Africa, essentially means shifting decision-making authority closer to the medical-humanitarian act and its beneficiaries. An evaluation of this initiative found that, next to positive effects, there was confusion amongst staff about the boundaries of FRC and other ongoing change initiatives.¹³ This might have played a role. An overly rigid initial interpretation of recentralisation by some project management staff resulted in lack of consultation with advisory units, and scarce communication with supervisory levels. This had an impact on the quality of strategic decision-making and thus on the direction the project took initially.

Delays in finding experienced MSF project staff. Many MSF respondents have highlighted the difficulties to find experienced management staff for this project. Some have mentioned that the project approach taken, i.e. working through DOH, requires MSF-experienced management staff with a very good understanding of what MSF can and cannot do. Frequent and long-term vacancies compounded this problem. Also finding South African clinical staff with solid NCD experience proved to be challenging. Major work has been done nationally in equipping nurses to manage HIV and TB to the neglect of NCD care. The project's integration of two areas—NCDs and health systems strengthening—that fell outside OCB's strategic priorities, coupled with its location in Southern Africa (a region of lower emphasis), may have posed challenges in promptly securing experienced staff and maintaining consistent institutional engagement.

Expectations between the project and higher MSF OCB management layers regarding the time to show impact were not aligned. Project staff underestimated the time it takes a hands-off project to produce results, compared to a traditional hands-on modus operandi, particularly when it concerns an NCD project with behavioural and health systems strengthening components.

The project's formalization and the MOU with DOH did not fully align expectations, which caused delays. A stable, experienced team might have yielded different outcomes. One MSF staff member noted that the seemingly rigid interpretation of the project's initial 'hands-off' approach strongly influenced its trajectory, with a tendency to respond to DOH requests, sometimes agreeing to deliver outputs that MSF was not equipped to provide.

This led to frustration with both partners, particularly concerning promises made to the DOH about its request to build a data tool for a country-wide monitoring and evaluation system that was able to track NCDs at individual patient level, very much like the systems DOH uses to monitor HIV and TB care. This task was beyond MSF's role in the partnership and beyond its expertise, and one that was not budgeted or properly discussed throughout the organisation's hierarchy, probably due to an incomplete medical strategy and project leadership that was not yet fully established. Conversely, the DOH expressed frustration where the DOH program manager for NCDs felt that MSF's initiatives were not directly linked to the DOH's reporting indicators.

Examples from project documents confirm misalignment of expectations between MSF and DOH regarding the operational strategy mentioned in some interviews. DOH expected a health systems

¹³ Amjad Idries, Javier Gabaldón, Sheila Debly-Magnus and Vanessa van Schoor. MSF-OCB Field Recentralisation Programme. MSF Stockholm Evaluation Unit, March 2023.

approach with scaled MSF involvement in primary care clinics and expressed disappointment at MSF's 'proof of concept' strategy, which meant deploying activities in a small number of sentinel clinics. MSF accommodated DOH's wish to scale-up by organising activities at the district level (e.g. trainings) or supporting district wide activities logistically.

SUFFICIENCY OF PARTNERSHIP INPUTS

Both partners provided considerable inputs into the partnership, including both tangible and less tangible inputs. An overview of the tangible inputs of each partner is listed in Table 2 (next page).

MSF's contributions included capacitating staff, organizing and funding training sessions, and implementing mentorship programs to ensure sustained improvements in patient management. MSF's interactive and case-based classroom teaching approach provoked such enthusiasm with DOH, that it applies this approach also to other trainings. MSF also funded participation in conferences for DOH staff. They also supported district and sub-district reviews, providing input that helped improve provincial performance. Other MSF inputs included facility-level advocacy and technical input for improved workflow and patient experience, and providing feedback to subdistrict management regarding facility-level challenges that required action by DOH management. MSF supported awareness campaigns, such as World Diabetes Day and World Hypertension Day, often initiating and organizing these events in collaboration with the DOH and community-based organizations. MSF also assisted in community mobilization about diabetes and hypertension, by developing promotional materials, as well as in funding new external PUPs. Furthermore, MSF provided rapid test equipment for HbA1c, which was adopted by all facilities in Amathole, including district hospitals (see [Table 1](#) for more details on project activities). The total financial contribution of MSF was between EUR 1,1 and 1,4 million annually, one of the smallest country budgets in MSF OCB's portfolio. In 2024, MSF only spent less money in Poland.

The DOH's enthusiasm, particularly from the Director General of NDOH, and the green light from various authorities, facilitated engagement and implementation of joint initiatives. The DOH's role was crucial in providing the playing field (access to key staff, facilities and data), procure essential consumable inputs (medicines, medical materials) and endorsing interventions. District and provincial management ensured that MSF's activities were welcomed at the facility level. However, there were instances where MSF had to compromise on the scale of their intervention to gain traction with the DOH, as being too small could result in being ignored. DOH EC budget in 2023/2024 was ZAR 29,1 billion, approximately EUR 1,5 billion. There are no public disaggregated financial DOH data available per district.

Table 2 Tangible inputs provided by each partner

MSF	DOH
General staffing	
Coordination staff (Project Coordinator, Logistics coordinator, Financial coordinator) Managing medical staff (Project Medical Referent, Nurse Activity Manager) Support staff (log, drivers, data)	Coordination staff at various levels (e.g. NCD manager, district manager, sub-district manager)
PUPs	
PUP Containers Equipment: • Fridges • Air conditioners • Laptops • BP meters • Scales Refurbishments	PUP buildings or containers PUP equipment Drugs
PHC Facilities	
Donated equipment PHC facilities • BP meters and cuffs • HbA1c POC testing equipment and strips • Scales • Height measures Refurbishments	Equipment • BP meters • Glucose meters • Scales • Ultrasound • X-ray Drugs, i.v. fluids, syringes, other consumables Facility staff (Operational Managers, nurses, CHWs, pharmacist, pharmacist assistants, cleaners, receptionist, etc.) Buildings and amenities
Data and filing	
Staff (Epidemiology Activity Manager, temporary data capturers) Computers, laptops Facility-held records Filing boxes	Data capturers Computers, internet Facility-held records Filing boxes, cupboards
Capacity building	
Staff: Nurse mentors Training and mentoring program NCD management for nurses Training CHWs in NCDs Skills training CHWs	Basic nurse training CHW trainings Guidelines, policies and SOPs

A significant concern was the inadequacy and quality of data systems, particularly for NCDs, which persists to date. MSF staff expressed long-standing concerns about the lack of quality-of-care data and the DOH's reluctance to let MSF run a parallel data system. While there is recognized need and verbal commitment from DOH at various levels to address NCDs, this has not translated into sufficient resources and actions to put a robust monitoring data system in place, comparable to *tier.net* for HIV.

DOH personnel acknowledged the need for better data and were keen on collaborative projects with MSF to establish NCD data capture systems. DOH's own data systems collect no individual-level data on NCDs, making it impossible to monitor its 90-60-50 targets with routine data collection. This poses a serious limitation on monitoring the quality of the DOH NCD interventions as a whole. In addition, there are some indications that access to data given by DOH was insufficient for the partnership to work effectively, certainly in the beginning. For instance, there are MSF reports mentioning no access to certain DOH data to establish a baseline, which constrained MSF monitoring and target setting, which would have been to the benefit of both partners.

MSF staff and DOH personnel frequently highlighted the critical issue of staff shortages as a primary impediment to effective delivery of quality healthcare and program implementation. This scarcity of human resources is not only a challenge for the DOH but also affects MSF's operations, leading to difficulties in sustaining mentorship programs. The problem is exacerbated by an overwhelming workload for DOH nurses who do consultations in the PHC facilities. They often see more than double the normal patient load, leading to compromised quality of care despite training efforts. Given these staff constraints, one could wonder if MSF input should have included more human resource inputs, despite its hands-off approach. Additional clinical nursing staff to (temporarily) fill the vacancies that DOH could not fund, could demonstrate how trained and mentored nurses would impact quality of NCD care in a clinic that was staffed according to DOH's own standards. Similarly, dealing with a backlog in proper FHR filing, MSF could have hired staff to help clear the situation, and then leave it to DOH to maintain the system.

A further consideration relates to the availability of mentoring capacity within the partnership. While MSF conducted a Training of Trainers (TOT) that included the district's only DOH nurse mentor, a single mentor was insufficient to cover the training and mentoring needs across the district. As a result, the human resources available to support the transfer and expansion of mentoring skills within the DOH were limited.

Logistical and infrastructural challenges also significantly hindered quality healthcare provision. These included frequent drug stock-outs, which were often beyond the control of local facilities, and basic infrastructure problems like lack of water and electricity, forcing some facilities to reduce operating hours.

DOH's input in providing access to staff and facilities was what it could do within the financial and human resource challenges of its own system in Eastern Cape. However, the constraints proved to be too limiting for e.g., the mentoring programme to yield its result in daily clinical practice.

Although most of MSF partnership inputs as described above seem in itself sufficient to support DOH in strengthening NCD quality of care *in the supported facilities*, it is difficult to establish whether MSF's interventions were at sufficient scale to amplify their achievements beyond the supported facilities.

DOH initially expressed some disappointment at the scale of MSF's initiatives in Amathole District, and while MSF wanted to demonstrate and pilot certain approaches and then advocate for change, early project closure prevented this advocacy to come to fruition. Lastly, although PUPs helped stable patients accessing their medication close to where they live, and provided additional services, their number is much smaller than originally planned partly due to DOH's lengthy accreditation process, and may not be sufficient to substantially decongest patient-load at the PHC facilities and increase access for remote communities. More on outcomes of the partnership can be found in EQ3 Partnership output, p. 34.

INITIAL CONSTRAINTS AND CONTEXTUAL FACTORS

Many (initial) constraints and contextual factors that weighed on the implementation of the EC NCD partnership have already been discussed in the previous sections of this chapter. However, there are three higher-level contextual factors mentioned by MSF and DOH staff that influenced the implementation and course of the project contributed to the earlier noted challenges.

MSF staff cite the National Assembly elections in May 2024, and suggest that it made communication with DOH difficult and DOH decision-making in the run-up to these elections slow, resulting in planning challenges. For instance, the electoral climate caused delays in formal permissions for media communication postings by the DOH. While project development and implementation continued, it showed "slow progress in electoral context" according to one of the quarterly project reports. The same report also mentioned that field access during the elections was limited, resulting in delayed budget spending. Despite these challenges, MSF continued its project development and strategy discussions, and sought to engage with the DOH.

Another significant constraint was the precarious financial position of the EC DOH. Financial mismanagement, with billions of Rand owed in medico-legal litigation, had led to understaffing and DOH defaulting on paying its various suppliers in the course of 2023. The Department owed ZAR 4 billion to suppliers of medicines and medical supplies, including medical implants, equipment, oxygen, and anaesthetic gasses. The department could not pay all its debts due to limited funds meant for goods and services. Many staff positions remained vacant, putting further pressure on service delivery, which contributed to concerns about continuity and quality of care.¹⁴ The Eastern Cape DOH remains committed to achieve national objectives and the South African treasury has allocated ZAR 1.3 billion for a range of DOH activities related to staff payment, service backlogs including antiretroviral therapy and TB, medicines and other goods and services, in the financial year 2023/2024.¹⁵

Perhaps the most significant contextual factor to take into account about the functioning of the health care system in Eastern Cape and, indeed in the whole of South Africa is the US funding withdrawal, particularly PEPFAR, in early 2025. The government made a self-reliance plan, and allocated a \$45

¹⁴ Luvuyo Mehlwana. MTN temporarily pulled plug on Eastern Cape Health due to non-payment. Spotlight, 4th September 2023. <https://www.spotlightnsp.co.za/2023/09/04/mtn-temporarily-pulled-plug-on-eastern-cape-health-due-to-non-payment/> accessed 27.07.2026

¹⁵ Vote 03, departmental allocation. <https://www.treasury.gov.za/documents/provincial%20budget/2023/3.%20Estimates%20of%20Prov%20Rev%20and%20Exp/EC/Vote%2003%20-%20Health.pdf>

million emergency fund to address gaps created by the withdrawal of PEPFAR funding. Despite these actions, the US funding cuts had an impact on the funding situation of the South African health care system at large as well as the programmes run by many NGOs active in the country and in Eastern Cape. It dealt another blow to areas that were already affected by the pre-existing financial problems. MSF Staff mentioned immediate reductions of data capture staff, and staff reductions across a range of positions for the HIV and TB programs, creating further challenges and barriers to development of integrated care. Withdrawal of staff due to lack of funding meant further pressure on the remaining staff with increased patient load and decreased capacity to take on new learning and responsibilities in NCD care. Also, the partner that implemented the CCMDD programme that allowed patients to get their medication at PUPs was funded with US money.

EQ2 PARTNERSHIP PROCESSES

To what extent did the processes established by MSF and the provincial DOH support the partnership objectives?¹⁶

The partnership relied on few formal enabling elements, mainly the MoU and regular coordination and review meetings. The MoU outlined responsibilities such as cooperation, access to facilities, joint program review, and mechanisms for procurement and stock access; a 2025 amendment allowed MSF involvement in patient management and access to FHRs. Regular meetings at sub-district, district, and provincial levels facilitated operational discussions, sharing of progress, and coordination of implementation. Ad-hoc meetings supported emergent needs and information exchange.

Informal day-to-day interactions, regular check-ins, and MSF's efforts to blend into DOH work culture were important for maintaining relationships. Both partners emphasized co-planning and co-implementation, with MSF involving DOH and CBOs, and DOH endorsing training and mentorship content. Trust, open communication, and transparency were highlighted as key elements.

Constraining processes included inconsistent communication across DOH levels, limited provincial and national engagement, and uncertainty about decision-making mandates. Early communication gaps occurred when MSF was unsure which DOH level required information, and that DOH permissions needed to be arranged top-down. Data collection was hindered by reluctance to share data and facility-level recording issues.

MSF navigated constraints by adapting its approach, relying on experienced staff, establishing the Amathole District Partners Forum, and gaining buy-in for interventions such as HbA1c POC testing and mentorship. Relationships often recovered after disagreements, and collaboration at district level remained strong.

¹⁶ For the sake of clarity, the formulation of EQ2 has been slightly changed here compared to the original in the inception report and evaluation matrix.

ENABLING ELEMENTS IN PARTNERSHIP PERFORMANCE

There were few formal enabling elements to support the partnership. The formal side includes the MOU, regular coordination meetings with the sub-districts, and the DOH quarterly meetings.

The MOU outlines specific responsibilities, including communicating intentions, ensuring cooperation, allowing access for MSF staff to DOH facilities and parts thereof, regularly reviewing joint programs, and supporting initiatives. The MOU also details mechanisms for medicine procurement, license co-application, access to DOH medical stock, and collaboration with academic institutions. An amendment of the MOU from 2025 adds the permission to MSF to be involved in patient management, to have access to FHRs, to interview patients, take photographs in facilities (all with informed consent) and that parties comply with privacy legislation.

The second main formal aspect of the partnership, after the MOU, was the regular set of coordination and review meetings between MSF and the DOH. MSF staff made efforts to visit sub-district offices monthly to provide updates and ensure DOH support for their activities. DOH from its side invited MSF to important meetings such as the quarterly reviews, and requested regular reports. These regular meetings focused very much on operational issues, and as such they were essential for discussing implementation, impact, sustainability, capacity building, and sharing experiences and lessons learned according to MSF interviewees and meeting minutes. Sometimes, also more formal issues were raised such as MSF strategies, joint planning and audits, and communication protocols. Ad-hoc meetings were also crucial for addressing emergent operational needs and maintaining proper communication beyond scheduled reports. Both parties committed to sharing relevant information, including progress reports and any health-related issues that arise from their statutory functions. As stipulated in the MOU, senior officials¹⁷ had meetings at least twice annually. Such meetings, and dedicated managers/coordinators at both sides, were vital for tracking MOU implementation, advising senior officials, and managing information exchange.

While formal agreements, such as the MOU, were slow to materialize, informal, day-to-day interactions and regular check-ins were crucial for maintaining relationships. MSF actively pursued coordination, initiating regular updates and feedback and reporting sessions with the DOH, which was appreciated by DOH staff. MSF staff found that blending into the DOH's work culture, rather than imposing MSF's own way of working, fostered better collaboration. Regular communication, even if informal, and keeping DOH staff in the loop on new developments were identified by both partners as effective practices to maintain strong relationships.

Both MSF and DOH participants stressed the importance of co-planning and co-implementation, particularly at the sub-district and district levels. MSF involved all stakeholders, specifically the DOH, but also CBOs involved in CCMDD and supporting PUPs, as well as coordination with (international) NGOs active in the district's health care system. At the district level, clear roles and responsibilities significantly contributed to successful collaboration to achieve mutual project objectives. This co-creation process demands a structured approach and a willingness to understand and incorporate

¹⁷ From the DOH side this was mostly the provincial and/or district NCD manager, from MSF side it was usually the Project Coordinator, the Project Medical Responsible and the Nurse Activity Manager attending of these meetings.

DOH requirements, which would help to achieve sustainable outcomes. For instance, MSF's baseline assessments identified critical gaps in quality of care and NCD knowledge of DOH staff, about which DOH was not necessarily fully aware, which were then addressed through targeted training and mentorship programs for DOH nurses and CHWs. DOH actively participated in developing training content and endorsed MSF's initiatives. This co-creation process ensured that interventions were relevant and aligned with the department's needs, ensuring broad acceptance and implementation in the engaged health facilities.

Successful partnerships are built on trust, mutual understanding, shared goals, and continuous learning, as highlighted by a DOH participant. Interviewees from both sides emphasized to take sufficient time, as building relationships and trust cannot be rushed. Key elements included open communication, regular meetings, and a willingness to adapt and co-create. Openness and transparency from partners, particularly regarding limitations and challenges in healthcare implementation, are highly valued for building a proper foundation for interventions. A DOH participant emphasized the importance of protecting relationships through honesty and commitment, ensuring partners feel secure and valued.

"And even when we talk about MOUs, we never had difficulties. They were very willing to do, you know, and yeah, let's adapt it. Let's do, of course, the policy. It has to go through many channels, so it delays, but it's not like there was any misgiving or not willing to do. And one time I was also there when there was a visit from the province, they used to come. And when they... there was... so there was quite a lot of cordial relationship between the project and the provincial team, you know." (KII MSF, pos. 32)

"Because we had those relations of open communication and sitting together and strategize. And even if they are going to do something, they don't leave me alone and run to my facilities. Even if I'm not going to be there physically and support them, they will inform me we are going to do, and then directly now this and this and this." (KII DOH, Pos. 155-157)

MSF staff noted that listening skills, flexibility, and humility are crucial, especially when dealing with diverse needs and expectations from different levels at DOH. MSF's proximity to where the action is, i.e. in Butterworth, was also mentioned by one DOH respondent as an important element of an effective partnership, with both partners being accessible and responsive to each other. Partners stress the importance of co-creating the entire project setup and implementation from the very beginning.

CONSTRAINING ELEMENTS IN PARTNERSHIP PERFORMANCE

Engaging with the DOH at multiple levels presented challenges, including inconsistencies in communication and agenda setting, and difficulties in getting different managers together.

There were quite a few challenges at facility level because of many managers were acting rather than permanent managers. Some of them were relatively inexperienced nurses who were not very well prepared for their position. In addition, they had to combine their management tasks with clinical duties. Effective management at facility level is critical for running an effective mentoring program as it engages not only clinical but also programmatic processes.

MSF staff noted that while relationships at the district and sub-district levels were generally strong (thanks to the aforementioned proximity), provincial-level engagement was sometimes limited by coordinators lacking decision-making power. Also, meetings with national level DOH representatives proved to be quite challenging, posing limitations on advocacy efforts at those levels where decisions are being made. MSF staff partly attribute this to challenges around logistics. Whereas Butterworth and project locations are very accessible to subdistrict-level DOH staff, the reverse is true for district, provincial, let alone national level staff. They have to spend their scarce time and resources to attend meetings or visit project activities.

One significant partnership challenge revolved around engagement with the various levels of the Department of Health (DOH). There was a significant communication gap and lack of alignment across national, provincial, district, and sub-district levels of the DOH, making it difficult to gain buy-in and implement initiatives. MSF initially failed to recognize that mandates needed to come from top-down within the DOH structure, leading to delays and sometimes abandonment of some efforts, like further engagement in the development of a data collection or monitoring tool.

“And because we're also on the ground and on the field, we were trying to push this piloting and implementing implementation on the field as well on the ground. (...) That may not have necessarily been the right approach, because what we then noticed is that even if we got like buy in from subdistricts, when we have to implement local. Oh no, wait, hold on, we actually have to go to the district. The district will do that and go like, oh, actually, hold on, you need to go to the province.” (interview MSF, Pos 15-17)

Several MSF interviewees reflected that engagement approaches appeared to work best when combining close collaboration and co-creation at district and sub-district level with engagement of provincial and national authorities on policy, guideline, and approval-related matters. They noted that innovations developed locally still required endorsement from higher levels of the health system, especially when compliance with policies or guidelines might be an issue, before broader implementation could take place.

Navigating these various layers of the DOH may have been the reason of some initial DOH complaints that MSF was not sharing information on a regular basis. MSF staff was not always aware what decision was the prerogative of which DOH layer (national, provincial, district, subdistrict) and therefore, what information should be shared with which level to make a decision. Apart from these early communication hiccups, DOH very much appreciated MSFs active communication style.

MSF faced difficulties in data collection due to DOH's reluctance to share data and facility nurses refusing to record file numbers, hindering monitoring and evaluation efforts. However, the relationship often bounced back from disagreements, as both parties recognized their mutual dependence.

What may have been lacking to some extent in the partnership between DOH and MSF, according to one MSF respondent, is to mutually agree on what is needed to have a certain level of quality of care and to align the ambitions regarding that.

“I think that what we haven't done is to engage on that discussion of, like, okay, what is the package that both parties ambition and at what quality of care? For me, a project that deals

with hypertension that doesn't have manometers, it's a severe threat to quality of care, of course.,[...] not having manometers in the consultation with each nurse, it's a... it's a limitation to our provision of care. It was only halfway on the project that we said, no, no, we're gonna buy manometers, and we're gonna provide them. And that is the discussion that could have happened before. (Interview MSF, Pos. 38)"

A concrete example could be the choice to support PUPs. There are other models of DMOC delivery operational in South Africa. These other models have never been explored in initial project discussions, so it is unclear if PUPs served as the best model to answer the needs of the populations in the project catchment area. This is a limitation of DMOC roll-out in this project.

The lack of discussion and clarity around the project's very short implementation time may have contributed to the issue above. Implementation time wasn't taken into account in the partnership planning. Set against the scale of ambition, a potential mismatch between a known constraint and the expectations MSF allowed to build up (with both DOH and internally) is a partnership process issue that could have been addressed early on to manage expectations and set realistic ambitions.

NAVIGATING ENABLERS AND CONSTRAINTS

There were some clear successes in navigating constraints. The three most important successes in partnership performance are:

MSF played an active role in establishing the Amathole District Partners (ADP) Forum, that brought all district stakeholders, including community organisations and international NGOs, together leading to joint initiatives and resource pooling.

MSF managed to get buy-in for its interventions such as HbA1c point-of-care testing at NCD sentinel clinics and agreement for robust nurse and Community Health Worker (CHW) mentorship.

MSF adapted its approach by blending into the DOH's work culture. The project managed to gain traction with the DOH by covering a sufficient number of high-volume facilities. Thus, MSF prevented being seen as irrelevant, though the spread among several facilities also stretched its resources.

MSF staff found that having experienced senior project staff familiar with the health system helped navigate complexities and maintain good relations while advocating for project needs. At the district level, clear roles and responsibilities fostered strong relationships and collaboration.

EQ3 PARTNERSHIP OUTPUT

To what extent did the partnership contribute to improvements in the quality of NCD care in the supported facilities?¹⁸

The partnership contributed to improvements in several structural and process dimensions of NCD quality of care. Nurse competency scores increased across supported facilities, and qualitative evidence suggests improvements in APC adherence, clinical decision-making, consultation practices, documentation, and the use of FHRs. Reviews of patient records and direct observation broadly confirmed these improvements, although gaps in documentation and occasional misclassification of patient stability remained.

The partnership also strengthened key equipment-related elements required for quality NCD care. Health workers reported that BP machines, scales, height meters, and HbA1c point-of-care devices improved patient assessment, clinical decision-making, and continuity of care. In particular, HbA1c testing enabled more timely treatment adjustments and patient counselling, although occasional equipment shortages and operational constraints limited optimal use.

Monitoring systems remained limited, but MSF support improved documentation, register use, and FHR management, increasing recorded NCD patient numbers and encouraging data-driven decisions. Connectivity issues and lack of patient-level data continued to constrain outcome measurement.

PUPs improved accessibility and reduced transport burden, though their effect on workload relief could not be demonstrated due to missing data. CCMDD enrolments increased substantially in supported facilities, though attribution to the partnership cannot be confirmed without comparative DOH data.

Evidence on outcome-level changes of quality of care is more limited and relies largely on qualitative data and intermediate indicators. While DOH aggregated data shows rising positivity rates for diabetes and hypertension in Mnquma sub-district, suggesting increased case-finding, a continuing upward trend is not evident later in the programme. However, a comparison of new case finding (positivity rates) of hypertension and diabetes between facilities that received MSF-support and facilities that did not receive such support, shows that case finding is generally higher in MSF-supported facilities. The percentage of controlled diabetes patients (by HbA1c levels) shows an increasing trend.

Patient experience was mixed—some appreciated medication availability and information, while others cited access barriers, inconsistent care, and poor nurse-patient interactions. Community members appreciated PUPs, and qualitative evidence suggests potential improvements in patient knowledge.

¹⁸ For the sake of clarity, the formulation of EQ3 has been slightly changed here compared to the original in the inception report and evaluation matrix.

Nurses expressed dissatisfaction due to severe understaffing and overwhelming workloads, compromising care quality. Conversely, CHWs reported high satisfaction with new tools but advocated for better recognition and expanded roles, like diabetes testing, with project data showing increasing HbA1c uptake and early signs of improved diabetes control.

STRUCTURAL AND PROCESS IMPROVEMENTS IN QUALITY OF CARE

Staff competencies and performance

Community health workers have received training on hypertension and diabetes, with some receiving initial training during their foundation phase and more specialized training during NCD-focused programs. A total 375 CHWs participated in 9 trainings about National Adherence Guidelines and hypertension and diabetes. CHWs generally feel confident in their knowledge of diabetes and hypertension, especially with the availability of new pamphlets written in isiXhosa, which they find very useful as a reference and guidance tool. These pamphlets help them understand what to tell clients and when to refer them to a clinic, as CHWs do not diagnose conditions.

MSF realised that nurses could not meet core NCD quality standards because they were insufficiently trained in managing NCD patients. The focus on extending the number and tasks of PUPs, while aiming for community engagement and access to differentiated models of care, (both expected project results), diverted resources from ensuring core quality care standards for clinical care in health facilities, which was one of the other expected results of the project. Therefore, MSF together with DOH set out to put a capacity building programme in place to train nurses in clinical NCD patient management based on DOH's Adult Primary Care guideline, and attach a mentoring programme to it to assist nurses in the application of the guidelines during consultations, thus safeguarding quality of care. The programme was implemented in four high-volume facilities in Mnquma Subdistrict—Ngqamakwe Community Health Centre, Tafalofefe Gateway Clinic, Macibe Clinic, and Butterworth Gateway Clinic—and in three facilities in Mbashe Subdistrict: Dutywa Community Health Centre, Nywara Clinic, and Gwadana Clinic. A total of 201 nurses, subdistrict managers, district managers and operational managers were trained in a total of 18 trainings, and subsequently mentored in using HbA1c measurement in routine diabetes management as part of the mentorship programme. The nurse training and mentorship programme, conducted by experienced MSF staff (South African nurses from the local area), and using material validated by the DOH, has fostered trust and improved the clinical competence of healthcare workers. The nurse mentor monitored five main areas of competency which include: (1) APC adherence and consulting process; (2) Knowledge; (3) Skill; (4) Attitude/ Behaviour; (5) Integration of Chronic Disease. There were 28 different points of assessment under these 5 main competency objectives. Project data from this mentoring programme monitor the competency level of nurses over time.

During the pilot of this programme, nurses at the pilot facilities demonstrated initial gaps in APC adherence, consultation processes, and clinical knowledge and skills related to NCD management, according to MSF and DOH staff, and supported by MSF data from the mentorship programme. MSF monthly medical reports mention notable improvements as mentees became increasingly familiar and

confident in applying APC guidelines during patient consultations. Individual improvements in clinical practice were evident within the first three weeks of mentorship support, according to project data from the mentorship competency health systems dashboard.

Nurses now apply their practical skills like interpreting blood results, adjusting treatment based on guidelines, and improving documentation, which was previously neglected, as MSF medical team reports note. DOH representatives recognize the value of APC training and mentorship in improving quality of care.

“We are seeing improvement whereby we are seeing nurses adjusting treatment as advised by the guidelines, which is something that we never had when we started.” (Interview # DOH staff, pos.10)

However, file audits conducted by MSF nurse mentors revealed some regression in performance during periods when mentors were not present in the facilities. Mentees reported that heavy patient workloads and pressure to reduce waiting times often discouraged consistent use of APC guidelines, as they perceived the consultation process to be more time-consuming when adhering closely to the protocols. Apart from insufficient staffing, elements that impacted work pressure and that MSF tried to address, were time spent to look for missing FHRs, and missing equipment from the consultation room (BP meters, HbA1c POC machine).

Through a combination of mentorship support and the provision of additional FHRs by MSF, facilities increasingly adopted the use of FHRs for patients with non-communicable diseases. According to the medical end-of-project report, nurse clinicians became more consistent in documenting consultations, clinical findings, treatment decisions, and follow-up plans within the official patient records. These improvements strengthened continuity of care, enhanced patient monitoring, and contributed to more comprehensive and reliable clinical records for NCD patients.

The data in [Figure 5](#) and [Figure 6](#) show the average monthly competency scores over the aforementioned 28 assessment points of the 5 competency domains of trained and mentored nurses in the seven participating facilities, all of which show an increasing trend with almost all clinics reaching maximum competency scores by May 2026.

Figure 5 increasing trends in average monthly nurse competency scores for hypertension, 2025-2026. Source: MSF Cycle 2 mentorship report.

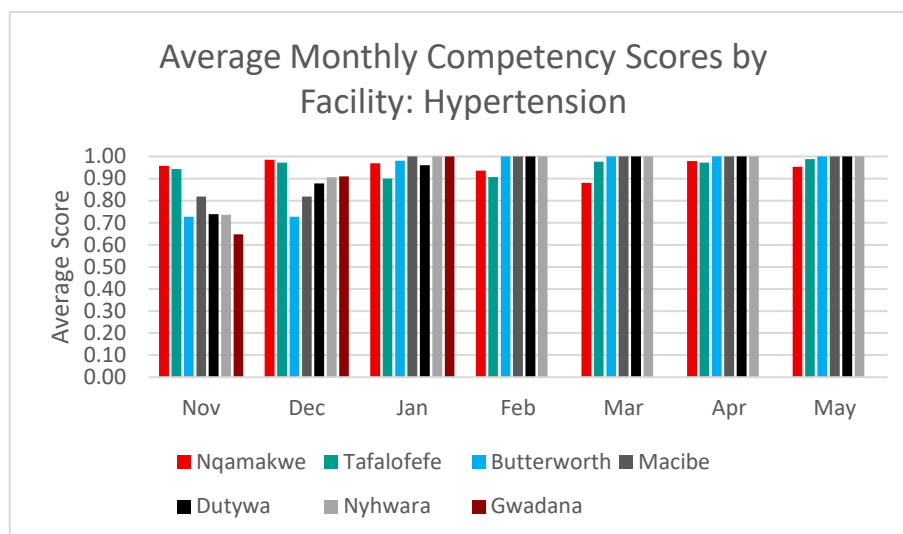
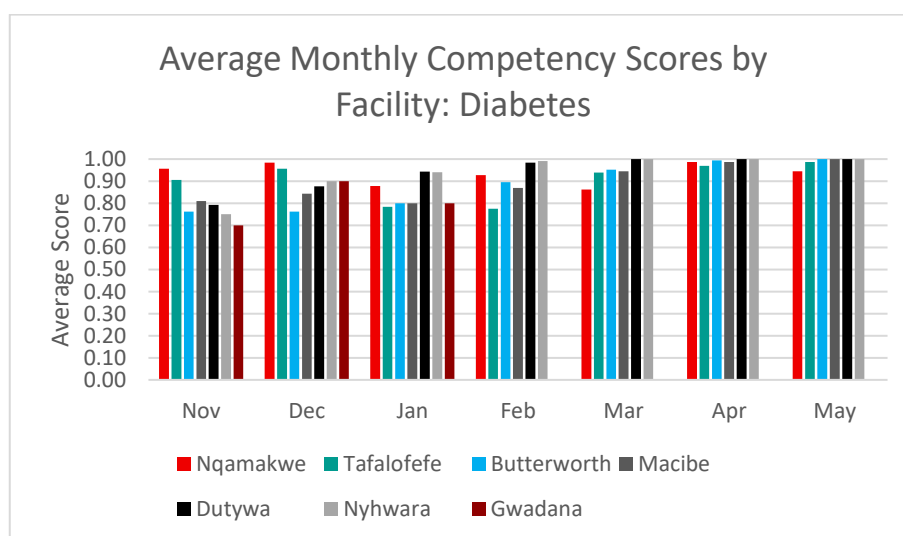


Figure 6 increasing trends in average monthly nurse competency scores for diabetes, 2025-2026. Source: MSF Cycle 2 mentorship report.



Direct observation and a review of FHRs conducted during this evaluation largely confirm the observations from the project regular monitoring data.

Overall, nurses do their best to do a complete consultation and record relevant information in FHRs. However, the reality of high work pressure forces them to deviate from completely adhering to the APC guidelines.

Nurses also omit information. For example, 20 out of the 37 FHRs reviewed during this evaluation¹⁹ missed a complete and updated patient profile, which provides an important overview of the patient's

¹⁹ The ambition was to review 10 FHRs per visited clinic. In one clinic, 3 files were not suitable for review.

clinical history and important demographic details. As the patient profile is usually entered at the first consultation, its absence reflects to a large extent the lack of proper record keeping in the past. Still, eight files had no, or very incomplete information entered about the most recent visit.²⁰ BMI is rarely entered in the FHRs, despite MSF providing scales and height meters to the participating clinics. Blood glucose results at first and at last visit was entered in 10 of 26 FHRs of diabetic patients, the rest had just one blood glucose result entered. HbA1c occurred in 16 FHRs of diabetic patients – all at their last visit. This likely reflects the recent availability of HbA1c POC test, and the training that MSF gave to the nurses regarding its use. Blood pressure information was more complete, with an entry for both first and most recent consultation in 25 out of 37 files.

Direct observation conducted during this evaluation revealed that nurses also enter non-performed items into the FHRs e.g., results of physical examinations while they did not do such an examination. This can be misleading at follow-up of patients, especially if they come with physical complaints of an organ system about which information was wrongly entered. Sometimes, nurses misclassify patients as stable, whereas their blood sugars or blood pressure measurements do not support that label.

Because this was a non-random selection of NCD patient files it is not appropriate to draw firm conclusions from this review. The fact that information was not present in the FHR, does not necessarily mean that an exploration or test was not done (e.g. one MSF medical team report noted that at baseline often patients' vital signs were only recorded in the patient-held record and not in the FHR). What can be said though, is that completeness of the information in the FHR can be improved, with possible areas of attention a completed patient profile, information on HbA1c and blood glucose and entry of the BMI. Proper record keeping is critical for patient monitoring and information gaps or incorrectly entered information hinder good quality clinical NCD management.

Beyond specific staff competencies, the mentoring programme raised the profile of NCDs among DOH staff, both at clinical and at management level.

"I think what was the eye opener in a way because we were before considering more of the HIV clients, everything, the paediatrics, the TB, the and of course the maternity clients, ANC, cancer screening and whatnot. We are not that much focussed as to causing impact to the chronic hypertension and mental health. We didn't consider going for or requiring, for instance, clients requiring and those clinics that needs to be immediately put on treatment. But because of continuous collaboration with MSF and them coaching and mentoring us, we are now vigilant that we need to also prioritise and consider our clients, especially the hypertensive, the diabetes and the mental health clients." (FGD DOH, pos. 27)

This sentiment is echoed by a KII participant who states that MSF's focus on NCDs was an "eye-opener" because "people use that, have that mentality that HIV and TB [are] the worst diseases in our life. (...) But now they know that the NCDs, which is diabetes and hypertension, are the worst and the slow

²⁰ Sometimes there is no information about a visit when the patient just comes to pick up a new prescription, although there are also instances where the nurse checks the patient's vitals and enters some basic information for that date, despite the reason for the visit.

killers". A nurse supervisor confirms that nurses' perceived importance of NCD has greatly improved compared to one year ago:

"The nurses themselves.... I, I have messages now, from nurses who, they.... just the kinds of insights that they have is just totally different. You know, today, Dr. A., I have a patient now who's on blah blah blah, this medication. The GFR has come back as 25. Please can you assist me in adjusting the doses of the medication? I mean, a year ago, I wasn't getting those messages." (KII DOH, pos.22)

Equipment

The mentoring process made MSF realise that they may have upskilled the nurses in NCD patient management, but that many structural elements were still missing at the facilities (e.g. essential equipment like blood pressure meters), rendering the consultation process inefficient with potential negative effects on quality. No HbA1c POC testing was available, meaning that nurses had to draw bloods to send to an external laboratory and ask the patient to return in a week for the results, which did not always happen. Therefore, MSF provided enough blood pressure (BP) meters (manometers) for every consultation room, various BP meter cuff sizes for accurate measurement, weighing scales and height measures to calculate Body Mass Index (BMI), and HbA1c POC testing equipment to produce instant results during consultation. The total of MSF medical donations to health facilities amounted to ZAR 2.9 million (EUR 152,000).

Nurses value the presence of BP meters in the consultation room. It helps them to confirm diagnoses and alleviate some of this pressure on consultation time, although not everywhere there is one BP meter per consultation room, as also direct observation in some of the clinics confirms.

"But there were machines that were issued by MSF, also the digitals we use to confirm the diagnosis. I mean, if the client had a high BP, we confirm those ones. You might find them in the consulting rooms. (..)" (FGD-DOH, Pos. 26)

"Enough machines. In case. In case this patient has got a high BP. So it should be able to do that in my consultation. Yes. Without sending the patient (....) The portable BP machines. That would be nice." (FGD-DOH, Pos. 123)

CHWs in the facilities and in MSF-supported PUPs reported that having BP machines made their work more effective and increased their credibility within the community. Before receiving these machines, they primarily relied on screening questions and referrals, but now they can perform immediate measurements and make more informed decisions about referrals. This direct testing capability was seen as adding "weight" to their jobs and improving community engagement.

Nurses cited the introduction of HbA1c POC testing equipment by MSF consistently as a major advancement in diabetes care. Previously, blood samples for HbA1c testing had to be sent to a laboratory, with results taking up to seven days to return. This delay often meant patients had to make multiple trips to the clinic, incurring transport costs and leading to treatment delays or non-adherence.

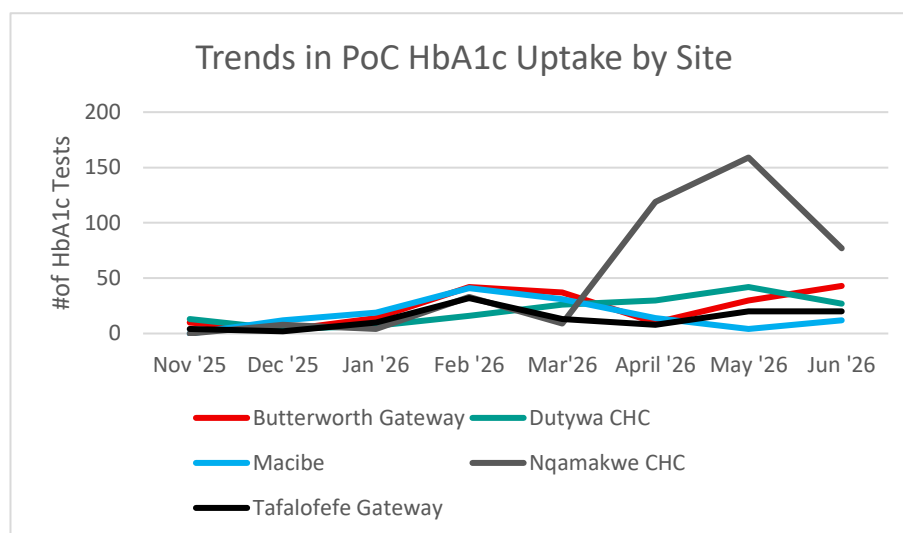
The introduction of POC HbA1c testing was intended to strengthen clinical decision-making, improve monitoring of glycaemic control, and facilitate timely treatment adjustments for patients living with

diabetes. Direct observation revealed the flipside of portable point-of-care HbA1c equipment. Although the test takes just 5 minutes to perform, it is valuable consultation time that adds to the workload of the nurses. Because of their portability the whereabouts of the device can be unclear and nurses spend time looking for it, or decide to not do the test. In some facilities, additional analysers were kept in secure storage to reduce the risk of theft, further limiting their accessibility during routine consultations. Nonetheless, the POC machines provided immediate results, enabling nurses to make on-the-spot treatment adjustments and provide immediate health education and lifestyle modification advice. A DOH representative expressed her appreciation with the HbA1c training and how to embed it in diabetes care:

“So, to understand, to get a reduction in HbA1c, you need this pathway to happen, whereas I think previously, the HbA1c result was being thought of, it was the patient's fault, if you want to put that in natural terms (...) you know, we need to understand when someone comes in with an HbA1c that's raised, there are... if you think about all these little arrows pointing towards it, there's staffing issues, access to, you know, to drugs, distance to travel”
(Interview DOH, pos. 10)

Based on MSF project data and MSF staff interviews, the uptake of HbA1c has been variable, but shows an overall increasing trend, with a dip in March and April 2026 related to operational challenges in accessing the portable machines at the facilities ([Figure 7](#)).

Figure 7 HbA1c uptake 2025-2026. Source: MSF project data HbA1c



Nurses felt that the availability of weighing scales and height meters contributed to a more comprehensive assessment of patients, moving beyond just blood pressure and glucose readings. However, some facilities still reported a lack of sufficient scales, and project documents and direct observation showed that existing ones were not always functional or calibrated, impacting the accuracy of the readings. To what extent this situation explains the poor BMI recording in the FHRs is not clear.

Overall, the equipment provided by MSF was appropriate and users found that they contributed to improving the quality of NCD care. The BP machines and HbA1c POC devices empowered healthcare workers to perform more immediate and accurate assessments, while DOH and MSF staff suggested that this led to better patient management. The equipment also enhanced the confidence of CHWs and nurses, enabling them to provide more comprehensive care and education. However, not everywhere there was sufficient equipment, and there were maintenance issues with BP meters or weighing scales.

Pick-up points

MSF supported five external pick-up points, complementing other providers who operate pick-up points at PHC facilities as a fast lane option to fill a prescription. The external pick-up points and other forms of DMOC were meant to improve access to medication by reducing transport costs and travel time. They were also meant to alleviate the work stress of the facility nurses, allowing more time per consultation and thus potentially contributing to improved quality of care, by allowing stable patients to collect a three-month supply without a consultation.

Initially, MSF wanted to create 30 PUPs in the first project year. This planned volume proved to be challenging for two reasons. Firstly, choosing spots for new PUPs strategically i.e., a high volume of patients and no duplication with other DMOC proved to be complicated. Secondly, setting up PUPs is subject to certain technical requirements (bank account, stable power supply, air conditioning, refrigerator etc.) before the PUP receives DOH accreditation, which is a lengthy process.

Accreditation complexities caused the strategy to shift towards setting up fewer model PUP with enhanced services, where CHWs would provide blood pressure screening / measurements and conduct health talks, distribute informational pamphlets, and engage in community dialogues to educate patients on NCDs, healthy lifestyles, and the importance of adherence.

Interviews in the community confirm that the PUP is close to the patients, and is accessible even in the weekend.

“It is enough accessible. That's one at all times. It's not like Monday to Friday, even the weekends. Yeah. They will come. Also, it's a walking distance unlike before, where they will pay 150 to go and just take the medication. So now it's a walking distance. It leaves a five-minute walk, ten-minute walk,” (KII PUP, Pos. 33)

Patients confirm using PUPs in their area but at the same time indicate that they do not always have all the needed medication.

“It is a bit of a challenge to receive certain services. So she's from Hebele Village. It's a bit of a distance away from Nqmakwe, which is the central town. But there is a small clinic in her village, but most of the time it doesn't have all the treatment that she needs, so she ends up having to find transport money to go to Nqmakwe. (Translator in FGD-patients, Pos. 125-127)

The extent to which PUPs have relieved work pressure for nurses is significantly hampered by DOH's inability to replace retiring or resigning nurses where even the extra time needed to decant a patient is perceived as extra workload and cumbersome.

Direct observation confirms persistent congestion, and nurses continue to report high workload. Qualitative evidence highlights positive aspects, including improved accessibility and additional services at PUPs that may enhance patient knowledge and self-management.

"The biggest achievement for me, even if it's not for the subdistrict, is that my clients are very happy. (...) That we are delivering a parcel to them. We are taking the services to the people." (KII DOH, pos. 142-149)

"So, because of facilities are far from the rural areas, some of them, they don't even have transport fee. So, when it's their date to just pick the meds, they go to a pick-up point. So, on the pickup points, we normally test them. We take BP and also glucose because remember, that patients were carrying the medication for 3 months at home, so you have to check if is their condition still controllable or what." (KII-MSF, Pos. 20)

"I think that we profiled the community. As a key player within a response to NCDs and presumably we have left behind communities who are more aware, more able, more empowered on NCDs and on diabetes in particular." (KII-MSF, Pos. 68)

Decanting decisions should occur at facility level between clinician and patient, but several challenges hinder this process: limited clinician knowledge of DMOC options, insufficient patient involvement in choosing a model, and the time required to complete electronic documentation. Intermediate data show fluctuating trends in active PUP clients.

Figure 8 Trends in active clients at MSF-supported PUPs, 2024-2026 (Source: DOH data)

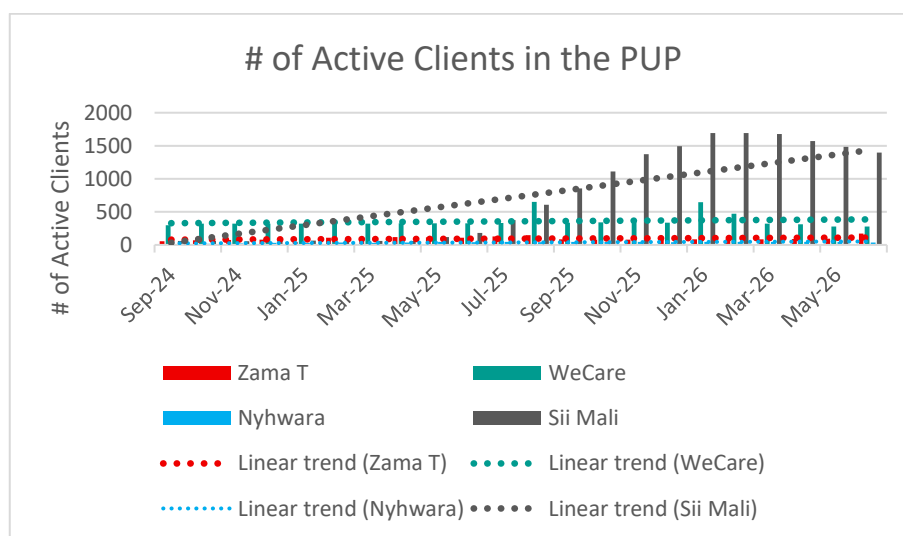
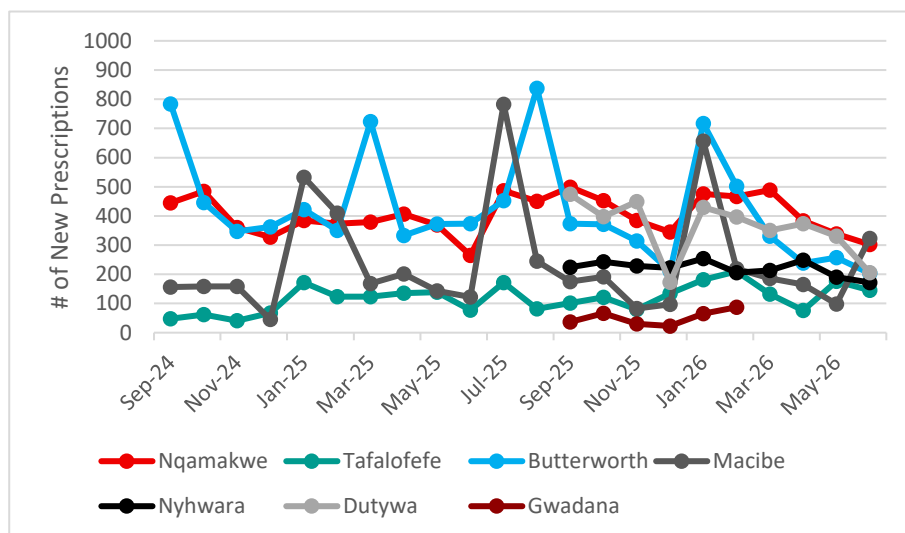


Figure 8 shows the trends in absolute numbers of active clients in the MSF-supported PUPs. Sii Mali shows a sharply increasing trend followed by a slight decline. In absolute numbers, Sii Mali is the PUP champion with up to 1692 active prescriptions – likely due to it being the only PUP in Nqamakwe. New CCMDD enrolments show very fluctuating trends (Figure 9), with increases influenced by prescription renewal cycles, and decanting of adherence club members after DOH stopped funding these clubs, while drug stock-outs may explain decreases.

The absence of a clear increasing trend may partly reflect improved back-referral of unstable CCMDD clients, enabled by PUPs offering basic clinical checks such as blood pressure and glucose measurement. These services allow early identification of uncontrolled conditions and timely referral, which may counterbalance enrolment increases. It may also reflect saturation of the PUP in small communities where all eligible clients in the catchment area have been decanted.

The question is whether the new prescriptions to CCMDD by the facilities, shown in [Figure 9](#) are high, or higher than before MSF and DOH started their partnership activities. Whether new CCMDD prescriptions are high relative to pre-partnership levels cannot be determined due to lack of baseline data.

Figure 9 Number of monthly new prescriptions submitted to CCMDD by facility (Source: DOH data)



If one compares the average number of clients enrolled in CCMDD by the clinics in 2022, with the average numbers in 2025 the difference is obvious. There is 14 to 35-fold increase in the number of CCMDD enrolments in the four facilities for which data about the same period are available ([Figure 10](#), further below). This could mean that MSF has been successful in increasing the decanting to CCMDD through the setup of these external PUP. However, some caution is warranted. In the absence of DHIS data from other, non-supported clinics over April-September 2025, there is no certainty that DOH, with or without support from other partners, has not achieved similar increases in decanting patients to CCMDD. Additionally, the earlier mentioned end of the DOH support to adherence clubs could explain a potential increase in decanting by other facilities to CCMDD. Unfortunately, DOH does not share data about decanting by other facilities and therefore a comparison between MSF-assisted decanting and DOH is not possible.

Unfortunately, data on defaulting or adherence are not available. However, literature shows that DOH's CCMDD programme has helped diminish defaulting and improve adherence, mostly in PLHIV

but also in diabetes.²¹ There is no reason to assume that Eastern Cape would differ wildly from other provinces, so increases in CCMDD enrolment could indicate an improvement in the quality of care. Overall, the setup of PUPs has been appropriate in addressing key aspects of NCD care, particularly in improving patient access to medication. The unconfirmed assumption is that this improves adherence and reduces defaulting. Patients and community leaders appreciated the model to bring services closer to their communities. However, without data on defaulting, adherence, or consultation volumes, it is difficult to assess whether four external PUPs were sufficient to materially reduce workload at sentinel facilities.

Monitoring data systems

DOH has a monitoring data system based on compiled data from NCD consultations, which is commonly called the tick register. It has a limited number of indicators and data are not available at the patient level.

The current data system primarily relies on tick registers and FHRs, which are used to collect data based on the DOH's national indicator data set. These indicators are limited, focusing mainly on the number of people screened for hypertension and diabetes, those requiring treatment, and those initiated on treatment. While MSF has supported strengthening the use of these existing DOH tools, including improving documentation, filing systems, and the opening of FHRs for chronic patients, the system still struggles to provide a comprehensive overview of NCD care. Also, DOH did not provide baseline data on MSF's request, which limits the ability to assess the extent to which the project has led to improvement of indicators. Nurses at the facilities refused to note down NCD patient file numbers, citing workload, making it difficult to get a view on the total numbers of NCD patients visiting a facility during a particular time period.

Initially, project staff aimed to develop and pilot a sophisticated NCD database tool, similar to the existing system for HIV and TB, tier.net, to collect comprehensive information on NCD cohorts and track longitudinal care and control. This ambitious project sought to create a system that could capture detailed patient-level data, including the 90-60-50 cascade for NCDs. The goal was to establish an international-standard data capture system that could integrate with existing DOH systems like CCMDD and SyNCH, and potentially be scaled up across other districts and provinces. However, this endeavour faced significant challenges, including a lack of official approval from the DOH, resource constraints, and a disconnect with DOH and MSF OCB priorities. A more modest MSF attempt to pilot a monitoring tool stranded in the face of early project closure, leaving insufficient time to complete an annual patient cohort for proper data collection, monitoring and analysis.

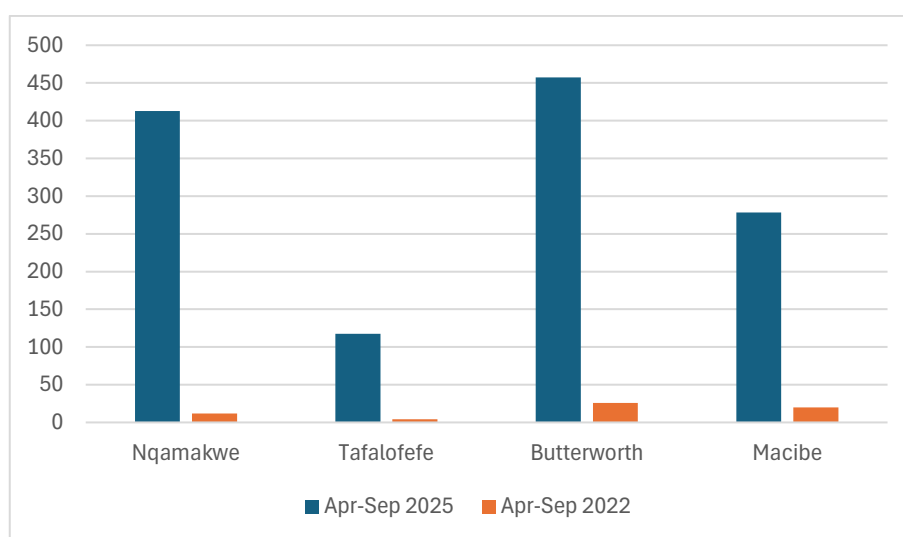
Despite the limitations of the current data system, there have been some improvements on this area. The increased focus on data capture, even within the existing tick register framework, has led to a better understanding of NCD patient loads and challenges. Facilities supported by MSF have shown a significant increase in recorded NCD patients, indicating improved data capture rather than an outbreak, according to an MSF staff member. This is confirmed by trends in new diabetes and

²¹ Sekopa RP, Netangaheni RT. Experiences of nurses and patients with the implementation of the CCMDD programme. Afr J Prim Health Care Fam Med. 2025 Jan 29;17(1):e1-e9. doi: 10.4102/phcfm.v17i1.4676.

hypertension patients in MSF-supported clinics, shown in [Figure 11](#). DOH staff mention that MSF's efforts have contributed to a change in culture, with a greater emphasis on data-backed decisions around patient health, even if not formalized. The strengthening of existing tools, such as the use of registers and improved FHR management, has made it easier to identify and manage NCD patients.

Connectivity issues, poor data quality (partly as a result of poor connectivity or power outages), and a lack of a centralized database for NCDs hinder the ability to track patients longitudinally, assess their clinical evolution, or even determine the exact number of people with diabetes or hypertension in follow-up. This fragmented approach means that crucial information, such as the proportion of patients whose conditions are correctly controlled or retained in care, is largely unavailable. Consequently, to date there is no way to monitor the NCD target of 90-60-50 with routinely collected data and patient-level outcomes cannot be tracked, other than by special operational or implementation research.

Figure 10 Average number of new CCMD prescriptions per facility, 2025 and 2022²²

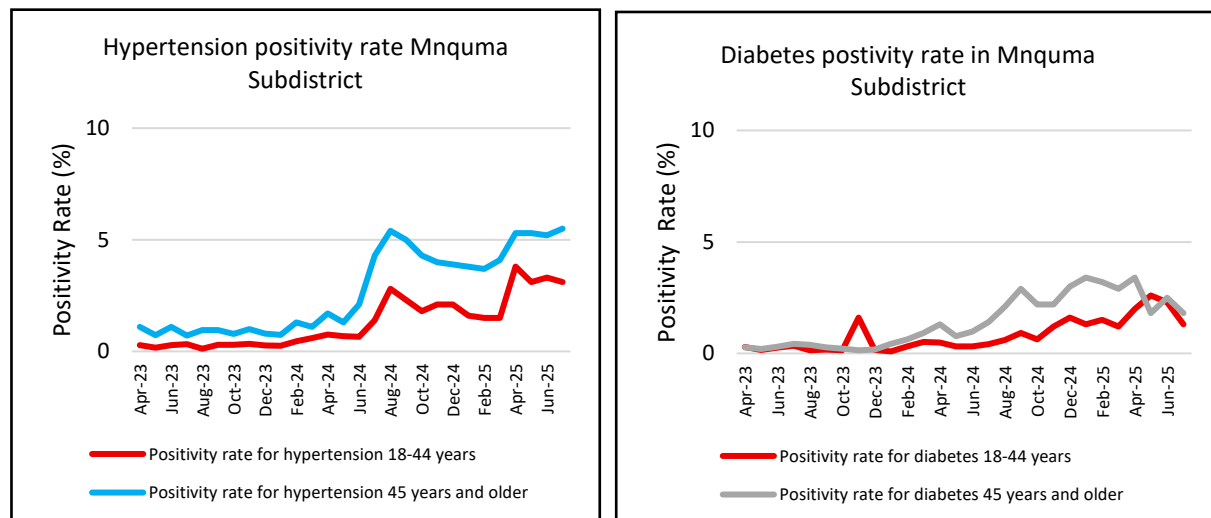


OUTCOME-LEVEL IMPROVEMENTS IN QUALITY OF CARE

As has been discussed before, there are no individual-level outcome data available within this project. DOH and MSF have some aggregated data about NCDs, based on their tick register. The most meaningful ones might be the diabetes and hypertension positivity rates – client screened for the condition and requiring/referred for treatment for that condition in the facility as numerator, with the total number of people screened for the condition and not known as having that condition, as denominator.

²² Sources: project monitoring data (2025) and DHIS data (2022)

Figure 11 Hypertension and diabetes positivity rates, Mnquma, Apr 2023- Jun 2025. Source: DOH data, tick register.

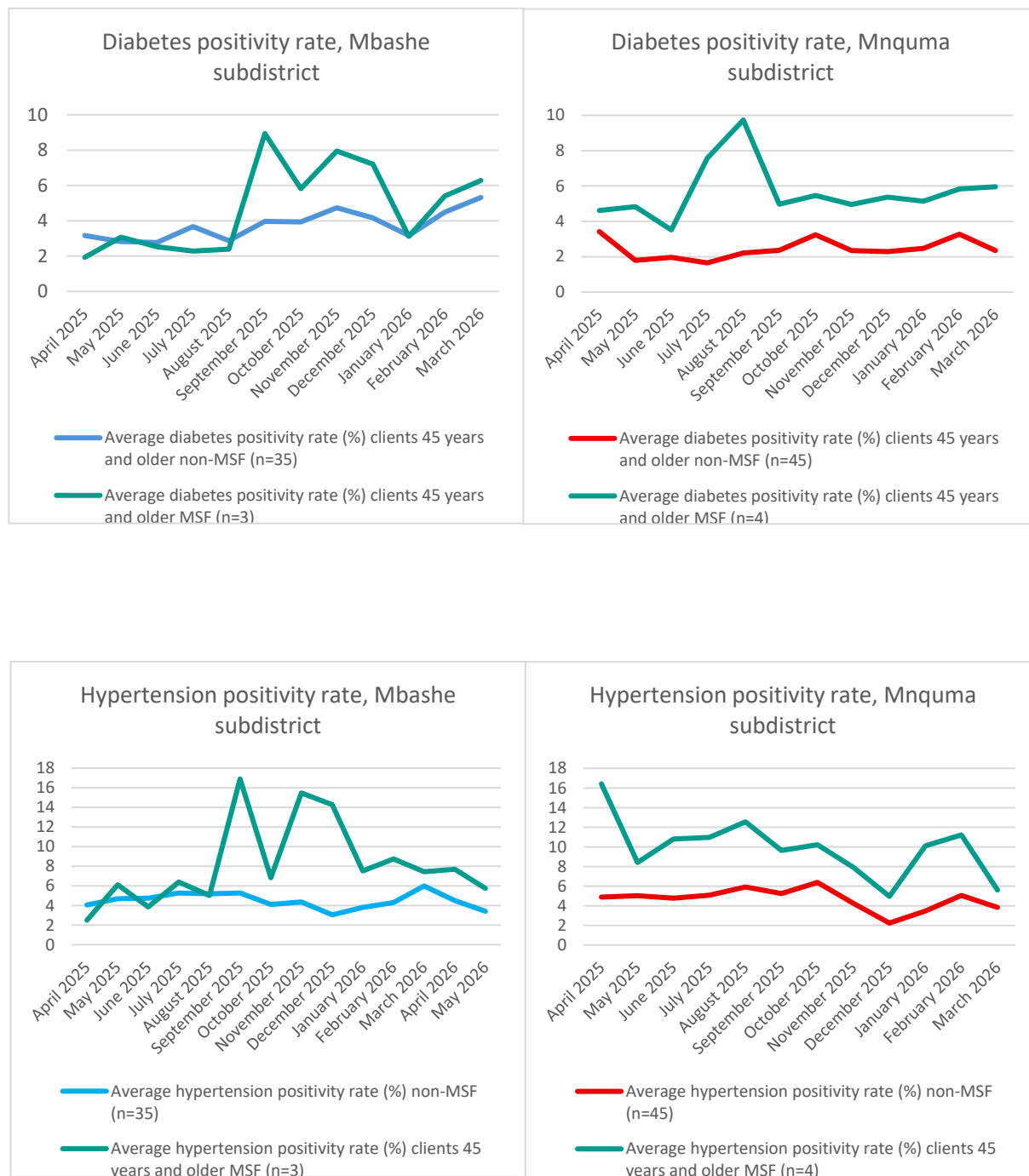


These examples starting from the early days in the project, show that the positivity rates for both diseases in Mnquma sub-district are rising, possibly not an expression of increasing prevalence, but of increasing case-finding as a result of the mentoring programme starting in 2024.

Later on in the programme, the data show no clear trend, or even a slightly declining one. The absolute level of people found needing an intervention remains at a higher level than at the very start of the project. On the basis of focus groups with nurses and CHWs, as well as interviews with MSF and DOH staff, one could say that this might be due to lifestyle counselling (with more patients coming forward) in combination with improved clinical skills of the nurses.

The DOH tick register data allow a comparison in hypertension and diabetes positivity rates in patients (clients) of 45 years and older between clinics with direct MSF support and clinics without MSF support, per subdistrict (Figure 12). The pattern for each condition and each subdistrict fluctuates, possibly due to data entry problems. Nevertheless, clinics with MSF support show most of the time higher positivity rates for each condition than clinics without MSF support, which likely reflects the projects contribution to improved NCD case finding.

Figure 12. Comparison diabetes and hypertension positivity rates, clinics with and without MSF support, by sub-district.
Source: DOH data tick register.



Interviews with nurses and other DOH staff suggest that HbA1c testing may contribute to an improved quality of care.

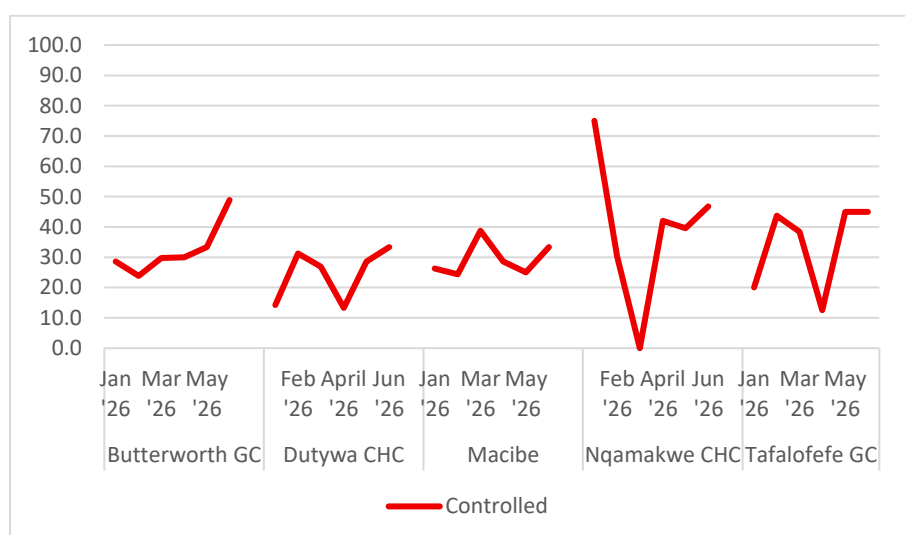
“Yes. Yes. If maybe it's today, then he come next week, Monday. Some person, they don't have the money to return back within seven days. But this one, at least you do it now. And you can take action immediately” (FGD DOH, pos.45)

“We manage. We are using this HbA1c machine. So our patients are improving because they are continuing to diabetes control.” (FGD DOH, pos. 174)

“We’ve seen some improvement on, on our patient’s conditions. (...) Like, our clients now are stable on treatment. (...) That, (...) HbA1c helped. (...) us. Now we can counsel our clients. But before. Before that point of care medicine, we used to take blood to the lab. That was delaying. (...) our counselling to the client. Because you will not know the results today.” (FGD DOH, pos.195-197)

Preliminary results from the project’s HbA1c capitalisation confirm what already became apparent in the aforementioned quotes. Figure 13 shows a generally increasing trend (except in Ngqamakwe) of the proportion of controlled and uncontrolled diabetes patients in the period January-June 2026, suggesting a contribution of HbA1c introduction.

Figure 13 Trends in diabetes control Jan-Jun 2026, 5 PHC clinics



Evidence on outcome-level changes is limited by the availability of routine data. In addition to the available indicators on NCD detection and diabetes control presented above, this evaluation therefore draws on patient experience and staff satisfaction as intermediate indicators of the outcomes dimension of quality of care^{23, 24}. The findings are presented below.

Patient experience

Patient experience with healthcare services, particularly concerning the treatment of hypertension and diabetes, varies among the individuals interviewed. While some express general positive experiences regarding the availability of medication and the information received, others highlight

²³ Maghsoud, F., Rezaei, M., Asgarian, F.S. *et al.* Workload and quality of nursing care: the mediating role of implicit rationing of nursing care, job satisfaction and emotional exhaustion by using structural equations modeling approach. *BMC Nurs* **21**, 273 (2022). <https://doi.org/10.1186/s12912-022-01055-1>

²⁴ Guzmán-Leguel, Y.M., Rodríguez-Lara, S.Q. Assessment of Patients’ Quality of Care in Healthcare Systems: A Comprehensive Narrative Literature Review. *Healthcare* **2025**, *13*, 1714. <https://doi.org/10.3390/healthcare1314171>

significant concerns regarding access to services, the quality of nurse-patient interactions, and the consistency of care.

On a positive note, several patients indicate positive experiences with the availability of their medication. One patient states: *"I am satisfied"* with the availability of medicine. Another patient mentions that *"metformin is always there. It's never said that it's not there"*. This is not a consistent finding, however. While metformin is generally available, other medications can be missing, requiring patients to make multiple trips to the clinic.

Some patients expressed positive experiences with the provision of information they get, and report receiving clear explanations and instructions on managing their conditions. One patient notes that the information given by the nurses is usually clear (*"Yes, they explain"*). Another states, *"They even give good information"* regarding managing hypertension with a salt-free diet. This, however, is not a consistent finding across patients, some of whom perceive a lack of thorough explanation. A case in point is the meaning of HbA1c for the management of diabetes. One patient in an FGD recently went to collect her treatment, but according to the translator *"they checked everything including Hba1c, but she's still not very clear on what it is"*. There's also a desire for more health education and support, especially regarding diet and lifestyle, which is often not adequately provided by busy nurses.

Access to services and financial strain is a recurring theme for patients, especially for those in rural areas. Patients often lack money for transport, making it challenging to get medication refills or attend appointments. The discontinuation of a three-month medication delivery system has forced some patients to visit the clinic monthly, incurring additional costs.

The consultation process and the attitude of nurses is a concern of quite a few patients. They complain about excessive waiting times and nurses rushing through consultations due to high patient volumes and understaffing. This leads to patients feeling that they don't receive enough attention or time to discuss their problems thoroughly. Several patients describe nurses as *"rude"* and *"aggressive,"* leading to feelings of *"embarrassment and shame"* and a reluctance to ask questions. Patients feel that some nurses are dismissive of patient concerns, such as skin issues, attributing them to allergies without further investigation.

Finally, perceived improvement of their condition is an important outcome measure for patients. Also here, the picture understandably varies. Some patients report significant improvements in their health since starting treatment. One patient, who previously had uncontrolled blood sugar, now has it under control and feels much better, even reducing pill intake. Another patient expresses being *"much better"* and able to *"do the things I like"*. Despite treatment, some patients report no improvement in their condition, with blood pressure and sugar levels remaining high or fluctuating.

Staff satisfaction

Nurses generally express dissatisfaction with their jobs due to severe staff shortages, which lead to excessive workloads and immense pressure.

"So we are not happy about the number of staff in the clinic. It's an overload, doctor. It's an overload. Yesterday there were only two professional nurses. I was on duty because another one is on leave. And sometimes each one of the staff can go on leave. And the other one, if my

husband got sick and I'm supposed to be next to him. So, there are those things. The shortage of staff, that is our problem. Otherwise, we don't have any problem with the clients because we are here for the clients.” (FGD DOH, pos. 31-39)

They report working under conditions where they are forced to perform multiple roles, such as nursing and dispensing medication, drawing blood, dealing with acute patients and often have to postpone essential procedures like vital sign checks for late-coming patients.

“if the client is coming for treatment, HPT client, hypertensive client, you know that we are supposed to take all the clients the vital signs. Sometimes those who are coming late, those who are coming late, like for it's an overflow, like 3:00. They are missing the vital signs because the overload. We end up postponing for some of them [clients].” (FGD DOH, pos.31-39)

This shortage has been a problem since 2015, with nurses retiring or resigning without replacement, and the Department of Health citing a lack of funds, which staff find incomprehensible given that positions were previously funded. This chronic understaffing results in stress, burnout, and a compromised quality of care, as nurses prioritize quantity over quality to manage the high volume of patients.

The lack of staff also means nurses often miss breaks and meals, leading to increased stress that affects their personal lives.

“But if you are coming from duty to home, you are shouting. Starting from your house. Find your son, your daughter, your grandson, whatever, (...) you are shouting towards them. Or my dogs. I'm shouting them. Hey, don't come to me! I'm chasing them away. Why? It's because of stress.” (FGD DOH, pos. 70)

They describe a constant feeling of being overwhelmed, with clients often becoming impatient and confrontational due to long waiting times. Despite these challenges, some nurses find satisfaction in their work, particularly when they see positive outcomes in patient care, and appreciate the support from organizations like MSF, which provides equipment and assistance, making their work more engaging and effective.

CHWs, in contrast to nurses, express high job satisfaction, particularly due to the recent acquisition of BP machines, which enhances their credibility in the community and allows them to perform screenings and referrals more effectively. They appreciate the flexibility of their roles, the opportunity for self-supervision, and the continuous learning experience gained from interacting with diverse households and their unique issues. The ability to work in their birth communities, knowing the local people and their situations, also contributes significantly to their happiness and confidence, especially with new educational pamphlets written in isiXhosa, which greatly help them find the right words to explain health issues in the local language of their communities.

“I would say we are very happy, much happy, because we are working in our facility, where we are born. And you know exactly the situation of your area. You know the people.” (FGD MSF, pos. 177-182)

However, CHWs also highlight several structural challenges that impact their work. A significant concern is the lack of certificates for specific trainings, which can lead to questions from professional

nurses in households and a perceived lack of formal proof for their expertise. Another issue is the absence of diabetes testing machines, despite improved knowledge and confidence on this condition with the CHWs and increased client demand. While a policy prevents CHWs from pricking patients, they question why this is allowed in facilities but not in the community, suggesting a need for policy review or additional training and supervision.

CONCLUSIONS

This chapter takes stock of the findings reported. It does so on three levels. First, it assesses to what extent the project improved the quality of NCD care in Amathole district, and identifies key factors that facilitated or hindered progress. Second, it identifies good practices and lessons learned working closely with a regulated governmental partner like the DOH, focusing on opportunities and constraints of exerting direct influence on quality of care and the role of advocacy and capacity building in contributing towards this objective. Finally, this chapter looks at adaptations needed for the implementation approach to work in other contexts.

QUALITY OF CARE IMPROVEMENTS

Through mentorship and targeted systems strengthening, the partnership contributed to improvements in the structural and process dimensions of NCD quality of care across supported facilities. These included strengthened patient documentation and monitoring practices, improved availability and use of key equipment, enhanced access to services, greater clinical competence among nurses and CHWs, and improved adherence to NCD care guidelines. Evidence on outcome-level changes is more limited, but suggests improvements in NCD case finding and early signs of improved blood sugar level control.

ENABLING AND CONSTRAINING FACTORS

The partnership benefited from strong DOH ownership, constructive dialogue, and alignment with DOH priorities. Perhaps the most important good practice by MSF is, that it decided to focus on NCDs *at all*, as some DOH representatives underscored. There was great trust at DOH in interventions and innovations that MSF proposed, rendering a certain freedom for MSF in implementation. These enabling factors were visible across multiple components of the project.

However, systemic constraints — including staff shortages, high patient volumes, and limitations in data systems, drug stock-outs — affected partnership processes and the pace of quality of care improvements. These constraints were repeatedly mentioned across KIIs, FGDs, and became apparent during facility observations.

The data system gap is a structural bottleneck limiting the ability to evidence outcomes. This has been challenging, particularly given the complexity of aligning internally and with partners, while huge efforts were made to address the issue without reaching a satisfactory solution. This highlights the importance of making data systems and requirements a joint priority from the start of any partnerships of this kind. The evaluation also highlights that pilot site selection matters: focusing exclusively on high-volume, highly deprived clinics where systemic failures constantly stall progress limited the project's ability to demonstrate scalable improvements. Selecting a mix of facility types would have increased feasibility and learning potential.

EFFECTIVENESS OF INDIRECT INFLUENCE

The hands-off model shaped how MSF could engage within DOH regulations. Indirect influence proved effective in strengthening structural and process elements of care, but its limitations were clear: MSF could not directly address gaps in data systems, clinical care and patient follow-up. The model worked best where DOH leadership was strong and facility-level implementation capacity was stable.

The project's systems approach, addressing multiple layers of the healthcare system (clinical staff capacity, structural elements like equipment, and community-level services and -engagement), contributed to indirect influence. The provision of equipment, for instance, directly improved the efficiency of consultations and empowered healthcare workers,

The evaluation also finds that MSF was not fully prepared internally for a model of limited direct implementation. The organisation's emergency response DNA, combined with limited experience in long-term health system strengthening, created frustration and slowed early progress. Projects of this nature require experienced staff with a mindset aligned to working with Ministries of Health (while knowing how to navigate its different management layers), longer timelines, and shared responsibility for outcomes. Therefore, agreement on key outcome indicators that are aligned with priorities of both partners, may help to strengthen buy-in and equal engagement.

NCD management is a long-term endeavour, and demonstrating clear patient-level outcomes and sustained indirect influence requires an extended project timeline, ideally 10 years, which contrasts with typical humanitarian timeframes.

ROLE OF ADVOCACY AND CAPACITY-BUILDING

Advocacy efforts contributed to alignment with provincial priorities and supported patient-centred practices. However, the project's focus on piloting small initiatives in remote areas and lack of data to demonstrate results and support advocacy limited visibility and opportunities for higher-level engagement. When advocacy is a key objective, selecting at least one project location closer to central DOH management increases visibility and facilitates engagement with DOH decision-makers.

The evaluation also highlights the importance of understanding DOH decision-making structures. In hierarchical systems, securing buy-in at higher levels is essential for innovations to filter down. Bottom-up approaches were useful for co-creating practical interventions, but they were insufficient on their own to secure broader adoption. Improved understanding of the local health system hierarchy, developed in the course of the project, helped to advocate informally and influence DOH training and point-of-care testing methodologies.

The lack of a robust NCD data system within the DOH hindered the ability to monitor targets and demonstrate the effectiveness of interventions, thereby limiting evidence-based advocacy.

Capacity building can be a driver of quality of (NCD) care, but can only be sustained in a context where the baseline operational capacity of the clinics is being supported and secured. Mentoring programs struggle to succeed in poorly financed, insufficiently organised, poorly managed, or understaffed facilities that lack basic equipment like blood pressure machines and functional patient filing systems.

A similar observation on the context of mentoring has been made in another MSF OCB project evaluation.

Training methods shifted effectively toward interactive, case-based learning using local clinical guidelines rather than passive lectures. This good practice fell on fertile soil, as DOH saw it as an innovation in capacity building and has now adapted MSF training methods for other capacity building activities.

Rather than imposing external standards, the project prioritized using training materials validated by the Ministry of Health (and based on DOH's own APC guidelines), which ensured that the training was recognized for professional accreditation

Human resource models should incorporate training-of-trainers approaches for DOH mentors to mitigate high staff turnover and at least preserve knowledge of training and mentoring on NCDs within DOH. It is acknowledged that without DOH employing more nurse-mentors, the influence of a TOT will remain negligible. MSF also needs to develop appropriate indicators for health system strengthening projects, and ensure internal alignment on expectations before launching such projects. Greater flexibility is required from MSF headquarters, as long-term systems strengthening projects will not produce data at the same pace as direct implementation projects.

Conversely, DOH could adjust expectations of NGO partners, moving beyond the assumption that international NGOs primarily provide goods and direct services, and instead exploring how partners can add value within the health system.

OVERALL

Despite contextual constraints and limited evaluability of outcomes, the partnership produced meaningful improvements in the quality of NCD care especially regarding structures and specific processes. Equally, it generated valuable lessons on collaborating with a strongly structured DOH through indirect influence. The experience demonstrates that hands-off models can strengthen quality of care foundations when grounded in capacity building, aligned with government priorities, and supported by sustained partnership processes, while also highlighting the organisational and contextual conditions required for such models to succeed. Effective collaboration and indirect influence require a nuanced understanding of the partner's context, sustained high-level engagement, and a long-term commitment.

It is clear that this approach warrants a different mindset within all the involved layers within MSF OCB's organisation. When MSF OCB sees this hands-off approach as an operational model that it may adopt more frequently in the near future, it needs to reflect what sort of interventions, and with which human resources, which skills, what type of operational and medical support, which metrics for monitoring, and what timeframes are needed to run a hands-off project successfully. It also needs to determine to what extent the context, emergency or non-emergency, matters when implementing a project in hands-off mode, and what the state of the health care system needs to be in order to accommodate such an approach with a reasonable likelihood for successful outcomes. In other words, it requires a sort of guideline for a package of interventions and the minimal organisational

requirements to support a hands-off approach successfully. This will bring clarity throughout the management lines, from project staff to support departments and leadership and hopefully side-step some of the pitfalls and blind spots that this evaluation has uncovered, thus avoiding delays and frustration on both sides of the partnership.

LESSONS LEARNED AND RECOMMENDATIONS

RECOMMENDATIONS FOR MSF

Partnership & Engagement

Lesson learned: Bottom-up efforts alone struggled; top-down buy-in is needed for scalability, guideline- or policy change. Co-creation worked for practical implementation, but high-level engagement and approval was needed for policy influence.

Recommendation M1: Engage at national level early and balance bottom-up and top-down approaches. This could include agreeing with DOH at higher levels on key targets and indicators of the project for joint monitoring and interest to achieve goals and to agree on policy-level changes. Work with districts and sub-districts in a bottom-up and co-creation manner to ensure buy-in and relevant interventions at the implementation level.

Project Design & Strategy

Lesson learned: Unclear focus and differing opinions about the interpretation of the operational model (always go by what DOH wants vs. work within DOH to catalyse changes), as well as the role and weight of medical advice created confusion at the beginning of the project (and the recentralisation programme may have contributed to this confusion). This negatively impacted the position of MSF in the partnership and delayed implementation of project activities.

Recommendation M2: Clarify objectives and priorities upfront internally if a non-standard operational model is envisaged, including the role of medical and other pertinent advice, and manage expectations with clear communication and planning to external and partners and within MSF. **Avoid** implementing non-standard approaches during a major operational management change.

Lesson learned: At central (headquarters) level there seemed to be the same expectations about the timeline in achieving and demonstrating results as with a project in an emergency context where MSF has full (or at least a lot of) operational control. NCD outcomes cannot be proven in typical 3–5-year humanitarian timeframes, certainly not if one is dependent on collaboration within a Ministry of Health.

Recommendation M3: Adopt an extended project timeline, preferably amounting between 5 and 10 years. This estimate is based on a number of publications on health systems strengthening.^{25, 26, 27}

²⁵ World Health Organization. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, Switzerland: World Health Organization; 2007.

²⁶ Rwabukwisi, F.C., Bawah, A.A., Gimbel, S., Phillips, J.F., Mutale, W., Drobac, P., 2017. Health system strengthening: a qualitative evaluation of implementation experience and lessons learned across five African countries. BMC Health Services Research 17.. <https://doi.org/10.1186/s12913-017-2662-9>

²⁷ Hemingway CD, Bella Jalloh M, Silumbe R, Wurie H, Mtumbuka E, Nhiga S, et al. Pursuing health systems strengthening through disease-specific programme grants: experiences in Tanzania and Sierra Leone. BMJ Global Health. 2021;6:e006615. <https://doi.org/10.1136/bmjgh-2021-006615>

Lesson learned: High-volume, deprived clinics alone stall progress; proximity to decision-makers increases adoption.

Recommendation M4: Select pilot sites strategically: diverse type, and near relevant central MoH office, depending on project and country context.

Lesson learned: Mentoring fails in underfunded, disorganized, or understaffed clinics lacking basic equipment.

Recommendation M5: Assess baseline health system capacity before mentoring. Within SAMU, there is a checklist on mentoring pre-conditions available.

Lesson learned: Some lessons learned regarding the pre-conditions for mentoring programmes were already available through and SEU evaluation of a mentorship programme in Mozambique.

Recommendation M6: Read evaluation about similar projects or similar contexts, and capitalize on their lessons learned before designing and implementing an intervention.

Operational & Human Resources

Lesson learned: MSF lacked the mindset/training/experience for HSS; small teams were overstretched.

Recommendation M7: Invest in experienced staff (partnership-building skills, experience with MOH collaboration, long-term mindset).

Lesson learned: MSF struggled with data collection and monitoring was inclined to use metrics suited for direct service, not for health systems strengthening (HSS). Concerning metrics for direct service, MSF struggled to monitor progress in the absence of individual-level data. Some routine data sources (CCMDD) did not allow comparison with non-intervention sites, limiting the interpretation of information.

Recommendation M8: Develop an MSF-tool with HSS-specific indicators, especially if more ‘hands-off’ or ‘light’ approaches working within the Ministry of Health is envisaged for the future.

To strengthen future data analysis of similar projects (e.g. for monitoring and evaluations), there should be provisions (including budget) to collect patient-level data if they are not routinely available and if they are essential to monitor project progress.

When using routinely collected partner data, request access to data from control sites in addition to those from intervention sites for comparison.

RECOMMENDATIONS FOR DOH

The following recommendations may help DOH at implementation level (district, sub-district) in cases of partnerships with NGOs that wish to engage in health systems strengthening approaches. Occasionally, recommendations may also apply at Provincial and Central level, e.g. when it comes to expectations towards NGOs (D1) and securing high-level engagement (D4).

Lesson learned: DOH initially expected direct service provision at scale, not HSS collaboration.

Recommendation D1: Shift expectations of NGOs and think of opportunities how partners can contribute to sustainable approaches to strengthen the health system.

Lesson learned: There was no deep discussion on what improved quality of NCD care means, and what it would require from both partners.

Recommendation D2: Clarify expectations, roles, and responsibilities of each partner in the partnership beyond what is formally agreed in an MOU.

Lesson learned: Mentoring and quality improvements require stable financing, management, and sufficient essential equipment.

Recommendation D3: Secure operational support for partners and **sustain baseline capacity at pilot sites.**

Lesson learned: MSF struggled to access national officials without DOH's support, which impacted smooth project implementation at lower levels in DOH's hierarchy.

Recommendation D4: Facilitate high-level engagement to create support and backing for new initiatives.

Lesson learned: Consultations often failed to reach all levels of DOH's hierarchy.

Recommendation D5: Improve internal communication to avoid misunderstanding and misalignment with the Department regarding activities implemented in the framework of a partnership.

ANNEX A. TERMS OF REFERENCE

Doctors Without Borders/Médecins Sans Frontières (MSF) is an international medical humanitarian organization determined to bring quality medical care to people in crises around the world, when and where they need regardless of religion, ethnical background, or political view. Our fundamental principles are neutrality, impartiality, independence, medical ethics, bearing witness and accountability.

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units tasked to manage and guide evaluations of MSF's operational projects, and works primarily with Operational Centre Brussels. For more information see our website evaluation.msf.org.

Promoting a culture of evaluation is a strategic priority to be accountable, seek for continuous improvements and achieve organizational learning. MSF does not evaluate only because of external requirements, for example donors related ones. These Terms of Reference should be seen as a starting point for the evaluation process. The evaluator(s) are welcome to challenge them and suggest for example different or additional perspectives, as they see fit during the inception phase. The evaluation process should rely on solid methodology to achieve credible results and should also ensure to put values and use in the forefront. The evaluation must involve and include different actors and counterparts in an adequate manner during the whole process.

Evaluation the Eastern Cape NCD project, Butterworth South Africa'	
Starting date:	December 2025
Duration:	Final report to be submitted by latest July, 2026
Requirements:	Interested applicants should submit: 1) A technical proposal 2) A financial proposal 3) CV 4) A previous (appropriate) work sample
Deadline to apply:	Sunday, 28 th .December.2025
Send application to:	evaluations@stockholm.msf.org
Other:	To align with the project's shortened timeframe and maximize the likelihood of observing early outcomes, we anticipate that primary data collection at the project level will take place around May 2026. However, evaluators are encouraged to propose alternative approaches or timing if they believed these would better serve the evaluation objectives. We value quality over quantity. Providing only the requested and necessary documentation should prove your interest, capacity and competency in the best possible manner.

MEDICAL HUMANITARIAN CONTEXT- OR – BACKGROUND

South Africa and Eastern Cape Health Context

South Africa faces a quadruple burden of disease: HIV/AIDS and TB, Non-Communicable Diseases (NCDs), maternal and child health problems, and injuries²⁸. The country operates a dual healthcare system comprising public and private sectors. There are over 400 public hospitals, central, tertiary, regional, and district, managed by provincial health departments²⁹. DOH) faces a contingent liability of approximately R30 billion for medico-legal claims dating back to 2004 and is currently unable to pay suppliers.³⁰

In 2021, the DOH launched a “turnaround strategy” prioritizing four areas of clinical care: maternal and child health, NCDs, mental health, and HIV, with a mandate to seek partnerships for support.

NCDs disproportionately affect people in low- and middle-income countries like South Africa, where 85% of premature NCD-related deaths occur³¹. Evidence indicates that the NCD burden has grown over the past 15 years, contributing to an estimated 37% of all-cause mortality and 16% of disability-adjusted life years (DALYs)³². This rise is linked to four key lifestyle risk factors: poor diet, physical inactivity, tobacco use, and harmful alcohol consumption³³.

South Africa is one of three countries with a policy supporting Differentiated Service Delivery (DSD) models for NCDs and the only one with scaled implementation. These models enable patients to collect chronic medication outside health facilities, through community-based options. DSD has been successfully scaled for HIV and NCD care via facility pick-up points, adherence clubs, and external pick-up points (PUPs) where pre-packed medication is delivered to community sites. However, most external PUPs are located in commercial pharmacies in towns, while much of the population lives in remote rural areas.

The Eastern Cape is among the most challenged provinces in South Africa’s health system. Amathole district, though rural and economically underdeveloped, has a high population density and limited healthcare access. The majority of residents are isiXhosa-speaking and face high poverty and unemployment rates, contributing to elevated crime levels.

The province struggles to meet NCD targets (90-60-50)³⁴ based on the National Health Indicator Data Set, while achieving 91%, 74%, and 88% of global HIV targets—progress that highlights retention in care as the greatest gap³⁵. NCD diagnosis and treatment remain chronically underfunded. A study by Cowan et al. revealed that the NCD directorate is severely under-resourced in budget and personnel and lacks routine data on disease

²⁸ National Planning Commission, Republic of South Africa, Ten-year review of National Development Plan, 2012-2022

²⁹ Ngobeni V, Breitenbach M.C, Aye G.C. Technical efficiency of provincial public healthcare in South Africa. Cost Effectiveness and Resource Allocation. 2020.

³⁰ [Province](#) of Eastern Cape, Provincial Treasury. Annual Report 2021/22 Financial Year.

³¹ Roomaney, et.al. Inequity in the Distribution of NCD Multi-Morbidity Adults in SA: An Analysis of Prevalence and Patterns. Int. J of Public Health. Cape Town, August 2022.

³² National Department of Health. National Strategic Plan for the Prevention Control of Non-Communicable Diseases (NCDs) 2022-2027.

³³ Ajaero, et.al The prevalence and contextual correlates of non-communicable diseases among inter-provincial migrants and non-migrants in South Africa. BMC Public Health. 2021.

³⁴ 90% all people 18 years and over will know whether or not they have raised blood pressure and /or raised blood glucose, 60% of people with raised blood pressure or blood glucose will receive clinical intervention (pharmaceutical and non-pharmaceutical), 50% of people receiving interventions are controlled.

³⁵ Province of the Eastern Cape Health, Annual Performance Plan 2023/2024.

magnitude³⁶. NCD mortality is comparable to infectious diseases, which receive significantly more funding from government and international agencies. Structural gaps in health facilities further undermine integrated NCD and HIV care, leading to poor coverage, low-quality services, mistrust in clinic staff, and weak defaulter-tracing systems. Emergency services are also strained: of 447 ambulances in the Eastern Cape, only 324 are functional³⁷.

In Amathole district, 43% and 36% of deaths among individuals aged 25–64 between 2012 and 2017 were NCD-related, and the district has the second-highest incidence of new diabetes cases (26%) in the province.

MSF involvement in Eastern Cape

MSF has previously supported the Eastern Cape Department of Health through several initiatives: decentralized HIV/AIDS care in Lusikisiki (2003), management of the government drug supply depot in Mthatha (2013), and assistance with the COVID-19 response in Butterworth and Livingstone hospitals (2020–2021).

In September 2022, MSF conducted an assessment of 11 health facilities in Amathole district. The findings revealed poor coverage of diabetes treatment, long travel distances for patients, and gaps in documentation needed to monitor the 90-60-50 Diabetes Management care cascade targets. These results informed the design of a new intervention—the Eastern Cape NCD Project in Butterworth.

MSF Eastern Cape NCD project in Butterworth

The EC-NCD project in Butterworth was designed as a five-year initiative, launched in 2023. Its primary aim, as per project strategy 2025, is to improve quality of care for people living with chronic diseases, focusing on non-communicable diseases (NCDs) such as hypertension and diabetes.

The project was conceived as a catalyst project—defined by MSF’s Strategy Paper (OCB Medical Department 2020–23) as projects where MSF adds value by demonstrating new ways of working, addressing chronic health challenges, developing new expertise, and prioritizing advocacy to drive systemic change.

Rather than providing direct clinical services, the project seeks to achieve its objectives through capacity-building and health system strengthening at the primary health care (PHC) level, in close collaboration with the Department of Health (DOH), partners, and communities. This approach, because of its exclusive hands-off model, applying a vertical program to address NCDs while focusing on systemic improvements have raised questions about how MSF can uphold medical, ethical, and quality-of-care standards while exerting only indirect influence on patient outcomes—an inherent challenge when aiming for systemic improvements within South Africa’s health system.

The project strategy and its ambitions have evolved significantly during the project life. The current general objective is to reduce morbidity and mortality among people living with NCDs in Eastern Cape Province by improving access to screening, diagnosis, and quality treatment through integrated PHC approaches in collaboration with DOH.

The project is structured around four key components:

³⁶ Cowan et.al. Understanding NCDs: combining health surveillance with local knowledge to improve rural primary health care in SA. Global Health Action Volume 14,2021.

³⁷ Province of the Eastern Cape Health, Annual Performance Plan 2023/2024.

1. Support to selected PHC facilities to improve NCD care quality. This support includes mentoring to DOH nurses, donations of HbA1c analysers and piloting point of care testing for patients with diabetes, strengthening data management, and referral of established patients to pick-up Points.
2. Expansion of Differentiated Models of Care (DMC). The project supports Community-Based Organizations (CBOs) and other community actors in establishing and implementing Pick-up Points (PUPs) at community level, for established patients.
3. Community engagement and health promotion. The project organizes radio shows and digital campaigns on healthy habits. It also provides training to CBOs and other community actors on NCD and mental health for them to organize awareness campaigns and other health promotion activities. Other trainings on wider skills to enhance their resilience are also offered to CBOs by the project.
4. Advocacy at provincial, district and national level. The main focus on the advocacy activities is around prioritization to NCDs, integration of NCD services, and establishing point of care using HbA1c.

The project operates in Mquma and Mbashe subdistricts of Amathole district. Seven facilities have been identified for support: Tafalofefe Gateway Clinic, Butterworth Gateway Clinic, Macibe Clinic, Ngqamakawe Community Health Center in Mquma, and Nyhwara Clinic, Gwadana Clinic, Idutywa Community Health Center in Mbashe. MSF plans to develop these into “NCD sentinel clinics”—centers of excellence for NCD care and advocacy to close gaps in clinical activities.

Due to poor data performance, the District Office has officially enlisted MSF’s support for the NCD program. The project will assist district and subdistrict levels in accurate NCD data collection and advocate for improved monitoring and surveillance systems.

The project has faced unexpected implementation delays and is not yet fully operational. Furthermore, internal strategic decisions within OCB have led to an accelerated closure scheduled for the end of 2026, with clinical activities planned to finalize around June-July 2026.

Since its launch, the project has achieved several important milestones. It has provided support to 7 health facilities in Amathole district, trained 134 Department of Health nurses on Non-Communicable Diseases, 21 data capturers on NCD indicators, and 112 CHWs on NCDs. It facilitated the formation of a Partners Forum in Amathole district, conducted 8 digital health promotion campaigns on different chronic disease and healthy lifestyle topics that reached 4,372,585, and organized capacity-building sessions for 10 CBOs in Mquma and Mbashe subdistricts on different topics such as mental health, advocacy, sustainability and empowerment.

PURPOSE AND INTENDED USE

PURPOSE. The evaluation aims to assess to what extent the project improved the quality of NCD care in Butterworth and identify key factors that facilitated or hindered progress. Given the shortened timeframe and apparent limitations in patient data, the evaluability of outcomes versus outputs remains uncertain.

The evaluation will generate lessons on collaborating effectively with a strong Department of Health, focusing on the opportunities and constraints of exerting indirect influence on quality of care. Additionally, it will analyse the role of advocacy and capacity-building in contributing towards this objective.

INTENDED USE. The evaluation findings will guide MSF-OCB in designing and implementing future interventions in contexts where a hands-off approach is the chosen or most appropriate option for MSF. Insights

on the effectiveness of indirect influence, advocacy, and capacity-building will inform strategic choices for health system strengthening and quality of care improvement in similar resource-constrained settings.

EVALUATION CRITERIA AND QUESTIONS

The following questions reflect the interest and priorities of the requesting parties of the evaluation. Evaluators are encouraged to refine or complement these questions and propose relevant evaluative frameworks and criteria during the inception phase. Any proposed changes to the TOR should be clearly explained and justified in the inception report.

1. Improvement of Quality of Care (Outputs or Outcomes)

- To what extent did the project achieve improvements in quality of NCD care in the supported facilities?
- Given the limitations in patient-level data, what proxy indicators or other type of evidence suggest progress toward improved quality of care, and how did this influence the improvements identified above?

2. Hands-Off Approach and Indirect Influence

- How effective was the project's hands-off approach in influencing quality of care?
- What were the main enablers and barriers to exerting influence in quality of care without direct service delivery?

3. Collaboration and Partnership

- How did collaboration with the Department of Health and other stakeholders affect project's ability to improve quality of care?
- What opportunities and limitations emerged from working within a government-led system, and how did these affect project influence?

4. Advocacy and Capacity-Building

- What role did advocacy and capacity-building play in driving improvements in NCD quality of care?
- To what extent were these strategies sufficient to address existing gaps relevant to quality of care, and what lessons can inform future approaches?

EXPECTED DELIVERABLES

1. Stakeholder analysis and engagement strategy

Analysis of primary and secondary stakeholders (MSF and external) relevant for the evaluation, and elaboration of a contextualized plan on their level of engagement throughout the evaluation process.

2. Inception Report

As per SEU standards, after conducting initial document review and preliminary interviews. It will include a detailed evaluation proposal, including theoretical frame and methodology.

Reformulation of evaluation questions, and suggestions of specific evaluation framework relevant to this exercise are encouraged.

3. Real time learning

Systematic and continuous communication with key stakeholders should be maintained throughout the process to foster and document process learning. Regular feedback to and from the SEU, the Evaluation Commissioner and Consultation Group will be an essential part.

4. Working and validation session

As part of the evaluation process at least two working sessions with the CG and the Commissioner are to be held to create space for live discussion on the evaluation's progress, validate preliminary findings and recommendations, and keep track on the contextualization of the evaluation.

5. Draft and Final Evaluation Report

As per SEU standards. It will answer the evaluation questions and will include conclusions, lessons learned and recommendations as well as address and keep track on written and verbal feedback from evaluation stakeholders. An executive summary will be required, and to be delivered additionally as a separate document.

6. Dissemination and Use

A webinar presentation to the MSF movement will be required. Other dissemination products targeting also MSF external intended users of this evaluation is expected but can be explored during the evaluation process. DOH, implementer partners, CBOs, and patients and communities are encouraged to be considered as targeted audiences.

TOOLS AND METHODOLOGY PROPOSED

In addition to the initial evaluation proposal submitted as a part of the application (see requirement chapter), a detailed evaluation protocol should be prepared by the evaluators during the inception phase. It will include a detailed explanation of proposed methods and its justification based on validated theory/ies. It will be reviewed and validated as a part of the inception phase in coordination with the SEU.

RECOMMENDED DOCUMENTATION

- Project documents (project proposals, logistical frameworks, situational reports, annual reports, project visit reports, regular monitoring data on mentoring and awareness sessions)
- Routinely collected patients data (DOH aggregated data on NCD, Patient files)
- MSF guiding documents (OCB strategy, OCB medical reports, MSF medical guidelines, MSF and OCB policies, and others)
- National and regional documentation
- MSF and external literature and documentation of similar experiences

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	Not specified
Timing of the evaluation	December 2025 to July 2026

PROFILE/REQUIREMENTS FOR EVALUATOR(S)

- **You should bring with:**
 - Solid experience in evaluation
 - Formal background in Medicine, Public Health, Epidemiology or other relevant fields.
 - Experience in NCD programming and clinical interventions
 - Experience in quality-of-care improvement
 - Professional experience in South Africa or Southern Africa region.
 - Proficiency in English (written and spoken)
 - Strong facilitation and stakeholder engagement skills

- **How you will stay out:**
 - Experience in health policy or advocacy work for health system strengthening
 - Experience in DSD and community-based programming for HTA and/or Diabetes
 - Experience or insight-understanding of MSF's way to operate
 - Knowledge and proficiency of relevant South African languages (isiXhosa or others)

ANNEX B EVALUATION MATRIX

		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
1. Partnership Input	1.	To what extent did the partnership between MSF and the provincial DOH provide sufficient inputs to produce an effective partnership that led to the desired partnership output i.e. improved quality of care for NCDs in supported facilities?	Evidence of inputs from mentioned data sources, and extent to which they are linked to specified outputs	MoU, project reports	KIIs (DOH MSF cell, project management)	
	1.1	How clear were the objectives of the partnership (i.e. the partnership problem) to both sides? Were they clear from the outset of the partnership?	Data sources including objectives of partnership Mentions of clarity (or lack thereof) in partnership objectives Mentions of objectives set in relation to partnership timeline	MoU, project reports	KIIs (DOH MSF cell, project management)	
	1.2	What resources did each partner contribute (technical, financial, human, material, knowledge, networks), and were these sufficient for the partnership processes and outcomes to happen?	Partnership resources appearing in data sources Data sources linking resources to partnership process and outcomes. Data sources indicating (in)sufficiency of resources	MoU, project reports	KIIs (DOH MSF cell, project management)	

2. Partnership Process		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
	1.3	Were there any initial constraints or contextual factors that shaped how the partnership could function?	Data sources highlighting constraints or contextual factors with regards to partnership.	MoU, project reports, partner communication (e.g, e-mails, letters)	KIIs (DOH MSF cell, project management)	
	2.	To what extent did the processes established by the partnership between the Eastern Cape DOH and MSF facilitate partnership functioning and ultimately produce improved quality of care for NCDs?	Evidence of processes and extent to which they link to specified examples of partnership functioning, or specified outputs in terms quality of NCD care.	MoU, Project reports, partner communication (e.g, e-mails, letters)	KIIs (DOH MSF cell, project management, RST, SAMU)	
	2.1	To what extent were partnership arrangements—such as roles, responsibilities, procedures, and coordination mechanisms—clear, timely, and functional enough to enable effective collaboration throughout the project period? Which elements were put in place to maintain the partnership (e.g. roles, procedures), and were they present from the beginning?	Data sources describing roles, responsibilities, procedures, coordination. Data sources mentioning elements that maintained partnership collaboration, also in relationship to project timeline.	Project reports, DOH documents, partner communication (e.g, e-mails, letters)	KIIs (DOH MSF cell, project management, RST, SAMU)	

		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
	2.2	Which elements in the partnership between MSF and DOH (e.g. leadership, roles, procedures, communication, problem solving) most strongly enabled or constrained partnership performance?	Elements that constrained or enabled partnership performance in project documents, communication Extent to which data sources mention elements that constrained or enabled partnership performance.	Project reports, DOH documents, partner communication (e.g. e-mails, letters)	KIIs (DOH MSF cell, project management, RST, SAMU)	
	2.2.1	How did these influence the achievement of the intended partnership output?	Evidence from the same sources of how these elements influenced partnership output.	Project reports, DOH documents, partner communication (e.g. e-mails, letters)	KIIs (DOH MSF cell, project management, RST, SAMU)	
	2.2.2	How effectively did MSF navigate these enablers and constraints?	Evidence from the same sources mentioning the role of MSF in handling partnership elements that influenced partnership output.	Project reports, DOH documents, partner communication (e.g., e-mails, letters)	KIIs (DOH MSF cell, project management, RST, SAMU)	

		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
3. Partnership Output	3.	To what extent did the partnership contribute to meaningful improvements in structure, processes and outcomes of NCD care in the supported facilities?	Extent to which evidence from data sources supports quality of care improvements in supported facilities. Level of improvement from quantitative monitoring indicators showing level of improvement compared to baseline Percentage of medical records showing improvement in quality of NCD care	Monitoring data, project reports, DOH reports, surveys	KIIs (DOH MSF cell, project management, RST, SAMU) FGDs (patients, nurses, other clinic-level DOH staff, CHWs, CBO staff)	Clinic processes: checklist consultations, checklist facility amenities and their utilisation Checklist CCMDD, medical record review
	3.1	Structure				
	3.1.1	To what extent were the structural elements that the partnership provided (capacity-building, donation of equipment, refurbishments, enhancing CCMDD) sufficient and appropriate to contribute to improvements in the quality of NCD care?	Quantity of structural elements provided by the partnership. Evidence from KIIs and FGDs indicating extent of sufficiency and appropriateness, and contribution to improvements in the quality of NCD care. Change of % of consulting rooms (in sentinel clinics) with designated	DOH and MSF Monitoring data, project reports, DOH reports, donation certificates	KIIs (DOH MSF cell, project management, RST, SAMU) FGDs (patients, nurses, other clinic-level DOH staff, CHWs, CBO staff)	

		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
			BP machine and glucometer, or change of number of BP machines and glucometers compared to baseline. Change in nurses trained in NCD management as percentage of all nurses in the supported facilities compared to baseline. Change in trainings conducted for CBOs and CHWs on NCDs compared to baseline. Change in number of HL group members capacitated for HL group facilitation compared to baseline. Number of MSF-supported PUPs approved by NDOH. Changes in a) number of SOPs or protocols for DM and HT b) content of these SOPs; compared to baseline.			
	3.2	Process				
	3.2.1	To what extent have improvements in the processes of NCD care		DOH and MSF Monitoring	KIIs (DOH	Clinic processes:

		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
		(diagnosis, patient management, management of complications, treatment adherence) been realised, and what was the project's contribution to these improved processes?	% of mentees with at least 75% competency score on NCD management and difference from baseline. Sources identifying improvements in process of NCD care. Improvements attributed to project.	data, project reports, DOH reports and - guidelines, surveys (e.g. HbA1c capitalisation data)	MSF cell, project management, RST, SAMU)	checklist consultations, checklist equipment utilisation Checklist CCMD (PUP)
	3.3	Outcomes				
	3.3.1	Which evidence (quantitative and qualitative) suggests an improved quality of NCD care (from the clinical, patient and health systems perspective), in the supported facilities, and to what extent has the project contributed to these improvements? Which gaps in quality of NCD care remain despite project attempts to address them?	Number of clients enrolled in CCMD from sentinel clinics, compared to baseline Number of patients screened for HTN and DM, compared to baseline Number of POC HbA1c tests done, compared to baseline Number of people reached with awareness sessions	DOH, MSF and SyNCH Monitoring data, project reports, DOH reports and - guidelines, surveys	KIIs (DOH MSF cell, project management, RST, SAMU)	Clinic processes: checklist consultations, checklist facility amenities and their utilisation

		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
4. Cross-cutting			Number of people reached with Digital HP campaigns Number of HL groups sessions conducted. Evidence from project logframe or TOC, and KIIs, linking interventions to outcomes. Statements from patient FGDs supporting improved quality of NCD care. Gaps: Quantitative indicators that show little or no improvement Statements identifying gaps in quality of care.			
	4	To what extent did the MSF–Department of Health partnership generate actionable lessons and good practices in intervention design and implementation, and what do these imply for the potential replication or adaptation of similar partnership-based				

		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
		interventions in comparable contexts?				
	4.1	What good practices and lessons learned in intervention and project implementation can be identified? What was the contribution of the partnership with DOH to these good practices and lessons learned?	Good practices and lessons learned identified by data sources. Contributions attributed to project in identified good practices and lessons learned. Data sources identifying structural elements as drivers of NCD quality of care. Data sources' information about capacity building as driver of quality of care for future approaches.	Project reports, DOH reports	KIIs (DOH MSF cell, project management, RST, SAMU)	Clinic processes: checklist consultations, checklist facility amenities and their utilisation Checklist CCMD
	4.2	Which of these good practices can lend themselves for replication or scale-up? Which contextual factors have to be considered?	Identified good practice suitable for replication or scale-up. Contextual factors mentioned when discussing suitability for replication or scale-up.	Project reports, DOH reports	KIIs (DOH MSF cell, project management, RST, SAMU)	
	4.3	To what extent was the project prepared to manage these types of operations? Which adjustment or	Identified elements of preparedness or ignorance about managing a hands-off approach.	Project reports, DOH reports	KIIs (DOH	

		EVALUATION QUESTIONS	INDICATOR	DESK REVIEW	KII, FGD	DIRECT OBSERVATION
		capacities are needed in order to run similar projects successfully?	Adjustments and capacities identified as necessary element to run projects with hands-off approach		MSF cell, project management, RST, SAMU)	

ANNEX C. GUIDE KEY INFORMANT INTERVIEW

Informed consent statement:

Thank you for your time to meet with me. My name is _____ and I am the evaluator / working on behalf of the evaluator who is conducting the evaluation of the MSF project Eastern Cape NCD project.

The evaluation covers the period 2023 to date.

The information gathered will support evidence-based decision-making, inform policy and strategic planning, and strengthen future programming. *Alternatively (e.g. implementing staff)* The information gathered will help to improve future projects like this one with MSF on NCDs.

It will help MSF to find new approaches to work. Your participation in this interview is entirely voluntary and declining to participate has no consequences for you. You may also leave at any time during the interview if you feel uncomfortable or you have to attend to other duties.

The interview will last approximately one hour. You don't need to answer all questions if you feel you cannot comment, for whatever reasons.

I would like to inform you that the safety of key informants and information about key informants is a priority for our evaluator. All information collected will be anonymous. The information will be used only for this evaluation and would not be available in any other cases.

Do you consent to this interview?

I would also like to ask for your consent to the audio recording of this interview. In order to maintain a high level of data security and to protect the interview process, we will use a secure server based in Switzerland to store the interview, which will be deleted once the analysis is complete.

Do you consent to the audio recording of the interview?

Do you have any questions for me at this stage?

Start recording and ask respondent to repeat consent

Key Questions – tailored to each stakeholder group.

General

Name:

Gender:

Location (country) of key informant(s):

Functional title:

Organisation:

Role:

(All stakeholders)

Please tell me a little about your position and your role in the MSF NCD project in Eastern Cape *[describe the project as the respondent is likely to know it]* Prompt: *How long have you been in that role?*

QUESTIONS FOR ADVISORS, MANAGERS AND SUPERVISORS

Input

1. Can you tell me briefly about the history of your participation in the partnership with MSF / DOH?
 - 1.1. What were the objectives of the partnership?
 - 1.2. Were they clear from the beginning?
2. What kinds of resources have you (has your organization) contributed to the partnership? *Clarify: financial, in kind, immaterial like networks, contacts, commitments*
 - 2.1. How much time do you (does your organization) devote to the partnership with MSF / DOH?
3. To what extent were the contributions of the partners sufficient to realise the objective of the partnership i.e. improved quality of NCD care in the supported facilities?
4. Were there initial constraints or contextual factors that had an impact on the functioning of the partnership?

Processes

5. Can you tell me about your overall impression of the partnership with MSF / DOH?
 - 5.1. What elements were put in place to maintain the partnership? Were they present from the start? *Prompt: roles, procedures, leadership, communication*
 - 5.2. Which elements in the partnership helped to realise the partnership's objectives? *Prompt: leadership, roles, procedures, communication, negotiating, problem-solving*
 - 5.3. Can you tell me about ways of working that supported this process?
 - 5.4. Can you tell me about ways of working that inhibited this process?
6. Can you tell me how these supporting and inhibiting factors influenced enhancing the quality of care for NCDs? **For MSF respondents:** What opportunities and limitations emerged from working within a government-led system, and how did these affect project influence?
7. What do you think are the partnership's greatest accomplishments?
8. Do you remember an occasion when you were particularly impressed with the functioning of the partnership with MSF / DOH?
9. Do you remember an occasion when you were particularly disappointed with the functioning of the partnership with MSF / DOH?
10. What is important for a creating/maintaining a successful partnership?

Outputs

Structure

11. What structural elements did the partnership provide with the objective to improve quality of NCD care? *Prompts: capacity-building, procurement of equipment, refurbishments, enhancing CCMDD, logistical and organizational assistance*
12. To what extent was that sufficient to address existing gaps relevant to quality of care?

Process

13. To what extent have improvements in the quality processes of NCD care (diagnosis, patient management, management of complications, treatment adherence) been realised? Can you explain the project's contribution to these improved processes?
14. **For MSF respondents:** What were the main enablers influencing quality of care without direct service delivery?
15. **For MSF respondents:** What were the main barriers influencing quality of care without direct service delivery?

Outcomes

16. How do supported facilities show that quality of NCD care (from the clinical, patient and health systems perspective) has improved? What makes you think that?
 - 16.1. Which improvements were fully realised because of the contribution of the partners?
 - 16.2. Which improvements were partially realised despite efforts of the partners?
 - 16.3. Which improvements were not realised despite efforts of the partners?

Cross-cutting

17. What good practices and lessons learned can you think of? What do you think of the role of capacity building to improve quality of care?
 - 17.1. What was the contribution of the partnership to these good practices or lessons learned?
18. Which of these good practices be replicated or scaled up? Which contextual factors have to be taken into account?
19. **For MSF respondents:** To what extent was the project prepared to manage these types of operations, i.e. hands-off and relying on capacities of existing health authorities? Which adjustment or capacities are needed in order to run similar projects successfully?

Closing questions.

20. Is there anything related to [project] that we have not discussed that you would like to point out?
21. Do you have any further questions?

Thank you very much for your time and for sharing your views!

QUESTIONS FOR IMPLEMENTING STAFF

Introduction as above

Please tell me a little about your position and your role in the MSF NCD project in Eastern Cape *[describe the project as the respondent is likely to know it]* Prompt: *How long have you been in that role?*

Partnership

1. Can you tell me about your overall impression of the project with MSF / DOH?
2. What worked well and what worked less well in the partnership / project?
3. What do you think are the partnership's / project's greatest accomplishments?

Quality of care

Structure

4. What did the project put in place to improve quality of NCD care? Prompts: classroom trainings, mentoring support in the consulting room from MSF nurse mentors, provision of equipment, refurbishments, enhancing CCMDD referrals, logistical and organizational assistance
5. Which of these things contributed most to improve quality in NCD care?

Process

6. To what extent did the management of NCDs (diagnosis, patient management, complications, adherence) improve since MSF and DOH partnered? Please give specific examples of this from your personal experience. What was the contribution of the project to these improvements?

Outcomes

7. To what extent can you see in the facilities that quality of NCD care has improved? What makes you think that?
 - a. Which of these improvements were fully realised because of the project?
 - b. Which of these improvements were partially realised because of the project?
 - c. Which of these improvements were not realised despite the project?
8. What do you think of the role of capacity building (like classroom sessions, and side-by-side mentoring) to improve quality of care?

Cross-cutting

9. Can you mention any good practices and lessons learned?
10. Could such good practice work elsewhere? Where, in which situation?

Closing questions.

22. Is there anything related to [project] that we have not discussed that you would like to point out?
23. Do you have any further questions?

Thank you very much for your time and for sharing your views!

QUESTIONS FOR CBOS

Introduction as above

Please tell me a little about your position and your role in the MSF NCD project in Eastern Cape *[describe the project as the respondent is likely to know it]* Prompt: *How long have you been in that role?*

Partnership

1. Can you tell me about your overall impression of the project with MSF / DOH?
2. What worked well and what worked less well in the partnership / project?
3. What do you think are the partnership's / project's greatest accomplishments? What are you proud of?

Quality of care

Structure

4. What support did the project give you / your organisation?
5. Which of that support contributed to improve quality in NCD care?

Process

6. What other things improved when it comes to NCDs? (Prompt: diagnosis, treatment, adherence) improve?

Outcomes

7. To what extent can you see that quality of NCD care has improved? What makes you think that?
 - d. Which of these improvements were fully realised because of the project?
 - e. Which of these improvements were partially realised because of the project?
 - f. Which of these improvements were not realised despite the project?
8. To what extent has the project realised improvements that would not have happened otherwise?
9. What do you think of the role of capacity building (classroom session trainings, side-by-side mentoring) to improve quality of care?

Cross-cutting

10. Can you mention any good practices and lessons learned?
11. Could such good practice work elsewhere? Where, in which situation?

Closing questions.

12. Is there anything related to [project] that we have not discussed that you would like to point out?
13. Do you have any further questions?

Thank you very much for your time and for sharing your views!

ANNEX D. GUIDE FOR FOCUS GROUP DISCUSSIONS

Ensure that there are some refreshments (drinks and snacks) for the participants.

Introduction of facilitator:

Informed consent statement:

Thank you for your time to meet with me. My name is _____ and I am working on behalf of the person who is doing the evaluation of the MSF project Eastern Cape NCD project. An evaluation means that you look into what worked and what can be improved. We are independent, which means we are not linked to MSF, or to DOH or any other party in this project.

The project started in 2023, so the questions are about 2023 until now.

The information you give will help to improve future projects like this one with MSF on NCDs. It will help MSF to find new approaches to work.

Your participation in this interview is entirely voluntary and declining to participate has no consequences for you. You may also leave at any time during the interview if you feel uncomfortable or have to attend to other duties.

The discussion will last approximately one hour and a half. You don't need to answer all questions if you feel you cannot comment, for whatever reasons.

I would like to inform you that the safety of participants in this discussion is a priority for our evaluator. If you are worried or upset because of some questions, please tell me as facilitator. You can also contact [name] on this number [write on flip-over or whiteboard or piece of paper]

All information collected will be anonymous. The information will be used only for this evaluation and will not be available in any other cases.

I would also like to ask for your consent to the audio recording of this interview. Nobody, except for the evaluator, will have access to it. The recording will be deleted once the evaluation is complete.

Do you consent to this interview and its recording?

Do you have any questions for me at this stage?

Start recording and ask respondent to mention their name (only first name is okay if they don't want to give their full name) and repeat consent.

PATIENTS

Structure

1. How easy is it to access health services for diabetes or high blood pressure in your community?
2. Are you satisfied with the availability of medicines and staff?

Process

3. Were you screened/tested for high blood pressure or diabetes during your (last) visit?
4. Did you feel that the appropriate time and attention was given by the consulting nurse to managing your diabetes or hypertension?
5. Did you receive clear instructions on managing your condition?
6. Were you referred to specialists or other services if needed?
7. Did you get any information about your condition? From whom? Did you understand that information? Could you follow-up the advice given? If not, why not?

Outcomes

8. Have you seen improvements in your condition since starting treatment?
9. What do you think of the overall quality of care you received for your condition? Has the quality of care for your condition changed the past two years? What got better, and what got worse? How come?

HEALTH CARE PROVIDERS (NURSES, CHWS, CLINIC MANAGERS)

Clarify that when we speak about NCDs we mean diabetes and hypertension

Structure

1. What facilities and equipment are available for NCD management (i.e., diabetes, hypertension)?
 - 1.1. Are essential medicines for diabetes and hypertension consistently available? Has anything changed the past 2 years?
 - 1.2. Are essential diagnostic tests and equipment for diabetes and hypertension consistently available? Has anything changed the past 2 years?
 - 1.3. How is staffing (e.g., doctors, nurses, dietitians) allocated for NCD services? Has anything changed the past 2 years?
 - 1.4. Who else apart from the consulting nurse or doctor in a routine clinic visit plays a role in the care of diabetes and hypertension (Prompts: CHWs, counsellors, dieticians)? Has anything changed the past 2 years?
2. Are there clear guidelines/protocols for NCD screening, diagnosis, and treatment?
3. How satisfied are you with your work in caring for diabetes and hypertension? What can be improved? What works well? (prompts include all the bullets above as well as others they may come up with)
4. How satisfied are you with the training you received on NCD care (classroom training and side-by-side mentoring)?
5. Is there ongoing training for staff on NCD management?

Process

6. Which data on NCD services are collected? How are they used for decision-making?
7. How are patients screened for NCDs (e.g., blood pressure, blood sugar)?
8. Are there any new initiatives or tools being used to improve NCD quality? Since when are they in place?

9. What services are patients receiving (e.g., medications, lifestyle counseling)?
10. What happens when a patient comes to the clinic?
 - 10.1. How often do patients come?
 - 10.2. When are they referred to CCMDD?
 - 10.3. When are they referred to a doctor or specialised service?
 - 10.4. How are follow-up appointments and chronic care visits done?

(Patient Engagement)

11. Tell me how patient education and empowerment works.
12. Tell me how patients are involved caring for their own disease.
13. Are patient feedback mechanisms in place (e.g., complaints, suggestions)?

Outcomes (Effects of care on health status)

Outcome

14. Have you seen improvements in hypertension/diabetes control in your facility in the past 2 years? How can you tell? Please give specific examples

Thank you for your time and information!

ANNEX E. OVERVIEW OF STAKEHOLDERS FOR KEY INFORMANT INTERVIEW OR FOCUS GROUP DISCUSSION

STAKEHOLDER	MODE	NUMBER OF KIIS OR FGDS	OUTLINE OF TOPICS
<i>MSF</i>			
Project Staff management level:	KII	5	QoC, Partnership
Project staff implementation level	KII	2	QoC
Project staff implementation level (Community Health Workers)	FGD	1	QoC, capacity building, job satisfaction
MSF management and support: SAMU, Brussels	KII	6	QoC, Partnership
<i>Department of Health (DOH)</i>			
Provincial Level: leadership, management level representative	KII	2	Partnership
District Level: management level representative	KII	2	QoC, Partnership
Sub-District Level: management level representative	KII	2	QoC, Partnership
Facility Level: Nurses in PHC facilities	FGD	4	QoC, quality of training / capacity building, job satisfaction
Operational Managers (OMs) in target facilities	FGD	1	QoC, partnership, capacity building
Operational Managers (OMs) in target facilities	KII	1	QoC, partnership, capacity building
Community Health Workers	FGD	1	QoC, capacity building, job satisfaction
<i>Community-Level Stakeholders</i>			
Patients	FGD	1	QoC, access
Patients	KII	6	QoC, access
External Pick-Up Points (PUPs) volunteers or staff	KII	3	QoC
<i>Other External Partners</i>			
International NGO (American Healthcare Foundation)		1	partnership
Total KII		29	
Total FGD		8	

ANNEX F. CHECKLISTS

CHECKLIST PRIMARY CARE CLINICS

Facility name:

See the facility manager and confirm that permission has been granted to assess this facility and take photographs. Thank him for his time and hospitality.

See the facility manager for KII if person is available, asked and gives consent

GENERAL	COMMENTS		
Services provided			
Average Number of patients/day			
Facility operates since (year)			
Staffing Nurses Pharmacist Data clerks Clinical officer CHW Psychologist Social worker			
How often are nurses / other staff trained? What does it mean? How often supervision? What does it mean?			
How is data flow from patient chart to computer / DHIS2?			
Filing system			
Amenities	Yes	No	Comments
Patient registration and flow			
Waiting area			
Health education in waiting area?			

GENERAL	COMMENTS		
Pharmacy			
Stock ruptures past 3 months			
Details			
<i>Medication available for hypertension</i>			<i>Note if expiry date is close or stock is low</i>
Hydrochlorothiazide 12,5 mg			
Amlodipine 5 mg			
Amlodipine 10 mg			
Enalapril 10 mg			
Enalapril 20 mg			
Spironolactone 25 mg			
Metoprolol 50/100 mg			
Acetylsalicylic acid 80 mg			
Methyldopa 250 mg			
Other			
<i>Medication available for diabetes</i>			
Insulin, short-acting/intermediate			
Metformin 500/850/1000 mg			
Glimepiride 1 mg			
Glibenclamide 2.5 mg			
Simvastatin 10/20/40 mg			
Other (needles, syringes for insulin)			
Laboratory			<i>Ask about any stockouts past 3 months</i>
Glucose, blood			Lab test / Test strips
Glucose, urine			Lab test / Test strips
HbA1c			
- Equipment in place			
- Check utilization log			

GENERAL	COMMENTS		
- Maintenance log			
Creatinine			
Lipids, cholesterol			Lab test / Test strips
Specimen collection material			
Sample transportation system			TAT
SOPs			Visible, accessible, do staff know?
Other	Yes	No	Comments
BP meters in consultation room			
Gloves			
Soap			
Water			
Alcohol			
Working computers			Number, accessibility, internet
SOPs			Visible, accessible, do staff know?
- Hypertension			
- Diabetes			
- Equipment maintenance			
Guidelines			Which?
APC clinical tool			
Health promotion material			
- Hypertension			
- Diabetes			
- Healthy diet			
- Physical exercise			
Comments			

GENERAL	COMMENTS
Signed	Date

CONSULTATION CHECKLIST

Verify permission of nurse and patient before attending each consultation

Explain process to nurse; stress observation is for evaluation purposes only, it is not a job performance assessment.

1. APC ADHERENCE AND CONSULTING PROCESSES	COMMENTS
Ask quick key psychosocial questions at the start of the consultation	
Correctly screen a patient for diabetes	
Correctly diagnose a patient with diabetes	
Correctly evaluate other organ systems that may be linked to diabetes	
Correctly identify and manage a patient presenting with hyper- or hypoglycaemia	
Complete the requirements of an initial visit for a patient with diabetes	
Correctly recommend non-pharmacological interventions	
Appropriately provide health education or refer to a health educator	
Appropriately provide adherence counselling or refer to an adherence counsellor	
Take appropriate action on normal and abnormal blood results	
Make the correct pharmacological treatment recommendations	
Identify stable patients and refer to appropriate fast-track options (fast-track lane for pharmacy pick-ups, meds distribution points, PUPs)	
Identify patients needing referral and refer appropriately	
2. Skill	
Demonstrate the relevant examinations in the care of a diabetic patient	
Write concise, clear and relevant notes in the correct stationery	
Enter relevant diabetic data into the tick register	
Explain the significance of the data being captured (including consequences of too little or too few data entries)	

1. APC ADHERENCE AND CONSULTING PROCESSES	COMMENTS
Correctly select and refer patients to a CCMDD option when stable	
3. Attitude/behaviour	
Demonstrate empathetic engagement with a diabetic patient	

ANNEX G. ETHICAL ASPECTS OF THE HANDS-OFF APPROACH

Reflection on the ethical implications of the hands-off approach was not included in the Terms of Reference and is therefore not part of the formal evaluation. Nevertheless, given the specific nature of the Eastern Cape NCD project within MSF, and at the request of the commissioner, this annex presents reflections by the evaluator on the ethical considerations associated with this operational model.

These reflections are informed by the evaluation findings but should be read as the evaluator's interpretation of potential ethical considerations and trade-offs rather than as formal evaluation findings. They are intended to stimulate discussion on how hands-off approaches relate to MSF's ethical, humanitarian, and operational values.

Unlike MSF's more traditional service delivery approaches, the project sought to improve patient outcomes primarily through support to and collaboration with the Department of Health rather than through direct provision of care by MSF staff. This raises questions about how such an approach relates to principles of medical ethics, including beneficence, non-maleficence, autonomy and justice, as well as MSF's humanitarian values of humanity, impartiality, independence and proximity to patients.

Given the project's results, the hands-off approach does not violate the basic rules of **medical ethics**. There was no harm to patients, rather, through its training and mentoring programme, health promotion and PUP services in the community, the hands-off interventions brought improvements to patients and promoted their well-being. Patients, MSF staff or DOH staff noted various of improvements in NCD care to which the project activities contributed. The hands-off approach also included health promotion and lifestyle counselling, which contribute to patients' health literacy and thus to their ability to make informed decisions about their own treatment and health care. Bringing services closer to communities where patients live through establishing additional PUPs and enhancing CCMDD carries a justice element. The aim of external PUPs was to set them up in rural communities that have little access to services. By establishing these PUPs, and doing outreach in delivery of medication, some of the inequalities in access to health services for these communities may have been mitigated.

Neutrality, impartiality, independence and humanity belong to the core principles of humanitarian action. **Neutrality**, not taking sides in a situation of armed conflict, does not apply to projects in South-Africa. **Impartiality**, prioritising interventions where the need is highest, has been observed by the project in several ways. MSF OCB selected the Eastern Cape as one of the poorest provinces with poor NCD indicators, and within Eastern Cape selected Amathole district as a district where poverty and unemployment rank high, and with one of the lowest expenditures per PHC headcount, high NCD prevalence rates and low treatment coverage. Within the district, the project prioritised work in high-volume facilities, some of which are rather remote. In summary, respecting impartiality is indifferent to the implementation approach, whether it is providing direct services, or working through a Ministry of Health in a hands-off approach. Being able to provide services in an impartial way depends on the relationship with authorities, and their understanding of and respect for

humanitarian principles, in other words on the quality of the partnership. One could argue that a hands-off approach poses a risk to **independence**, as the health authorities are in the lead and can deny MSF to work in a particular area or address a certain problem. In the case of the Eastern Cape NCD project, preconditions for a good partnership were fulfilled such as trust and mutual understanding, while both partners realised their mutual dependence on each other without this affecting fundamental project choices e.g. those related to impartiality. Complete independence from any authority is an illusion, also when MSF provides its own services hands-on. Also in such a situation, MSF needs an MoU with authorities, needs certain permissions and approvals from those in power in order to implement humanitarian action. Therefore, independence does not depend (no pun intended) on a hands-on or hands-off implementation approach. Finally, there is the principle of **humanity**. For MSF, it means alleviating suffering, protecting human dignity. These principles show themselves through compassion with people who suffer, respecting and recognising them as human beings. **Proximity**, being next to people in distress as an MSF operational value can be seen as rooted in the principle of humanity. It is perhaps humanity that at first sight may be at risk under a hands-off approach. It is clear that being next to patients is not part of a hands-off approach. In the case of the Eastern Cape NCD project, the hands-off approach was aimed at strengthening systems and does not involve direct, clinical patient care. Less proximity does not mean one does not respect patients, and their communities, as people whose dignity and autonomy is to be protected and whose suffering needs to be alleviated. Implementing a hands-off approach also means that MSF staff is dealing with building their networks, its health care system counterparts, who are also part of the same community that the patients are coming from – certainly at a very decentralised level like the sub-districts and even more so when it concerns contacts with CBOs and CHWs as also happened in this project. Therefore, humanity and proximity is not the prerogative of clinical care. It is a mindset that can, no should, transpire through actions ‘even’ in a hands-off approach. One small, but concrete example may be that the nurse mentor needs to check if the nurse mentee can ‘demonstrate empathetic engagement’ with the patient.

While the hands-off approach clearly comes at a cost to proximity, there is potentially a trade-off in this case between proximity and **sustainability**. While sustainability is not among MSF’s core operational objectives, it has its own merit to design and implement an intervention that is having its effect long after MSF leaves. This is typically not the case when MSF ceases a hands-on humanitarian intervention despite a handover to local authorities or another NGO. The project achieved some sustainable elements e.g., where DOH staff mention that NCDs are now more top of mind for them since MSF implemented the project, or when one DOH representative mentioned that DOH now adopted MSF training approaches i.e., not only lecturing but a mix of lecturing and interactive methods. There is much more potential for sustainability in this project exactly *because* of its hands-off, systems strengthening approach. The nurse-mentoring approach could be institutionalised through TOTs and thus be more sustainable, the extended PUP-with-services could be more firmly established, more advocacy around HbA1c POC could result in scale-up and a place in a revised guideline. This sustainability potential is not likely to be realised, however, because of the decision to close the project one year ahead of time. MSF return of investment in the system (also in its people), therefore, will be low and far below what could have been achieved if the project was left to

run the full implementation period, which is already short as it is, given the systems strengthening approach and the slow start of the project, effectively leaving barely 2 years for implementation. Quite a few interviewees from both MSF and DOH have expressed their regret at the short implementation period and some of them argued that implementation of a systems strengthening project on NCDs should typically run 10 years, much in the same vein as the Khayelitsha project. With the current shortened implementation, one could also argue that it comes at the cost for patients, who cannot benefit from robust improvements to the NCD health services they so desperately need.