

EVALUATION OF

THE EASTERN CAPE NON- COMMUNICABLE DISEASES PROJECT

South Africa
January 2023 – June 2026

SUMMARY REPORT

SEPTEMBER 2026

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).

It presents a summary based on the full evaluation report. We invite readers to refer to this report for more details as well as nuances and formulations from the evaluation team.

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.

INTRODUCTION

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.