

BACKGROUND

The Eastern Cape Non-Communicable Diseases Project (EC-NCD project) aims to improve the quality of care for people living with NCDs, particularly diabetes and hypertension, by building the capacity of nurses and community health workers, alongside broader health system strengthening efforts at the primary health care level. A distinctive feature of the project is what MSF refers to as a **hands-off approach**: care is delivered by Department of Health (DOH) staff rather than directly by MSF.

The evaluation aims to assess the extent to which the project contributed to improving the quality of NCD care in Butterworth and to identify the key factors that facilitated or hindered progress. It also seeks to draw lessons on how effective partnership with the Department of Health can support improvements in NCD care.

METHODOLOGY

-  Mixed-method approach
-  Desk review
-  Observation of consultations and facility assessments
-  40 Patients file review
-  29 key informant interviews and 8 focus group discussions with MSF and DOH staff, community-level stakeholders, patients and external partners.

RECOMMENDATIONS FOR MSF

Partnership & Engagement

- Engage at national level early and balance bottom-up and top-down approaches.

Project Design & Strategy

- Clarify objectives, priorities and expectations upfront when using a non-standard operational model.
- Plan for an extended project timeline (5–10 years).
- Select pilot sites strategically, considering diversity and proximity to relevant MoH structures.
- Assess baseline health system capacity before mentoring.
- Draw on lessons from similar projects and contexts during design and implementation.

Operational & Human Resources

- Invest in experienced staff (partnership-building skills, experience with MOH collaboration, long-term mindset).
- Develop an MSF tool with Health System Strengthening (HSS)-specific indicators for hands-off or light-touch approaches.

RECOMMENDATIONS FOR DOH

In case of partnerships with NGOs engaging in health system strengthening approaches.

- Shift expectations of NGO partners and explore how they can support more sustainable approaches to strengthening the health system.
- Clarify roles, responsibilities and expectations of each partner beyond the MoU.
- Secure operational support for partners and sustain baseline capacity at pilot sites.
- Facilitate high-level engagement for new initiatives.
- Improve internal communication to reduce misunderstanding and misalignment.

MAIN FINDINGS

Were the inputs provided by MSF and the provincial DOH sufficient to support the partnership objectives?

MSF provided capacity-building, organised awareness campaigns, supported community mobilisation, funded external pick-up points (PUPs), and supplied equipment. DOH provided access to staff, facilities, data and consumables, endorsed interventions, and facilitated MSF participation in reviews. While MSF's inputs were generally sufficient to strengthen quality of care within supported facilities, the project's relatively small scale, the strained operating context, operational challenges and logistical constraints limited its broader effects.

Did the processes established by MSF and the provincial DOH support the partnership objectives?

Partnership processes generally supported collaboration and implementation, although communication challenges, unclear decision-making pathways, and data-sharing constraints caused delays. Regular coordination meetings (at sub-district, district, and provincial levels), ad-hoc exchanges, and informal interactions helped maintain relationships, with trust, openness, and transparency seen as key elements. Constraints included inconsistent communication across DOH levels, uncertainty around mandates, and weaknesses in data-sharing and recording systems. MSF adapted its approach, and despite the challenges, district-level collaboration remained strong and supported achievement of partnership objectives.

Did the partnership contribute to improvements in the quality of NCD care in the supported facilities?

The partnership improved several structural and process dimensions of NCD quality of care, including nurse competencies, clinical decision-making, consultation practices, record keeping and equipment. HbA1c testing supported more timely treatment adjustments and counselling, although equipment shortages and operational constraints sometimes limited its use. Evidence of outcome-level change remained limited, but case finding was generally higher in MSF-supported facilities and the percentage of controlled diabetes patients increased. Patient experience was mixed, nurses reported that understaffing and heavy workload compromised care quality, while CHWs expressed satisfaction with the new tools and interest in expanded roles.