UNIVERSITY OF KWAZULU-NATAL

MONOTORING AND EVALUATION IN PUBLIC GOVERNANCE: A CASE STUDY OF THE KWAZULU-NATAL DEPARTMENT OF HEALTH

THEMBEKA MARY-PIA MNGOMEZULU

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MONITORING AND EVALUATION IN PUBLIC GOVERNANCE: A CASE STUDY OF THE KWAZULU-NATAL DEPARTMENT OF HEALTH

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Submitted in the fulfilment of the requirements of the degree of Doctor of Administration in the School of Management, Information Technology and Governance, College of Law and Management Studies, University of KwaZulu-Natal, Durban – Westville. South Africa.

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Submitted: 2014

DECLARATION

I, **Thembeka Mary-Pia Mngomezulu** declare that:

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DEDICATION

I dedicate this work to my husband, Phillip Dumisani Mngomezulu; my son Ziphezinhle and my daughter-in law Noluthando; my daughters, Thandeka Mhlanga, Thabiso Gumede, Ntokozo and Fezile Mngomezulu; not forgetting my grandchildren Nceba, Nombulelo, Khuthazelani, Siyamthanda, and Kwakhona. Finally, I also dedicate this work to my maiden family name, Mncadi; to this clan, Shazini!

ABSTRACT

Monitoring and evaluation (M&E) systems have in the recent past attracted attention as an important management tool that monitors performance and evaluates outcomes against set targets and within set timeframes. This means that M&E measures efficiency and effectiveness of programmes or interventions. However, despite the introduction of the Government-Wide Monitoring and Evaluation (GWM&E) System in 2007, performance was not sufficiently achieving the overall goal of the Department of Health (DOH) - optimum health for all the citizens of the Province. This deficit was expressed by the populace through media reports and corruption that was rife in the Government in general and in the DOH in particular. Simultaneously, the establishment of the DPME in the Presidency at national level resulted in the M&E being a “buzz-word or a magic bullet” (Chilimo 2009: 320) that would solve all performance problems, improve service delivery and rid of corruption.

The study examined the effectiveness and efficiency of the M&E System of the DOH and its use as a management tool throughout all the spheres of the Department, namely: Province, Districts and Sub-districts or Facilities. A combination of the M&E Theories and the Public Administration Models formed the theoretical foundation of the study. The investigation was conducted in the Head Office (at Province) and in the Districts and the Facilities using the Unit and Component Managers at Head Office; the District Managers, their Deputies, Programme Managers, District Information Officers and the Facility Information Officers.

Data collection was undertaken through structured interviews of 12 participants at management level; and ten focus group discussions conducted in the eight selected districts and the two at Head

Office. Over and above this, the document reviews were undertaken in reports and other relevant Department records.

Findings of the study indicated that despite the fact that the M&E System in the DOH was introduced in 2008; four years later it has still not been accepted by the majority of Programmes and Components particularly at Head Office. It was partially accepted at the district level. Although the Clinical Managers accepted it, they did not fully comply with some of the Framework prescripts. The non-clinical Managers did not completely feel part of the whole process. At facility level little was known about the M&E, which caused it to be poorly implemented. The study also established that poor implementation was because the M&E System was not well introduced from its inception - readiness assessment and participation was not undertaken. The staff felt that it was imposed on them resulting in poor political will. This condition was aggravated by other factors, namely: lack of the M&E structure; the M&E function not incorporated in the job descriptions of the relevant staff; the lack of knowledge of the M&E concepts; lack of necessary skills to implement M&E as well as the negative attitudes of the staff, which was counteractive to the implementation.

In addition to the lack of capacity, there were inadequate data collection and verification tools; and standard operating procedures. This resulted in the poor mainstreaming of the M&E System and poor utilisation as a management tool throughout the Department. Such findings resulted in the proposal of a new model to evaluate the M&E System of the Department. The proposed model was not tested; once tested it could be adapted and used in other departments or organisations as the case may be.

The study recommended that a review of the M&E System of the Department be conducted. In this regard, the priority should be the establishment of a structure that will be committed to the mainstreaming of M&E and the creation of a conducive environment. A red thread should run through the structure from the Head Office through to the facilities and vice versa. This means that a

top-down and bottom-up approach should be adopted. Its function should change from the silo function and adopt a participatory approach which will involve the relevant stakeholders. The study also recommends that the M&E System should have a framework that has an Implementation Plan that monitors its implementation. The Framework should incorporate all the activities necessary to drive the process of mainstreaming the M&E System, namely: data quality measures, data verification systems, dissemination, usage and reporting to mention but a few. The M&E Framework should also include a guideline for the districts, programmes and facilities to develop their own M&E Implementation Plans to monitor the District Operational Plans based on the District Health Plans.

Furthermore, an M&E Forum should be established with the terms of reference that will enable representation of all the Units. This Forum would be responsible for the review of the system, its implementation and serve as an information sharing platform. Training on M&E should be conducted for all the staff on an on-going basis and the induction for the newly employed should include a module on M&E. The correct data collection tools should be in place and the standard operating procedures are available in order for all to understand systems and processes. Additionally, the study recommends that at Head Office a Health Information Team should be formed and similar teams reinstated at all levels. In order for the Teams to properly scrutinise the data (and reports), they should be supported and guided by the M&E Component.

Finally, the study recommends regular reviews of the M&E system of the Department. A model that was developed and proposed for evaluating the M&E system should be used periodically to assess if the M&E System is succeeding in achieving its goal.

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LIST OF ABBREVIATIONS AND ACRONYMS

10-PPP	10-Point Plan Priorities
AIDS	Acquired Immuno-deficiency Syndrome
APP	Annual Performance Plan
ART	Anti-retro Viral Therapy
CEO	Chief Executive Officer
CHC	Community Health Centres
CHW	Community Health Workers
COGTA	Co-operative Governance and Traditional Affairs
DHIS	District Health Information System
DHP	District Health Plan
DIO	District Information Officer
DOH	Department of Health
DPA	Department of Public Administration
DPME	Department of Monitoring and Evaluation
DQPR	District Quarterly Progress Report
EPMDS	Employee Performance Management and Development System
FIO	Facility Information Officer
GAF	Generic Assessment Framework
GWM&E	Government Wide Monitoring and Evaluation Framework
HAST	HIV, Anti-retroviral Therapy, Sexuality Transmitted Infections and Tuberculosis
HIT	Health Information Teams
HIV	Human Immuno-deficiency Virus

KRA	Key Results Area
KZN	KwaZulu-Natal
KZNDOH	KwaZulu-Natal Department of Health
M&E	Monitoring and Evaluation
MCWH	Mother, Child and Women's Health
MDG	Millennium Development Goals
MEC	Member of Executive Council
MMS	Middle Management Service
NDOH	National Department of Health
NPM	New Public Management
NSDA	Negotiated Service Delivery Agreement
OPS	Operational Plans
PGDS	Provincial Growth and Development Strategy
PHC	Primary Health Care
PMES	Performance Monitoring and Evaluation System
PMTCT	Prevention of Mother to Child Transmission
PMS	Performance Measurement System
RSA	Republic of South Africa
SMS	Senior Management Service
SOP	Standard Operating Procedure
Stats SA	Statistics South Africa
TB	Tuberculosis
UNAIDS	United States Agency international development
UNFPA	United Nations Population Fund

CHAPTER ONE

INTRODUCTION

1.0 Introduction

The purpose of this chapter is to introduce the study and provide a layout as well as the background information that forms its basis. The chapter also presents a general overview of the Provincial Department of Health as an entity, its summarised monitoring and evaluation (M&E) system and the M&E developments in other parts of the world. The problem statement, objectives and broad areas for investigation are also discussed with further explanation of why the study is significant. The research methodology provides a summary of research design. Based on the primary objectives, are few assumptions that guide the study; and are also included in the research methodology. At the end of the Chapter, there is a presentation of the structure of the thesis.

1.1 Background

Internationally, the number of governments working towards the improvement of their performance is growing. Governments improve performance by setting up systems to measure and facilitate understanding of performance whether good or poor. These are the M&E systems developed to measure, among others, the quantity and quality of the governments' or organisations' products or services - the outputs, the outcomes and the resultant impacts. Evidence shows that the M&E Systems are the centre for the achievement of good governance. According to Mckay (2007: iii), M&E systems are a requirement for achieving "evidence-based policy making, budget decisions, management, and accountability". Regarding this connotation, the extent to which M&E

information is used to improve performance of a government, is a yardstick for its success.

There are several reasons for the increased need to establish or strengthen the M&E systems, which differ from country to country and from government to government. For instance, in 1998 the Australian Government developed systems that would conduct an evaluation of the programmes. This practice was done every 3 to 5 years and the expenditure and the process was managed by the Department of Finance (Mckay 2007: 38). As a result the new Financial Year budget proposals are guided by the findings from such evaluations. In Colombia, the M&E System is managed by the Department of National Planning. Where the relevant manager has underperformed, he is required to submit an explanation. Regular management control meetings are held with each Minister. In 1994 the Government of the United Kingdom established a system for performance targets in the Public Sector. Departments make presentations on performance after every 6 months for internal planning and accountability purposes. In 2002 the United States established a Programme Assessment Tool to measure government performance. It allocated a responsible office to analyze the M&E information on programme performance. Latin America is no exception to this practice as it already had 20 countries working towards strengthening their government M&E Systems (Mckay 2007:17).

The World Bank also did the same to countries who borrowed from it. The Poverty Reduction Strategy also exerts pressure on member states putting emphasis on monitoring of performance towards realization of the Millennium Development Goals (MDGs) and reporting on them (Mckay 2007:17). South Africa is no exception with regard to reporting on the MDGs.

Mckay (2007:19) further revealed that in Africa there are more than 16 National Evaluation Associations. Some of these are in Nigeria, Ruwanda, Kenya and South Africa. These Associations are, however, challenged by limited M&E Champions and capacity constraints. Uganda and Tanzania have a good understanding of the importance of reliable and comprehensive performance information. Other countries in Africa prepare their National Plans and draw their budget based on the M&E information. It is crucial to mention that these countries face a challenge of not reviewing their M&E systems; have problems with data quality; and have too much data with insufficient information owing to lack of capacity and weak government demand for M&E information (Mckay 2007:19).

In South Africa the Office of the Presidency has established a Directorate of Monitoring and Evaluation as well as Administration. This occurred after the introduction of the M&E Framework known as the Government-wide Monitoring and Evaluation System (The Presidency 2007:5). The Government–wide Monitoring and Evaluation System (GWM&E) Framework states that, the M&E System is a Public Sector tool that evaluates Public Service's performance and identify the factors which contribute to Public Service's delivery outcomes (The Presidency 2007: 9). This is a tool that "encourages inter-governmental relations and systems integration across and within the spheres of government" (Sahadeo 2012: 2). The first M&E principle is to contribute to improved governance which is transparency, accountability, participation and inclusion (The Presidency 2007: 9). The announcement made by the Minister of Performance Monitoring, Evaluation and Administration (2010/07/07) stated that since 1994 despite enormous steps by the Government in providing services to the citizens, there have been massive increases in expenditure which barely produced the required results, hence the results-based measurement approach (www.thepresidency.gov.za). This elaboration demonstrates that the South African Government is committed to the

implementation of the GWM&E System. All the South African Government Departments have started to develop their respective M&E Systems based on this framework.

In 1998 the KZN DOH developed the Departmental M&E Framework. This Framework was used immediately though it was officially adopted and signed later by the Head of Department (KZN Provincial M&E Framework: 2010: i). The main purpose of this Framework was to "propose the parameters within which M&E can function to promote accountability and transparency by providing relevant stakeholders with appropriate performance information at all levels of the health care system. The M&E framework is flexible to embrace the changing priorities of the Department" (KZN Provincial M&E Framework 2010:7).

Owing to the need to fulfil and promote accountability and transparency, the Department had to generate quality reports that would display these attributes. Besides the pressure to achieve the four MDGs' targets by 2015, the government's commitment to the MDGs was emphasised in the Negotiated Service Delivery Agreement . The Negotiated Service Delivery Agreement "is a charter that reflects the commitment of key sectoral and inter-sectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government" (Negotiated Service Delivery Agreement Output 2: 3). The Health Minister and the provincial MECs has signed the agreement having 12 key outcomes with key indicators for its programme of action for the period 2010 – 2014 spread over all the Government sector (Day and Gray 2010: 211). The priority for the health sector is to improve the health status of the society and to contribute to Government's vision of "A Long and Healthy Life for All South Africans", which is line with the MDGs. The strategic outputs enlisted by the Negotiated Service Delivery Agreement (Output 2:3) for this are as follows:

Output 1: Increasing Life Expectancy;

- Output 2: Decreasing Maternal and Child Mortality;
- Output 3: Combating HIV and AIDS and decreasing the burden of diseases from Tuberculosis; and
- Output 4: Strengthening Health System Effectiveness (Sourced from the Annual Performance Plan 2010/11 - 2012/13: 38).

The above outputs have set targets and a timeframe of 2014. Tangible achievements that show improvements in the effectiveness of the health system must be attained and substantiated by pragmatic evidence that clearly links to the four output areas. The DOH is also required to achieve the National Health Systems 10 Point Plan Priorities by 2014. Amongst the outputs that constitute the National Health Systems which the DOH is expected to meet is Priority Eight: Mass mobilization for better health for the population. This Priority includes the Millennium Development Goals (MDGs), which should be met by 2015 (as a set timeframe). These MDGs are to:

1. Eradicate severe poverty and hunger;
2. Reduce child mortality;
3. Improve maternal health; and
4. Combat HIV and AIDS, malaria and other diseases (The Department of Health KwaZulu-Natal Annual Performance Plan 2010 - 2012/13:34 - 35).

Evidently, this mammoth work calls for a rigorous monitoring and evaluation system.

In its endeavor to meet these requirements, the DOH is constrained by limited financial and human resources.

It is, therefore, crucial to strengthen the M&E systems to measure performance towards good governance, as per the above discussion. Like other governments that have taken a stand on strengthening their M&E systems, the South African Government in general and the DOH in particular is no exception.

1.1.1 The statement of the problem

For more than three years the Department of Health in KwaZulu-Natal was the centre of focus with several media reports and direct allegations of poor health service delivery that illustrated how the Department was failing in its performance. Such publicity could be symptomatic of challenges faced by the Department in the attainment of its objective to provide quality health service to the people. This could raise doubts on the effectiveness of the M&E System towards provision of results-based performance (that would facilitate the achievement of expected objectives). It is important also to look at good governance within the realm of the M&E System. As the situation was such that the Department could not meet its objectives, it implied that the principles of governance (transparency and accountability) were not applied. Also, poor performance could demonstrate lack of usage of the M&E information, meaning that the department did not use the M&E system as a departmental management tool. Questions that emanated were: 1) How the Department's M&E System developed? 2) How well was the Department's M&E System performing? The study seeks to answer these questions. The results from a study conducted by Professor Cameron (2008:5), from the University of Cape Town that investigated Public Service Reform in South Africa between 1999 and 2008, showed that several elements of the New Public Management had been used over several years but was unsuccessful owing to the lack of guidelines and skills on performance management; and commitment from the implementers.

As reported by Cameron (2000: 5), initiatives towards good governance were challenged by lack of financial capacity in the Department. This was not completely new as Collins (2000: 26) observed that the same conditions were experienced in Botswana during its transition. Collins states that during the previous era in Botswana communities were divided, which was also experienced within the government set up at all levels causing

lack of integration in the work environment. He further asserts that a state where there is no sense of responsibility (inherent fragmentation instead) is not limited to certain countries, but it is experienced by most countries in transition. According to Collins (2000: 294), to curb this fragmentation, concrete strategies are required to strengthen public service following a structural adjustment. Taking this into account, the researcher conducted a minor situational analysis (baseline study) to map performance of the KZNDOH against the basic values and principles that govern Public Administration as enshrined in the Constitution (Constitution of the Republic of South Africa of 1996 Chapter 10). According to the Constitution, the basic values and principles are also a requirement for all Departments to comply if service delivery is to be improved. These values and principles are listed below:

a) A high standard of professional ethics must be promoted and maintained.

It is a concern that the Department deals with people's lives and it is required to render service that would improve life expectancy; and the health status of the citizens by providing quality health care service;

b) Efficient, economic and effective use of resources must be promoted.

Providing quality health care service required meticulous policies, strategic plans, Operational Provincial Health Plans, Annual performance Plans and commitment through governance - participation, transparency and accountability (The Presidency 2007: 3);

c) Public administration must be development-oriented.

The continuous and disturbing public complaints and dissatisfaction on the efficiency of the health service raised more concerns;

d) Services must be provided impartially, fairly, equitably and without bias.

The latter factor being the issue of governance, raises an aspiration to evaluate the Departmental M&E System; taking cognizance that, governance as a principle of the M&E system, could best be attained where there is close performance monitoring and regular reporting (The Presidency 2007: 9);

e) People's needs must be responded to, and the public must be encouraged to participate in policy-making.

In conducting this study the researcher will be developing her research capacity and add to the body of scientific knowledge on performance management and good governance in the public sector. This will benefit other departments within the Provincial Government and the citizens of the KZN Province through improved quality of health care service (The Presidency 2009: 4);

f) Public administration must be accountable.

To ensure accountability the Department has a 5 year Strategic Plan that affects all levels. This is measured through reporting on the indicators in the Annual Performance Plan (APP), the National Health System 10 Point Plan Priorities the Negotiated Service Delivery Agreements Negotiated Service Delivery Agreement and the Millennium Development Goals (MDGs) within it. Reporting on these is aimed to ensure continuous monitoring of progress towards achievement of targets set in the APP and the Operational Plan. The generation of the Treasury Quarterly Reports also aimed at ensuring accountability. However, the extent to which compliance occurs towards this principle needs to be established;

g) Transparency must be fostered by providing the public with timely, accessible & accurate information.

The Departmental data management system is required to ensure that data is captured and is accessible in the District Health Information System (DHIS) and made available to relevant stakeholders on request. The M&E Component should perform data analysis, circulates and disseminate reports to Programme Managers, Component Managers, Districts and the lower levels of the Department. Reports should be kept where all stakeholders can access them;

h) Good HR Management and career-development practices, to maximise human potential, must be cultivated.

Lately, there are new developments in the Human Resource (HR) Section. For instance, bursaries are awarded, nurses graduated, employees participated in Adult Basic Education and Training, practitioners in different fields are trained and there is evidence of partnerships established with other training institutions. It is required that monitoring towards achievement of targets in this regard is undertaken; and

i) Public administration must be broadly representative of the SA people with employment & personnel management practices based on ability, objectivity, fairness, and the need to redress the imbalances of the past.

It is a requirement that the human resource management adheres to the prescripts that recognizes equity in the employment of different racial groups according to the prescripts laid down in the Employment Equality Act 2010 in order to redress the imbalances created by the previous government.

Looking at the Department's performance against the above-mentioned basic values and principles led to the researcher choosing the topic for the study. Additional factors

that were causal to the choice of the topic were the need to investigate how and to what extent the M&E System in the KwaZulu-Natal Department of Health is used by the Programme Managers as a management tool. The study will explore use of the M&E information in planning and decision-making for improving service delivery. This is important because the South African Government has mandated the entire Department to implement the Government Wide M&E System in order to ensure governance.

Different countries have admitted that using M&E Systems to monitor their performance enable them to determine if they are making any progress towards the realization of their goals and objectives. They also periodically or at the end of the project evaluate whether they have efficiently and effectively utilised allocated resources. This research will contribute positively to debates on monitoring and evaluation systems as this is a new concept which is not yet widely understood in the South African Government; and towards developing a model to follow for conducting evaluation in the respective departments. It will be of particular interest to the departments' evaluations of their M&E Systems as the National Department of Performance Monitoring and Evaluation (DPME) has recently published the Evaluation Framework to be followed by the entire government (Department of Performance Monitoring and Evaluation 2011: 5).

1.1.2 Purpose of the study

The study seeks to critically review how the existing M&E system had developed; how well it was performing; the extent to which the M&E information was used to improve the performance of the Department towards reaching its goals and objectives; and the extent to which good governance had been achieved.

1.1.3 Primary objectives of the study are to:

1. Critically examine the M&E governance arrangements nationally and provincially and within the three provincial spheres of the DOH;
2. Examine to what extent the M&E was complied with in the DOH;
3. Establish the level of commitment of the senior management towards the implementation of the M&E Framework in the Department and used as a management tool (in planning and decision-making);
4. Evaluate the M&E capacity of senior management in the DOH;
5. Explore challenges and remedial actions towards improved utilization of the M&E information policies and their implementation; and
6. Determine important facts to consider for evaluating the M&E system in the Department.

1.2 Broad problems to be investigated

1.2.1 Capacity of management to effectively and efficiently manage M&E in the Department of Health

To understand how well capacitated the Senior Managers were, to be able to manage the M&E system of the Department with efficiency and effectiveness.

1.2.2 Compliance of the Department of Health to the basic tenets of good governance

To understand if the Department realised the basic tenets of governance (transparency, accountability, participation and inclusion), which were core to the efficiency of the Department.

1.2.3 Compliance of the DOH to the tenets of the existing GWM&E System

To understand DOH compliance to the assumptions of the GWM&E System as it was a Framework to which the Public Sector should adhere.

1.2.4 The extent to which the M&E information was utilised in management

Monitoring and evaluation systems formed a context for governance and thus quality service. The study was set out to understand to what extent the DOH utilized the information obtained from M&E reports in decision making and planning.

1.2.5 The M&E challenges in the Department and how they could be addressed.

The study seeks to understand the DOH work environment, its culture and challenges that are inherent as they may impact on performance and service delivery.

1.3 Key questions to be answered

1. Is the DOH being efficiently and effectively managed?;
2. Is the Department complying with the basic tenets of the GWM&E System and of good governance?;
3. What benefits were accrued from the Departmental M&E System?;
4. What are the M&E challenges currently being faced by the Department and how should they be addressed?; and
5. What are the essential elements of an Evaluation Framework for an M&E System for the Department?

1.4 Assumptions of the study

The study was guided by the following assumptions:

1. Compliance to the M&E Framework would enhance performance (efficiency and effectiveness) of the Department;
2. The level of commitment of senior management towards the implementation of the M&E Framework in the Department would contribute to information use (as a management tool for planning and decision-making);
3. The M&E capacity of senior management in the DOH would ensure effective implementation of the System (efficiency and effectiveness);
4. Identifying the challenges and applying the remedial actions would result in improved utilization of the M&E information policies and their implementation; and
5. To improve the M&E System required determining facts to consider in the evaluation of the M&E System in the Department.

1.5 Significance of the study

The above discussion indicates that there was an urgent need for the provision of quality health service to the community of the KZN Province. South African history has revealed that its Public Service was isolated from international development**.** When the New Public Management (NPM) Philosophy was introduced, the Government was still in transition from the apartheid to the present regime.

Despite the fact that the SA Constitution laid down the basic values and principles that should govern Public Administration, the Public Service had not entirely implemented them; rendering this legislature and policy+ to only exist in theory. It was only after the

establishment of the Human Resource Development Framework by the National Government that the NPM was taken seriously (Human Resource Development Strategic Framework 2008: 30). The on-going capacity challenge in the Public Service remained. When the MEC of the DOH took position in 2009, he referred to it in his Budget Speech (Dlomo 2009:3).

In the KZN Provincial DOH, the Planning, Monitoring and Evaluation Unit had been in existence for more than five years. Within this Unit, there was a Monitoring and Evaluation Sub-component established in 2007. As a result, the Department had an M&E Framework designed by this sub-component and an existing M&E System. With these resources in existence, it is sensible to examine the Department's performance and good governance towards achieving its goal. It is also crucial to mention that South Africa, like many developing countries experienced a health crisis due to the increasing burden of disease. The issue of co-infection between TB and AIDS aggravated the health status. This was evidenced by an increase in TB infection amongst HIV infected people as well as increased deaths due to TB/AIDS; child and maternal death rates; other factors contributing to the burden of disease will be discussed in Chapter two in the section on disease profile mentioned before (Mid-term Report DOH 2009: 10).

The above illustration of the problem hypothetically showed that the basic values and principles that govern Public Administration and good governance, to a certain degree, impacted on the performance of the Department. Failure to comply could be attributed to inefficiency in the Departmental M&E System. However, as this was just an assumption its reality and the extent to which these factors impacted still needed to be established. The research project set out to establish this in greater detail; for that reason, it was significant to conduct a study of this nature as it was also hoped that the findings would

enlarge the body of scientific knowledge and shed more light on the emerging Performance Management Approach in South Africa.

1.6 Definition of concepts

Monitoring is a systematic ongoing assessment of an intervention or a programme with indicators against which the extent of progress and achievement of objectives is measured (Mckay 2007:141). Monitoring involves data collection, collation, analysis, interpretation and reporting based on identified indicators. It is also an exercise that primarily provides management and the main stakeholders of an intervention with early indications of progress, or lack thereof, in the achievement of results and progress in the use of allocated funds (KZN Provincial M&E Framework 2010:3). In disease management in the public health field, UNAIDS (2008: 13) refers to impact monitoring in health-related events as tracking the prevalence or incidence of a particular disease, which is also referred to as surveillance.

Monitoring provides information that will be useful in:

- Analysing the situation in the community and its project;
- Determining whether the inputs in the project are well applied;
- Identifying problems facing the community or project and finding solutions;
- Ensuring all activities are carried out properly by the right people and in time;
- Using lessons from one project experience on to another; and
- Determining whether the way the project was planned is the most appropriate way of solving the problem at hand (UNFPA 2004:3).

Evaluation is “a periodic, selective exercise that attempts to systematically and objectively assess progress towards and the achievement of an outcome or defined impact” (KZN Provincial M&E Framework 2010:3). The evaluation process attempts to

assess relevance, efficiency, effectiveness, impact and sustainability of interventions or programmes. UNAIDS (2008: 13) contends that there is a type of evaluation called formative evaluation which is intended to improve performance undertaken during the design and pre-testing of the intervention or programme. This according to Mckay (2007: 139) is called the **Ex ante** evaluation which he also agrees is performed before the implementation of an intervention or a programme. Mckay goes on to explain **Ex post evaluation** as the evaluation that is performed after the intervention or a programme has been completed (Mckay 2007:139). In disease management, Claiborne, Vandenburgh, Krause and Leung (2002: 61-70) refer to evaluation measurement as a means to demonstrate the level of treatment (or intervention) effectiveness within and across programmes. Regarding this contention, outcome evaluation attempts to attribute observed changes to the intervention tested.

Monitoring and Evaluation

Monitoring and evaluation systems are closely related as they are necessary management tools to inform decision-making, planning and accountability. This means that as much as evaluation does not substitute monitoring, monitoring does not substitute evaluation. However, analytically generated monitoring data is critical for successful evaluations (United Nations Population Fund - UNFPA 2004:1). Findings from monitoring and evaluation are significant for making a decision on whether to continue or terminate a programme (Thornhill 2006: 686). The characteristics of monitoring and evaluation are tabulated below:

Table 1.1: Characteristics of Monitoring and Evaluation

Monitoring	Evaluation
Continuous	Periodic milestones such as mid-term of programme implementation: at the end or a substantial period after programme conclusion
Keeps track, oversight, analyses and documents progress	In-depth analysis; compares planned with actual achievements
Focuses on inputs, activities, outputs, implementation processes, continued relevance, likely results at outcome level.	Focuses on outputs in relation to inputs; results in relation to cost. Processes used to achieve results; overall relevance; impact and sustainability
Answers what activities were implemented and results achieved	Answers why and how results were achieved. Contributes to building theories and models for change
Alerts managers to problems and provides options for corrective actions	Provides managers with strategy policy options
Self-assessment by programme managers, supervisors, community stakeholders and donors.	Internal and or external analysis by programme managers, supervisors, community stakeholders, donors and or external evaluators.

Sourced from The United Nations Population Fund Division for Oversight Services (2004: 3).

At this point, it is important to mention that there are basically four types of monitoring and evaluation, namely:

- Input indicators: describe the proceedings in the project. For instance the number of bricks brought on site and amount of money spent;
- Output indicators measure products and services resultant from the completion of activities within a development intervention. That is, the project activity - number of classrooms built;

- Outcome indicators denote changes in development conditions which occurred between the completion of outputs and the achievement of impact. For instance they describe the product of the activity - number of pupils attending the school; and
- Impact indicators measure positive and negative long-term effects on identifiable population groups produced by development intervention, whether directly, indirectly, intended or unintended. These are on a large scale where they measure change in conditions of the community - reduced illiteracy in the community (The UNFPA 2004: 2).

Governance generally refers to authority and control and can be well defined in a particular context or on the kind of a government or an organisation. Within the context of the corporate world, governance is viewed as placing emphasis on enhancement of performance (King Report 2002: 5). Kearsey and Wright (1997: 2) declare that governance enhances corporate performance through "supervision or monitoring of management performance and ensuring accountability of management to shareholders and other stakeholders". Munshi and Abraham (2004: 52) define governance as "participative, responsible, accountable, based on principles of efficiency, legitimacy and consensus for the purpose of promoting rights of individual citizens and the public interest". The Presidency (2007: 3) defines governance as constituting participation, transparency, inclusion and accountability.

Effectiveness is one of the core objectives of evaluation. It is the extent to which the desired outputs and outcomes of a programme or an intervention has achieved the desired outcomes, that is, the achievement of results (United Nations 2008: 12). Effectiveness asks the question of whether the job achieved the desired result (KZN Provincial M&E Framework 2010: 30). Effectiveness is also used as aggregate measure of (or judgment about) the merit or worth of an activity. That is, the degree to which an

intervention has attained the main objectives as expected or in a sustainable manner and with a positive institutional development impact. This means that effectiveness assesses if the programme or an intervention has produced intended effect (Mckay 2007: 138; Thornhill 2006: 687).

Efficiency measures the productivity of the programme intervention (UNFPA Tool number 5 2004: 5)**.** It captures how effectively resources are translated into service delivery. It asks the question of whether the job was performed without wasting resource, that is, it measures results against cost. Efficiency indicators are usually measured by an input/output ratio or an output/input ratio (KZN Provincial M&E Framework 2010: 30).

According to Mckay (2007: 138), the term efficiency is a "measure of how economically resources or inputs (funds, expertise, time, etc.) are converted to results". The United Nations AIDS (2008: 12) defines efficiency as a measure of how economical are inputs (resources such as funds, expertise, and time) converted into results. This ascertains if there was adequate justification for the expenditure incurred and examines if resources were spent as economically as possible.

Thornhill (2006: 286) concludes by stating that outcomes evaluations assess if programmes were effective - benefits achieved in relation to the costs incurred: efficiency.

1.7 Scope and limitation of the study

This study critically reviewed the extent to which the existing DOH M&E System developed; how well it performed; the extent to which the M&E information was used to

improve performance of the Department towards reaching its goals and objectives; and the extent to which good governance was achieved.

By establishing the above-mentioned issues, the study critically examined the M&E governance arrangements nationally and provincially within the DOH. This would impact on different categories complying with the M&E Framework Implementation Plan and use the M&E System as a management tool towards policy formulation, planning and decision-making. The M&E capacity of the staff in general and of the senior management in particular would determine the extent to which the M&E System would be successful in achieving the Departmental goals.

The possibility for a project/programme to have inherent challenges is always there and exploring such challenges and possible remedial actions towards improved utilization of the M&E information policies and their implementation would be an advantage. This would bring about contributions towards the important facts to consider for the evaluation of the M&E System in the Department.

In investigating the M&E information usage by senior management in policy formulation, planning, management and decision-making, the study was limited to the DOH services provided by the categories in the management positions. The study investigated some of the relevant national and provincial policies and strategies for the development of the M&E framework and its utilisation for improving performance towards good governance. Owing to the nature of the study, it was difficult to measure empirically how M&E Systems improved individual performance. However, an attempt was made to evaluate the M&E System's implementation and how best it can be reviewed for inclusion, participation and transparency for all so that the political will is developed and sustained; and has impacted on the optimal health for the citizens.

1.8 Research methodology

A detailed discussion of the methodology of the study will be discussed in chapter four, however, a brief overview is provided. The purpose of this study was to investigate the extent to which the existing M&E has developed; how well it performed; the extent to which the M&E information was used to improve the Departmental performance towards reaching its goals and objectives; and the extent to which good governance had been achieved. This investigation was carried out by examining the extent to which M&E System was used as a management tool using a case study in the DOH.

The study adopted a qualitative study design. The qualitative methodology was undertaken where a case study was used for a qualitative design. The case study facilitated a diagnosis of the DOH M&E System that would help in developing the Action Plan. Findings would map future M&E systems of the Department and also provide information for evaluation of the M&E system.

The Study Population

The study population was the employees in the DOH at all levels; i.e. at the levels of Senior and Middle Management Service levels as well as employees directly involved in the M&E implementation (M&E Officials). The external stakeholders, persons directly involved in the implementation of the Government M&E Policies in their respective Departments or Organisations, also formed part of the study population.

Though the study had several hypotheses based on the study objectives, there were two hypotheses that it needed to establish a relationship between the two variables namely:

Null hypothesis = There is no relationship between M&E information use and good governance.

Alternative hypothesis = There is a positive relationship between M&E information use and good governance.

Basically, the purpose of this research was to test if such predictions were true. The research questions formulated were based on these hypotheses. Whether these propositions were proved or disproved will be stated together with the study results.

Sampling

The qualitative methodology used **Convenience sampling** (recruitment of participants that were near at hand, easy to recruit and participants that it was felt would easily respond); **Snow-balling sampling** (study participants pointed out others who met similar criteria); and **Purposive sampling** (selection done on the basis of the researcher's decision/discretion of participants who fitted a specific purpose in her/his mind as an expert). This sampling method was also used on groups of stakeholders with particular characteristics in the monitoring and evaluation of the programmes within the Heath Districts in the DOH.

Though this was a qualitative study, quantitative sampling methodology was used where simple random sampling to ensure that all participants had an equal chance of being selected. A sampling frame with all employees at the Senior Management Services (SMS) and Middle Management Service levels and the M&E Officials was used.

Data collection

Primary data - the original data was collected by the researcher using questionnaires, unstructured interviews and focus group discussions as data collection tools. These data collection techniques are discussed briefly below:

Interviews

Face to face and in-depth (unstructured) interviews were used. Where this was not possible, telephonic interviews were used as an alternative. This provided the researcher an opportunity to probe the dimensions of the problem.

Focus group discussions

Unstructured Focus Group Discussions were also conducted.

Questionnaires

Self-administered questionnaires were circulated to some SMS and MMS Managers, M&E Officials as well as external stakeholders. However, this was a method of data collection that had challenges which are discussed in the section on challenges in data collection.

Secondary data was also adopted. Data was obtained from document reviews conducted from several sources amongst the Department's abundant information relevant to the study. These sources included books, articles in journals, magazines, newspapers, archived material, published statistics, Department's quarterly, annual and mid-term reports, Strategic and Annual Performance Plans; the M&E Framework, the internet as well as the Acts of Parliament. Other sources of information were national and provincial government legislation and policy documents on service delivery; national and provincial workshops and interdepartmental M&E Forum meetings.

Validity

In order to have valid data, triangulation of methodologies was undertaken. This involved use of different data sources as mentioned above. A detailed discussion on validity is provided in chapter four.

Data analysis

Qualitative data derived from the interviews and focus group discussions were analysed using a thematic approach. Data presentation to relevant stakeholders was done using graphs, tables and narratives. The methodology used in this study is explained in detail in Chapter Four.

1.9 The structure of the thesis

At the beginning of the thesis, there is a list of acronyms and glossary of names and concepts used in the dissertation. This list precedes chapter one of the thesis.

Chapter One: Introduction

In brief, this chapter provides general introductory information about the study that includes its overview; the background information of the problem; the objectives and the significance of the study. The scope and a brief outline of the research methodology used to carry out the study are also outlined.

Chapter Two: Provincial Governance and Development in KwaZulu-Natal with particular reference to the Department of Health

This chapter defines governance and presents the situational analysis of the Department of Health in order to provide the context in which this study is based. The chapter also highlights the governance structure, the historical background of the Provincial Health Care System, the current health demographics and the service delivery status.

Chapter Three: Monitoring and Evaluation in South Africa: Legislative and Policy Aspects

This chapter explains the developments regarding the Monitoring and Evaluation system in South Africa in general and how the M&E system in the Department of Health developed. This discussion involves the literature review conducted in order to establish which problems and answers other researchers have encountered in their research in a similar field. This is undertaken to position this study within similar studies; and available knowledge in the similar research area. The chapter also elaborates on the legislative and policy aspects that also add to the context of the M&E system, its Framework and Implementation Plan.

Chapter Four: Research Methodology

This chapter presents methods and procedures followed to conduct research. It provides all segments of the research design and methodology that were adopted. This includes data collection and statistical procedures used to analyse data. An elaborate explanation of procedures followed and experiences that transpired during the process of data collection are also provided.

Chapter Five: Data Presentation, Analysis and Interpretation of results

This chapter presents the study results; a discussion on interpretation of the study results by attributing meanings and implications of the results. Results are presented in the form of figures, tables and narratives.

Chapter Six: General Conclusions and Recommendations

This chapter summarises the findings and also provides the conclusions of the study. Recommendations are presented based on findings and in relation to the research questions and primary objectives of the study. There is also a presentation of

important issues to consider for the evaluation of the M&E system in the Department of Health. As already mentioned that these inputs are based on the findings and recommendations that emanated from the study, they also apply to the three spheres of the Department. Suggested areas for further research are presented at the end of the chapter.

1.10 Conclusion

Chapter 1 set the scene for and described the study in an attempt to fill in gaps left by previous studies in investigating the M&E Systems in the Government Departments in South Africa. Several issues were discussed in this chapter. These included the background of governance endeavours entered into globally, continentally and in the Sub-Saharan countries including South Africa. Other issues discussed included the background and statement of the problem; and the objectives of the study. Other issues discussed were assumptions of the study, significance of the study, methodology, definition of the key concepts, the scope and limitations of study and the outline of the thesis.

The key issues that emerged from Chapter One are that the Monitoring and Evaluation systems have been taken as a crucial management tool used by companies in the corporate world as well as governments both locally and abroad. It was briefly demonstrated how the South African Government in general and the Department of Health in particular initiated the use of the M&E System in performance measurement and in reporting for accountability and improved service delivery. It emerged that though the literature has elaborated on the implementation of the M&E Systems, a great deal of this information is more theoretical than evidence-based.

Chapter One shows that in South Africa, though the M&E System has been an issue in discussion at the National level, it has not been fairly implemented at the Provincial and lower levels of the Departments. Therefore, more research-based evidence is required to ascertain if implementation is undertaken province-wide in general and Head Office wide in particular. For those Departments which have implemented the M&E Systems, a regular evaluation of their M&E System is required in order to achieve measurable results.

CHAPTER TWO

PROVINCIAL GOVERNANCE AND DEVELOPMENT IN KWAZULU-NATAL WITH PARTICULAR REFERENCE TO THE DEPARTMENT OF HEALTH

2.0 Introduction

As a point of departure the chapter provides a definition of governance in general and a discussion of public governance in particular. How various factors impinge on good governance is provided followed by elaboration on the structures that constitute governance nationally, provincially, at district and sub-district levels and local government level. This discussion is followed by an explanation of the structure of the South African Government, governance arrangements with a particular discussion of the KwaZulu-Natal Department of Health (DOH). The Provincial Growth and Development Strategy is a national framework with which all Provinces and Departments should comply. This is discussed in relation to its linkage to the disease profile of the Province as laid down by the DOH. The chapter also briefly describes the health service delivery status of the KZNDOH over a five-year period (from 2005 to 2009). This is presented as poor health service delivery and in the form of a situational analysis.

It is equally important to provide the historical background of the Health Care System of the Province, because the current status quo of the health system is a product of what transpired over the years in the health care environment (including governance issues). The discussion on the historical emergence of the South African Health Care System, from its inception to date, is presented; and the efforts the Provincial KwaZulu-Natal Department of Health has made in order to ensure that its M&E system guarantees governance.

2.1 Public Governance

It is important to start this section with a brief outline of what constitutes governance in general terms. The outline will provide the basis of understanding what constitutes public governance.

2.1.1 Defining governance

The King Report (2002: 14) postulates that the "the 21st century *could be* the century of governance". This statement is intended to encourage the promotion of the highest standards of corporate governance in South Africa (King Report 2002: 5). The term governance generally refers to authority and control. Internationally, defining governance is a challenge; its operational definition depends on a particular context or on the kind of a government or an organisation. For instance, the United States, within the context of the corporate world, views corporate governance as placing emphasis on the enhancement of performance. Kearsey and Wright (1997: 2) agree that there is no single way to define corporate governance; however, they declare that governance enhances corporate performance through "supervision or monitoring of management performance and ensuring accountability of management to shareholders and other stakeholders". Munshi and Abraham (2004: 33) contend that in India, solving a problem using "both political will and administrative competence" constitutes good governance. After examining the concept widely and in various contexts, Munshi and Abraham (2004: 52) conclude that the definition of governance should be placed in context. They define governance as "participative, responsible, accountable; based on principles of efficiency, legitimacy and consensus for the purpose of promoting the rights of individual citizens and the public interest".

Ibrahim (2012: 9) when defining governance takes the point of view of the citizen. The definition encompasses “the political, social and economic goods and services that any citizen has the right to expect from his or her state, and that any state has the responsibility to deliver to its citizens”.

The Economic Commission for Southern Africa Office (2007: 65) contends that “governance is about the equitable distribution of societal resources.” This definition also encompasses participation, information, accountability and ensures objective performance that is in line with the roles and duties of participants. In South Africa, a democratic country, governance also recognizes the rights of the people and putting the citizens first. This was first announced in the White Paper on Transforming Public Service Delivery in 1997 and is commonly known as the Batho Pele (People First) initiative. It aims to highlight goals and procedures in the Public Service in order to improve service delivery (Cameron 2008: 25). Public governance is briefly discussed in the following section.

2.1.2 Conceptualising public governance

Governance is a broad concept that operates at every level from a household to a village municipality up to a government and a country. For this reason The United Nations (2007:2) contends that due to inherent diversity in literature there exists several definitions of governance. The United Nations considers favourably a notion by Nzongola-Ntalaja who defines governance as the “way a society sets and manages the rules that guide policy-making and policy implementation”. The Chief Directorate Office of the Premier (KwaZulu-Natal Provincial Government Five Year Report 2004-2009: 30) states that Governance is about the state’s ability to serve its citizens; and that it involves the rules, institutions, processes and behaviour by which human, natural and

economic resources are managed, with powers exercised so that development is equitable and sustainable. This further contends that where there is good governance even scarce resources are more likely to be well managed to ensure that maximum benefit is obtained and equitably enjoyed.

The key characteristics of good governance are accountability, transparency, equity and participation. Good governance can be ensured if the principles of good governance are delivered in the Batho Pele way where the community's lives are taken as a priority. The United Nations (2007: 3) defines governance as both formal and informal arrangements determining how public decisions are made and carried out for the purpose of maintaining the constitutional values of a country. Public administration is an essential pillar of governance. It further contends that governance has "traditions and institutions by which authority is exercised. This includes the process by which governments are selected, monitored and replaced; the capacity of the government to effectively formulate and implement sound policies; and the respect of citizens and the state for the institutions that govern economic and social interactions among them" (United Nations 2007: 1; **http://info.worldbank.org/governance/wgi/index.asp**).

After looking at the different aspects of governance compiled by different authors the United Nations (2007: 3) came to a concise definition that governance "is not just how government and social organisations interact; and how they relate to citizens, but it concerns the State's ability to serve citizens and other actors, as well as the manner in which the public functions are carried out, public resources are managed and public regulatory powers are exercised" (United Nations 2007: 3).

Given this background, it is apparent that governance cannot be viewed just as a mode by which authority is exercised for the "common good" but as relating to the capacity of a

government towards supporting the citizens' ability to realize "individual satisfaction and material prosperity' (United Nations 2007: 4). In this regard Ile, Allen-Ile and Erisia Eke (2012: 13) state that use of resources by the public officials is open to public scrutiny (accountability) and that the voice of the historically disadvantaged should be heard (participation and inclusion).

When explaining governance, some authors generally refer to it as authority and control (King Report 2002: 5; Kearsey and Wright 1997: 2). They stipulate that governance can be well defined in a particular context; in a particular kind of a government or an organisation within the context of the corporate world. They view governance as placing emphasis on enhancement of performance and also declare that governance enhances corporate performance through "supervision or monitoring of management performance and ensuring accountability of management to shareholders and other stakeholders". Munshi and Abraham (2004: 52) define governance as "participative, responsible, accountable, based on principles of efficiency, legitimacy and consensus for the purpose of promoting rights of individual citizens and the public interest". The Presidency (2007: 3) defines governance as constituting participation, transparency, inclusion and accountability.

The United Nations (2007: 2) states that despite many definitions there are three main types of governance. These are: a) political or public governance whose authority is the State, government or a public sector and refers to the process of organizing how the entity organizes its affairs and manages itself; b) the economic governance, whose authority is the private sector, refers to governance as policies, processes or organisational mechanisms needed in the production and distribution of services and goods; c) social governance whose authority is the civil society: citizens and non-profit organisations refers to a value and belief system necessary for social behavior and

public decisions. From this explanation of governance, it is apparent that it should not be reduced to government as all the three types are interdependent in society. For instance, the public governance guarantees order and cohesion in society; and while economic governance focuses on material foundations; social governance provides the moral foundations.

Internationally, in the 1980s and the 1990s service delivery and good governance were key themes. These were supported by government legislation to improve performance. There were more efforts towards strengthening of improvement of services in Germany. This was done by using other approaches that would lower expenditure; that were more flexible and with results oriented resource management systems. It was apparent that how society judges the organisation is not dependent on service delivery, but it needs to also excel in how it exercises “political, environmental and social responsibilities” (Löffler and Bovaird 2003: 315).

The government alone could not solve related problems but problems could be solved when there was public private partnership that was based on trust. Citizens were seen as playing a major role if involved on planning, designing and in managing public initiatives. There was a need to align all strategies and policies between agencies and between sectors. Defining public governance should be context specific and may differ from country to country and between stakeholders. Also, different institutions and individuals attribute personal meanings to this term due to “the ways in which stakeholders interact with each other in order to influence the outcomes of public policies” (Löffler and Bovaird 2003: 316).

According to the Presidency (2007: iii) public governance could be regarded as efficient when it allocates and manages resources to respond to collective problems; this means

that a State provides good quality products or services of good quality to its citizens. This implies that in order to ensure good governance both qualitative and quantitative analysis of the government services need be undertaken. This can be maintained if there are guiding principles in place on the development and use of different governance indicators. Among an array of governance indicators are accountability, transparency, effectiveness, quality, participation and inclusion. It is important to implement policies and initiatives to promote governance indicators as they are for assessing and comparing the institutional quality of a government/organisation; and they can assist in research and policymaking. It is thus of great significance to measure governance quality (The Presidency 2007: iii).

In his description of governing Ibrahim (2012: 7) postulates that it is described as 'delivering on a promise'. This further states that in the case of a government and its citizens, governing constitutes adequate service delivery which results in governance. Governments promise to improve the quality of life of citizens; from experience to meet this goal is its central challenge. For instance, from time to time a government should refer to the political context and assess itself if it is better off today than it was five years ago. To meet this challenge, a government should devise a clear and comprehensible set of ideas that contribute to a vision; and use available resources and instruments as efficiently as possible to produce the results that are expected by the citizens (Ibrahim 2012: 7). This requires both leadership and responsible governance. It is through developing goals, objectives and governance indicators with achievable targets that a government can strive towards delivering on a promise; and finds the maximum ways significant to progress.

Initiatives to ensure that governance indicators are achieved require a deliberate formulation of monitoring and evaluation systems (M&E). The implementation of M&E

system guarantees that governance is strengthened through improvement of transparency, by enhancing accountability relationships and by building performance culture within governments/departments to support policy making, budget decision-making and management.

2.1.3 Factors impinging on performance towards good governance

The work environment

There are factors which highlight that functions or activities do not occur in a vacuum. Booyens (2002: 43) states that in a particular environment there are environmental inputs or the needs of the citizens that must be recognized, processed and brought back to the societal environment as outputs. Within the health sector outputs that are created by the Public Administration and Management are known as health care (Thus public service delivery becomes the product of public administration and management (Du Toit, Knipe, Van Niekerk, Van der Waldt, and Doyle. 2002: 80). Booysens (2002: 2) in his system's approach indicates that the DOH is a system, which operates within a larger social system, and as such it should function in interaction with other subsystems as it influences and is influenced by them.

Poor skills

Poor skills level within the public service is a second problem perpetuating the on-going challenge faced with service delivery. It has a negative impact on the attainment of the departmental goals.

Nature of appointments

If practiced, Public Service appointments must be based on merit in order to enhance the efficiency and productivity of an administrative system. However, merit-based

appointments within the government departments is still a complex and debated issue due to a past legacy of lack of skills that still continues (Cameron 2008: 29).

Staff shortages

The shortage of staff has been an on-going problem in the public service in general and in the DOH in particular. This is mentioned repeatedly in the routine Districts' reports. The shortage of staff is aggravated by the moratorium on recruiting new staff.

Retention of skills (attrition rate)

Attrition is rife owing to moving away of the skilled professional staff either to the private sector, migrating abroad, getting promoted from one department to another or opting for private practice within a short period of time and leaving behind inefficient managerial staff. Failure to retain the skilled staff has also been indicated by the Heads of Departments Public Service Commission - PUBLIC SERVICE COMMISSION (Public Service Commission 2008: 15; UMgungundlovu District Report Quarter 1 (2013/14).

Public governance will also be discussed in Chapter Three where interplay with other theories is demonstrated. The Presidency in the Government-Wide M&E Framework (The Presidency 2007: 3) provides tenets and a brief definition for governance, as illustrated below:

Tenets of governance

1. ***Transparency:*** Findings are made available to the public and also adheres to policies that protect certain information;
2. ***Accountability****:* Performance and the use of resources are open for public scrutiny;
3. ***Participation:*** Historically marginalised people are given a voice; and

4. ***Inclusion:*** The traditionally excluded interests are represented throughout the M&E processes.

Another concept in the discussion of governance is good governance. This concept requires that the public is encouraged to participate in policy-making processes for governance. This exercise includes providing comments on policy proposals; participation in the improvement initiatives; and providing assessments through public opinion surveys.

As illustrated in the discussion of the tenets of monitoring and evaluation in Chapter Three, section 3.3, apparently governance through transparency, accountability, participation and inclusion, form an integral part of the M&E System. However, disregarding the context in which performance occurs may hinder the realization of the optimum goal of the Department. Without the proper structures in place, governance and satisfactory service delivery will not be attained. The following section illustrates the structure that prevails at the three spheres of the Government.

2.2 Structure of the South African Government

As already mentioned above, the Government of South Africa is a constitutional democracy with a three-tier system of government; and independent judiciary. The national, provincial and local spheres of the government have legislative and executive authority in their own rights. These spheres are defined in the Constitution as “distinctive, interdependent and interrelated” **(www.southafrica.info/about/government/gov.htm).** They operate at both national and provincial levels and are advisory bodies drawn from South Africa’s traditional leaders. It is stated in the Constitution that the country should be run on a system of co-operative governance.

2.2.1 Parliament

The legislative authority is vested in Parliament, which is situated in Cape Town and consists of the National Assembly and the National Council of Provinces. The Parliament is bound by the Constitution and must act within its parameters (Venter and Landsberg 2011: 104).

- **The National Assembly** consists of its members selected for a five-year period of a common voter's roll. It is directed by the Speaker who is assisted by the Deputy Speaker.
- **The National Council of Provinces** participates in the legislative process; and is formed to achieve co-operative governance and participatory democracy. It is through the National Council of Provinces that the national and provincial interests are aligned to the national legislation that affects the provinces. Additionally, local government representatives may participate in the National Council of Provinces though they do not vote (Van Niekerk, Van der Waldt and Jonker 2001: 72).

2.2.2 The President and the Cabinet

Law-making

The National Assembly may pass any legislation that would maintain national security; economic unity and essential national standards; establish minimum standards for rendering of services; and prevent provinces from taking action that may prejudice another province or country (Van Niekerk et al. 2001: 73; Venter and Landsberg 2011: 105). Any Bills that are passed in the National Assembly are referred to the National Council of Provinces for consideration. The latter has the power to pass, propose amendments or even reject a Bill. For Bills that affect the Provinces, the National Council

of Provinces of each province has power to vote so that consensus is reached in the Provinces first before proceedings are undertaken at National levels.

The National legislation deals with matters that the Province cannot solely effectively deal with and maintains uniformity across provinces through norms and standard. The national legislation is also required to ensure national security; economic unity; to mobilize goods, services, capital and labour; ensure economic activities prevails across provinces equal opportunity and equity and protection of the environment (Van Niekerk et al. 2001: 73).

State institutions

The State institutions that support the constitutional democracy are the Public Protector; The Human Rights Commission; the Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities; Commission of Gender Equality; the Auditor-General and the Electoral Commission. The functions of the public institutions across the three spheres of the Government relate to the contribution of the particular sphere to the wellbeing of the populace. This is why functioning of the defense force and foreign affairs affect the entire state and are therefore the responsibility of the national sphere of the government (Venter and Landsberg 2011: 108).

2.2.3 The Provincial Government

As shown in the above discussion on the South African nine-province states, KwaZulu-Natal is one of the provinces. Each Province has its provincial Government with the legislative power vested in a provincial legislature and executive power vested in a provincial premier; and exercised together with other members of the provincial executive council.

2.2.4 The legislature

Van Niekerk at al. (2001: 75) claims that “the executive authority of a province is vested in the Premier’s Office”. The Premier exercises the executive authority with other members of the executive council known as the Executive Council consisting of about 30 to 40 members elected for a period of five years. The Provincial government has various roles that it should play. According to Venter and Landsberg (2011: 105) these roles include:

a) **Strategic role:** development of visions and framework for integrated social and economic development in the province through the Provincial Growth and Development Strategy (PGDS). In the chapter, the PGDS is discussed in more detail in connection with the KwaZulu-Natal province disease profile.
b) **Development role:** provincial government should ensure that any planning being conducted should also incorporate the social and economic development of the community;
c) **An intergovernmental role**: the provincial government should include the local government in decision making through establishing relevant forums;
d) **Regulatory role:** includes the provincial and national spheres using the legislative and executive authority to ensure effective performance of municipalities;
e) **Institutional development and capacity building role:** provincial sphere has a role to establish and develop capacity of municipalities to manage their own affairs and effectively perform their functions;
f) **Fiscal role:** provincial sphere should establish task teams that would monitor the financial status of municipalities;

g) **Monitoring role:** provincial sphere monitors maintenance of the local sphere for performance within acceptable public service standards and good governance; and

h) **Intervention role:** provincial sphere has powers to intervene in the local government affairs to ensure compliance with the minimum standards of service delivery and that it performs according to the constitutional mandates.

Where the province fails to fulfil its constitutional obligations the national sphere intervenes in the way it deems necessary to maintain national standards, economic unity, national security and prevent jeopardy on other provinces or of the entire country (Venter and Landsberg 2011: 105).

2.2.5 The Local Government

The local sphere of the Government is referred to as grassroots because of its proximity and close relationship with the people on the ground – the community it serves (Van Niekerk et al. 2001: 77). In terms of the Constitution of the country (Constitution of the Republic of South Africa of 1996 Section 151) this sphere consists of municipalities that govern on a Four-year term basis to run local affairs subject to national and provincial legislation. However, the provincial legislation may not compromise or impede a municipality's right to exercise its powers or perform its functions. In line with the principles of co-operative government, the national and provincial government must support and strengthen the capacity of municipalities to manage their own affairs.

The South African Local Government Association has a mandate to transform the local government and to represent its interests at provincial and national level. The members of the municipal councils are selected every four years (Van Niekerk et al. 2001: 77;

Venter and Landsberg 2011: 106). Venter and Van der Waldt (2007:3) support the above description of the local Government and its responsibility with the understanding that the "contemporary era brings the government to the local populace and gives the citizens a sense of participation in the political processes that influence their lives".

Metropolitan municipalities

Metropolitan municipalities have exclusive municipal executive and legislative authority in their areas. Throughout the country there are eight metropolitan municipalities. EThekwini Municipality (Durban) is one metropolitan municipality in KwaZulu-Natal. The Metropolitan municipalities have a choice of two types of executive systems, namely the mayoral executive system and the collective executive committee.

District and local councils

The district and local councils are interdependent and involve a division of powers. A district council has municipal executive and legislative authority over a large area, its primary responsibility being district-wide planning and capacity-building. Within a district council's area are individual local councils which share their municipal authority with the district council under which they fall.

2.2.6 Governance arrangements within a Province

The Provincial Administration provides strategic leadership and management geared towards evidence-based service delivery in line with legislative imperatives, service delivery needs and good governance practices.

- Intergovernmental Relations in the South African context concern the interaction of the different spheres of government. The Intergovernmental Relations system

is informed by the South African Foreign Policy priorities, provincial leadership direction and global trends.

- The primary location of Intergovernmental Relations system is within the Department of Provincial and Local Government in conjunction with the Cabinet Governance and Administration Cluster. The Department of Provincial and Local Government is responsible for various programmes and policy interventions geared towards predictability, stability and institutionalisation of the Intergovernmental Relations System and it has so far put in pace the Intergovernmental Relations Framework Act, No.13 of 2005 **(www.cogta.gov.za).**
- The Provincial International Relations Framework, adopted in November 2006, subscribes to the Constitutional principle of '*one country*' and on-going alignment between the three spheres of government.
- The Intergovernmental Relations supports the concept of the developmental state and the promotion of an African Renaissance and New Partnership for Africa's Development to target international relations that address National and provincial needs and priorities of the Accelerated and Shared Growth Initiative of South Africa and the Provincial Growth and Development Strategy.

The Office of the Premier

Like the President at national level, the Premier is elected by the legislature at provincial level to be in office for five years. The premier appoints members of the executive councils (MECs) for the Departments to function at a provincial level. The MECs are accountable to the legislature.

The Office of the Premier of KwaZulu-Natal is a centrally placed department that has the responsibility of providing strategic leadership and direction. This office also coordinates programmes, legislation and transversal issues in the provincial administration.

The Office of the Member of the Executive Council

The purpose of the Office of the MEC is to ensure the effective and efficient governance arrangements and systems in support of the MEC; provides technical support to the MEC to manage and accounts for the performance of the Provincial Health Portfolio. In this way the MEC is accountable to the legislature for the exercise of his/her powers and functions in their portfolio. In this respect, they are expected to provide full and regular reports to the provincial legislature (Venter and Landsberg 2011: 118).

The functions of the Member of the Executive Council

The Office of Member of the Executive Council (MEC) is responsible for the following functions:

- To liaise and interact with the Office of the Premier, the Department of Foreign Affairs, and the Diplomatic Corps as the official contact and liaison point for International Relations in the Department;
- To act as an information network that facilitates international interaction;
- To promote the Department internationally in conjunction with role players such as the Office of the Premier and Tourism KwaZulu-Natal;
- To promote the African Agenda and New Partnership for Africa's Development;
- To participate in the negotiation and conclusion of Provincial cooperation arrangements;
- To monitor and evaluate departmental international relations and provide a comprehensive quarterly status report to the Executive Council; and

- Maintain departmental international relations register and database (Van Niekerk et al. 2001: 72).

After the MEC, the next senior member in position is the Head of Department (HOD). In the Department of Health the purpose of the Office of the HOD is to provide strategic and supportive leadership.

The office of the Head of Department

The Office of the Head of Department is responsible for the following functions:

- Ensure compliance to legislative and good governance imperatives;
- Formulate evidence-based policies;
- Align planning to the legislative mandate;
- Monitor efficient utilisation of resources; and
- Ensure quality service delivery to the people in the Province (Venter and Landsberg 2011: 117).

Functions of the office of the Head of Department

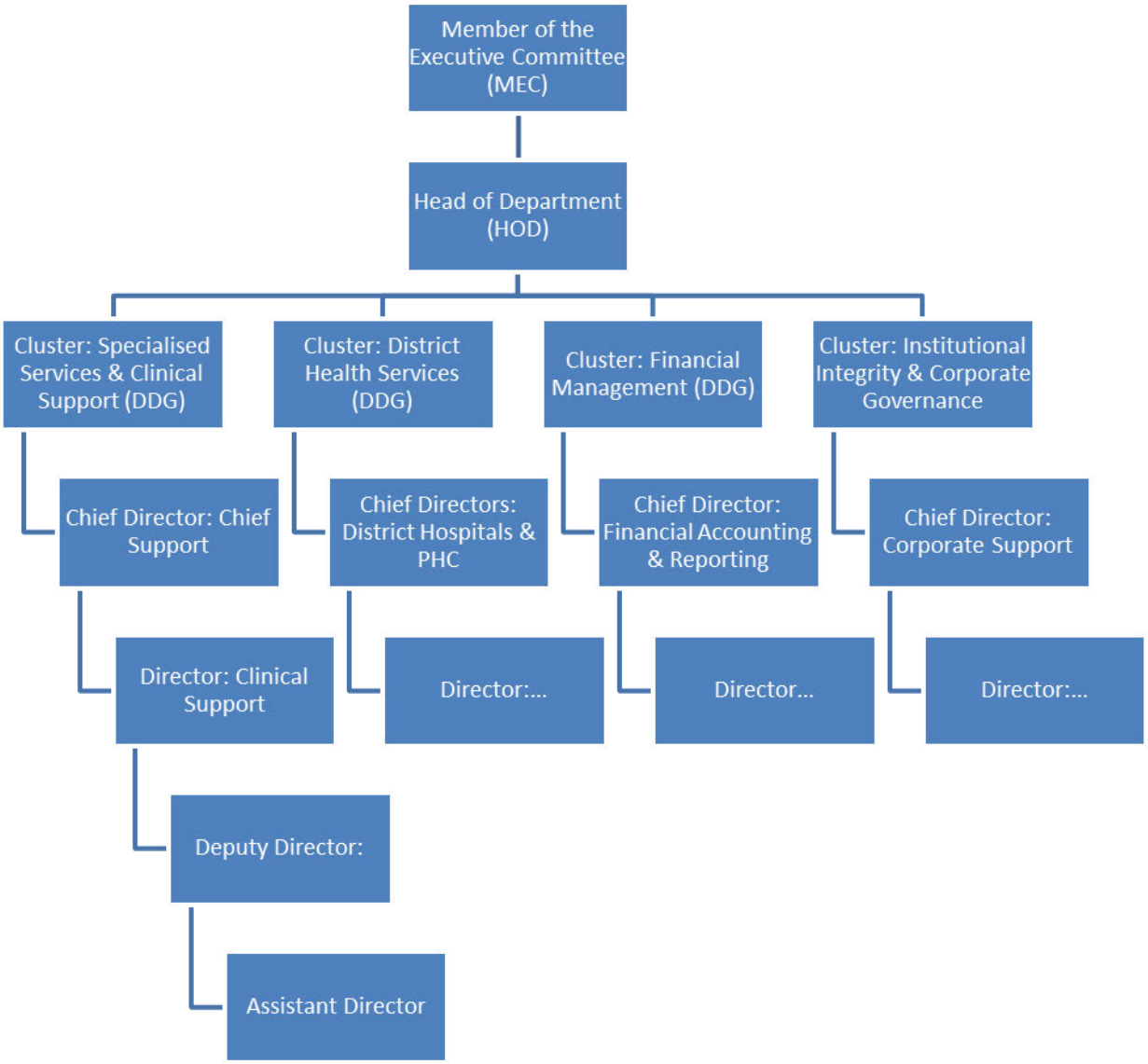
The Constitution prescribes that the HOD should specifically:

- Formulate evidence-based policies and strategies in line with National and Provincial priorities, legislative mandates, existing evidence and the '*voices of communities*';
- Ensure that enabling systems and processes in support of health service delivery are developed, implemented and sustained;
- Rigorously monitor and evaluate service delivery and health outcomes; and
- Allocate resources in line with service delivery needs and priorities.

2. 3 The Department of Health and Governance

In KwaZulu-Natal Province, the Member of the Executive Committee heading the Department of Health is Dr. S. Dlomo who is a Medical Practitioner by profession. The Director General who is the Head of Department is Dr. S. Zungu, also a Medical Doctor. The following diagram shows a cadre of Deputy Director General Managers who head each Unit. The following figure (Figure 2.1) is an illustration of how the Department structure looks like.

Figure 2.1 Structure of the KwaZulu-Natal Department of Health



Adapted from the DOH Annual Performance Plan (2013/14 – 2015/16: 63)

It is important to state that the above structure does not show all the Units in the Department. After the HOD, who is the Director General of the Department, is the level of the Deputy Director Generals shown in the diagram. This is followed by a category of Chief Directors. Both the Deputy Director Generals and the Chief Directors' categories are at Senior Management Service level. The Deputy Directors, and the Assistant Directors are at a Middle Management Service Level. From this category follows other categories down to the lowest level of General Assistants and Security Officers.

The same structure is depicted at a District Level where the District Manager is a Chief Director followed by the Deputy Directors and others. At Sub-district Level or in Hospitals and Clinics there are CEOs and Nurses-in-charge. Though mentioned here is the clinical side of the directorate of the Human Resource and Financial and other categories follow have a similar structure at each level.

2.3.1 Structures that govern the Department of Health

The administrative activity of the Department is two-fold: the one regarding the national sphere and the one for the provincial sphere. For instance, the National Ministers of the South African Department are political cadres of the ruling party and are politically elected in their ministerial positions. This is according to the Constitution of South Africa (Constitution of the Republic of South Africa of 1996). This structure is reflected in the Provincial sphere where the Member of the Executive Council (MEC) is the most senior member in a department. It is within this historical background that the DOH should be understood. Presently, the DOH is headed by the MEC with the HOD being the deputy. Both these portfolios are occupied by the members of the ruling party who are, therefore, politically elected.

When things go wrong, actions of the government machinery and the responsible members of government become the focus of interest. As its role the parliament controls the government by holding the ministers accountable. The focus is on the functioning of the government machinery and on policy making with the shift towards improving governance. Transparency towards policy implementation is crucial (The International Monetary Fund 2000: 5).

2.4 Establishing the baseline

Owing to the identified need to expand and strengthen its current monitoring and evaluation practices, the KZN DOH aimed to develop and implement an integrated results-based monitoring and evaluation system. This system would provide accurate, up-to-date and strategically important information as needed at the various levels of the health system to inform planning and decision making.

To meet this requirement the Department conducted a readiness assessment situational analysis at a Provincial level that looked at the existing M&E system. In the process it looked at the accomplishments and the shortcomings of the system. The methodology used was a review of documents relating to existing M&E practices and reports on previous situational analyses. Interviews with various key personnel in the DOH were also conducted. Before the Departmental situational analysis of the M&E System was conducted, the researcher evaluated the Departmental performance towards meeting the basic values and the principles that govern Public Administration (Constitution of the Republic of South Africa of 1996 Chapter 10 Section 195). The findings were as follows:

2.4.1 Findings on the basic values and principles that govern Public Administration

a) A high standard of professional ethics must be promoted and maintained.

The vision of the Department is based on core values of trust, integrity, open communication, transparency and consultation; commitment to performance; and courage to learn. There are also the code of ethics in place that govern the professional positions like nursing, pharmaceutical Services, Laboratory Services and other Programmes. Evidently, the DOH complies with this principle, that is, presence of relevant documentation.

b) Efficient, economic and effective use of resources must be promoted,

Overspending in billions affected the KZNDOH budget resulting in the general moratorium on filling of posts, infrastructure development, lack of accommodation across the Province and delays in payment of companies' contractors. At a glance, these factors show that this principle is not adhered to.

c) Public administration must be developmentally oriented

There have been new developments within the Department, namely reporting that is based on the National 10 Point Plan Priorities and the Millennium Development Goals (MDGs). These establish how far the Department is from achieving targets at given timeframes. Incorporating other programmes like the Operation Sukuma Sakhe – the Flagship Programme, Phila Ma, meaning 'healthy mother', (a programme to prioritise the health of mothers), 18 priority Districts and Make-Me-Look-Like-a-Hospital Programmes, show compliance with the principle.

d) Services must be provided impartially, fairly, equitably and without bias.

The DOH wishes to comply with the principle through its vision: “achieving optimal health for all persons in KZN”. The service delivery indicators are aligned with the National Health 10-Point Plan Priorities and aim to cater for all citizens. The second National Health System Priority of the 10 Point-Plan Priorities is about the establishment of National Health Insurance. This prescribes medical accessibility, affordability and equitability for all South Africans. Five hospitals in KZN are targeted for piloting the implementation of the National Health Insurance initiative. The KwaZulu-Natal DOH MEC in his budget speech, delivered in 2009, agreed that “poor leadership & management capacity is a constraint especially at operational levels of the public sector” But it is yet to be established if performance is aligned with this principle.

e) People’s needs must be responded to, and the public must be encouraged to participate in policy-making.

The rights of the SA people are considered through The Bill of Rights, and Batho Pele Principles. These are recognised through The Waiting Times Survey the Satisfaction Survey and the Occupation-Specific Dispensation. The participatory approach is being followed in policy development before it is approved at the Management Committee meeting. For instance rigorous participation was embarked upon during the development of the Departmental Monitoring and Evaluation (M&E) Framework.

f) Public administration must be accountable.

To ensure accountability the Department has a 5 year Strategic Plan that affects all spheres of the Department. Compliance to prescripts of the Strategic Plan levels measured through reporting on the indicators in the Annual Performance Plan (APP), which includes the Negotiated Service Delivery Agreement and Cabinet Lekgotla, the 10 Point Plan Priorities and the MDGs within it. Reporting on these is aimed to ensure

continuous monitoring of progress towards achievement of targets set in the APP. Generation of Treasury Quarterly Reports also meant to ensuring accountability.

g) Transparency must be fostered by providing the public with timely, accessible & accurate information.

The Data Management Component ensures that data is captured and is accessible in the District Health Information System (DHIS). This raw data is available to stakeholders on request. The M&E Component performs data analysis and circulates reports to Programme Managers and Component Managers and Districts. The Districts are expected to cascade it down to the lowest level. Reports are kept in the shared drive for all concerned to access. To ensure timely reporting the M&E Sub-component sets reporting time frames, monitor adherence and in turn reports timely to stakeholders. Data verification should be done at lower levels before it is sent to the upper levels. At provincial level verification is done by identifying deviations from targets (either above or below targets) and confirmation is made with the Districts. A new Data Capture Tool to capture non-DHIS data was developed and rolled out to all districts to use for capturing non-clinical data.

h) Good HR Management and career-development practices, to maximise human potential, must be cultivated.

There are new developments in the Human Resource (HR) Section. For instance, the bursaries awarded to employees include those for post-matriculant students to be trained as doctors in Cuba, graduate in nursing and for employees to participate in Adult Basic Education and Training.

i) Public administration must be broadly representative of the SA people with employment & personnel management practices based on ability, objectivity, fairness, & the need to redress the imbalances of the past to achieve broad representation (Constitution of the Republic of South Africa of 1996 Chapter 10 Section 195).

According to the report obtained from the HR Department, designated groups for affirmative action are Blacks, Coloureds and Indians; women and people with disabilities. This also affects the Employment Equity Plan as it is based on the demographic profile of the workforce on each category and all levels.

The study did not investigate all of the above values and principles but selected the more critical to service delivery in the context of good governance and development. These are: Public administration must be developmentally oriented; services must be provided impartially, fairly, equitably and without bias; people's needs must be responded to; public administration must be accountable; transparency must be fostered by providing the public with timely, accessible and accurate information (Constitution of the Republic of South Africa of 1996 Chapter 10 Section 195).

2.5 The area of study

As mentioned in Chapter One, the scope of this study is the KZN Department of Health with particular focus on the provincial office (Head Office) and the Districts. The following sections elaborate on the overview of the study area as mentioned above.

2.5.1 Setting: The geographic location of KwaZulu-Natal Province

The Province of KwaZulu-Natal is situated in the eastern part of South Africa. Map 2 below illustrates the geographical location of the Province in the country. The Province

shares borders with Swaziland and Mozambique in the North, Mpumalanga in the North-West; Free State and Lesotho in the West; and the Eastern Cape in the South. The Northern Districts of UMkhanyakude and Zululand attract patients from Mozambique and Swaziland and similarly, patients from the Eastern Cape utilise health facilities in the Southern Districts of UGu and Sisonke (Annual Report 2008/9: 7).

KwaZulu-Natal is a Province with the second largest population in South Africa. It has an estimated population of 10,467,466 (21% of the South African population).

MAP 2.1: KwaZulu-Natal Health Districts per Management Area

Adapted from the Annual Performance Plan of the KZNDOH (2008/2009-2010/2011)

Spatial considerations

Natural features including rivers, wetlands and mountainous terrain, as well as scattered distribution of homesteads in the rural areas pose unique transport and access challenges for equitable service delivery.

The KwaZulu-Natal Department of Health serves ten Municipal Districts and one Metropolitan District (eThekwini). The health service boundaries are aligned to the municipal boundaries, as determined by the Municipal Demarcation Board. Below is an illustration of the three Service Delivery Areas that are shown in the map above.

Table 2.1: Health Service Delivery Areas

Area	District	Population per District
Area 1: Southern Eastern	UGu	724,188
	EThekwini	3,537,796
	ILembe	538,815
Area 2: Western	Amajuba	451,156
	UMzinyathi	505,700
	UThukela	729,279
	UMgungundlovu	1,008,713
	Sisonke	510,134
Area 3: Northern Eastern	UMkhanyakude	626,387
	Zululand	921,037
	UThungulu	912,235

Figures are adapted from the Annual Performance Plan of (2011/2012 – 2013/2014:3).

(For the illustration of these areas reference is made to the map above). It is estimated that 54% of the total population lives in rural areas; the majority of the rural population are women and children; and 10% of the urban population live in underdeveloped informal settlements. The distribution of population in the above table shows that

eThekwini Metropolitan Municipality has the largest population of more than 3 million people. According to the Annual Report (2008/9: 7) this comprises a population density with 1,394 people per km² and 33.8% people; Amajuba District is having the lowest population of 4.32% (Annual Performance Plan of 2011/12 to 2013/14: 3). The influx of people into the eThekwini Metropolis has a huge impact on service need versus delivery as is evident in the increase in patient numbers versus decrease in staffing numbers. In-migration of people also increases catchment populations which present unique challenges in determining staffing norms and standards (APP 2010/11 – 2012/13: 9). This illustrates the diversity in the Province and the challenges it poses for equity in health service delivery.

According to the situational analysis in the APP (2008/9 – 2010/11: 5), rural areas have a greater percentage of children in the age range 0-15 years, and promotion and integrated development programmes should, therefore, target this age group to promote healthy lifestyles and habits. The significant differences between the urban and rural areas of the Province also imply that policies and implementation strategies suitable for urban communities may be less applicable to their rural counterparts. Policies and strategies should be 'tailor made' based on demographic and social determinants, target groups/ beneficiaries, and health profiles. "One size fits all" intervention strategies to address the burden of disease in the Province may exclude health beneficiaries most in need of health services.

2.5.2 The Provincial Health Profile

a) Determinants of health

According to the World Health Organisation, determinants of health are what determines health move "beyond the obvious physical and biological causes of ill-health" (Raphael

2003:100). The statement goes on to say that health is a socially constructed reality: a product of the physical and social environment in which people live and act. This is affected by biological and social and economic status. Such determinants range from living in an unhealthy environment that is crowded and with poor quality of houses, lack of nutrition, problems that are congenital, poverty, lack of education to lifestyle related diseases like, stress, smoking, substance abuse, and other maladies. Natural disasters and migrations also add on to the list.

Additionally, the place of residence also has an impact on the health status. This refers to the place of residence whether rural or urban; exposure to vulnerability, health-seeking behaviour, access to health services, responses of the health provider and health consequences (Raphael 2003:100).

To this the Department of Health (DOH) Annual Performance Plan (APP -2008/09: 13) states that rural areas are faced with very different challenges as compared to urban areas, compounded by poverty and the triple burden of disease. The domains making up the multiple deprivation indexes include: Income and Material Deprivation, Employment Deprivation, Health Deprivation, and Living Environment Deprivation.

b) Poverty and Socio-economic Profile

It is imperative to mention that the KZN Province has suffered unemployment rate of 0.6% on average annually between 2001 and 2007 (APP 2011/12 – 2013/14: 5). This resulted in unemployment growth of 33.8% in the same period. The unemployment rate for females remained higher than that of males since 2002.

People living in unhygienic environments i.e. areas with poor drainage systems, inadequate sanitation, and lack of access to piped water, suffers higher levels of

morbidity and mortality. Evidence shows that access to water correlates strongly with the survival of children under-5 years, while malnutrition, a major cause of child morbidity and mortality, can also be related to environmental degradation. This information is exceptionally important in addressing child health (MDG 4) and should be monitored in conjunction with Local Government to ensure appropriate action. The following is an illustration of additional socio-economic indicators, namely: access to piped water, good sanitation and electricity:

Table 2.2: Data on socio-economic indicators

Indicator	Access	
Households having access to piped water inside the dwelling	39%	962,685
Households having access to piped water inside the yard	19%	469,000
Households getting water from the stream or river	10%	246,842
Households having flush toilets with sewage system	40%	987,368
Households using pit latrines	22%	543,052
Households having no access to sanitation	10%	246,842
Households having access to electricity	73%	-

Data sourced from the APP 2011/12 – 2013/14

In addition to the above picture, in 2007 a community survey identified 27% (668,135 households as having no income at all or with an income less than R400 per month with these mostly in eThekwini, UMgungundlovu, UGu and UMkhanyakude Districts. There is a reported rise of 2.5% from 2007. The households headed by females were identified

as the more likely than male headed to have hungry people, which tallies well with the unemployment rates (25% unemployed females against 20.4% males).

The burden carried by rural households is significant as they are more likely to be female headed, have more foster children compared to their urban counterparts, are about two times more likely to go hungry compared to urban households, are less likely to have access to safe water and electricity, and more likely to use wood as the primary source of energy. It is therefore not surprising that the burden of disease in rural/ deep rural areas is different to that found in urban communities. Planning and resource allocation is sensitive to specific demographic and health profiles in order to ensure equity and improved quality of care. EThekwini Metropolitan Municipality has the biggest population density with 1,394 people per km², and Sisonke the lowest with 42 people per km². This illustrates the diversity in the Province and the challenge it poses for equity in health service delivery.

Given the picture on the socio-economic and environmental profiles of the Province, it is apparent that there is little armour for the disease that may affect its population. The disease profile below best elaborates on the issue.

The integrated Operation Sukuma Sakhe - Flagship Programme), borne out of the 2009 KZN Cabinet Indaba, gained momentum in 2010/11 aiming to accelerate Economic growth; Community development; Job creation; Strengthening institutions; and Poverty alleviation through empowered communities. The Department, in collaboration with the Department of Social Development, commenced with an integrated Youth Ambassador and Community Care Givers Programme as critical component of Operation Sukuma Sakhe and revitalisation of Primary Health Care (PHC). The programmes aim to improve integrated and comprehensive community-based services

in line with Government's intention encapsulated in Outcome 2 of the Negotiated Service Delivery Agreement Negotiated Service Delivery Agreement . Outcome 2 is, "*A long and healthy life for all South Africans*" (KZNDOH APP 2011/12-2013/14: 6).

c) Disease profile

This section provides a brief explanation of the health status in the KZN province, which forms the basis for the Provincial Department of Health deliberations to address health service delivery situation. Public Service is the vehicle with which the Government fulfils its promises of "securing the wellbeing of the people of the Republic" (Human Resource Development Strategic Framework, 2008: 22). The effective performance of the public officials and the capacity of departments to deliver services are both critical in all aspects of Government's agenda for transformation and development. This is noted by the Minister for Public Services and Administration in the same document (Human Resource Development Strategic Framework, 2008: 22).

As stated in the Annual Performance Plan (2009/10 – 2011/12: 46), the main purpose of the Department was to develop and implement sustainable, coordinated, integrated, comprehensive and seamless services based on Primary Health Care System. However, this should occur on the background of the rural and the urban areas facing challenges differently that were "compounded by poverty and the triple burden of disease" (APP 2008/09 -2010/11). For instance, there was a national decline in life expectancy, which was considered to be largely due to HIV & AIDS and TB. According to the 2010 Mid-Year Population Estimates (Statistics South Africa), the life expectancy of both males and females in KZN increased over the period 2001-2006 and 2006-2011 from 46.4 to 49.1 years for males (52.2 national) and from 50.6 to 50.2 years for females (54.3 national).

The results from the KwaZulu-Natal PHC Disease Profile above indicated that diseases of lifestyle constituted a major part of the burden of disease in the Province. According to Profile results, non-communicable diseases constituted 31.54% of conditions seen at PHC. According to the Confidential Enquiry into Maternal Deaths, the Provincial maternal mortality rate is estimated at 210/100,000 live births. There were still conflicting data on child mortality rates. According to Statistics South Africa (2010 projections) the infant mortality rate was estimated at 46.9/1000 live births in 2010. The AIDS Committee of the Actuarial Society of South Africa estimated the infant mortality rate at 56.5/1000 live births and the under-5 mortality rate 87.7/1000 live births in 2010.

The HIV incidence in KwaZulu-Natal is estimated at 1.7%, which is similar to the Health Systems Trust estimate of 1.6%. KwaZulu-Natal has consistently recorded the highest HIV prevalence in pregnant women since 1990. According to the National Survey of 2009 the Provincial HIV prevalence increased from 38.7% in 2008 to 39.5% in 2009 – still the highest in the country. The 2009 TB incidence rate was 1,160/100,000 population. These elaborations of the health profile portrayed a grave health status that required immediate and rigorous interventions. One of the means to attain this was a proper structure of the Department as shown in Section 2.3.7 above.

Van Niekerk, der Waldt and Jonker (2000: 137) pointed out that the promotion of ethical behaviour is ensured by adherence to values and that where there is no ethical conduct corruption and fraud originates. He says that in order to counteract occurrence of such untoward actions, monitoring, evaluation, transparency, and accountability should be in practice that is, M&E System that also monitors the realisation of governance. According to this contention, putting these processes in place should be preceded by putting in place the mechanisms to ensure that values and ethical governance are practiced.

2.6 Environmental factors that influenced immediate intervention

Before the inception of this study the above exposition of the disease profile in the KZN Province required intervention to ascertain that the DOH's performance addressed challenges which perpetuated disease escalation. Over and above this there were even more environmental factors that seemed to aggravate the health situation and prescribed urgent intervention. These factors are discussed below.

Dissatisfaction with the DOH service delivery: *In principle a Department is* responsible for the implementation of the legislative imperatives, National and Provincial health policies, service delivery priorities as well as routine health services based on the standard service delivery package at different levels of care.

According to the assessment reports that were generated by the KZNDOH, the Department had suffered a recession in its performance. For instance, there was financial overspending in billions, which resulted in reduction of the budget allocated to all the Units and all the levels of the department (Districts, Facilities: Hospitals, Primary Health Clinics and Community Health Centres). The limited budget impacted negatively on the standard of the quality of service provided for the KwaZulu-Natal communities.

It is crucial to mention that even before 2008 the Department had already started to be a public talk. The quality of service delivery was affected by non-compliance to policies, standards, norms and procedures resulting in complaints from the public. These were media reports, where people openly expressed their dissatisfaction on services rendered by both health workers and doctors. Such reports also included repeated reports on poor infection control measures resulting in disease outbreaks like Klebsiella in some KZN Hospitals. Corruption and poor governance had also been reported. Such topics became

rife in 2009 and 2010. Concerns raised by the public and or through the media can be categorized as follows:

Management: "The Health Minister must go" (The Witness of 27/01/2009); "Doctors forced to operate in sweltering operating theatre. Patients' lives are endangered by the lack of working air conditioners in the Operating Theatre in one of KZN hospitals" (Citizen 2nd edition 06 January 2010: 4); *"Zilala ezinqoleni iziguli"* (patients sleep on stretchers and wheelchairs) in a certain hospital, which was named. Further down this topic it was revealed that even in the wards there were stretchers for patients to sleep. (Ilanga 28 January 2010: 27); "The (KZN) Department 10 Point Plan Priorities is just a rhetoric – an increasing ineffective initiative to hide the consequences of the profound incompetence of the management of the KZN DOH" (The Mercury 18 January 2010: 7).

Poor work conditions: The media continued with reports on disease outbreaks and dissatisfaction of communities with regard to service delivery from health facilities (Ilanga Newspaper 28/09/2009; Ilanga Newspaper 09/2009: 3-5). People suing the Department for negligence increased.

Fraud and corruption: The issue of the Department overspending was up in the papers: "Doctors place greed before need" (Daily News 27/08/09: 20); "The KZN government remains a long way off from reclaiming grants that were fraudulently accessed by its staff, with the health department apparently failing to undertake disciplinary proceedings against implicated officials" (Mercury 20 January 2010: 4); *"Sixoshwe nenqwaba isikhulu sesibhedlela*", meaning 'The Chief Executive Officer (CEO) of a hospital was sacked with millions of Rand that were allocated for TB treatment' - (Ilanga 11 January 2010: 5).

Poor service delivery: Food poisoning in a certain hospital was reported in The Witness (28 January 2009: 3); “Judge rules in favour of infected woman - A (name of the area in Johannesburg) woman was infected with HIV by a Kwazulu-Natal health department paramedic who attended to her, the Pietermaritzburg High Court said” (Mercury 19 January 2010: 4); Food poisoning in a certain hospital was reported in The Witness (28 January 2009: 3).

Staff shortages: As a result of the moratorium, staff shortage caused chaos as was reported “The Pediatrics Department was plunged into chaos when its children’s outpatients department was closed because of a shortage of staff” (Mercury January 2010: 1). When the Natal Mercury Newspaper (19 January 2010: 9) perceived that the implementation of the 10 Point Plan by the Department was going to fail because of shortage of human resources it said, “There are doctors out there wanting to work; just unfreeze the posts immediately”

Staff dissatisfaction: The Daily News Newspaper of 13 January (2010: 5) reported that Doctors in senior posts at a (KZN) hospital were demoralised and disappointed at The huge cuts they were going to suffer in their January salaries because of the Occupation-Specific Dispensation payment system, where the scarce skills allowance had been deducted from their pay; “Nurses embark on go-slow” and as a result of the go slow “an HIV positive woman said the nurses stopped treating them, saying they were unhappy that the hospital management failed to address problems they had raised” (Mercury 12 January 2010: 5).

Medicine shortage: “Doctors at several hospitals reported that shortages of basic pharmaceutical products were hampering their ability to treat patients” (Mercury Newspaper 13 January 2010: 4); “Patients are being turned away from several state

hospitals in the province because they do not have basic medicines to treat patients with hypertension, tuberculosis and HIV and AIDS related illnesses" (Mercury Newspaper 12 January 2010: 3).

The assessment reports showed that the decline in its performance resulted in reduced allocation of resources to the entire department. As a result of the inevitable blanket moratorium, there was staff attrition; and the staff that left the public service was not replaced, which in turn resulted in increased workload for both doctors and nurses. The increase in the burden of disease due to more people becoming ill from HIV/TB co-morbidity aggravated the workload on the staff. Owing to the increased staff attrition rate and loss of scarce skills (clinicians and practitioners), the districts made repeated reports of overburden. This budget limitation impacted negatively on the standard of quality of service provided to the communities (Districts and Provincial Quarterly Reports 2008/2009 to 2009/2010).

District reports kept on narrating about the staff dissatisfaction, low morale, de-motivation, staff turn-over, and general dissatisfaction on conditions of work including the increased demands of the Occupational Specific Dispensation. The Occupation-Specific Dispensation started in 2007 after a long strike by public servants, which resulted in skilled public servants such as doctors, nurses, prosecutors and teachers being promised salary package increases of up to 50% to bring pay in line with that in the private sector. Having not been paid by the proposed deadline, issues culminated in a provincial strike that involved the Practitioners, Clinical staff and the nurses in 2009.

As the effects of a blanket moratorium on almost all financial expenditure mounted, more pressure was felt by Departmental Components at a Provincial Level. Programmes and individual employees felt the impact as employment of new staff could not be undertaken

due to freezing of all posts irrespective of their importance. Performance according to expectation was literally not possible. A vicious cycle was created which resulted in even worse performance due to workload from staff shortage. One of the vivid solutions towards the realisation of service delivery and good governance seemed to be compliance with the basic values and principles that govern Public Administration.

The above occurrences in the Department were obvious to everyone including the Department authorities. Hence the response from the Strategic Planning Component during its Strategic Planning Workshops held during 2010, which mentioned the following as the root causes for the Department's over-expenditure:

- Historical under-funding;
- Increased burden of disease without concomitant budget for health services;
- Poor financial management and lack of adjustments and alignment, competencies; accountability and discipline (especially at facility level);
- Non-alignment of budget with service delivery and poor financial controls;
- Policies that are unfunded to allow translation into service delivery;
- Lack of planning, priorities and package of services and effective costing model to inform budget allocation.

The Fiscal Adjustment Plan that aimed to curb over-expenditure, improve financial management, take cognisance of the above challenges and ensure sustained management practices was later implemented and monitored.

2.7 Link between the Disease Profile and the Provincial Growth and Development Strategy

Having had the picture on the profile that includes both the economic and disease profiles of the Province above, it is imperative to also discuss the role played by the

Provincial Growth and Development Strategy (PGDS) in this context. The PGDS is a national strategy to address the integrated economic development nationwide. Based on the national strategy the provinces developed their own provincial growth and development plans, hence the KwaZulu-Natal Provincial Growth and Development Plan. The "growth and development" concept refers to growing the economy for the development and improvement of the quality of life of all people living in the province of KwaZulu-Natal. It seeks to attain its vision through seven strategic goals which have objectives (by 2030), indicators, targets and interventions and in phases of which the first phase is by 2015 (PGDS Report 2011: 20). More description of the Provincial Growth and Development Plan is provided in Chapter Three.

The Department of Health contributes to the implementation of Goal 3 "Human and Community Development" of the PGDS in addressing the challenges related to health as mentioned in the disease profile.

The three strategic objectives of Goal 3 are poverty alleviation and social welfare; enhancing health of communities and citizens and enhancing sustainable household and food security. The strategic objectives have indicators as well as proposed interventions per objective and the Department has started implementing according to these objectives. The three strategic objectives are discussed as follows:

Strategic objective 3.1: ***Poverty alleviation and social welfare.*** Though the Department is not directly involved in the alleviation of poverty it does report on this objective through the proxy-indicators as this is also an objective of the Millennium Development Goals (To alleviate poverty and extreme hunger).

Proxy indicators:

1. Percentage children malnourished;

2. Vitamin A coverage; and
3. Number of Health Promoting Homes (One-home-garden).

In order to ensure that targets for these indicators are reached the following interventions were proposed.

Proposed interventions

1. Supplying of food nutrients;
2. Implementing One-home-one-garden strategy;
3. Implementing One-School-one-garden Health Promoting strategy; and
4. Food supplements to vulnerable groups.

Both the Nutrition and the Health Promotion Programmes (Healthy Lifestyle) collaborate with relevant Departments like Agriculture, Social Development and the Operation Sukuma Sakhe (Flagship Programme), in the Office of the Premier.

Strategic Objective 3.2: ***Enhancing health of communities and citizens*** - an objective that necessitates the development of a comprehensive primary health care programme in KwaZulu-Natal that is premised on a proactive approach and the capacity to deal with diseases. Indicators for this objective with the targets and timeframes being the year 2030 are:

1. Prevalence of preventable infant, child, and maternal mortality;
2. % of births attended by Skilled Health Attendant;
3. Prevalence of preventable chronic illnesses;
4. Prevalence and incidence of communicable diseases;
5. Longevity- health adjusted life expectancy;
6. Number of health care professionals in relation to the population; and

7. Quality of teaching and training of health professional (The Provincial Growth and Development Strategy 2011: 6).

This objective is in line with the already existing Government mandates to combat diseases and address other social determinants of health. These are the Primary Health Care re-engineering; the National Health Insurance and the Millennium Development Goals, to mention but a few.

Proposed interventions:

1. Development and implementation of comprehensive primary health care;
2. Accelerate HIV/AIDS intervention programmes;
3. Support the introduction of the National Health Insurance System;
4. Promote physical and mental health programmes; and
5. Promote awareness programmes against substance abuse (The Provincial Growth and Development Strategy 2011: 6).

These interventions are mostly in line with the Primary Health Care re-engineering; and the implementation of the National Health Insurance fund, which are currently the priorities of the Department of Health.

Strategic objective 3.3: Enhance sustainable household food and security

This strategic objective seeks to ensure that there is adequate food security in the households in the Province. This is undertaken by monitoring implementation according to the following indicators and proposed interventions:

Indicators

1. Dietary diversity index;
2. Hunger episodes; and
3. Child malnutrition as a measure of food insecurity;

Proposed Interventions:

1. Establish early-warning systems
2. Developing infrastructure for local markets;
3. Support to informal economy;
4. Skills development to support local production;
5. One-Home One-Garden and roll-out of school and community gardens;
6. Permaculture Practices; and
7. 100ha Programme by Traditional Councils.

Though the Department may not be directly involved in the implementation of some of the above-mentioned interventions, it works in collaboration with the directly involved Departments. Monitoring of progress towards the achievement of the targets on the relevant interventions is undertaken.

In order to monitor the progress on performance the Department has set targets based on the 2012 baselines achievable in intervals that run over to 2030. It is envisaged that the monitoring of the implementation of the PGDS, the Negotiated Service Delivery Agreement, the Millennium Development Goals (and other interventions) will together contribute to the improvement of the quality of life of the KwaZulu-Natal citizens. It is, therefore, crucial to monitor progress towards the achievement of these objectives.

In order to draw a clear picture of the stages the health sector within the SA Government went through in an attempt to provide quality health care to the citizens, a discussion on the historical eras that brought it to the present era are discussed in details below:

2.8 The history/emergence of health care in South Africa

2.8.1 Emergence before the 1990s

According to Van Rensburg (2004:52), the development of the South African health care started in the 17th century. He describes the South African health care system as emergent over 5 phases described in 2 eras, namely:

The Colonial Era

The Colonial Era, which was the first era under the Dutch influence between 1652 and 1795. This was the period of transition towards a modern scientific medicine. Though it was still characterised by the ancient beliefs of witchcraft, it formed the basis for the establishment of health care in the Cape with some under-qualified practitioners deployed in the rural areas. The period that followed was known as the period of expansion and control that coincided with and was captured by the British rule between 1795 and 1910. Like other facets of life during this period there was great influence also on health care. The first Public Health Act was promulgated in SA in 1833 following the small pox epidemic in Kimberley. For the first time this made compulsory the notification and vaccination of infectious disease. The Contagious Disease Act 25 of 1868 and the Medical Act in 1874 were established as a means to finance the provincial hospital (Zwarenstein 1994: **www.ncbi.nlm.nih.gov/pubmed/12345506).** The South African Act that was resultant from the Public Health Act 4 of 1883 and the Medical and Pharmacy Act 34 of 1891 was among legislation that existed. In addition to the legislation, professionalism took charge over the health care system (Van Rensburg 2004: 56).

Among developments that occurred in the healing professions were medical doctors, pharmacies, clinical services including nursing services, nurses and midwives. By the end of this period there were already hospitals and institutional care.

The National Convention of 1909 created the Union of the four colonies of the Cape of Good Hope, Natal, Transvaal and the Orange River Colony. The Act did not have much reference to health care. The local Authorities were responsible for environmental hygiene and means to address infectious disease outbreaks. There were inadequacies in the responsibilities in the public sector. This resulted in the Public Health Act No. 36 of 1919 (Zwarenstein 1994: **www.ncbi.nlm.nih.gov/pubmed/12345506).**

The periods that followed were characterized by both Western and Traditional medical practices. Though these were practised concurrently, the Western practices took precedence and recognition such that the traditional practice though still continued was eventually not recognized as legal (Van Rensburg 2004: 68). Up to this day, the same is occurring (Zwarenstein 1994: **www.ncbi.nlm.nih.gov/pubmed/12345506).**

Amongst the legislation that was passed was the 'Native' Labour Regulations Act which prescribed that the gold and other mining industries should provide hygienic housing, adequate diet and hospitals to the Native labourers that they employed. Mission hospitals were established in rural areas where local authority was not capable of providing financial contribution (Van Rensburg 2004: 8).

The Public Health Amendment Act of 1946 separated the functions of the Central Government and the Provinces. While Provinces were responsible for general hospital services the government continued with other institutional services. The Act made provisions for refunds to the provincial administrations and local authorities with regard

to any outpatient services independent of general hospitals. Financial and implementation challenges arose (Zwarenstein 1994). The structure of South Africa's health service (Zwarenstein 1994: **www.ncbi.nlm.nih.gov/pubmed/12345506)**

The 'Contemporary' Era

The second phase was the contemporary and recent history further described over 3 different periods, namely: 1910 to 1948 the post-colonial era where there was self-governance and pluralistic health structures.

After 1948 health policy and planning became the responsibility of a political than a health criterion where the focus was on satisfying the needs of the white population. The Tomlinson Report of 1954 recommended a separate Bantu Health Service causing further fragmentation of service delivery and policy in South Africa. A shift was seen when the Health Act of 1977 included Provincial Administrations and the Local Authorities in order to have a comprehensive health service for the population of the Republic of South Africa. Van Rensburg (1995: 59) contends that despite the integration aimed at by this activity the fragmentation between the three tiers of authority (central, provincial and local) and services continued. Provinces remained responsible for hospital services; local authorities were responsible for preventive and promotive care and the central tier responsible for overall coordination. For greater overall coordination the Health Matters Advisory Committee and the National Health Policy Council were established.

From 1948 to 1990 was the apartheid era with a segregated and discriminatory health care. This period was characterised by a system that favoured one racial group of the white rich business people. This was further aggravated by segregated settlement of the social groups which comprised the 'haves' and the 'have not' and rural/urban divide (Van

Rensburg 2004: 77). From 1980 onward, there was great fragmentation in health services and policy co-ordination. There was the implementation of homeland policy and the Tri-cameral System in 1983 led to the four provincial administrations breaking into seventeen different political entities many of which had little political legitimacy. Public facilities also had separate services for the non-white population. This was extended to having facilities with separate white and non-white hospitals. In 1986 a report from the Browne Commission reported that "there was excessive fragmentation of control over health services and lack of policy direction, resulting in a misallocation of resources, duplication of services and poor communication between the various tiers (Zwarenstein 1994: 10).

The developments in the late 1980s and early 1990s resulted in the segregation of public hospitals, which in turn had remarkable growth in the private hospitals, affecting cost in medical aid for many years to follow. The third period is described in the next section and is marked by major changes that were fundamental to the contemporary health system.

2.8.2 Restructuring the S. A. health care system between 1990 and 1994

The period from 1990 to 1994 is marked as the end of the apartheid regime that characterised and formed the essential transformation of the health care of the Country. Of the above exposition, only the post-apartheid era and the transformation of the South African health care system from 1990 onwards will be discussed. For instance the 2nd of February 1990 became a cornerstone that brought drastic changes in the socio-political transition towards "a democratic non-racial, unitary and equitable dispensation" (Van Rensburg 2004: 98). This was not just concerning the political future of the country; it was also crucial to the South African health care system, as it was to set a political dispensation in which the health care system was embedded.

The steps that emerged during the transformation commenced with the most primary fundamental developments in health care during the brief transitional period (1990 to 1994). There emerged a new health care approach based on what already manifested in the 1990s, namely: the National Policy for Health Act (1990) and the National Health Service Delivery Plan for South Africa (1991). In terms of the National Policy for Health Act 116 of 1990 (Government Gazette 13.07.1990) the Minister of National Health and Transformation was mandated to determine health policy, targets and priorities for government health Services to ascertain efficient coordination of the health services (Van Rensburg 2004: 98).

The National Health Service Delivery Plan of 1991, within the Department of National Health and Population Development 1991(c), committed itself to establishing an affordable "comprehensive health service" (Van Rensburg 2004: 98) in the period between 1990 and 1995. A framework and guidelines were developed. Principles that were laid down included accessibility, effectiveness, affordability, equity and acceptability. These were incorporated into the Plan in terms of the National Norms and Standards (Van Rensburg (2004: 99). After 1994 these developments were phased in health care developments such that the structural features and structural trends from the transition period continued to dominate the "transition-to-transition period" (Van Rensburg 2004: 99). These features were very remarkable in the ten homeland health systems that emerged from the apartheid system.

The Department of Health Services and Welfare was partly characterised by racial control administration that had fragmented management and service delivery. The 3 tier division of authority namely central, provincial and local geographical fragmentation continued; privatisation caused fragmentation between public and private sector. Further

fragmentation was caused by continued specialisation and high technology in health care in the private sector and management independence to academic hospitals. Establishment of health services and facilities was concentrated in urban areas leading to health providers getting interested to settle where there were best chances to make profit: that is, in urban areas (Van Rensburg 2004: 99).

2.8.3 Health Reform and the Reconstruction and Development Programme

In the provision of health services, there was a shift from secondary and tertiary (curative care) to preventive care or community based care and institutional care. This was known as the Primary Health Care (PHC), which was marked by the establishment of the Community Care Health Centres (CHCs) and the Community Health Workers. The South African health care continued to grow towards the private sector making the curative care a comparatively more profitable market that was concentrated in urban areas. Race and social class inequities of apartheid still prevailed. However, at this instance taking into consideration the Freedom Charter (1955) resulted in abolishing all apartheid laws and practices (Van Rensburg 2004: 101) The Charter further stated that preventative health scheme should be run by the government; free medical care and hospitalisation should be provided to all; special care should be available to mothers and young children; the aged, orphans and the mentally ill should be cared for by the government. The Reconstruction and Development Programme (1994a) and the National Health Plan (1994b) shared the same sentiment, resulting in the compilation of a framework to incorporate these reforms in the health system. The more rigid structures and structural features of the South African health care became, the more the deterrence towards profound transformation of the health care system (Van Rensburg 2004:103).

From the above discussion, it is apparent that the South African health care system was not an event but was a process that occurred over time. The Reconstruction and Development Programmes included meeting of the basic needs, upgrading of the human resources, strengthening of the economy, and making the government and the public sector more efficient. Programmes that emanated from these deliberations included feeding schemes for primary school children, free health care for children under 6 years of age and for pre- and post-natal mothers including the building of new clinics, rural water provision and projects in other departments. (Van Rensburg 2004: 113).

The Reconstruction and Development Programme planned for a total re-engineering of the health care system revising the legislation and the institutions. It could be said that the Reconstruction and Development Programme thus formed the basis for creation of the National Health System, which drew in all relevant stakeholders from both public and private sectors. This had a role in the integration of a preventive and promotive curative and rehabilitative service within a "district based PHC system that strongly emphasized social development, community participation and empowerment, intersectoral collaboration and cost effective care (Van Rensburg 2004: 113). Among guidelines laid by the Reconstruction and Development Programme for translation of the International Norms and Standards on service delivery, it further laid down target diseases, which were most challenging or problematic; the most vulnerable groups including children and women; health care programmes like Emergency Services Programme, Promotion of Healthy Lifestyle, youth health, essential drugs targets for HR; strengthening of PHC and budget allocation to priority areas. Though policies and legislation were there, there was failure to implement these (Van Rensburg 2004: 113).

Pre-1994, there were fourteen separate departments, namely: four homelands and six self-governing territories; multiple ministries and departments based on race (Tri-cameral

system) and ethnicity (homeland governments); and the vertical fragmentation was in provincial and local authorities. There was also public health service for the whites which was better than that of the blacks and the rural divide where health services in urban areas were better than in the rural areas; and prioritisation of tertiary health care services over Primary Health Care Services was also to be observed. Further fragmentation was also between the private and public sector. There was the artificial paradox of the best First World medicine and the worst Third World medicine within the same locality resulting in extreme inequality in the health country's health sector. This was evident in the health indicators in life expectancy, mortality which was comparatively higher among the black people. This was also seen in access to water and sanitation, housing and how they contributed to poor health status of black South Africans (Van Rensburg 2004: 113).

The national health system came up with a 5 year planning framework. Since 1994 the focus was on increasing access to health care mostly in the inadequately served rural areas. From 1999 to 2004 the attention was on quality issues in health care and legislature that had focus on the private sector. From 2004 to 2009 the focus was on consolidation of the health system and resolving human resource issues. There was capacity building of programme managers and development of health professionals. The health sector has suffered human resource drain through the International Recruitment of Health Workers. This was more strained by the impact of HIV and AIDS, injuries and violence resulting in increased vacancy rates (Van Rensburg 2004: 114).

The public health structural transformation resulted in building or renovations of many health facilities. More posts at primary health care level and access to health care have greatly improved. Owing to the quadruple burden of disease that the health care is suffering, the improved health care does not reflect gains. Consequently, the

performance of the health system of South Africa is ranked low in comparison with the middle income countries and some lower income countries. This is evident when considering the life expectancy of males (50 years) and females (53 years) expressed by the South African Demographic and Health Survey 2003). Taking the impact of HIV and AIDS, projections show that almost 60/1000 children die before they reach their 5th birthday; and almost 83/100000 women die giving birth. The status is aggravated by the HIV/TB co-morbidity **(http://www.mrc.ac.za).**

2.8.4 The period after 1994

From 1994 the public health system was reformed administratively in line with the Constitution of South Africa. Nine provincial health administrations were created and were responsible for hospital and primary health care. The overall responsibility for health policy is for the National Minister of Health assisted by the National Department of Health.

In 1996 the Growth, Employment and Redistribution Framework Strategy was introduced. This focused on the macro-economic strategy for re-constructing the economy, which compromised the Reconstruction and Development Programme that was people-centred, people-driven and emphasising on social reform. GROWTH, Employment and Redistribution was clearly not in the interest of the poor majority; instead it was to perpetuate different inequalities (Van Rensburg 2004: 114). After abolishing policies and the legislature that precipitated apartheid, every person had the right to achieve optimal health and the right to be treated with dignity and respect. The government was held responsible for providing conditions to secure the health of the people and eradicating all forms of discrimination in the sector. The basis for the restructuring of the health system was the PHC approach (through preventive, promotive

and rehabilitation and curative care) through the PHC facilities prioritising the rural areas and impoverished urban areas (Van Rensburg 2004: 114).

The PHC approach would fully involve community participation in planning, provision, control and monitoring of services within the framework of a decentralised district health system that was responsible for all community health services. The intersectoral approach to health would be approached in order to deal with the complex health challenges. This would include the interdepartmental collaboration as health challenges included more than health determinants per se, but an array of such health determinants are spread over other departments like Environmental Department (water and sanitation); and Works Department for access to the health facility. A single comprehensive, equitable and interrelated National Health System was to determine national health guidelines, priorities for health and to coordinate all aspects of health care delivery. Planning was such that the National Health Systems structuring was to be spread over different levels namely, central level (National Health authority), Provincial level (nine heath authorities and District and Community level (a large number of district health authorities). These were planned and regulated accordingly at the most appropriate level to ensure that resources were rationally and effectively used (Van Rensburg 2004: 114).

Funding of the National Health System was from the general tax system such that the promotive and preventive services had free health care introduced in the public health for prioritized patient groups. The Plan would attend to health needs specifically of the vulnerable groups. Programmes that qualified were Maternal, Child and Women's Health, nutrition, mental health, Communicable Diseases Control, and violence. These changes in the Health system required skilled personnel. Therefore, a training and reorientation of employees was essential as well as the redistribution/deployment of staff

to the underserved areas in order to balance the past inequalities on access to health service. There was also a need for a comprehensive health information system, which was seen as essential for the National Health Systems planning and management that would inform the whole system and strengthen effectiveness. In this manner, a systematic collection and analysis of appropriate health data was seen as an answer to address this need (Van Rensburg 2004: 115).

In order to create the environment to implement the segment of the Plan, several policies were developed. These attended to Emergency Services Programme, health technology, care for the elderly including environmental health, HIV and AIDS including traditional healers. The developed policies laid down tenets and processes including targets and time frames in order to translate policy into action. Frameworks on the new National Health Systems based on these were developed and communicated across Human Resources development and the proposed National Health Systems information system. This formed the basis for restructuring the health system, which emphasized PHC and a single equitable and integrated National Health Systems, the District Health System that emphasized community involvement in health matters (Van Rensburg: 116).

However, the principles of the Plan were seen as a privilege rather than a right, as they benefitted only the privileged classes. The Constitution of the Republic of South Africa of 1996 gave attention to the issue of “rights for health care for all”. The Constitution also expected the government to take measures within the existing resources to ensure the realization of the laid down rights some of which pertain to health rights. These are specified in the Bill of Rights (Chapter two of the Constitution) and they guide decisions on policies, legislation and implementation. Furthermore, these structures mostly recognise such rights in respect to the vulnerable groups (Van Rensburg 2004: 112).

Considerable achievements have been made since 1994; however, dualism in health care is still there; the private-for-profit and the public health sectors. Though the basic rights approach ensuring health for all South Africans particularly the poor has been the order of the day, it has not resulted in equity. A 'better life for all' was the goal was characteristic of the hopes raised by the new government. Amongst interventions announced were eradication of racially based services, free health care for pregnant women and children.

Section 27 (1) of the Constitution of the Republic of South Africa of 1996 states that everyone has the right to have access to health care service including the reproductive health care; emergency treatment; and the rights to basic health care services for every child.

2.9 New Dispensation: provincial governance and developments in KZN with particular reference to the DOH

The above discussion on the emergence of the health care apparently supports the fact that "the Republic of South Africa is a sovereign, democratic state that (among other values) was founded on the values of "supremacy of the constitution and the rule of law" (Constitution of the Republic of South Africa of 1996). It was mentioned in the above discussion that structurally, the Government of South Africa is constituted into a hierarchy of 3 levels or spheres, namely: the National, Provincial and the Local levels. Each of the levels has a duty to carry out the function of the Government. While the National sphere makes decisions and has legislative power on matters at National level, the Provincial level makes decisions and has legislative power on matters at its level; so is the local Government with legislative power at its level (Kearsey and Wright, 1997: 68).

The Government makes institutions that enforce maintenance of law and order (governance) through legislatives, executives and judicial authorities in all its segments. In order that this duty is maintained the government executes its activities through what Kearsey and Wright (1997: 65) call a “hierarchical pattern of authority, responsibility and accountability relationships” that ensures integrated functioning of its structures.

Furthermore, the national legislation is essential for the national security, economic unity, and the mobility of goods, services, capital and labour, the promotion of economic activities across provincial precincts, the promotion of equal opportunity or equal access to government services, and the protection of the environment. According to Section 100 (Constitution of the Republic of South Africa of 1996) when the provincial government is unable to meet the constitutional requirement, the relevant national government minister intervenes by ordering the province to comply and assume its responsibility according to the norms and standards (Venter and Van der Waldt 2007: 68-9).

The government was divided into several departments that constituted the Public Service. These Departments are: Education, Finance, Justice, Health, Transport, Agriculture and several other departments. In turn, the Provincial Departments have authority over the District or local municipality. When the District/local municipality does not fulfil its legal obligations, the provincial Member of the Executive Committee (MEC) of that particular department, intervenes in the same way the national does to the non-complying province. Intervention undertaken in this way may include issuing of directives that describe the extent of the failure to comply and also prescribing the steps that need to be taken in order to be responsible (Venter and Van der Waldt 2007: 170). This means that each higher sphere is responsible for ensuring that a lower sphere is able to fulfil its “constitutional task”. The higher sphere is assigned functions that overlap with functions of the lower spheres. The interdependence between the spheres is required to

ascertain the success of the national progress. The spheres do this by among others, supporting each other; working together on matters of common interest; and by committing themselves to where they are in agreement with each other (Venter and Van der Waldt 2007: 171).

In this respect, governance ensures that government structures are established in order to carry out the government functions by ensuring the rendering of services that promote the quality of life for the people. It is thus crucial that strategies and objectives to carry out quality services are developed and relevant structures execute this function. For this purpose the Constitution of the country was developed. All South African Citizens (the President, citizens and the people) adhere to it through structures in order to execute its activities so that the rights of all people are protected.

The Constitution provides the basic values and principles governing Public Administration (PA) to which all the departments should succumb. In order that there is progress in the government initiatives (developments) there must be harmony between the PA and development, which Collins (2000: 267) describes as complex and “fraught”. He says that this state of affairs is due to certain factors among which are ongoing management transitions, which are promising at the beginning, become unpleasant and slow to move forward; and because of low standard of integrity it is obscured by corruption resulting in a crisis in service delivery. However, the public policy and administration is expected to play a pivotal role at all levels of the Government (Collins, 2000: 267).

For South Africa, a country that had changed from one era to the other apparently needed a practical transformation from an apartheid-driven bureaucracy towards a more democratic public service if the government was to perform optimally. However,

governance was challenged because of lack of human as well as financial capacity (Cameron 2008:5). To Collins (2000: 26) this was not completely new as the same was observed in Botswana. This country also experienced similar problems during its transition. He states that during the previous era, the communities were divided, which was also experienced within the government set up at all levels causing lack of integration in the work environment.

The fundamental reforms which kick-started with the pre-selection documents, namely: The Reconstruction and Development Programme (1994a) and a National Health Plan for South Africa (1994b) were followed by restructuring of the government and a series of other policies and legal documents which continued the reform of the Health Sector. As a result of the general elections in 1994, South Africa opted for a merger between the federal system and unitary state and the three layered system of national, provincial and local spheres of government. According to Van der Waldt et al. (2002: 17), there was then re-demarcation from four provinces of the former Government to the nine Provinces namely:

1. The Eastern Cape;
2. Northern Cape;
3. North West;
4. Western Cape;
5. Limpopo;
6. Free State;
7. Gauteng;
8. Mpumalanga; and
9. KwaZulu-Natal (Venter and Landsberg 2011: 104).

The mentioned nine-province dispensation is rooted in the post 1994 negotiations based on the Constitution, that changed the political setting of the country as it integrated the former homelands out of which the nine Provinces emerged (Venter and Landsberg 2011: 103). Further discussions on the reforms of the 'New South Africa' as it was generally called by the South African Citizens, is undertaken in the following sections.

At this juncture it is important to present the summary findings of the situational analysis of the information systems that prevailed in the Department; which added to the compelling reasons towards the development of the M&E system in the Department.

2.10 Summary findings of the Situational Analysis:

A need to strengthen the prevailing monitoring and evaluation and developing an M&E strategy for the KwaZulu-Natal Department of Health was identified. To do this, it was necessary to have a thorough understanding of the M&E situation in this Department. It is for this purpose that the situational analysis on the Departmental M&E system was conducted in 2007 by the Department of Health in collaboration with the Department for International Development and AIDS Multisectoral Support Programme. The situational analysis of the prevailing situation would feed to the development of a Departmental M&E strategy or framework. The following discussion constitutes the summary findings of the situational analysis conducted Department for International Development and AIDS Multisectoral Support Programme and Department of Health 2007: 1):

(a) Indicators

There are poorly defined indicators that result in different interpretations; there are no clear lines of reporting so that different people reported to different stakeholders; indicators were duplicated – e.g. Number of women on Anti-retroviral Therapy (ART) and proportion of women on ART, which needed proper rephrasing; and there were no data

collection or verification systems in place including audit trails and Standard Operating Procedures (SOP) the tools in use. The implication of this was confusion amongst health workers regarding poorly defined indicators which impacted on data quality. The inaccurate indicator interpretation which was based on individuals also affects the quality of data. Owing to various reports generated, quantity superseded quality. Poor recording at the data source affected reliability and validity of reports generated (including the DHIS reports). There was no comprehensive document that described the Health Information System.

(b) Plethora of health information systems

There were different Health Information Systems functioning differently and parallel to each other. For example, the District Health Information System, the Active Sentinel Surveillance, the Paper System (used in the ART Programme), Electronic TB Register and a few others. Some of these HIS are paper-based and programme specific instead of being electronically stored. Lack of integration to the Provincial HIS e.g. the Active and Sentinel Surveillance programme. The implications for this were that the analysis, the data quality and reporting was cumbersome in a paper-based system. Data analysis did not occur at the data source and data flow procedures were bypassed. The Fragmentation and duplication existed in the data collection system. The inability to monitor all the Health Information Systems was a challenge (Department of Health 2007: 16).

(c) Information Culture

There existed weak information culture due to lack of resources, capacity, commitment, buy-in and understanding (DOH M&E Framework 2010: 42). The Focus was mainly on the implementation of services disregarding monitoring of performance. This means that data was collected for compliance and not to inform planning and decision-making. The

Health information was not used to revise or develop policy directives. Data collection and compilation of reports was done for reasons of compliance instead of an understanding of the meaningfulness of data, its analysis and how it could be used. The rating of data showed inconsistency and inaccuracy. What this implied was absence of information usage to revise or develop policy directives. There was poor use of information in planning and decision-making. This caused de-motivation of Health workers and in turn poor quality data and data that is not timely (Department of Health 2007: 13).

(d) Support to the districts

There were no M&E systems for feedback at all levels so that data flow was not clearly defined. The roles were not clearly defined, for example, Facility Information Officers (FIOs) also captured data instead of focusing on Information Management and Monitoring. There was high staff turnover and resultant vacancies are not filled, causing staff shortage. Only 73% of District Information Officers (DIOs) were able to engage in independent data analysis and interpretation. The implications of this plight were lack of integrated effort in M&E at all levels of data processing, disillusionment and de-motivation of staff at lower levels. At each level, data management was undermined because of lack of verification systems. There was, therefore, poor quality data because of a lack of capacity at facility and district levels to verify the data for accuracy and reliability. As the FIOs were involved in data capture, they had insufficient time to validate and feedback data to the original data collection points; i.e. wards, theatre, Out Patients' Department and other sections of the Facilities (Department of Health 2007: 15).

(e) Reporting, information use and access

There was a strenuous reporting load on District Managers as they were also asked to provide *ad hoc* reports. The problems surrounding reporting were lack of clarity on the required information or reports, uncoordinated reporting, managers' individualised mindsets and no reporting formats (DOH M&E Framework 2010: 43). The lack of documentation of what information was available where and how it was best accessed. Some reports are requested from managers at district and facility levels bypassing data validation process. Both at National and Provincial levels, there is a perceived overlap of the increasing and confusing reports required by the DOH in different formats. What this implied is that there were reports sent without validation, making quality questionable. The problems encountered during the development of the APP were suggestive of unreliable data sources. The information is not accessible and, therefore, cannot be used in decision-making and strategic planning needs related to programme cycles. The inaccessibility (and transparency) of information to the public violates the legal mandate (Department of Health 2007: 26 - 27).

(f) Evaluation

Evaluation as a concept is not clearly understood at all levels of the department. There are no personnel allocated to do evaluation. There are no processes in place to identify programmes that need evaluation. There is no documentation of used and disseminated results as well as SOPs with criteria for approving or rejecting evaluation. The implications for this were the overdue evaluation of DOH programmes and HIS resulting in poor planning. A further negative element was the stagnant M&E system that does not progress from an input/output M&E system towards an outcomes/results-based M&E system. Thus information obtained and DOH research results are not harnessed to improving public health (DOH M&E Framework 2010: 44).

Conclusions on the findings of the situational analysis were an array of gaps or challenges that were identified in the situational analysis radiating from the absence of a recognised M&E Framework that guides the M&E system in the Department. These gaps included the inaccuracy in the indicator system, the different HIS that functioned separately, lack of capacity and verification systems leading to poor information culture, reporting system and data usage (DOH M&E Framework 2010: 44). As a result, data quality was also described as unreliable and invalid to inform policy directives, programme planning and decision-making. One of the crucial gaps related to the M&E system itself is that it still adopted a traditional approach with the focus is on inputs and outputs.

Recommendation of the Situational Analysis

The Department had to respond by developing a comprehensive document that describes the Health Information System. As the organisational culture of the Department embraced the use of information through capacity building, accountability and awareness the Department was required to develop a systems master plan to address disparate Health Information Systems and that the M&E system that prevailed should move towards a results-based approach that focused on outcomes.

Conforming to the findings and the recommendations of this situational analysis, this far, the DOH had its M&E Framework adopted and signed by the Head of Department (KZN Provincial M&E Framework 2010: i). Besides the pressure to achieve the targets of the MDGs by 2015, the DOH is also required to achieve the National Health Systems 10 Point Plan Priorities by 2014; and the four outputs for the Negotiated Service Delivery Agreement. In its endeavors to meet these requirements, the DOH is constrained by limited financial and human resources, which makes the above discussion on strengthening the M&E system in measuring performance towards good governance,

very crucial. Like other governments that have taken a stand on strengthening its M&E systems, the Government of South Africa in general and the DOH in particular, is no exception.

The DOH has about 500 performance indicators that are related to numerous presidential goals. For each indicator, recording is undertaken for the objectives; strategies on how to achieve it; baseline performance; annual targets; actual performance against targets; and imputed amounts spent by programmes. Therefore, the system includes a large number of indicators on government performance. In addition, where a target has not been met the Programme Manager is required to present an explanation on reasons for the shortfall. These exceptional reports are included in the database, the core of which is publicly available on a real-time basis.

2.11 Conclusion

This chapter provided an elaboration on the emergence of the South Africa Health Care System way back from the Colonial era in the 1600s to the present. This was succeeded by the discussion on the area of study, its demographics, and profile. The health profile presented the determinants of health as social, economic, and environmental and how these impact on the disease profile of the Province. It went on to highlighting the development of the M&E System in the South African Government: in the Provinces and the Departments specifically in KwaZulu-Natal DOH.

The health services delivery status in the KZN province was presented and how the scenario precipitated to public dissatisfaction. The blanket moratorium added to an already overstretched general performance of the employees bursting into a national strike. A summary of the situational analysis, its findings conclusions and

recommendations were presented as well as the M&E Framework. It was time for the Department to seriously take into cognisance the recommendations of the situational analysis on the M&E System conducted within the Department.

The Legislature and the Policy Framework were presented with a detailed illustration of policies and legislation that underpinned the establishment of the M&E System in the Department. A brief assessment of the extent to which Department complies with the basic values and principles that govern the Public Administration was conducted. All these factors became a strong factor underpinning the establishment of the department. Finally, the Provincial Growth and Development Strategy was discussed together with its linkage to the provincial disease profile, as one of the recently introduced policies.

CHAPTER THREE

MONITORING AND EVALUATION IN SOUTH AFRICA: LEGISLATIVE AND POLICY ASPECTS

3.0 Introduction

As background to the discussion on monitoring and evaluation (M&E) in public governance, the chapter presents the literature review that provides the theoretical foundation on which the study is based. This discussion includes the M&E endeavours globally, nationally, provincially – particularly in the Department of Health and locally.

The reason for conducting the literature review was to place the study within other similar studies and to explore existing knowledge in and understanding of the study area in order to be familiar with the relationship between the problem and the body of knowledge in this field. Other reasons were to establish the need for this kind of research and to acquaint the researcher with the methodologies that have been used by other researchers to "find answers to research questions similar to the ones investigated in this study" (Chilimo 2009: 55).

Together with the literature review, there is a discussion on the M&E developments globally, in the Government of South Africa and in KwaZulu-Natal with a particular focus on the Department of Health (DOH).

3.1 Definition and organization of literature

The literature review is a "systematic, explicit and a reproducible method for identifying, evaluating and interpreting the existing body of recorded work produced by researchers, scholars and practitioners" (Chilimo 2009: 55).

The chapter provides an understanding of what other countries have done to establish their M&E systems in order to ensure governance. To discuss these deliberations, the chapter presents a brief explanation of the recommendations of the situational analysis that was discussed in Chapter Two, which will give a picture of the magnitude of the problem, conclusions and recommendations thereof. Based on the recommendations the M&E system in the Department was established. The chapter elaborates on how the development of M&E resulted in the development of the M&E Framework and the Implementation Plan thereof. The Legislative and Policy mandates that underpin the M&E systems in South Africa in general and KZN (DOH) in particular.

3.2 Purpose of and organization of the literature

The purpose of the literature or information review is to put the research being conducted into a particular field. It is a general practice that researchers use theories either to ground their study or to guide and examine the hypotheses raised. Literature review lays out the foundation for the justification of the research (Terre Blanche, Durrheim and Painter 2006: 19).

It is further stated that the literature review helps identify knowledge gaps and develops the research problem. The research problem needs to be clearly stated and explicit parameters defined. This is a process undertaken by reading and examining the published historical and the empirical work (Terre Blache, Durrheim and Painter (2006: 19).

Thornhill (2006: 606) agrees with the above statement and further states that in research, identifying a theoretical framework is the second purpose of literature review that helps to refine the research problem in order to identify the theoretical framework on

which to base the research to be conducted. Once this is accomplished, it becomes more feasible to develop related variables and related hypotheses and research questions. Once this is done a system on how information will be collected, that is, sources, space of time and the appropriate information, are determined.

It is crucial that conceptual and operational definitions are identified. This means that concepts should be defined to address ambiguity. Such concepts should be operationalised in scientific terms in order to be appropriate for being used scientifically. Literature review also helps the researcher to identify the most appropriate methodologies to use as she bases her own on methodologies used by other researchers that were tested and found reliable. The whole exercise of literature review gives the researcher search skills as more literature is searched. This in turn provides the researcher with more knowledge of related concepts and vocabulary. Terre Blanche, Durrheim and Painter (2006: 23) refer to this as using a “controlled library catalogue”.

In this study discussion on the literature commences with the study definition of public governance as a concept; and how governance relates to the topic. An explanation of how public governance interplays with M&E is undertaken; This is followed by a discussion of the magnitude of implementation and utilization of M&E Systems worldwide, which will finally lead to the explanation on the linkage of governance, M&E and other theories discussed in the study. The chapter will conclude by providing the theoretical framework that guides the study.

3.3 Monitoring and Evaluation Systems

The Monitoring and Evaluation System

Internationally, the number of governments working towards improving their performance is growing. They improve performance by setting up systems to measure and facilitate the understanding of performance, whether good or poor. These are the M&E systems developed to measure, the quantity and quality of their products or services; that is, their outputs, outcomes and the impacts. Evidence shows that the M&E systems are central to the achieving of good governance through "evidence-based policy making, budget decisions, management, and accountability" (Mckay 2007: iii). According to this notion, the measure of success is the degree to which the M&E information is being used to improve government performance.

Monitoring and evaluation is one of the systems that can present unique information about performance on the Government policies, programmes and projects. It allows the identification of what works; what does not work; and provides reasons. The M&E system also provides information about performance of individual Government Departments, managers and the staff. By using the M&E information, the government attains improved government performance. Governments also utilise information from the M&E systems to develop, strengthen, and fully institutionalise their M&E systems. Making use of the M&E information significantly improves a government's performance policies, programmes, and projects (Mckay 2007: 10).

Tenets of monitoring and evaluation

Monitoring and evaluation should be:

1. Contributory to improved governance through elements like: transparency, accountability, participation and inclusion;

2. Rights-based: through the Bill of Rights, the rights-based culture is promoted and entrenched by including it in the value base of all M&E processes;

3. Developmentally-oriented – nationally, institutionally and locally: by encouraging good orientation, service delivery and performance, learning, Human Resource Management and impact awareness;

4. E*thically undertaken and with integrity:* through confidentiality, respect, representation, competence and fair reporting;

5. Utilization-oriented: this involves defining, meeting expectations and utilisation of support;

6. Methodologically sound: must have consistent indicators, be data or evidence-based, be appropriate and triangulated; and

7. Operationally effective: with planned scope and managed cost effectiveness (The Presidency 2007:3; Ile et al. 2012: 13).

The above-mentioned M&E tenets, should not be viewed as a narrow and technocratic activity, but as a requirement to achieve evidence-based policy-making, management, and accountability. This means that, by using M&E, the department is able to achieve a results-oriented and accountable public sector; and improved performance culture (Mckay 2007: 10). When M&E systems are used in policy making, they help the Government Departments to manage activities at both Departmental and Programme levels. For instance, it improves service delivery and management of staff; enhances transparency and sustains accountability by displaying the extent to which desired goals have been accomplished. It is for this reason that the Government of South Africa recommends a results-based M&E system as a management strategy that would focus on performance and the achievement of outputs, outcomes and impacts (Ramafoko 2012: 14). McKay (2007: 2) concludes that improved government performance contributes to good governance.

Hughes (2003:54) stipulates that the organisations should focus on the results. This entails putting emphasis on performance by both the Departments as well as individuals within the Departments. This is a process that commences with the performance agreements and contracts written and negotiated between the department and employees. The quantifiable performance is clearly specified for a given time frame and is measured against targets at the end of the period. Poor performance is reprimanded and the realisation of targets is rewarded with incentives.

At this point it is important to refer to the Framework for Strengthening Citizen-government Partnerships for Monitoring Frontline Service Delivery published by the Department of Monitoring and Evaluation in 2013. The Framework brings to attention the monitoring angle that has been neglected by the Government M&E system – that of monitoring the government performance "that focusses on the experiences of ordinary citizens in order to strengthen public accountability and drive service delivery improvements (Department of Performance Monitoring and Evaluation 2013: iv). In this approach citizens are active participants in shaping what is monitored and are involved in the whole process of monitoring; including actions that are derived from the collected data and analysis made. This approach is known as the Citizens-based Monitoring.

The Framework provides a set of principles to guide the Government Departments in the implementation the Citizens-based Monitoring. These principles are:

- As a democratic nation, the voice of citizens is integral to building a capable, developmental state in South Africa. *This means that the public administration must be accountable and transparent; and be encouraged to participate in the policy-making process*;
- Government monitoring systems need to include the views and experiences of citizens. *There must be independent citizen monitoring mechanisms that will*

ensure that the information derived from monitoring is verified by using methodologically sound mechanisms that would ensure independence and relevance;

- Government departments must encourage independent monitoring by civil society. *For healthy democracy, citizens have a right to monitor the government and the government should provide platforms to participate in information sharing;*

- Citizen-based monitoring is not a once-off event, but an on-going process of relationship building and performance improvement. *The Citizens-based Monitoring is also about building trust between the government and the citizens with regard to service delivery. It encourages the citizens to provide feedback about issues relevant to them so that the government has an insight of what goes on at a local level;*

- Citizen participation in planning strengthens citizen participation in monitoring. As *monitoring is linked to planning processes, involving the citizens in this phase ensures that they will fully participate in planning and implementation of programmes;*

- Citizen-based monitoring must form an integral part of service delivery improvement plans and management decision-making processes. *Information derived through Citizens-based Monitoring is core to service delivery and should inform decision-making, planning and budget processes. In this way the Citizens-based Monitoring must be institutionalised to* through training of staff;

- Monitoring mechanisms should be workable and suit the context in which they are applied. *The mechanisms used in the Citizens-based Monitoring should be comprehensible; at the level of the citizens; within the context in which they are installed; financed and aligned with the existing core business processes;*

- Monitoring findings and planned improvements need to be communicated to citizens timeously. *The feedback loop must be on-going and include detailed explanation of corrective actions taken, timelines and responsible persons;* and
- Communication strategies must be informed by the target audience. *Audience analysis must be conducted so that correct communication is made to the relevant people. This exercise will also provide understanding of the level of literacy, relevant language, medium of information dissemination, the level of feedback and other relevant factors* (The Presidency 2013: 19).

3.4 The magnitude of monitoring and evaluation implementation

Internationally, the number of governments working towards the improvement of their performance is growing. Governments improve performance by setting up systems to measure and facilitate the understanding of performance whether good or poor. These are the monitoring and evaluation systems developed to measure, among others, the quantity and quality of the governments' or organisations' products or services - the outputs, the outcomes and the resultant impacts. Evidence shows that the M&E systems are the centre for the achievement of good governance. According to Mckay (2007: iii), M&E systems are a requirement for achieving the "evidence-based policy making, budget decisions, management, and accountability". Regarding this connotation, the degree to which the M&E information is used to improve government performance, is a yardstick for its success.

There are several reasons for the increased need to establish or strengthen the M&E systems and this differs from one country or government to the other. For instance, in 1998 the Government of Australia requested the development of the evaluation systems that would conduct evaluation of programmes while taking performance information as a

responsibility of the departments to manage. The evaluation practices are executed every three to five years; the expenditure and the process is managed by the Department of Finance. As a result, the new Financial Year budget proposals are guided by the findings from such evaluations. The increased concern about quality of performance information led to the increased reviews of the departmental performance information (Mckay 2007: 38).

Chile developed its M&E System in 1994. Evaluation findings are being used intensively in budget analysis of each ministry to input into budget decision making. The success for the Chilean M&E system is attributed to a "highly centralized budget system and a highly capable and extremely powerful finance Ministry" (Mckay 2007: 35). Due to its utilization of the M&E information Chile's M&E System is regarded as one of the strongest and cost effective M&E systems in the world.

In Colombia, the Department of National Planning manages the M&E system. There is a list of performance indicators to monitor Government performance. Where there has been underperformance on certain indicators, the relevant manager is required to submit an explanation. The President conducts regular management control meetings to discuss under-performance with each Minister (Mckay 2007: 15). The major emphasis of the Colombian M&E system was initially on monitoring dimension rather than on evaluation (Engela and Ajam 2010: 18). The same report by Mckay further reveals that in 1994 the Government of the United Kingdom created a system of performance targets based on the goals and objectives in the Public Sector. Targets are expressed as outcomes that need to be achieved. The Departments present their performance against set targets after every six months for purpose of internal planning and accountability. Evaluations on expenditure are conducted over a period of three years. The

Departments use the reports from the National Audit Office for the purpose of planning and accountability.

In 2002, the United States established a Programme Assessment Tool to measure government performance over four aspects, namely: clarity of the programme objectives and design; quality of the strategic plan and targets; effectiveness of the programme management; and actual results achieved. Ratings are made and decisions taken by an allocated office that analyses the M&E information on programme performance based on set criterion.

Latin America is no exception to this practice, as it already had 20 countries in 2007 working towards strengthening their government M&E systems. This was embarked on because in Government performance there was no value for money and there was dissatisfaction on expenditure which did not correspond with "quality or quantity of services provided" (Mckay 2007: 17). There was also increasing pressure for Government accountability to ordinary citizens.

The African Countries were compelled to establish M&E Systems. For instance, the World Bank expects the same to countries who borrowed from it. The Poverty Reduction Strategy also exerts pressure on member States putting emphasis on monitoring of performance towards the attainment of the Millennium Development Goals (MDGs); and reporting (Mckay 2007: 17). Furthermore, it was revealed that there are more than 16 National Evaluation Associations. Some of these Associations are in Nigeria, Ruwanda, Kenya and South Africa. However, the challenges experienced by the Associations are the limited M&E Champions and the lack of M&E capacity. Uganda and Tanzania have considerable understanding of the importance of reliable and comprehensive performance information. For instance, the Ugandan Government established an

integrated M&E mechanism for its Poverty Eradication Action Plan, which focused on outcome indicators. In Tanzania a poverty M&E system was also established in order to track progress using a set of core indicators (Engela and Ajam 2010: 18).

Other countries in Africa prepare their National Plans; and draw their budget based on the M&E information. It is crucial to mention that these countries face a challenge of not reviewing their M&E systems; have problems with data quality; and have too much data with insufficient information due to lack of capacity and weak government demand for the M&E information (Mckay 2007: 19).

South Africa is not an exception in this regard; there is an expectation to report on the MDGs. To this effect, the Office of the Presidency established a Directorate of Monitoring, Evaluation and Administration. Engela and Ajam (2010: 18) postulate: "Now that the monitoring systems have been established, the quality of data needs to be improved". Such postulations may require further investigations, however, for the purpose of this study, the following is a discussion of how the M&E systems developed in South Africa.

3.5 Theoretical framework and perspective of the study (Theory and model)

This section provides background information on theories and models and their use in qualitative and quantitative research. The section will also present the theoretical framework and models which guided the study. Kerlinger (1970: 64) defines a theory as constituting several concepts that are interconnected; definitions and assumptions that show a phenomenon in a systematic way which spell out relationships among variables in order to explain and predict a phenomenon. Chen (1990: 17) contends that in research, a theory is a frame of reference that provides guidelines for analysis of a

phenomenon; that it also provides a system which helps to understand the implication of the research findings. When describing the role of the theory, Chilimo (2009: 58) says it gathers and brings together the scattered and isolated pieces of empirical data into a comprehensive conceptual framework that makes sense of the social world.

A theory may be presented as a visual model by translating variables into a visual picture. This enables readers to envision interrelationships of variables. A model can connect independent and dependent variables in order to build theory. In quantitative research, a theory is at the beginning of the study so that the researcher conducts research to verify the theory by testing the hypotheses that emanate from it instead of developing it. That is, the theory forms guidelines as a framework of the study (Creswell 2008: 56). Creswell (2008: 61) further asserts that a theory in qualitative research is also used to broadly explain behaviour and attitudes and that it has variables, constructs and hypotheses. Hypotheses are tested and they give broad explanations in the same way as theories. In qualitative research, the use of a theory differs. Some researchers may use a theory as a final outcome at the end of the study as in grounded theory (Creswell 2008: 49). In other qualitative studies, theoretical models are used at the beginning as they inform the study by providing guidance on what issues to investigate and people to be studied, how the researcher needs to position himself without being biased and how to present his findings. "Increasingly, philosophers and scientists have affirmed that all knowledge is theory-laden and that methods are theory-driven" (www.ncbi.nim.nih.gov/pubmed/8265050). These assertions raise important questions related to the role of theory in both quantitative and qualitative research.

3.5.1 Theories and models in qualitative and quantitative research

Qualitative research methods are exploratory in nature and are used to investigate

phenomena that are difficult to measure using quantitative methods. These could be complex organisational dynamics that can influence organisational culture. Unlike quantitative research, qualitative research describes the complicatedness, extensiveness or array of occurrences or phenomena. Qualitative research does not occur in close or experimental settings but it occurs in natural settings and produces open-ended discussions and observations (Curry, Nembhard, and Bradley 2009: 2).

Qualitative data seeks to uncover the context, perceptions, quality and opinions on particular experiences or conditions according to their observation. For data collection, this method adopts a participatory approach that uses open-ended questions, which allows respondents to elaborate on answers they provide while simultaneously progressing to more crucial issues. The participatory method is used commonly in monitoring and evaluation processes. Qualitative methods mostly use purposive sampling techniques. It is in rare conditions that this method requires robust establishment of sample size (Mngomezulu 2009: 66).

On the other side, the quantitative research methods have emphasis on quantification of constructs where numbers are assigned to perceived qualities of objects (Mouton 2001: 49). As this research method counts occurrences by estimating prevalence, frequency magnitude and incidence it is not to measure complex phenomena like organisational processes, social interactions underlying particular outcomes. Quantitative research is conducted in “randomized or non-randomised experimental and natural settings and uses standardized processes and instruments with predetermined response categories” (Curry et al. 2009: 2).

The study used both qualitative research methods. The study aimed at evaluating the M&E system of the Department of Health and its contribution towards public governance. How theory is used in evaluation is discussed in the next section. The discussion on countries that implement M&E Systems showed that one of the objectives to conduct evaluations is to use findings on decision making, planning and budget allocation (Mckay 2007: 15-16). It was in 2011 that the Evaluation Policy Framework was created in South Africa (Evaluation Policy Framework: 2011).

3.5.2 Models and theoretical perspective that guided the study

In conducting research on monitoring and evaluation towards good governance in the Department of Health, the study highlights the limitations in relation to three motivational theories discussed below. These are:

- Public Administration and Management Theory;
- New Public Management Theory;
- Monitoring Theories; and
- Evaluation Theories.

3.5.2.1 Public Administration

According to Du Toit and Van Der Waldt (1999: 42), Public Administration is a system whereas Public Management is a subsystem of Public Administration. This means that Public Management is the extension of Public Administration. Mitchell and Harrison (1991: 3) describe Public Administration as the action part of the Government and the means to attaining the goals and objectives of a government; and that the primary concern of Public Administration is service delivery.

To emphasize this contention, Du Toit and Der Waldt (1999: 94) illustrate the following principles of Public Administration:

1. The Constitution and the authority of Parliament, which refers to the legislation that governs PA in order to ensure that policies are made through Acts that provide frameworks for tasking action; and that they are carried out in the organizational structure. Cameron (2008:8) states that PA is based on the notion of hierarchy and authority in the organizational structure and management;
2. The Legislature prescribes responsibilities and roles for the structures;
3. Values of society are about the guidelines or principles for good behaviour; and how functions can be carried out in a fair and reasonable manner. Truth, efficiency and effectiveness are some of the key words in this principle (Du Toit and Van der Waldt: 1999: 103);
4. Legal rules is a principle that refers to the code of conduct for employees - rules and ethics; and
5. The Eight "Batho Pele" Principles provide a framework for transformation of public service delivery (Du Toit and Van der Waldt 1999: 110; Constitution of the Republic of South Africa of 1996; and Cameron 2008: 4)

The following discussion is on the specific basic values and principles that govern Public Administration:

"A high standard of professional ethics must be promoted and maintained; efficient, economic and effective use of resources must be promoted; Public Administration must be development oriented; services must be provided impartially, fairly, equitably and without bias; people's needs must be responded to, and the public must then be encouraged to participate in policy-making; Public Administration must be accountable; transparency must be fostered by providing the public with timely, accessible and

accurate information; good human-resource management and career-development practices, to maximize human potential, must be cultivated; and Public Administration must be broadly representative of the South African people, with employment and personnel management practices based on ability, objectivity, fairness, and the need to redress the imbalances of the past to achieve broad representation" (Constitution of the Republic of South Africa of 1996).

With reference to the Public Administration, Kettie (2002: 204) postulates that it provides a limited set of points of departure because it can hardly be translated into actions. This postulation has also been agreed upon by Collins (2000: 268) who adds that within the workplace in the Public Service there is a lack of integration; and that instead there is inherent fragmentation due to lack of responsibility. Findings of a study conducted by the Fortune Magazine as reported by the Human Resource Development (2005: 35), showed that sixty percent (60 %) of organizations do not link a strategy to budgeting; seventy percent (70%) of organizations do not link middle management incentives to a strategy; eighty five percent (85%) of executive teams spend less than one hour per month discussing a strategy; and ninety five percent (95%) of the typical workforce does not understand the strategy of their organization.

Public Administration and Management

Administration and Management constitute activities and functions with interrelated processes which when successfully executed enable the employees of the public service to achieve required service delivery to the people (Du Toit et al. (2002: 12). These functions operate in the work environment where there are public needs that must be met. Both Public Administration and Public Management operate in conjunction with good governance (Du Toit et al. 2002: 80). This particularly refers to the open-system

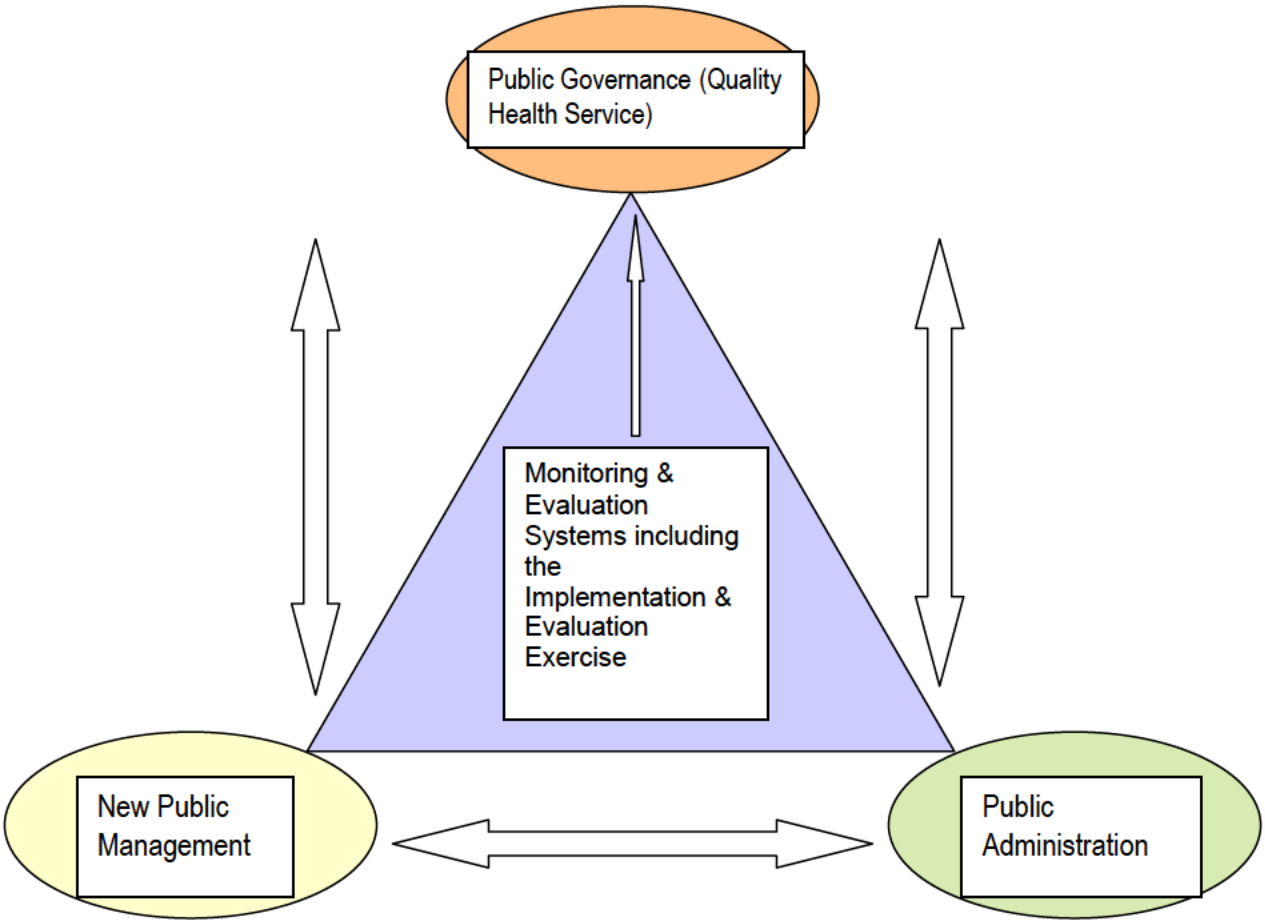
approach of public administration and management where the environment influences the functions of PA and PM in which they occur (Du Toit et al. 2002: 27).

According to Guldenhuys and Knipe (2002: 124), Public Management has a responsibility to ensure that in a democratic government the environment is conducive for good governance and principles of efficiency and effectiveness towards service delivery. It is for this reason that the concept, governance, was introduced. Though this was discussed in Chapter Two, it is important to repeat that the Department of Public Service Administration (2008: 23) refers to good governance as "processes and systems by which an organisation (department) operates and the government is established to administer these processes and systems". In its vision the Department of Public Service Administration clearly states that the South African Government seeks to promote good governance; and that it can be understood well when thought of in the context of "good government practices" (Collins (2000: 180). This refers to efficiency that is based on accountability, transparency, and participation in the processes of developing and implementing the policies within professional ethics. Guldenhuys and Knipe (2002: 90) contend that in order to achieve good governance, the Department has a responsibility to develop goals and objectives. Good governance can only be achieved if the government achieves its ultimate goal of quality of life.

To further explain this, governance principles of public accountability mean that people should be accountable for their actions in public and must have an obligation to act and exercise transparency. Action should be in the open – there should be no secrecy or confidentiality in executing government duties. Employees need to display a sense of responsibility when performing their duties, which includes performance without ulterior motives or conflict of interest; otherwise it will require public accountability (Guldenhuys and Knipe 2002: 129).

The following diagram shows how different elements interplay in order to contribute towards public governance.

Figure 3.1 Interplay between Public Administration and Management Theory and Monitoring and Evaluation Systems



The elements in Figure 3.1 show that there is interplay between the Public Administration and the Management approach and the New Public Management approaches, as the latest theory prescribes how the public service should be administered or governed. The NPM approach prescribes that there is an employee/employer contract that is entered into. In order to ensure service delivery, the

objectives and duties that the employee has to carry out are laid down clearly (Du Toit et al. 2000: 28). This is similar to the performance agreement and the key results areas (KRAs) that the employee should achieve and account for. As mentioned above, it is anticipated that transparency and accountability may result in good governance.

3.5.2.2 The New Public Management Theoretical Framework

According to Cameron (2008: 3), New Public Management (NPM) approach is not a theory but a range of different streams of Public Management ideas that seek to bring change in management systems by moving away from a more bureaucratic administrative style of the public sector, towards more individualistic, less rigid and flatter hierarchies. Such ideas include "decentralization of authority and responsibility to managers; rightsizing which entails reducing the size of the public sector; corporatization in the form of converting departments into free standing units; the creation of the Senior Management System (SMS) category; the use of the contract system for heads of departments; the creation of a more flexible human resources system; and the introduction of Performance Management and attempts to improve service delivery" (Cameron 2008: 3-5)

Another aspect of the NPM is more focus to the outcomes and efficient management of the budget. According to this principle, the beneficiaries of the Public Service are referred to as customers and shareholders (Boston, Martin, Pallot and Walsh 1996: 50). Mckay (2007: 22) refers to this kind of budgeting as "indirect performance budgeting". He denotes that this is the most common form of performance budgeting. Performance budgeting is not limited to the budget allocated for programmes and M&E information, but consideration of other sources of information – like priorities of the government's policy (including equity issues), also influence the allocation of budget.

The Government of South Africa implemented various features of the NPM over the past 15 years. These features have not been very successful. However, the study focuses on the two latest features of the NPM, namely: improving efficiency through performance measurement; and health service delivery.

3.5.2.3 Monitoring Theories

Performance management

After 1994, there was a mission to do away with a long-standing tendency of poor performance in the government departments. The Performance Management System (PMS) was an intervention to curb poor performance in "public service institutions" (Malefane 2010: 1). This further denotes that the PMS is about realising the relationships between individuals, teams and departments in their performance in order to achieve government targets in general and departmental targets in particular. This goes hand in hand with the consideration of the relationship between performance and the impact it has on the citizens.

The above exposition tallies with that of Kumar and Sanga (2011: 2) that the performance of a government has a direct influence on the well-being of the citizens, particularly the vulnerable, who are solely dependent on the public service. The government that is faced with challenges may be ineffective in its performance. Therefore, it is important to have a PMS that would enable the government to address challenges that may affect its performance. According to Williams (2002: 11) performance management is a "system for managing organisational performance, a system for managing employee performance and a system for integrating the management of organisational and employee performance". Kumar, and Sanga (2011:

2) define performance management as “an ongoing, systematic approach for improving results through evidence-based decision-making, ensuring continuous organisational learning, and focusing on accountability for performance”. As mentioned above, this is PMS which in the South African public service aims to do away with poor performance that is inherent in public service as set out by the Department of Public Service Act (2001: 1).

In Chapter One it was mentioned that the citizens of KwaZulu-Natal expressed dissatisfaction about service delivery in general and on health care service rendered by the Department of Health in particular. The dissatisfaction was also on the conduct of the employees of the Department of Health, which resulted in protests for improved benefits.

Performance management is a “system for managing organisational performance; a system for managing employee performance; and a system for integrating the management of organisational and employee performance” (Williams 2002: 11). The aim of the PMS in the South African public sector is to do away with poor performance that is inherent in the public service.

Mlefane (2010: 3) takes this further and says that the PMS is about setting and measuring desired outcomes and activities of individual employees, components, teams, or programmes that contribute to the attainment of the departmental strategic goals. PMS enables realistic planning that lets the department to “assess impact of its process and strategies, and to enhance accountability” (Mlefane 2010: 3).

The integrated organisational performance relationships between individuals, teams and programmes’ performance contribute to the realization of departmental performance targets. When the Government of India introduced Performance Monitoring and

Evaluation Systems, it aimed to measure the performance of government departments "in a fair, objective and comprehensive manner in order to create a results-based government" (Kumar, and Sanga (2011: 2).

Though these statements about performance management depict PMS as infallible Kumar and Sanga (2011: 3) state that the effectiveness of the performance management tools to some degree has been restricted by routine implementation, fragmented institutional responsibilities where there are more than one principle, multiple objectives, weak incentives, and delay in providing evaluation information.

In the Department of Health, Performance Management is known as the Employee Performance Management System (EPMDS). It is based on a vision, mission, strategic frameworks and policies. The EPMDS involves setting the plans and guidelines; having necessary resources, objectives, targets, performance standards; and continuous activities and processes for managing improvements.

In applying the EPMDS systematic reviews or monitoring of performance are conducted at regular intervals. The process includes measurement and evaluation of performance (Williams 2002: 11).

As an example Table 1 below shows a framework of how the Department monitors its performance (Mother and Child and Women's Health Programme – MCWH) on quarterly basis using indicators based on strategic objectives and targets to be achieved within a set timeframe. This is applied to all the Departmental Programmes.

Table 3.1: Quarterly targets for the Mother, Child and Women's Health Programme for 2011/12 performance Indicators

Strategic Objectives	Performance indicators	Annual Targets 2011/12	Quarterly Targets			
Reduce child mortality to 45/1000 live births by 2014/15	1. Immunisation coverage under 1 year	**Quarterly**	**Q1**	**Q2**	**Q3**	**Q4**
		90%	80%	85%	88%	90%
Reduce maternal mortality to ≤ 100/ 100 000 by 2014/15	6. Antenatal visits before 20 weeks rate	60%	39%	46%	54%	60%
	7. % of pregnant women tested for HIV	100%	96%	97%	98%	100%
	8. % of pregnant women who are eligible placed on HAART	95%	82%	87%	92%	95%

Adapted from the Annual Performance Plan (2011/12 – 2013/14).

Performance management as a system for managing employee performance

Planning improvement and reviewing processes are also included in the Performance Management Model. The line manager has a responsibility for planning, supporting and reviewing the performance of an employee. According to the Department of Public

Service Administration (2007: 29), evaluation of the EPMDS should help determine if the system is functioning effectively. Furthermore, an evaluation schedule should be drawn in the early stages of the performance cycle in order to assist supervisors in identifying and developing targets of the desired outcomes of the EPMDS.

The line manager supports the employee's performance so that performance review is jointly undertaken by both the manager and employee on a continuous basis.

Performance management as a system for integrating the management of organisational and employee performance

This model assumes that the vision and mission and goal setting have occurred such that the objectives have been set within key results areas and that all processes have been communicated across sections and that employees understand what is involved. Performance management supports the department's strategic goals by linking each employee's work to the overall vision/mission of the department (Williams 2002: 15). This model is in line with what Mlefane (2010: 3) contends, that performance management is part of a larger system that begins as soon as a job position is filled and ends when an individual leaves the position or the department. The system aligns the roles of an individual employee with the attainment of the departmental goals and objectives. This means that the employee's performance conforms to the strategies of the department, so that their performance strives towards realization of goals. This is displayed through job descriptions that are assessed by supervisors through performance/work plans that respond to the objectives and goals. Performance agreements that show full understanding of what the job entails are presented (Department of Public Service and Administration 2007: 12).

The performance agreement is entered into by, and between the Department as represented by the manager in his capacity as a manager of a Unit; and an employee – on his or her capacity or designation in the personnel salary system (PERSAL) number. The purpose of entering into this agreement is indicated; that it seeks to communicate to the employee the performance expectations of the employer. The performance agreement is accompanied by a work-plan that will be used as the basis for assessing the suitability of the employee for permanent employment (if on probation); and to assess whether the Employee has met the performance expectations applicable to his or her job.

The agreement also stipulates the period over which the agreement will be valid. The content of the agreement may be revised at any time during the above-mentioned period to determine the applicability of the matters agreed upon; particularly where changes are significant. The purpose of the job fully describes the overall focus of the job, as it relates to the vision and mission of the Department. It captures the overall accountability that the job-holder has in relation to his/her position according to the legislative mandates of the Department; and further states how often relevant reports will be generated.

There is normally a list of key results areas (KRA) on which the employee will be monitored. These are weighted and performance is measured against 100% which the employee should achieve. Based on the KRAs the employee draws a work plan which lays out activities, indicators and timeframes which the employee will strive to achieve. Both the manager and the employee sign on agreement of the work plan and KRAs. There are also reporting requirement and assessment prescripts, which outlines to whom the employee member shall report (job title of the supervisor in the Department). The Employee shall ensure that he or she communicates any factors that may not allow for him or her to perform his or her job and amend any targets if necessary. In turn the

supervisor shall ensure that meetings take place at least four times a year to provide feedback on performance and to identify areas for development.

Performance Assessment Framework

Performance is assessed in accordance with the information contained in the work-plan, and in the Generic Assessment Framework (GAFs) framework. During the period of this agreement the KRAs and GAFs will be in accordance with what is set out in the table below. The employee member focuses on and actively works towards the promotion and implementation of the KRAs within the framework of the laws and regulations governing the Public Service. The specific duties and outputs required under each of the KRAs are outlined in the work-plan. The KRAs should include all the special projects in which the employee is involved. The work-plan should outline the employee's specific responsibilities in the special projects. Weighting of the KRAs must total up to 100%. The employee's assessment is based on her or his performance in relation to the duties and outputs outlined in the work-plan, as well as the GAFs. Generic Performance Assessment elements refer to aspects of the job that requires attention to support the achievement of the strategic and operational objectives. At least five elements that are applicable to the particular post should be marked. The details of the five elements are to be completed by the supervisor and the employee. The GAFs may include all or some of the following elements:

Table 3.2: Assessment Elements

Generic Assessment Elements	Weight 100%
Quality of work: The extent to which the employee's work meets agreed upon standards.	**20%**
Initiative: The extent to which the employee generates new ideas and improves where circumstances requires.	**20%**
Flexibility: The ability to adapt to others and to circumstances.	**20%**
Planning and execution: The ability for an individual to systematically embark upon his/her task and purposefully finalises it.	**20%**
Leadership: The ability to influence, motivate and control and lead others	**20%**
TOTAL:	**100%**

Conditions of performance include the fact that the employer will provide the employee with the necessary resources and leadership to perform in terms of this agreement. Resource requirements should be outlined in the work-plans of the Department's Components and the individual employees.

The assessment of an employee is based on her or his performance in relation to the KRAs, GAFs and the performance indicators, as set out in the performance agreement. As mentioned above, the performance of the employee in respect of all individual KRAs and all individual GAFs will be assessed using a 5 point rating scale on the Employee Performance Measurement and Development Standards (EPMDS) policy. The employee's KRAs contribute 80% and the GAF's 20% of the final assessment. The performance feedback is made in writing on the September Review Form and Annual Review Form respectively; based on the supervisor's assessment of the employee's

performance in relation to the KRAs and GAFs and standards outlined in the performance agreement; taking into account the Employee's self-assessment.

The employer and the employee agree on the employee's key development needs, in Relation to his or her current job and envisaged career path in the Public Service. If the Training needs coincide with the employer's requirements, the developmental needs of the employee are reviewed as part of the September Review and the annual assessment of performance. Taking into account the financial realities, the employer develops the employee in these areas. The development objective, reason for development, type of intervention, if it will be a short course, bursary required and the targeted time of the year in the financial year are noted.

In the management of poor performance outcomes, the manager and employee will identify and develop interventions together to address poor and non-performance in the feedback sessions; or any time during the performance cycle. The performance agreement also covers the issues on dispute resolution, should any disagreement arise between the employer and the employee member in respect of matters regulated by the agreement. Reference is made to the process outlined in the EPMDS that needs to be followed. If this process fails, the employee may apply the formal grievance rules of the Public Service (published in *Government Notice R1012* of 25 July 2003).

Any dispute about the nature of the employee's performance agreement, whether it Relates to key responsibilities, priorities, methods of assessment and or salary increment in the agreement is mediated by the next person in the hierarchy. Amendments to the agreement are made in writing and can only be effected after the Discussion and the agreement by both parties. The contents of the document are Discussed and agreed with the employee concerned. Both the employer and the

employee endorse their signatures in agreement with the contents of the performance agreement.

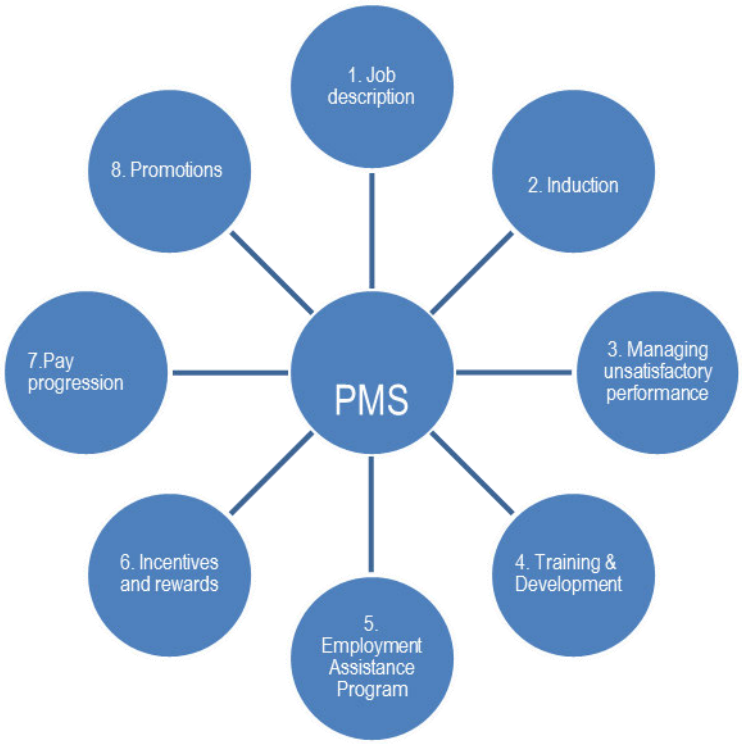
From the performance perspective performance management involves indicators that measure performance. In order that this is executed successfully there should be a measurement system in place in order to monitor the effect of the strategic plans, evaluate performance in order to track improvement potentials and setting yardsticks, to diagnose whether there are achievements or performance that is below target so as to have warning signs; to manage towards continued improvement; help motivate towards efforts more investments to identify gaps in performance and have a record of developments to the stakeholders. In order to measure all this, there should be relevant multiple performance indicators to measure process and result, a scoreboard (Williams 2002: 15).

Performance management as a system for integrating the management of organisational and employee performance

This model assumes that the vision and mission and goal setting have occurred such that the objectives have been set within key results areas and that all processes have been communicated across sections and that employees understand what is involved. Performance management supports the department's strategic goals by linking each employee's work to the overall vision/mission of the department (Williams 2002: 15). This model is in line with what Mlefane (2010: 3) contends, that performance management is part of a larger system that begins as soon as a job position is filled and ends when an individual leaves the position or the department. The system aligns the roles of an individual employee with the attainment of the departmental goals and objectives. This means that the employees' performance conforms to the strategies of the department, so that they strive towards realisation of goals already mentioned. This

is displayed through job descriptions that are assessed by supervisors through performance/work plans that respond to the objectives and goals. Performance agreements that show full understanding of what the job entails are presented.

Figure 3.2: Performance management in operation



As shown in figure 3.2 above at the onset of a probation period *induction* is conducted in order to orient the employees. During their performance they may not reach the target (under-perform) and *management of unsatisfactory performance* is undertaken. *Training* and development come into place so that they are trained and coached in order to address gaps in performance. Where poor performance is due to personal problems, the *Employee Assistance Programme* intervention plays a significant role. Regular feedback usually plays as a reward and incentive towards better performance.

The Annual performance agreements are signed between the employer and the employee providing details of the work expected during the financial year. This involves the development of the work plan by an employee that gives detailed and verifiable activities towards the fulfilment of their roles and responsibilities. Together with the work plan indicators to measure and means of measuring their achievement is created; hence, the creation of the Performance Monitoring and Evaluation System. In the Department this is embedded within the general Departmental M&E System.

The performance cycle culminates when performance appraisal is done. This is evaluation and assessment of an employee's performance against performance standards or key performance areas in the job description. It is at this stage that rewards/incentives in the form of promotions and pay progression are done. Under performance may also be rewarded by demotions to lower positions or transfer to more conducive environments. The stage of performance appraisal at the end of a 12 months' probation period may mean dismissal of non performing employees.

Performance at individual level is continuously monitored in order to identify barriers and challenges; it also addresses development and improvement needs as they arise (Department of Public Service Administration (2007: 15). As much as appraisal is on individual employee performance it is, however, towards performance of the whole department. This points to the fact that the departmental performance "is an outcome of the sum total of individual employees, and team components' performance contribution" "Department of Public Service Administration 2007: 5). That is, organisational performance relationships.

3.5.2.4 Evaluation Theories

National Evaluation Policy Framework defines evaluation as “the systematic collection and objective analysis of evidence on public policies, programmes, projects, functions and organisations to assess issues such as relevance, performance (effectiveness and efficiency), value for money, impact, sustainability and the recommended ways forward.” (The Presidency, Department of Performance Monitoring and Evaluation. 2011: iv). According to the DPME there are six types of evaluation namely, the diagnosis evaluation, design evaluation, implementation evaluation, impact evaluation, economic evaluation and evaluation synthesis.

Theory in evaluation

Use of theory is not restricted to research only but also implies that theory use in evaluations is essential to formulate the programme elements, rationale, and causal linkages. There has been neglect of programme theory in doing evaluations. Chen (1990: 18) contends that the atheoretical (without a theoretical basis) view applied in evaluations has a tendency “to result in a simple input/output or black box type of evaluation”. It is illustrated by a primary focus on the general relationship between inputs and outputs of a programme disregarding the transformation processes in the middle. In essence, evaluation is a practical science and therefore both as a practice and a science it must have a theory.

The purpose for conducting evaluation is to provide timely relevant feedback information for policy formulation (Chen 1990: 25). Evaluations that are not based on a programme theory are just simple input/output or black box evaluations that may provide information which shows whether the programme works or not but do not succeed in pinpointing the underlying causes that brought the results. Usually, it does not perceive the input/output

of the environmental context thus neglecting relationships between outcomes and the planned results; between strategic goals and the measurable goals and between the intended and the unintended effects. This shows that such evaluations have no sensitivity in identifying deficiencies in order to give guidance for the improvement or development of future programmes. The findings and conclusions elicited from the black box evaluations are vague, ambiguous and unsatisfactory (Chen 1990: 19).

Purpose of conducting evaluation

Evaluation is conducted in order:

- To improve policy: This refers to the process of identifying strengths and weaknesses so as to enhance quality, improve and adapt the theory of change as well as ensuring cost effectiveness;
- To improve programme or project performance: That is, evaluation for continuous improvement in order to provide feedback to programme managers;
- To improve accountability: evaluation answers the questions of where the public spending goes; and if the spending is making a difference;
- To improve decision-making: this addresses the question of whether the intervention should be continued or not; or whether the intervention should be changed; how it should be undertaken; and whether or not the budget should be increased;
- To generate knowledge (for learning). This means that the evaluation increases the knowledge about what works and what does not work with regard to a public policy, programme, function or organization (The Presidency 2011: 7).

People planning to conduct evaluations in their government departments should have full understanding of the stage of development their department is. This is important because there are different types of evaluations that may be conducted depending on

the developmental stage of the department, as laid down by the Department of Performance Monitoring and Evaluation (The Presidency 2011: 9).

Types of evaluation

Generally, evaluation can be pre, during and post implementation of a project. Evaluation provides information on the strategy to explore if the right things are being done; provides rationale or justification thereof; and provides a clear theory of change. Evaluation also provides information of operations if things are being done right. That is show effectiveness in achieving expected outcomes; efficiency in optimising resources; client satisfaction; and information on learning – on the better ways for example what alternatives, best practices and the lessons to be learned.

According to Hughes (2003: 54), all levels of healthcare workers are responsible for identifying areas for evaluation and evaluate their performance accordingly on a regular basis. Programme or Component Managers should provide guidance on the general approach to be adopted when conducting the evaluations. The management of the evaluation process should be the responsibility of the relevant M&E sub-component at the level of such evaluations. The Research sub-component and Epidemiology should be an integral part of these evaluation processes.

Table 3.3: Types of evaluation across the Government

Type of evaluation (What)	Covers (How)	Timing (When)
Diagnostic Evaluation	Preparatory research to ascertain the current situation and to inform intervention design. It identifies problems and opportunities to be addressed, causes and consequence, and the likely effectiveness of different policy options. Enables drawing up of the theory of change.	At key stages prior to design or planning.
Design Evaluation	Analyse the theory of change, inner logic and consistency of the intervention, to see whether the theory of change is likely to work. Should be used for all new programmes. It also assesses the quality of the indicators and the assumptions	Before an intervention starts, or during implementation.
Implementation Evaluation	Evaluate whether an intervention's operational mechanisms support achievement of the objectives or not and understand why. Looks at activities, outputs, and outcomes, use of resources and causal links. Improve efficiency and efficacy of operational processes. Can be rapid, primarily using secondary data, or in-depth with extensive field work.	Applied once or several times during intervention operation.
Impact evaluation	Measure changes in outcomes (and well-being of target population) attributable to a specific intervention. Inform high-level officials on extent to which intervention should be continued or not, and if any potential modifications needed. Implemented on a case-by-case basis.	Designed early on, baseline implemented early, impact checked at key stages e.g. 3/5 years.
Economic Evaluation	How do the costs of an intervention relate to the benefits? Includes: •cost effectiveness analysis, or •cost benefit analysis	At any stage.
Evaluation Synthesis	Synthesising a range of evaluations to generalise findings across government, e.g. a function such as supply chain management, a sector, or a cross-cutting issue such as capacity	After a number of evaluations are completed.

Source: The Presidency 2011: 9

The basic values of programme evaluation

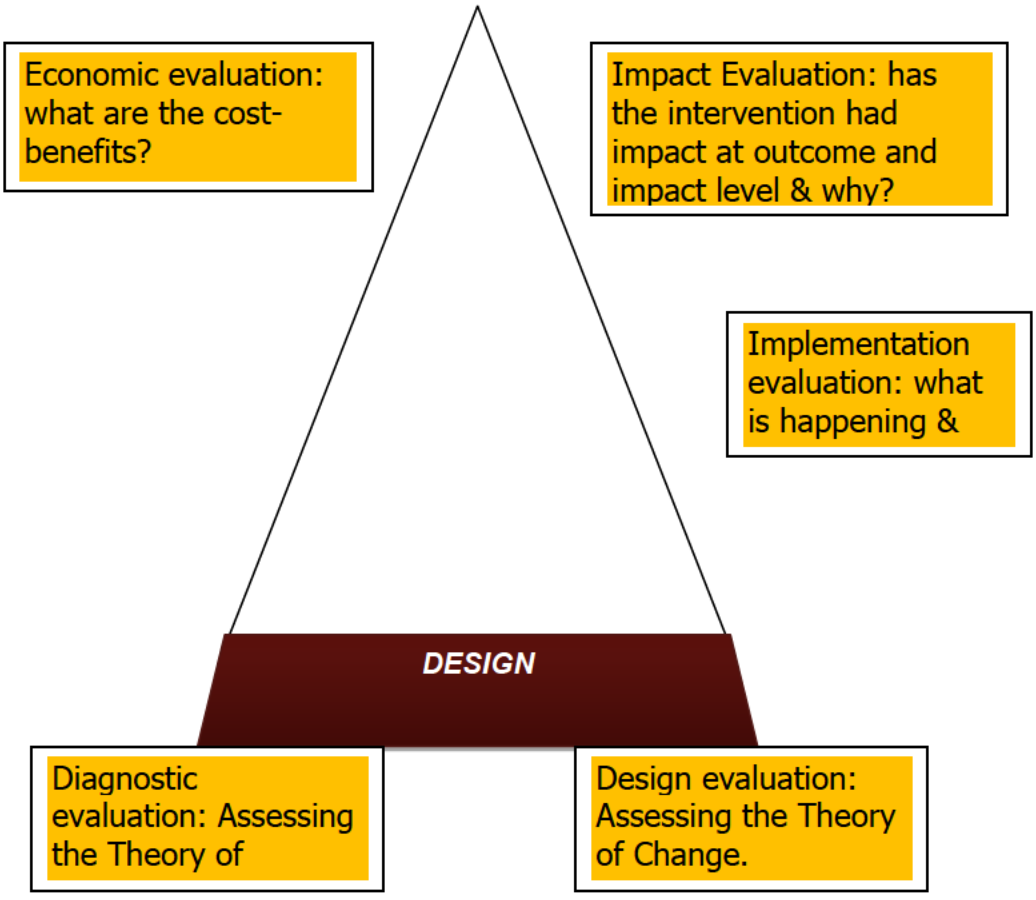
Evaluation can be applied to both newly established and already existing programmes. The type of evaluation used in new programmes is the diagnostic evaluation in order to understand the situation and develop a theory of change and design evaluations to check the design and theory of change after planning has been undertaken. The Presidency (2011: 10) suggests that evaluation of the existing programmes or projects is conducted in five years of the programme/project existence. From 3 years and above an implementation type of evaluation is recommended. For credibility and quality, this Framework contends that an evaluation plan must lay out how the results of the evaluation should be used. This is done by focusing on certain features namely: relevance and timeliness for decision-making; legitimate and unbiased with the involvement of the relevant stakeholders through conducting of peer reviews; and validation processes using research methodologies that may include statistical validation approaches (The Presidency 2011: 11). Construction of a theory is value laden. This means that the programme theory will be based on values that underlie the programme.

The major task of the evaluation is to assess the merits of a programme. It is for this reason that a set of values to judge the quality of the evaluation is essential in quantitative research. This involves a distinction between internal and external validity. What the internal validity is concerned with is whether an intervention makes a difference; the external validity is about populations, settings, intervention and measurable variables; and if such findings can be generalized. There is a list of fundamental values to discuss relationships between values and programme theory. These are responsiveness, objectivity, trustworthiness and generalisability. The list is non-exhaustive as alternative classification can always be constructed (Chen 1990: 60).

Integrative evaluation approaches

The integrative approaches combine both the stakeholder approach that emphasizes the value of responsiveness to key stakeholders' perspectives, views, ideas and expectations. This means that evaluators cannot rely on their knowledge or expertise in the construction of the programme theory. The social change approach is also included and it emphasizes the value of objectivity, trustworthiness and generalisability in the construction of a programme theory. This approach contends that the programme theory should be developed from the information on both how the programme operates and the existing social change theory and knowledge (Chen 1990: 67). The basic values of programme evaluation will be discussed in the chapter on methodology. However, below is the diagram that shows the programme theory that guides the study made in relation to questions around the outcome model.

Figure: 3:3 Different types of evaluations



The study uses Implementation Evaluation to evaluate whether The M&E System intervention's operational mechanisms support achievement of the Departmental goals and objectives or not and understand why. The evaluation will look at the activities, outputs, and outcomes, use of resources and causal links; whether it improves efficiency and efficacy of operational processes. The methodology used can be rapid, primarily using secondary data, or in-depth with extensive field work.

3.6 Different theories/models of Monitoring and Evaluation

3.6.1 Theories of change

Theory of change is a tool that describes a process of planned change from the assumptions that guide its design and its planned outputs and outcomes, to the long term impacts it seeks to achieve (The Presidency 2011: 9).

In most cases theories of change may adopt a holistic approach, which includes a number of change theories relating to the targeted actors, the developed approaches and the issues at stake. It is only in this comprehensive combination of several theories that one can adequately understand the relevance and effectiveness of the theory of change in the M&E system (Körppen, Mkhize and Schell-Faucon 2008: 44).

According to these researchers, the theories of change may focus on 'who' needs to change (i.e. which individuals, groups and which relationships); and on 'how' the change can happen (i.e. approach and methodology). These theories also focus on what aspects the successes of change intervention are closely interrelated to the effectiveness of the programme; and on 'what' (i.e. institution, policy and social norms and justice) can be observed (Körppen, Mkhize and Schell-Faucon 2008: 45).

Who?

To a large extent the M&E function is based on the idea of the individual change, the development of healthy relationships and connections. If transformation involves consciousness, attitudes, behaviour and skills of many individuals - breaking down the isolation, division and polarisation among individuals and groups, a critical mass to advocate for political will and ownership emerges. Concrete examples for change theories may include the following elements:

- **Leadership:** M&E needs championship that has a vision and that is adequately trained; adequate resources that include budget, equipment; and will power to change. This also involves creating a platform for individual employees to share experiences and challenges in order to strengthen their relationships, which will in turn foster more responsibility commitment and accountability;

- **Management:** Managers' political will, well trained, provided with tools, know policies that underpin their function, having clear guidelines and frameworks with distinct roles and responsibilities.

- **Employees:** At all levels employees should be on the same page: awareness, sound knowledge and skills, relevant tools, roles and responsibilities, reporting system and data flow, basic understanding of data management and need for data collection, data quality and the concept of accountability (Körppen, Mkhize and Schell-Faucon 2008: 45).

How?

- **Holistic and systemic:** The M&E champions adopt a holistic manner support employees by recognising challenges in their daily functioning.

- **Sensitivity to organisational culture:** This refers to the explanation of the M&E concepts and taking into consideration the environmental or organisational factors that impact on functioning. These also ensure that the environmental culture is conducive to implementation where everyone has political will; see the need; want to work hand in hand with others to bring about required change. Accountability is crucial where standard operating procedures are adhered to.

- **Authenticity and credibility:** M&E champions facilitate and go along with the processes; are open-minded; listen instead of coming with answers; and remain impartial. Acknowledgement of authentic and credible performance contributes to increasing certitude that things can be made differently resulting in good governance.
- **Ownership driven:** All stakeholders are made to understand what is expected of them, as the main resource for change; and encouraging them in their activities to improve their areas of work (Körppen, Mkhize and Schell-Faucon 2008: 46).

What?

If one assesses the changes brought about by the M&E intervention over time (evaluation conducted at 3 years and 5 years intervals), the observation of changes since the inception are made. While organisational policies and norms change, this might not be at the forefront. By encouraging leadership forums where critical discussion of good governance and M&E issues are undertaken, results on these can be observed (Körppen, Mkhize and Schell-Faucon 2008: 46).

3.6.2 Outcomes Theory

Outcomes Theory is a new theory that provides an integrated perspective on the function and optimal design of the 'outcomes system'. Of significance are two concepts within the Outcomes Theory, namely:

- **The outcomes hierarchy.** This concept explains the cascading of sets of cause and effect that underlie all performance management systems. Stout S., Evans A., Nassim J. and Ramey L. (1997: 46) distinguish between the hierarchies: input and output hierarchies where input indicators measure implementation and process of the project while output measures performance and the final impact at a higher level.

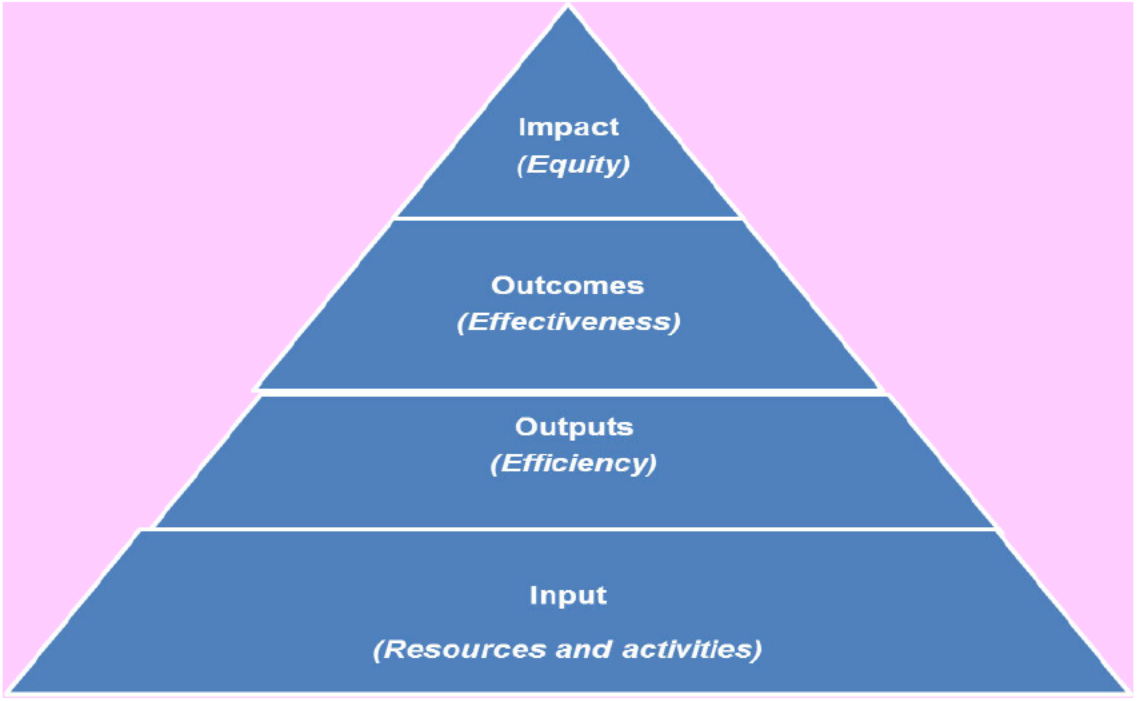
- **The outcomes system.** Outcome system directs the organisations to bring about changes in the level of measurement of the data elements or indicators within an outcomes hierarchy. This occurs through use of specific sanctions or incentives, which attempt to facilitate implementation of frameworks within which interventions occur. Duignan (2009: 4) states that these processes maximize the achievement of higher-level outcomes that are specified in one or more hierarchies **http://www.outcomestheory.org).** Furthermore, the measurement of progress is based on the baselines; made by looking at the trends; and comparing with the targets towards achieving the goals - at a higher level (Stout et al. 1997: 46). Table below illustrates how the outcome hierarchy and the outcome system interplay in the execution of a programme.

Table 3.4: Results – measurement matrix (adapted from Ile et al 2012: 126).

Results	Indicators	Baselines	Interim targets	Ultimate targets (to be achieved several years)
Impact	Long term indicators	What was there at the start	Quarterly or annual achievements	Three year or five year period and more
Outcome	A change due to an intervention	As above	Quarterly or annual achievements	
Output	That which was obtained	As above	Quarterly or annual achievements	
Input	Amount Material (financial, material & human)	Amount at hand	Amount by the end of short term	

The above table shows the results measurement matrix that illustrates both the outcomes hierarchy and the outcomes system discussed above. This is best understood if compared to figure 3.4 below, which demonstrates the results of chain elements from the lowest rung of input/activity to the highest – impact level.

Figure 3.4 Results chain elements



Adapted from Ile et al. 2012: 121

This diagram shown above illustrates that at the impact level, equity should be evident where products of the programme benefit the broader society across communities in all geographic areas. This can be measured through observing if the objectives were reached against the extent to which outputs were able to generate intended outcomes (effectiveness). Efficiency is reached through the presentation of how well the resources were utilised to create the outputs. This refers to the output/input ratio showing the cost and timing of acquisition of resources and execution of activities (Ile et al. 2012: 126). Reference is also made to the Results Chain Model (Figure 3.5) below.

The NPM is influential in shaping Public Service Reform (Cameron 2008:23). Setting of the explicit goals and measurement of performance is a key feature of the NPM (Hood 1991: 9). This occurs through performance indicators and targets developed within specified time frames.

It is the NPM approach to measure performance towards adequate service delivery. The Outcomes Theory looks at how the highest level of performance is reached or used within the hierarchy system. This implies that both the NPM and the Outcomes Theory can be used together and can also be linked to the M&E systems**.**

It was mentioned above that under-performance is reprimanded and the realization of targets is incentivized; hence a results-based M&E that ensures accountability through performance from individual employees as well as the department is essential.

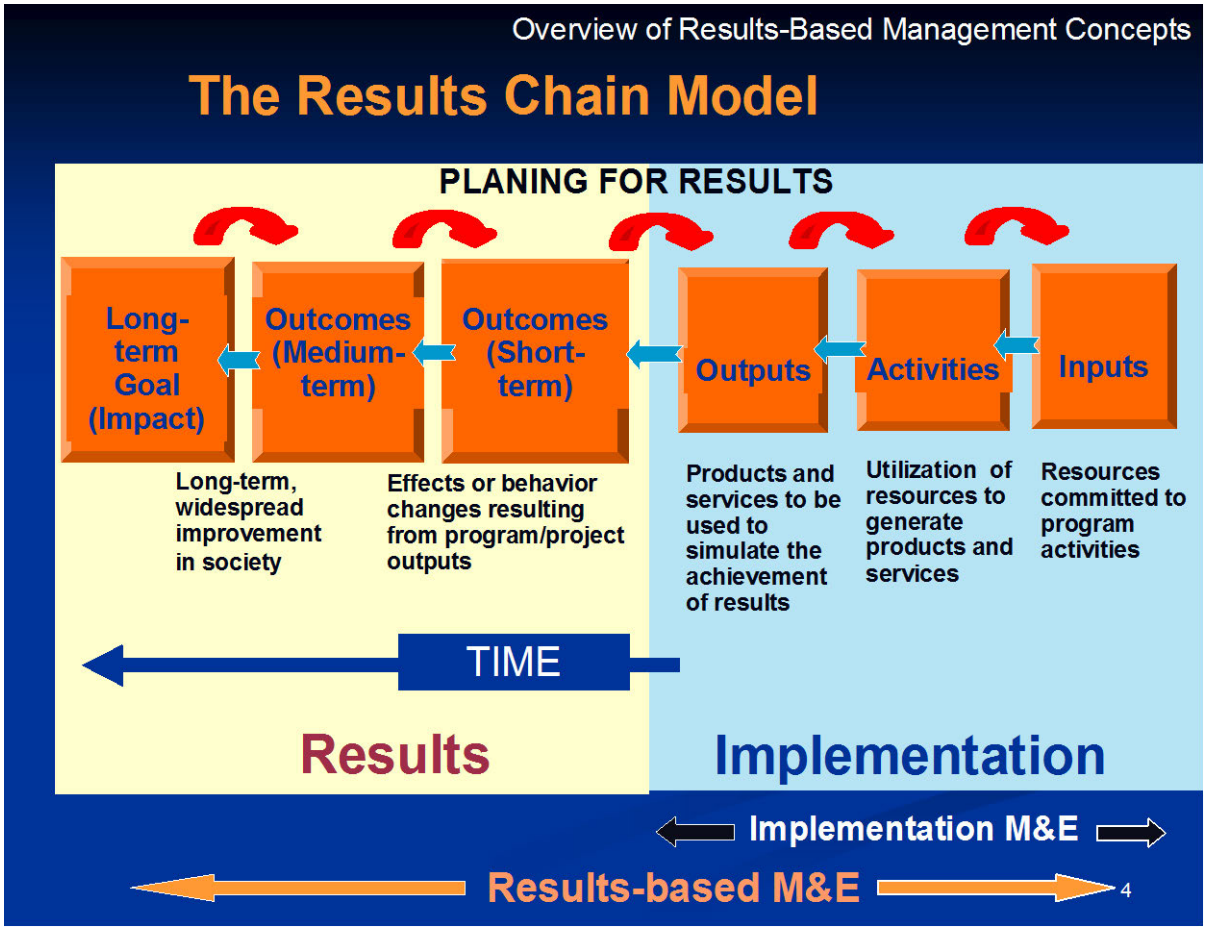
3.6.3 Results-Based Approach to M&E

The Result-Based M&E system has its focus on the results obtained rather than just on the inputs used or the activities conducted. Such systems are designed to address what still needs to be done after activities have been executed and outputs have been generated. It provides feedback on the actual outcomes and goals of government actions. Results-based monitoring is a continuous process of collecting and analysing information to compare how well a project, programme, or policy is being implemented against expected results.

The proposed results-based M&E system will place the goals of the Department in perspective and assess if they have been achieved and put forth evidence of

achievement. Rather than simply ending with a focus on implementation, i.e. on inputs, activities, and outputs, a results-based M&E system moves beyond to focus on outcomes and impacts. Figure 2 (Results Chain Model[1]) illustrates movement from Traditional to Results-Based M&E.

Figure 3.5: Results-based M&E system



Sourced from Andrew O. Asibey's Presentation 2007:4

The above diagram illustrates a Results Chain Model of the Results-Based Management (M&E) system on a continuum. On one side of the continuum is implementation – the inputs (resources), activities (processes to utilise the resources) and outputs (products and services to simulate the achievement of results). The results side of the continuum

[1] Source: Presentation by Andrew O. Asibey, Senior M&E Specialist, World Bank

looks at the outcomes, which could be short, medium or long term. At the far end of this continuum, is the impact level which takes a long period of time to attain and encompasses the society at large (Asibey 2007: 4). There is a thin line between the 'Traditional' M&E system and the Results-based Management in that the latter moves further from the 'Traditional' M&E (of input, activity and output levels) towards results or outcomes and the impact the Traditional M&E concepts have on the population. This means that the evaluation of what has been accomplished is the core activity to be carried out in the Results-based M&E system. It is for this purpose that the entity case study seeks to evaluate the existing DOH M&E System.

Public Governance linkage to Public Administration and Monitoring and Evaluation

In this section definitions of governance and Public Administration are presented in order to find a link between them. Van Niekerk, Van der Waldt and Jonker (2002: 64) in simple terms define governance as including maintenance of law and order. They also add to the above definitions by stating that governance is an act of governing – the way rules are set and implemented; and the way power is exercised in the management of the government of a country. Furthermore it involves decisions, power/control, verifying performance, and leadership process. Good governance is the quality of governance within an organisation or a department.

Public Administration (PA) on the other side concerns itself with development, implementation and the parts of the government policy. That is, it is about planning, organising, directing, coordinating and controlling government operations. Furthermore, PA is about the implementation of government policy and is concerned with organisation of government policies and programmes as well as the behaviour or conduct of the officials. This means that PA encompasses the whole structure, policy, implementation and delivery from political administration setting and culture of rules and regulations,

labour division, control; interaction. PA moves to Public Management which is about rendering services (who question). Practitioners in PA “constantly need to answer questions about how to act” **(http://books.google.co.za** accessed on 30/04/2013).

The connection between the two - Public Administration and governance gives an exposition that governance occurs in three levels as explained below:

1. **Constitutional level of action (policy setting)**

   This is a political system where legislative attention and responsibility sits. It occurs at a national level sphere where the government involvement or action is in designing policies and implementation. That is, policy formulation and provision of guidance on implementation is made in clear and controlled way through frameworks that clarify actors and their roles.

2. **Directive level (institutional setting)**

   This is in relation to the structure of the intergovernmental system, that is, the three spheres of the government, namely: the national, provincial, and municipal or local layers. The Government structure is not only about these layers, but it also includes their character of legitimate authority, both general and specific policy and how they relate to each other i.e. intergovernmental relationship. **http://books.google.co.za** accessed on 30/04/2013) call it a system of command – supply-demand relationship networks.

3. **Operational level of action (micro-setting)**

   This is the implementation level where there is a variety of implementing organisations or departments - production and procedures. This dimension uses goals, relationships, supervision, disciplinary strategies, relations with other organisations and the staff.

According to the Public Service Commission – National Treasury Report (2005/2006: 26) governance therefore is about carrying out the Public Administration prescripts; Monitoring and Evaluation (M&E) is a vehicle driving towards successful implementation (of these prescripts) by providing processes and systems towards governance and eventually towards effecting the public administration prescripts. Put differently the M&E enhancement ensures effective PA **(www.treasury.gov.za)**.

3.7 Overview of Government Monitoring and Evaluation

It is mentioned elsewhere in this study that the primary concern of the first democratic government's term of office was the fundamental restructuring of the apartheid state into a modern public service. The second term was concerned with the coordination and the integration of government systems and services. The third term (current) has a number of strategic priorities. Key amongst these priorities is to address the increasing effectiveness of the Government in order to achieve greater developmental impact. According to this notion, the Public Service Act of 1997 gives a mandate for Public Service transformation towards increased effectiveness, efficiency and improved service delivery (The Presidency (2007: 21). This could be done by putting emphasis on monitoring and evaluation initiatives based on the M&E systems. This practice is essential and has positive effects at all levels of operation, as it improves policies, strategies, plans as well as performance that optimise the results. Improving the M&E systems leads to the improvement in the quality of planning (driven by comparisons between what was planned and what was done) and in enabling better recording of what services are delivered; and results that have been achieved (The Presidency 2007: 4).

This led to the introduction of the Government-wide M&E Framework Policy (GWM&E). The Framework seeks to put in place a management system within the public sector, that would articulate with other internal management systems such as planning, budgeting and reporting (The Presidency 2007: 21). This conception further stipulates that the GWM&E system may or may not be supported by an Information Technology Software and other tools, as the emphasis is on the integration of systems and "inter-operability" (The Presidency 2007: 21). Additionally, it was mentioned that monitoring the derived information contributes to planning.

3.7.1 Aims and objectives of the Government-Wide M&E system

The aim of the GWM&E system was to contribute to the improved governance and enhanced effectiveness of the public sector in general. The objectives of the GWM&E are: data collection, collation, analysis, information dissemination, application of information on the progress and impact of the programmes; and initiatives in order to ensure transparency and accountability. It also aims to promote service delivery; ensure compliance with statutory and other requirements; and to promote a learning culture in the public sector (Chief Directorate Presidency, Draft 5 2005: 14). If these objectives are adhered to the following results will be accomplished:

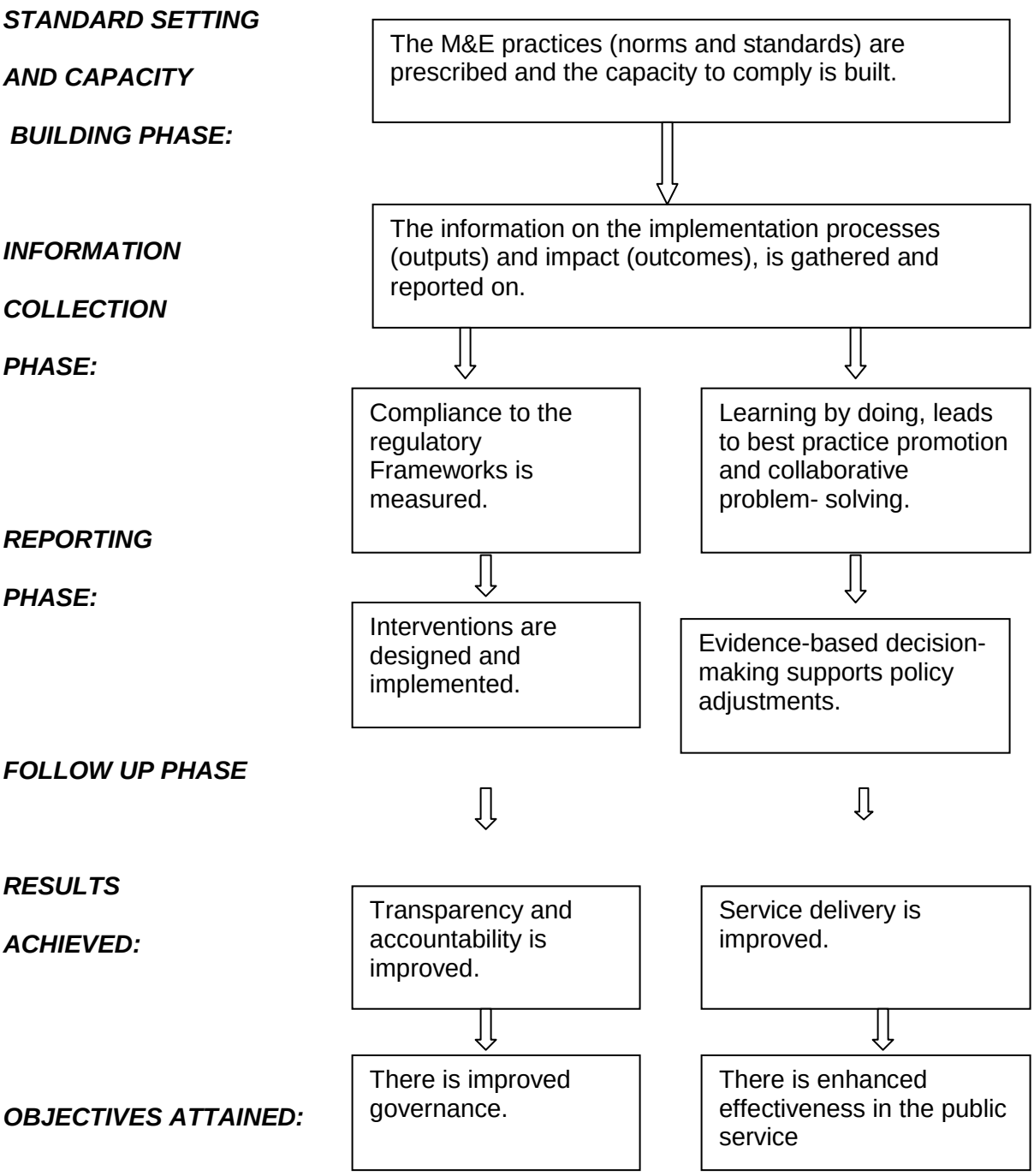
Result 1: Collection of the updated, accurate and reliable information on the progress of implementing the Government and other public sector programmes on an on-going basis;

Result 2: Periodical collection and presentation of the information on the outcomes and impact achieved by the Government and other public bodies; and

Result 3: Continuous improvement of the quality of monitoring and evaluation practices in the Government and other public bodies (Chief Directorate Presidency, Draft 5 2005: 14).

The above discussion indicates that the GWM&E system by promoting certain practices and by collecting and providing information to system users, positive consequences will result. In this regard, the intended progression of events is depicted in a logic model below:

Figure 3.6: Logic Model



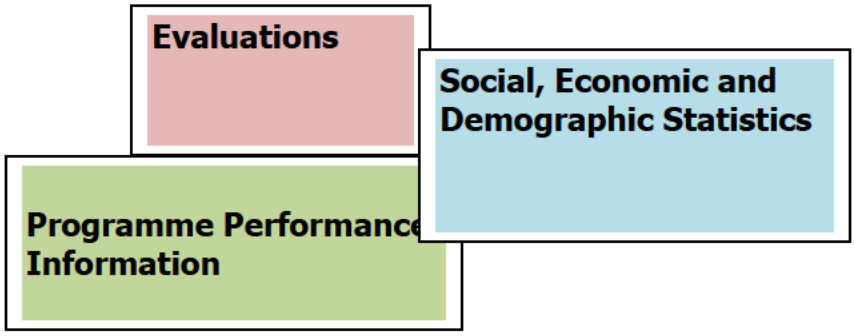
Adapted from the Chief Directorate Presidency Draft 5 (2005: 15).

The above figure of the logic model illustrates a series of events that need to occur if effective public service and good governance are to be attained. For instance, there

should be clear M&E practices (norms and standards) and the capacity to comply must be built. This includes gathering the information to implement the processes (outputs) and impact (outcomes) and providing the reports. This ensures compliance to the regulatory frameworks and therefore collaborative exercise in problem solving. The model emphasises the improvement of governance through the elements of transparency and accountability. In turn, the effectiveness of the public service will be enhanced. (Chief Directorate Presidency Draft 5 2005: 16).

On one hand there are three data terrains that underpin the GWM&E system. Each of the terrains is subject to a dedicated framework that describes what is required for them in order to be fully functional. The terrains for M&E purposes are shown in the following diagram:

Figure 3.7: Terrains underpinning the GWM&E system



Adapted from Ile et al. (2012: 17) and Public Service Commission (2008: 12).

The Framework for Managing Programme Performance Information (2007) was issued by the National Treasury; the South African Statistical Assessment Framework (SASQAF - 2007) was developed by Statistics South Africa; The Evaluation Framework Policy was issued by the Presidency – Department of Performance Monitoring and

Evaluation in 2011. The GWM&E system depends on the Departments at all levels for the information against which Government performance can be assessed (Public Service Commission (2008: 13). In support of this initiative is the National Treasury's Framework for Managing Programme Performance Information and the South African Statistical Quality Assurance Framework (SASQAF) of Statistics South Africa (Sahadeo 2012: 2). The Offices of the Premiers play a crucial role to coordinate the M&E functions in the Departments in their respective Provinces.

On the other hand, the Department of Performance Monitoring and Evaluation in the Presidency (Chief Directorate, Monitoring and Evaluation 2010: 4) spells out that the M&E system of the Government is based on the six terrains discussed below:

Government Wide Institutional Terrain states that institutions establish legislation, regulations and practices on collection, collation of M&E information. Central to this is the information collected by the Provincial Treasury, Co-operative Governance and Traditional Affairs (COGTA), Auditor- General and Statistics South Africa;

Cluster based initiatives have a central coordinative responsibility as it provides coordinative, reporting and implementation forums. This it does by coordinating the implementation of priority programmes; convening cluster meetings, which serve as a channel for monitoring the progress of implementation;

Sector M&E Initiatives are systems and practices that are sector specific initiatives covering several departments. They are focused in particular sector areas like health, housing, municipal service delivery and others;

Provincial M&E Initiatives are reporting processes rooted in the Provincial Executive Council;

Provincial Nerve Centre: A Nerve Centre is an information system used as a platform to interconnect data systems across the provincial departments in order to support integration of the M&E systems and practices in each department.

Extra-Governmental Institutional Terrain: Outside the government several institutions are also involved in M&E practices. These also engage in evaluation research and so request evaluation reports on certain governmental programmes and policy interventions by using secondary research analysis. In this way departments are able to use the information derived from recommendations on evaluation findings.

The Province has a Provincial M&E Forum coordinated by the Office of the Premier. This forum meets once per quarter. Its responsibility is to bring together the Provincial Departments' M&E Officials with the aim to build an M&E Community that monitors implementation of the Programme of Action of the Province. The HOD of a department verifies that the principles and practices as per National Treasury Framework for Managing Performance Information comply with non-financial information about government services and activities (Chief Directorate M&E 2010: 7). Should there be non-compliance with the principles the Office of the Premier is informed immediately in order to remedy the situation as soon as possible.

According to the Office of the Premier (undated paper on the Province of KwaZulu-Natal Monitoring and Evaluation Strategy Part 1 (Chief Directorate: Monitoring and Evaluation), the M&E should generate performance information that gives impartial and independent insights to the department's achievements and operations. The KZN M&E

Strategy is based on provincial goals and priorities as set up in the Integrated Development Plans (IDPs), Millennium Development Goals and the Strategic and Annual Performance Plans. Reliable M&E information informs the Strategic Plan of a Department.

With regard to this requirement, the Province has an M&E Forum that meets once per quarter. It brings together the Provincial Sector Departments' M&E Officials with the aim to build an M&E community of practice for monitoring the Plan of Action. The HOD of the department verifies that the principles and practices as per National Treasury Framework for Managing Performance Information comply with non-financial information about government services and activities (2010: 7). Where there is non-compliance with the principles, the Office of the Premier is informed immediately in order to remedy the situation as soon as possible.

According to the explanation above, the M&E units should manage budgets so that a budget is allocated in an equitable manner using M&E information in (budgeting and) planning. In the Department this function is undertaken by an M&E person in the Finance Section. He develops the M&E data system to guide planning, decision-making and budget allocation as the system would have demonstrated that progress is being made. In this regard, it could be postulated that the M&E System's information used for planning and budget allocations is accurate and reliable to ensure good governance.

It is a necessity for the Government Department to demonstrate its good governance by disseminating data and analysis on its service delivery. In the DOH the Health Service Planning Monitoring and Evaluation Unit has an M&E Sub-unit that is specifically responsible for carrying out the M&E initiatives. It develops and monitors key

performance indicators; arranges stakeholder feedback; reviews and regularly performs evaluations of key performance areas.

The M&E Manager directs the Sub-unit and has a dedicated staff, namely: The Deputy Manager, two Assistant Managers, and the Administrative Officer. The Sub-unit works hand in hand with Data and Information Management Sub-unit that controls the District Health Information System (DHIS) which captures collates and analyses data from Districts and Facilities within each district. The M&E Sub-unit monitors performance for each indicator progress for accuracy in terms of outliers/inliers, inaccuracy/validity, timeliness, completeness and trends.

The M&E Sub-unit monitors the District performance on core indicators. Reporting to explain District performance is done through use of specific tools: a spreadsheet for quantitative data and a narrative tool for qualitative data analysis. Data in the spreadsheet is validated against the DHIS and all reports generated by the Department are based on these systems. Data flows from the facilities to the districts and to the Head Office through the M&E Sub-unit.

This occurred after the introduction of the GWM&E Framework (The Presidency 2007: 5). This Framework states that the M&E System is a Public Sector tool that evaluates performance by the Public Service and identifies factors which contribute to Public Service's delivery outcomes (The Presidency 2007: 9). The first principle among the M&E principles is to contribute to improved governance - transparency, accountability, participation and inclusion (The Presidency 2007: 9). The announcement made by the Minister of Performance Monitoring and Evaluation and Administration (2010/07/07) stated that since 1994 despite enormous steps by the Government in providing services to the citizens, there have been massive increases in expenditure which barely produced

the required results, hence the results-based measurement approach **(www.thepresidency.gov.za).** This elaboration demonstrates that the South African Government is committed to implementation of the GWM&E System. All the South African Government Departments have started to develop their respective M&E Systems based on this framework.

At this juncture, it is important to refer to three of the most important recommendations of the situational analysis discussed in Chapter Two, namely:

- The Department had to respond by developing a comprehensive document that describes the Health Information System and monitoring and evaluation system; and
- The Department was required to develop a systems master plan to address disparate Health Information Systems; and
- The M&E system that existed should move away from traditional M&E that focused on inputs and outputs but should strive towards a results-based approach that focused on outcomes.

Conforming to the findings and the recommendations of the situational analysis, the KwaZulu-Natal (DOH had its M&E Framework adopted and signed by the Head of Department (KZN Provincial M&E Framework 2010: i). It is an integrated framework that incorporates almost all the health programmes of the Department of Health and there is mainstreaming to the district and the institutional levels. It emphasizes recognising the goals and objectives of the Department by achieving all the set targets of the programmes and the various prescripts. One of the prescripts is to achieve the targets of the MDGs by 2015. The DOH is also required to achieve the National Health Systems 10 Point Plan Priorities by 2014; and the four outputs for the Negotiated Service Delivery Agreement Negotiated Service Delivery Agreement . In its endeavors to meet these

requirements, the DOH is constrained by limited financial and human resources, which makes the above discussion on strengthening the M&E system in measuring performance towards good governance, very crucial. Like other governments that have taken a stand on strengthening the M&E systems, the Government of South Africa in general and the DOH in particular, is no exception.

The DOH has about 500 performance indicators, which are related to numerous presidential goals. For each indicator; recording is undertaken of the objectives; strategies to achieve it; baseline performance; annual targets; actual performance against targets; and imputed amounts spent by the Programmes. Thus the system includes a large number of indicators on government performance. In addition, where a target has not been met, the Programme Manager is required to present an explanation on the reasons for the shortfall. These exceptional reports are included in the database, the core of which is publicly available on a real-time basis.

3.7.2 Monitoring and Evaluation System in the Department

The above discussion clearly shows that it was not by chance that the DOH embarked on the establishment of its M&E system. The events that culminated in the development of the M&E System in the Department were mentioned in the previous chapters. The discussion of the situational analysis made it clear that governance was challenged due to lack of both the human capacity and financial resources (Cameron 2008: 5). This was not completely new as Collins (2000: 26) observed the same conditions for Botswana, which also experienced similar problems during its transition. He explains that during the previous era in Botswana, the communities were divided, which was also experienced within the government set up at all levels causing lack of integration in the work environment. He further asserts that a state where there is no sense of responsibility

(inherent fragmentation instead), is not limited to certain countries, but it is experienced by most countries in transition. According to Collins (2000: 294), “More concrete thinking has to be applied to strengthen public services after a structural adjustment”.

Taking these assertions into account, the researcher conducted a minor situational analysis (baseline study) to map the KZNDOH in terms of performance based on the basic values and principles that govern Public Administration. These basic values and principles are in the Constitution and a requirement for all Departments to comply if service delivery is to be improved (Constitution of the Republic of South Africa of 1996).

Reports generated also revealed that the performance of the KZNDOH had declined. For instance, the Department had financial overspending in billions, which resulted in reduction of budget allocated to all the Units; and at all levels of the Department, namely: districts, hospitals, Primary Health Care Clinics and Community Health Clinics. There was a blanket moratorium in all the aspects that required funding. The staff members that left the public service were not replaced, which in turn resulted in the increased workload for both doctors and nurses. The workload was aggravated by an increase in the burden of disease because of more people becoming ill due to co-morbidity between Tuberculosis and AIDS. As a result, the staff attrition rate and loss of scarce skills (clinicians and practitioners) increased. Consequently, the limited budget impacted negatively on the quality of service provided by the Department to the communities (Province of KwaZulu-Natal Quarterly Reports 2008/2009 to 2009/2010).

With regard to compliance with the values and principles laid down in terms of public administration and good governance, to an extent, the situational analysis conducted showed a shortfall in the Department. As mentioned above this shortfall is acknowledged by the GWM&E Framework (2007: 5), when it contends that the key strategic challenge

in the government is the lack of effectiveness in its performance. The Framework further acknowledges that the public service effectiveness should be augmented if the government is to achieve its desired outcomes and strategic objectives.

These findings mean that having appropriate policy in place does not ensure that the functions will be carried out accordingly; or that the required results will be achieved. Stout et al. (1997: 24) contend that the policy makers have a dilemma to determine how best to ensure that the interventions are delivered, given the difficulties of measuring the effectiveness of the health service delivery programmes. This explains the fact that there is little empirical evidence that can be found on the effective delivery system.

In respect of this discussion, good governance requires public participation in the policy-making processes, which makes monitoring and evaluation critically important because governance is an important component of M&E (The Presidency: 2005: 13). With reference to the M&E System and governance, the GWM&E seeks to ensure transparency and accountability; to promote service delivery improvement; ensure compliance with statutory and other requirements; and to promote the emergence of a learning culture in the Public Sector (The Presidency 2007: 14).

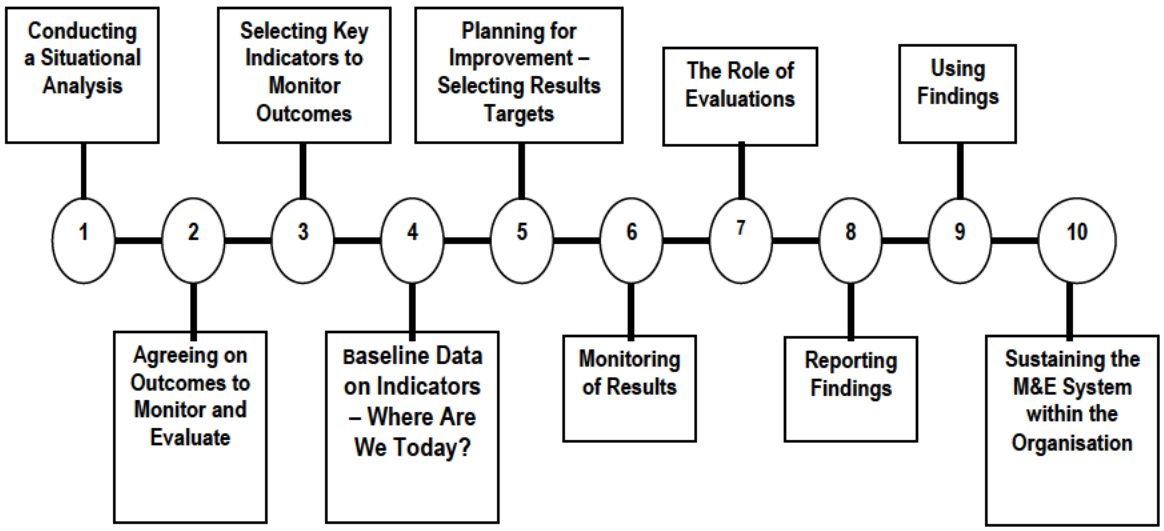
The need to expand and strengthen the monitoring and evaluation practices in the Department was identified. Fulfilling this need would inform planning and decision making. The Department therefore planned to develop and implement an integrated results-based monitoring and evaluation system that would provide accurate, up-to-date and strategically important information required at the various levels of the health system. To meet this requirement, the review of documents relating to the existing M&E practices, reports on the previous situational analyses; and interviews with various key personnel conducting was the methodology used.

However, as a first step towards the implementation of the recommendations, the M&E Component was established within the Health Service Planning Monitoring and Evaluation Unit. Over and above this, broad policies and legislature that bounded the Department to have the M&E System were examined. This formed the basis of the M&E Framework. One of the policies that played a major role in this exercise was the Government Wide M&E Framework (2007), which served as a guideline towards the development of the entire Departments' M&E Systems.

Steps taken to develop the M&E of the KwaZulu-Natal Department of Health

For developing the M&E system of the Department, the Ten Step Model to design and build the Results-Based M&E system was followed. This model is illustrated below:

Figure 3.8: Ten Steps to Designing, Building, and Sustaining a Results-Based M&E system.



Sourced from Risit and Kusek (2006).

Visually, the steps in the above illustration appear as a linear process, in reality it is not. One will inevitably move back and forth along the steps, or work on several simultaneously. The Department in developing its results-based M&E framework followed these 10 steps. The steps incorporated a brief description that was relevant to the Department as well as the roles and responsibilities of those tasked in realising these steps. The identified roles and responsibilities supported a results-based M&E system in the Department.

Based on the above illustration a comprehensive Departmental M&E Framework that formed the basis for the integrated Departmental M&E System was developed. This Framework described the master plan to address different Health Information Systems. Recommendations further stipulated that the Departmental M&E System should move towards a results-based approach that would focus on outcomes. It also implemented an integrated results-based monitoring and evaluation system that was expected to provide accurate, up-to-date and strategically important information as needed at the various levels of the health system to inform planning and decision-making.

It was from the findings and recommendations of the situation analysis (together with the prescripts of the GWM&E Framework) that the M&E Component was established in 2007 in the KZNDOH. Over and above this, there were broad policies and legislature that bound the Department to have the M&E System. Other prescripts that guided the M&E System of the DOH were the Department's Strategic Plan), the Annual Performance Plan (APP) and the Operational Plan (OPs Plan). These policy documents also guide the formulation of the District Health Plans (DHPs), the District Health Expenditure Reviews and the health section on the Integrated Development Plans (IDPs) of the Local Government Municipalities.

In 2010 the Government emphasised the importance of performance monitoring by establishing the Department of Performance Monitoring and Evaluation discussed in the following section.

3.7.3 The role of the Government in strengthening M&E in South Africa

The Public Service Commission plays a major role in promoting good governance in the public service. According to the Public Service Commission News (February/March 2012: 5) the Public Service Commission commenced the M&E role in 1996 where it implemented the nine values and principles that define governance in public administration. This initiative aimed to enhance transparency and accountability of the government. The Public Service Commission Transversal M&E System that seeks to measure the impact of the policies to improve efficiency has been operational since 2001 and has influenced M&E in the departments. It also strives towards evidence-based planning, decision-making and improving performance. The Public Service Commission has also played a major role in the establishment of the South African M&E Association which also guides and strengthens M&E. The development of the Department of Performance Monitoring and Evaluation (DPME) in the Presidency strengthened the Public Service Commission function on M&E.

The role of the Department of Performance Monitoring and Evaluation

The role of the DPME is to introduce the outcomes approach to detail planning, implementation, monitoring and evaluation; promote M&E in the government; monitor performance at the three spheres of the government; and monitor service delivery (The Presidency 2012: 13). Ministers of the Departments signed the performance agreements to ensure compliance by the respective departments known as the Negotiated Service Delivery Agreements. In 2010 the 12 priority outcomes based on the Medium Term

Strategic Framework was adopted by the Cabinet. The two outcomes of the Negotiated Service Delivery Agreements, namely: Outcome 12 - efficient, effective and development-orientated public service; and Outcome 9 - efficient and effective local government, are essential to achieving all the other outcomes. This is due to the fact that it is necessary to have effective and efficient administrative machinery in order to successfully implement policies and programmes.

Effective service delivery depends on the translation of inputs into outputs through a range of generic management practices. Management performance assessment involves assessing the quality of these management practices and is intended to contribute to establishing a uniform level of effective management competence and capacity (The Presidency 2011: 4).

These agreements are monitored by the Implementation Forums at the Provincial Clusters in order to provide the report according to their respective delivery agreements and report to the Cabinet. The Department of Health signed the Health Outcome of “long and healthy life for all South Africans”.

In 2010 the DPME in collaboration with other departments developed a Management Performance Assessment Tool (The Presidency 2012: 2) and this Department was mandated by the Cabinet to lead the development of the Tool. The Management Performance Assessment Tool (MPAT) measures the efficiency and effectiveness of the management practices of the departments and municipalities with the assumption that “if management practices are effective and efficient they should lead to the achievement of outcomes” (The Presidency 2011: 4). The DPME uses the Management Performance Assessment Tool o assess the departments through the Offices of the Premiers. The Offices of the Premiers and the provincial departments also assess the municipalities.

Among the areas that the tool assesses is to collate the existing management policy and guidelines into a single framework of standards and indicators of good management practice; provide a snapshot of the quality of management practices in departments and municipalities across a range of key performance areas; enable managers to test their own management practices against others, and identify management practice and improvements that will enhance service delivery; provide a basis for on-going learning about improved management practices; and enable targeting of support programmes and interventions (The Presidency 2011: 5).

Recently, the DPME conducted training on the Management Performance Assessment Tool 1.3 excel self-assessment template. The deadline for the submission of 2013 self-assessment is at the end of September. This process will be followed by the moderation process conducted by the selected moderators. Eventually scores will be allocated by the moderators, which may either support the department's self-assessment scores or oppose them depending on the evidence submitted by the Department.

As discussed elsewhere in the document there was an interplay of various legislations, which influenced taking this stride. Legislative and policy aspects that guide the Department are presented below:

3.8 Policies and legislative mandates

The legislative mandates are as follows:

3.8.1 The Reconstruction and Development Programme – 1994

3.8.2 A National Health Plan for South Africa – 1994

3.8.3 The Policy and Legal Reforms of South African Health Sector – 1994 and after:

The Constitution of the Republic of South Africa – 1996: *Chapter 10, Section 195 on Basic Values and Principles Governing Public Administration states: "Transparency must be fostered by providing the public with timely, accessible and accurate information." Also, refer to Promotion of Access to Information Act, 2000.*

Health Policy and Policy reforms

- **White *Paper for the Transformation of Health System in South Africa – 1997:*** *Illustrates the mission statement of the health sector – that it aims to provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa, and to provide caring and effective services through a primary health care approach".*
- **White Paper on Transforming the Public Service Delivery – 1997:** *National and provincial departments must provide full, accurate and up-to-date information about the services they provide, and who is entitled to them*
- **Patients' Rights Charter – 1997:** *Is a common standard for achieving the realisation of right of access to health care services that is guaranteed in the Constitution of the Republic of South Africa - 1996).*

Public Finance Management Act (PFMA - 1999). *The aim of this act is to secure transparency, accountability, sound management of revenue, expenditure, and assets and liabilities of the institutions to which this Act applies. In this regard, the* Public Finance Management Act *requires performance monitoring and reporting.*

- **Treasury Regulations (2002).** *Procedures for quarterly reporting must be established for the institution to facilitate effective performance monitoring, evaluation and corrective action.*
- **Municipal Finance Management Act (2003).** *Section 40 (3) (a) (b) require that annual reports and financial statements represent 'state of the affairs' of the department.*

- **Public Service Act (PSA - 1994):** *The Public Service Commission provides legal mandate/background and is an active proponent of M&E culture for all levels of Government. It enhances control over public expenditure and empowers public sector managers to use resources in a more efficient way.*

3.8.4 Legislation and legal reforms on health-related matters

- **Choice on Termination of Pregnancy Act – 1996:** *To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith.*
- **The National Health Bill Act 61 of 2003**
- **Section 23 (ix):** *Epidemiological surveillance and monitoring of provincial trends with reference to major disease and risk factors for diseases; and (x) obtaining processing and use of statistical returns*
- **Section 31 (b):** *Ensure coordination, planning, budgeting, provisioning and monitoring of all health services that affect residents…*

National Health Act, 2003

- **Section 74 (1):** "The national department must facilitate and co-ordinate the establishment, implementation and maintenance ... [of] a comprehensive national health Information system."
- **Section 74(2):** "The minister may prescribe categories or kinds of data for submission and collection and the manner and format in which and by whom the data must be compiled or collated and must be submitted to the national department."
- **Section 75:** "The relevant member of the Executive Council must establish a committee for his or her province to establish, maintain, facilitate and

implement the health information systems contemplated in section 74 at provincial and local level".

- **Section 25(1)** "The relevant member of the Executive Council must ensure the implementation of national health policy, norms and standards in his or her province."
- **Section 25 (2)** "The head of a provincial department must … (b) plan and manage the provincial health information system; …n) control the quality of all health services and facilities; … and (t) promote community participation in the **planning, provision and evaluation of health services."**
- **Section 31: "**Municipalities must provide within resources available to them, the health services that they are providing…"
- **Section 92(b)**: of the National Health Act "The executive Council may assign any duty and delegates any power … to any officer in the relevant provincial department or any council…"

3.8.5 KwaZulu-Natal Health Care Bill Draft 11 2007

- **Section 5 (f):** Structures and provide for the implementation of a district health system… supervision, monitoring, evaluation and review of the district health system and the management.
- **Section 5 (ix):** Epidemiological surveillance and monitoring of provincial trends … for disease.
- **Section 14:** *Functions of district health councils:* This section stipulates that, a district health council must ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services…
- ***Section 38:*** *Health care delivery standards:* This section stipulates that the MEC shall prescribe minimum norms and standards for the delivery of health

care services, including Section 38 (c) the monitoring and evaluation of all health care establishments.

- **Section 70:** Establishment and functions of Inspectorate for Health Establishments. This section stipulates that the Inspectorate should institute monitoring activities and processes for quality assurance.
- **Section 74 (a) (vi):** *Outlines the responsibility of the Department for "evaluation, monitoring and impact assessment of programmes, projects and services rendered".*
- **Section 78:** *Monitoring, evaluation and impact* ***assessment***
- **Section 85:** All programmes and projects …are subject to monitoring, evaluation, impact assessment and the submission of a written report by the inspectorate as established in terms of Section 70 also refer to Sections 70 (a): (i), (ii) and (iii) submit reports as required in terms of such frameworks.

Framework for Measuring Programme Performance Information (2008).

This Framework aims to:

- *Clarify definitions and standards for performance information;*
- *Improve integrated structures, systems and processes required to manage performance information;*
- *Define roles and responsibilities for managing performance information; and*
- *Promote accountability and transparency by Parliament, Provincial Legislatures, Municipal Councils and the public with timely, accessible and accurate performance information.*

Treasury Regulations (2002): *This prescribes procedures for quarterly reporting must be established for the institution to facilitate effective performance monitoring, evaluation and corrective action.*

Public Service Act (PSA) (1994): *The Public Service Commission provides legal mandate/background and is an active proponent of M&E culture for all levels of Government. It enhances control over public expenditure and empowers public sector managers to use resources in a more efficient way.*

3.8.6 Legislation on local government-related to health care

- **The Local Government Municipal Structures Act of 19198:** *Selection of the executive Committee; and term which the members should remain members of the Committee.*
- **The Local Government Municipal Systems Act of 2000:** *Legal nature, rights and duties of municipalities; functions and powers; community participation; and Integrated Development Planning; monitoring and review of performance management system* (RSA Government Gazette No 21776 Volume 425).

3.8.7 Provincial Growth and Development Strategy as discussed below:

The Provincial Growth and Development Strategy (PGDS) is a long term strategic development perspective and vision of the province that aims to ensure coherence in policy development and planning across the Provincial Government and strengthen performance monitoring and evaluation in order to enable the Government to assess the pace required to deliver on the desired outcomes. The “growth and development” concept refers to growing the economy for the development and improvement of the quality of life of all people living in the province of KwaZulu-Natal. The PGDS envisages KwaZulu-Natal as a prosperous Province with a healthy, secure and skilled population and acting as a gateway to Africa and the World by the year 2030. It seeks to attain its

vision through seven strategic goals which have objectives, indicators, targets and interventions and in phases of which the first phase is by 2015 (PGDS Report 2011: 20).

The strategic goals for the PDGS are: 1) job creation, 2) human resource and development, 3) human and community development, 4) Governance and Policy, 5) Environmental Sustainability, 6) Strategic Infrastructure, and 7) Spatial Equity.

The PGDS operates within the National 12 outcomes of the following Clusters:
The Social Protection, Community and Human Development; b) the Economic Sector and Infrastructure Development; c) the Governance and Administration; and the Justice Crime and Security Clusters.

Amongst the five expected outcomes within the Social Protection, Community and Human Development Cluster Outcome Two is: 'A Long and Healthy Life for all South Africans'. The Department of Health subscribed to achieving this outcome together with the Negotiated Service Delivery Agreements and the Millennium Development Goals. The indicators, targets and systems have been developed to implement and monitor the progress; and the first phase of the PGDS and the mentioned prescripts need to be achieved by 2015.

In broad terms the PGDS of the Province seeks to ensure coherence in policy development and planning across the Provincial Government; strengthening performance monitoring and evaluation and enables the government to assess the performance required to deliver the desired outcomes (PGDS Report 2011: 21).

Additionally, the PGDS has a Provincial Growth and Development Plan, which covers the National and Provincial spectrum that focuses on the 5 priorities (besides the 12

outcomes) and the Millennium development Goals which encompass the Provincial economic and the disease profiles. These are:

a) Using sector strategy and department strategic plans which include the IDP in the local level;
b) The Economic and infrastructure Development Cluster;
c) The Social Protection Community and Human Development Cluster;
d) The Governance and Administration Cluster; and
e) The Justice Crime Prevention and Security Cluster.

These clusters will not be discussed except for the Social Protection Community and Human and Community Development Cluster as it involves the Health Department. By 2030, the Province of KwaZulu-Natal should have maximized its position as a Gateway to South and Southern Africa, as well as its human and natural resources so creating a safe, healthy and sustainable living environment (PGDS Report 2011: 22). This involves actions against poverty, inequality, unemployment and current disease burden; such that the basic services must have reached all the people in this Province and long and Healthy Life for all South Africans as an outcome on which the DOH focuses. The following figure is the framework that illustrates the strategic goals and interventions on how the KZN Province will achieve its vision.

Figure 3.9: The KwaZulu-Natal Provincial Growth and Development Strategy Framework (Adapted from the presentation to the PGDS Committee 2011)

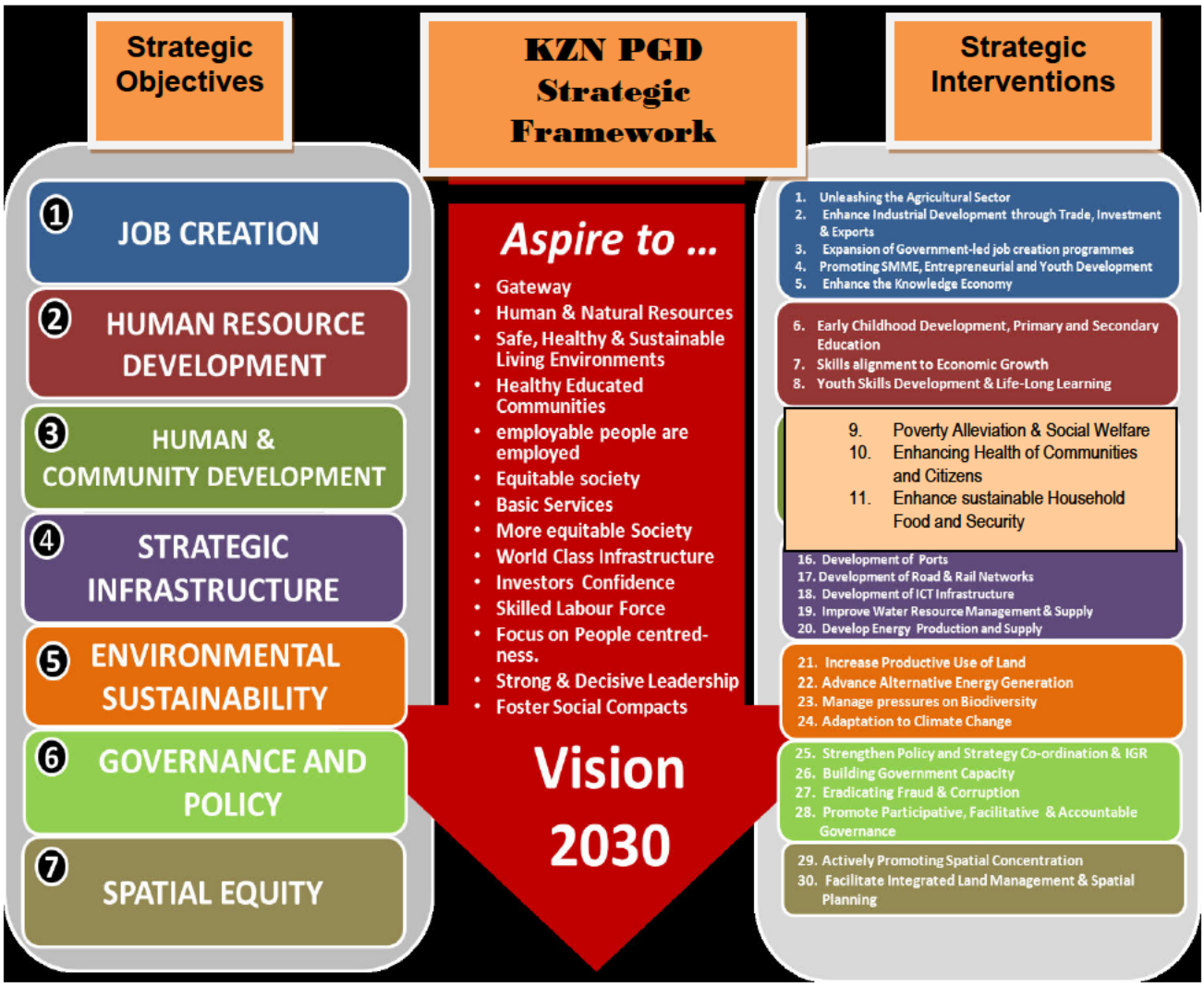
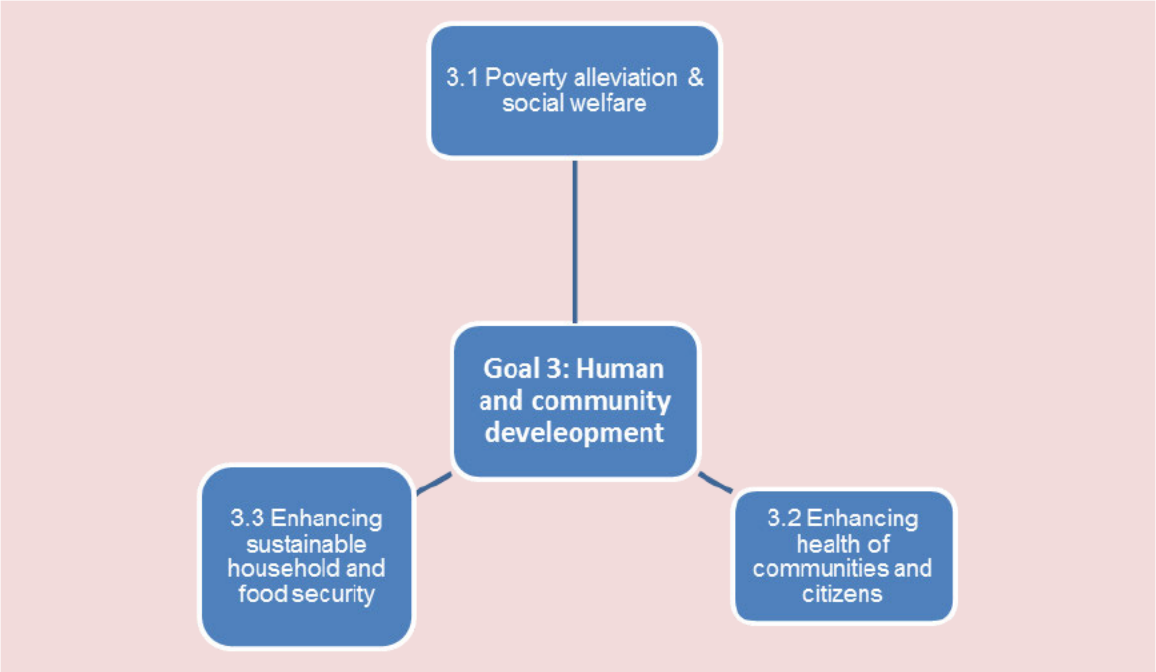


Figure 3.7 above shows how growth and development in the context of the PGDS refers to the growing economy for the development and the improvement of the quality of life of all the people living in the Province of KZN. Reference is made to the Strategic Intervention in the above figure numbered 9 to 11 - poverty alleviation; enhancing Health; and sustaining food and security, respectively. As mentioned above, the Department of Health developed indicators to monitor performance in these areas in order to guard against severe hunger and malnutrition; and ensuring food security thus

improving people's lives which is envisaged to eventually result in long and healthy life for all.

Whereas Figure 3.7 above shows the three PGDS strategic objectives that are relevant to the Department of Health, Figure 3.8 below shows the PGDS Goal 3 to which the DOH subscribes. It also demonstrates how the DOH features in the picture.

Figure 3.10: Goal Three of the Provincial Growth and Development Strategy



Adapted from the Provincial Growth and Development Plan **presentation to the Technical Committee (2011).**

Illustrated in the figure are the three strategic objectives of Goal three. The application of the Provincial Growth and Development Plan to the provincial health profiles was discussed in details in Chapter Two.

3.9 Conclusion

The chapter provided information on the purpose and the importance of the literature review. Different theories and models that explained the relationship between the monitoring and evaluation systems, governance, public administration and management, were presented. An illustration of how these provided the theoretical framework of the study was also provided. The literature review covered the magnitude of the M&E systems worldwide, nationally, provincially as well as departmentally.

Thereafter, the literature review was organized thematically by using themes and sub-themes related to the study. Previous studies on M&E and governance were also reviewed; studies which facilitated the identification of gaps in the literature.

Therefore, relevant research in a specific environment is needed to bridge the gap between M&E expectations for M&E mainstreaming towards good governance (in a government) within the departments; and the reality of how M&E system is being implemented in practice.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.0 Introduction

The purpose of this study is to critically review how the existing M&E system developed; how well it performed; the degree to which the M&E information was used to improve the performance of the Department towards reaching its goals and objectives; and the extent to which good governance had been achieved. To attain this purpose, data on M&E governance was collected nationally and provincially within the Department of Health (DOH) using different data collection methods on the following areas:

- The extent to which the staff complies with the M&E system;
- The level of commitment of senior management to implement the M&E Framework in the Department; and its usage as a management tool (in planning and decision-making);
- The M&E capacity of the senior management;
- Challenges and possible remedial actions towards improved utilisation of the M&E information, policies and their implementation; and
- Developing and proposing a framework model for the evaluation of the M&E system in the KwaZulu-Natal DOH.

In order to answer the research questions raised in and achieve the objectives of the study as stated in the first chapter, a case study research design using both qualitative and quantitative data collection methods was undertaken. However, the sample was too small to use quantitative data analysis methods.

This chapter elaborates on the methodology that was undertaken in conducting the study. Where necessary it provides a description and justification of the methods and procedures followed in this study. Sections included in this chapter are on research design that was used to conduct the study, study population, sampling procedures followed, data collection methods and instruments used in data collection. Validity and reliability are also discussed including ethical considerations as well as data analysis. The chapter also engages with problems encountered during data collection.

4.1 Research design

Chilimo (2009:134) describes research design as “a plan or a blueprint of how a researcher intends to conduct a study”. In general, that is an outline of data collection and analysis towards the solution of a research problem. This includes an elaboration of steps to be taken from developing a hypothesis and its operational implications and the final data analysis.

4.2 Qualitative versus quantitative research methods

There are two major approaches used by researchers in social research namely the quantitative and qualitative approaches. Quantitative approaches measure objective facts with the emphasis on measurement and analysis of the causal relationships between variables within a value free context focus on variables, with hypothesis testing and reliability as key concepts with theory separated from data and are independent of the context in which research is conducted. The researchers are detached and distance themselves from the research context and people or events they study. This means that in order to understand the investigation the quantitative approach takes an outsider’s

stance. This approach also uses many cases or subjects and statistical analysis (Terre Blanche, Durrheim & Painter 2006: 7).

On the other hand if the researcher believes that the phenomenon to be studied lies on people's subjective experiences of the phenomenon, an interactional epistemological approach is chosen. This is a qualitative approach which establishes socially constructed reality by attaching meaning. It focuses on interactions between ordinary people by observing and describing their lives. It is thus value laden in nature, explaining subjective reasons and meanings that lie behind social action (Terre Blanche, Durrheim & Painter 2006: 7). Both theory and data are fused after few cases have been used. Its analysis uses thematic analysis and the researcher is involved. This means that the researcher attempts to get an insider's view of the phenomenon of study (Neuman 2006: 9 &13; Welman, Kruger and Mitchell 2010).

Chilimo (2009: 135) contends that the ontological and epistemological positions of the two research approaches influence the selection of methodology to follow and data collection methods to use. As the quantitative approach adopts a positivist epistemology it mainly uses survey methods and questionnaires in data collection. On the other hand, the ant-positivist or qualitative approach allows the researcher to develop theory during the process of data collection. This implies that theory is built from data or is grounded in the data allowing the interaction between theory and data. This gives the researcher flexibility to move to any direction as the interesting data emerges (Neuman 2006: 158). Amongst the different methods that the researcher uses in qualitative approach, is ethnography, participant observation methods and structured/unstructured interviews, focus group discussions, diaries and documentaries for data collection (Chilimo 2006: 135).

4.3 Justification for combined methods

This study used a case study design and combined both qualitative and quantitative methods for data collection. This is synonymous to triangulation where more than one method is used to look at issues from multiple angles in order to have a better understanding of a phenomenon (Terre Blanche, Durrheim and Painter 2006: 287). In the above section a mention of the shortfalls of both quantitative and qualitative research methods was discussed. If used together they, therefore, are complementary to each other and exert more strength towards making the study more comprehensive. (Neuman 2006: 150; Terre Blanche et al. 2006: 380). This is what Chilimo (2009:136) calls a "combined paradigm approach in research". He also agrees that when combined the qualitative and quantitative approaches give a better understanding of the research problem than when a single approach is used.

The use of both approaches was meticulously undertaken in consideration of lack of financial and time constraints. In order to provide the insights from each approach and to answer the research questions in designing this study both approaches were used though the qualitative approach was more dominant (dominant-less-dominant - Creswell 1003: 136).

4.4 Case study research

A case study that combined quantitative and qualitative data collection methods was used for investigation in this study. According to McNabb (2002: 278), "the case study is one of the most often used approaches to conducting research in public administration". The supporters of the case study design are mostly in favour of qualitative methods, such as participant observation and unstructured interviews, as these methods give the

detailed examination of the case studied (Mitchell et al. 2010: 194). In support of this approach, Mdluli (2006: 179) reveals that the case study is an “empirical inquiry that investigates a contemporary phenomenon within its real life context”. Furthermore, McNabb (2002: 278) contends that a case study is instrumental to measure the performance of an organisation or a company. For instance, a case study has a purpose to establish a theory; test existing theory; identify factors that led to a certain phenomenon; establish the importance and relevance of the existing factors in relation to the phenomenon; and establish the important case to other potential factors.

With regard to choosing the research methodology, a case study was considered suitable because a single unit was selected; that is, the KZN Department of Health. This methodology would allow the intensive study of the entire department. It would also allow several methods of data collection thus giving a thorough understanding of phenomena to be studied (Mitchell et al. 2010: 193). For this research, a case study would facilitate making a diagnosis of the DOH M&E system in order to provide full understanding of its strengths and weaknesses. The diagnosis would help develop the Action Plan to map future M&E systems of the department; and provide information for the evaluation of the existing M&E system. In order to understand the issues around the institutionalisation of the Government-wide M&E (GWM&E) in the department, the diagnosis would focus on the role played by the M&E activities (Mckay 2007: 71).

A case study design was also appropriate for providing the researcher an opportunity to conduct the in-depth data collection from different participants at different levels. The study investigated their understanding of the concept of monitoring and evaluation, their role, capacity as well as the relevance and usefulness of the M&E system in their specific programmes or area of work.

Case studies can be used to test an existing theory. When used for this purpose a case study can be preceded by a theory that guides the study and provides a framework for the study. This means that the researcher should be clear about the theory on which the study is grounded. A case may also be used for developing a new theory. Using a case study in this way is dependent on a 'detailed exploration of a particular case so as to generate insight into social processes and so give rise to a theoretical formulation' (Chilimo 2009: 139).

The study was conducted within the social setting of the work environment, where participants provided the data as they experienced or made interpretations of it. The study investigated how well capacitated the Senior Managers were to be able to effectively and efficiently manage the M&E system in the Department; DOH compliance to the assumptions of the Government Wide Monitoring and Evaluation System as a Framework to which the Public Sector should adhere. The study also investigated if the M&E system formed the governance context to ensure quality health service; and the extent to which the Department utilises the information obtained from the M&E reports in policy formulation, decision making and planning.

As a recent practice to measure performance, monitoring and evaluation is expected to encounter various challenges in its implementation. The study investigated the DOH's work environment, its culture and the inherent challenges as they impacted on performance and service delivery. It was envisaged that the outcomes of the study would inform evaluation models to be followed for future evaluation of the Departmental M&E systems.

A case study has implications for theory development. It can generate a new theory. A theory can be defined as a "system of interconnected ideas that condenses and

organizes knowledge about the social world" (Neuman 2006:50). A theory can give explanation to the cause of the problem (theory of explanation) or can provide direction for the intervention for problem solving (theory of intervention). A theory can also be defined as a proposition, a perspective or a conceptual framework for interpreting data that elicit several hypotheses that are related (Roberts and Yeager 2004:105). An elaborate exploration of a specific case can create insight "insight to social processes" which in turn can result in new theories being formulated (Chilimo 2009: 139).

In this study theory was used as a premise to guide the research. This explains reasons for using theories at the onset of this study - to provide the researcher guidance to what needed to be investigated. This exercise assisted in the clarification, modification and extension of theories used to guide the study.

4.5 Study population

A study population can be defined as a study object that may consist of individuals, groups, organisations human products or events and the context in which they operate and to which the researcher wishes to draw conclusions (Chilimo 2009: 139; Mitchell et al. 2010: 52). Defining the study population is one of the steps in developing the research design. The study population is a large group of cases from which the researcher draws a sample and to which results can be generalized (Neuman 2010: 224). It is for this reason that the researcher should carefully define the population of study before engaging in sampling.

With regard to this study, the unit of analysis was the employees in the DOH at all levels. That is, the levels of Senior Management Service and Middle Management Service personnel. This included all the other categories of employees directly involved in the

M&E implementation (Programme Managers and M&E Officials). These were deployed at different spheres of the Department namely Provincial, District and at Sub-district (Facility level). Additionally, the external stakeholders, people outside of the DOH but with vexed interest in the subject matter, also formed part of the study population. These included other departments as they constituted the Provincial M&E Forum, the Office of the Premier and some Non-governmental Organisations.

The sampling frame consisted of the stakeholders that were directly involved in implementing the basic values and principles that govern Public Administration, the policy makers, M&E Officers, and any other relevant informant (Constitution of the Republic of South Africa of 1996). The following section provides explanation on methods and procedures adopted in the selection of the sample that was studied.

4.6 Sampling procedures

A sample is a small collection of units or group drawn from a larger study population which the researcher studies and makes more accurate generalization about the larger population. It is a subset of the study population used to acquire information about the entire population (Neuman 2006: 219; Welman, Kruger and Mitchell 2010: 57; Chilimo 2009:140). The primary aim of sampling is to collect specific information that may give deeper insight on and understanding of the study phenomenon. In this regard the sample must be representative in order to be generalisable to the larger population. This means that the sample should have similar properties in the same proportion as the population from which it was drawn, such that it depicts the larger population.

There are two major sampling methods used in research: the probability-sampling and the non-probability sampling. The probability-sampling representativeness is used in

larger populations where it includes random, stratified random, systematic and cluster samples. The non-probability sampling includes but is not limited to purposive, snowballing, self-selection and convenience sampling (Welman, Kruger and Mitchell 2010: 56). In probability sampling a selection of a number of subjects, objects or cases representing the large population is selected. In this case the researcher determines the probability of any element having a chance of being included in the sample. The probability sampling is used in quantitative research.

Unlike in probability sampling, in non-probability sampling some elements of the sample do not have a chance of being selected. This means that sampling represent only a particular group or a section of a group. The examples of non-probability sampling are purposive sampling, quota sampling and purposive sampling. This method of sampling is used in qualitative research methods (Neuman 2006: 219; Welman, Kruger and Mitchell 2010: 56).

The sampling population was the employees of the KZN Provincial DOH. As this was mainly a qualitative (case) study, convenience, snowballing and purposive sampling methods were appropriate to be used. This study constituted four categories of units of analysis, therefore, **Convenience sampling** was adopted. This involved recruitment of participants that were nearby, easy to recruit and who it was felt would easily respond. This method was to help explore the complex economic evaluations of the DOH through the Audit Committees, CFOs and the Human Resources management. (Mngomezulu 2009: 74).

Purposive sampling is a non-probability sampling in which the researcher uses expertise to select participants on the basis of his judgment. In this way purposive sampling is also known as judgment sampling. Cases selected are unique and especially

informative with regard to a study being conducted (Nueman 2006: 222; Chilimo 2009:149). Purposive sampling was also adopted for this study on the basis of the researcher's decision/discretion of participants to fit a specific purpose in her mind as an expert. The researcher used her expertise to sample according to her understanding of the Provincial DOH as a unit of study. Purposive sampling, however, is a "subjective deliberation of the researcher" (Mngomezulu 2009: 74) than on scientific principles. This method of sampling cannot be generalised to a wider population; random sampling of health districts was also employed for the study. The random sampling method was also used on groups of stakeholders with particular characteristics in monitoring and evaluation of the health programmes within the Heath Districts in the DOH.

Additionally**,** the **snow-balling sampling** method was also employed. This involved the participants pointing out other members who they felt had similar criteria. However, choosing this sampling method meant that anonymity would not be addressed as the members knew one another as they were from the same working community (Mngomezulu 2009: 73). Sampling in all the four categories of units of analysis of the study ensured that the suitable population was obtained from the larger population of unit of analysis. In this way obtaining appropriate data for the study was ensured.

In qualitative research, rather than being predefined, the sample size is determined by data saturation. This means that the sample size is considered sufficiently large when no new data is obtained (Mngomezulu 2009: 73). The sample size was not determined prior to the study as the rule of saturation was used.

4.6.1 Selection of cases to be involved in the study

Participants involved in the study were selected based on the purposive criteria defined in table 4:1 below:

Table 4.1: Criteria of selection to the study

Criteria	Condition used
KwaZulu-Natal Government Departments	Participants involved in the study were either the KZNDOH employees; any KZN Department employees; and the employees of the KZN Office of the Premier.
Location	The participants of the study were selected from the 3 spheres of the Department namely the provincial, district and sub-district levels.
Level of employment	Participants involved were those in the senior and middle management positions. These included participants at any other level who were involved in M&E work.
M&E interest	The external stakeholders were participants that had vexed interest in the M&E Systems and somewhat directly or indirectly involved in the M&E work.

The criteria used in the selection of participants were also used by Chilimo (2009).

Though the larger population was the DOH employees, those who did not meet the criteria set out in the study as listed in Table 4.1 above were excluded from the sample. The Department has a number of employees at various levels and spheres of the Department. Monitoring and evaluation is a new paradigm that is not known by many in the workplace as they may not be involved in any M&E related activities. Participants

excluded from the study had no involvement in and had no clue of monitoring, evaluation and reporting. Categories of participants were as follows:

4.6.1.1 Head Office participants

Purposive sampling was employed in the selection of the Head Office (Provincial Sphere) category of participants. In the case of selecting this category the researcher requested the Human Resource Section to provide a list of employees in the Senior Management Service and Middle Management Service levels of employment through use of the PERSAL System of the DOH. The KZNDOH Head Office had a total of 215 employees of the SMS and MMS categories. From each category 10% was interviewed giving a total of 22 interviews conducted.

All the M&E District Deputy Managers from the selected Districts were interviewed. Focus group discussions were conducted with the Programme Managers in the eight districts. The information from the facility level was obtained from the record reviews of reports generated from the M&E support visits and from the reports generated by the districts. A short description of each category is provided in the following section.

4.6.1.2 District participants

The KwaZulu-Natal Province has 10 Districts and one Metropolis which is normally categorized as the eleventh District. Each district has a District Manager (SMS level), a M&E Deputy Manager and a Planning Manager (both at MMS level). A proposal to conduct research in the eleven districts was submitted to the District Managers with an explanation that it was not all managers that would be selected. Selection was undertaken from the four better performing districts and the four lowest performing

districts. From all these eight districts a District M&E Manager and the Programme Managers were targeted.

4.6.1.3 Sampling of other categories of participants

Snowballing also known as network chain referral or reputational sampling refers to case selection in a network. This kind of sampling is analogous to a snowball which starts small but grows bigger as it is rolled over the snow (Neuman 2006: 223). The selection starts with a few cases and grows as cases point out the others who can provide the required information. For the study the researcher asked the SMS and MMS level employees to identify other relevant cases for inclusion who are involved in M&E and reporting in their areas of work. This gave the researcher a list of all employees that were involved in monitoring, evaluation and reporting process. These were from different levels of the employment rung and are M&E Officials referred to in the Study population section above.

Convenience sampling is non-random sampling that occurs when a researcher haphazardly selects cases that are convenient for the study. It is important to point out that this method of sample selection is not representative of the target population as the researcher may choose anyone deemed conveniently suitable for the study (Neuman 2006: 220). The researcher in the selection of the external stakeholders did not just select anyone that suited the criteria but instead used purposive sampling to locate this category which is highly specific and difficult to reach the population. Reaching them was made possible by the existence of a Provincial M&E Forum that meets quarterly in the Office of the Premier. Necessary arrangements were made to obtain the list of the members and were contacted individually.

4.6.1.4 Sampling adequacy

In research if sampling techniques used were appropriately conducted they ensure representativeness. While probability sampling is a method of reference as it allows generalization to populations, non-probability sampling is any kind of sampling that does not use statistical principle of randomness to select elements for the study. Non-probability sampling in qualitative research are useful for testing a theory about the processes that are considered to be universal (Terre Blanche, Durrheim and Painter 2006: 139).

Non–probability sampling of convenience, purposive and snowballing sampling techniques were used in this study. Research participants were selected according to the mentioned non-probability sampling techniques. The population constituted the DOH employees at different levels whose performance was close to data/information; and that were involved in report writing.

4.7 Methods of data collection

Data collection occurred between December 2011 and August 2012. Data collection was conducted in the selected districts where on arrival the researcher disseminated the questionnaire to the District Managers. The Deputy District Manager (Monitoring and Evaluation Manager) grouped together the Programme Managers for the Focus group discussions, which were conducted by the researcher.

4.7.1 Primary data collection methods

Primary data is the original data "collected by the researcher for her/his own study at hand" (Welman et al. 2005: 149). Data for this study was collected using both qualitative and quantitative methods of data collection. For instance in-depth interviews, semi-structured interviews, focus group discussions and questionnaires were applied. It was crucial to apply more than one method of data collection in order to check and balance regarding flaws that could be elicited from each data collection method. The following section elaborates on data collection methods used in the study.

4.7.1.1 Interviews

In research, interviews refer to interaction with study participants with the aim to obtain data or information about the study phenomenon being studied. Chilimo (2009: 150) defines interviews as "face-to-face encounters between the researcher and the respondents for a specific purpose of obtaining research-relevant information" and is therefore a direct verbal interaction between individuals. Besides being just verbal interaction between people in research 'interviews are skilled performances' aimed to get an understanding of how people being interviewed think and feel (Terre Blanche et al. 2006: 297). This can also be deduced from non-verbal cues elicited by the people being interviewed.

In research interviews an interpretative approach may try to find out how people experience and feel about particular phenomenon, thus creating an environment of openness and trust for both the interviewer and the interviewee so that they are able to genuinely express themselves. On the other side a constructionist approach contends that meanings created in an interview are co-constructed between the researcher and

the interviewee. Construction of such meanings is not restricted to only these parties but is a product of a "larger social system for which these individuals act as relays" (Terre Blanche et al. 2006: 297).

During an interview the researcher is accorded a greater opportunity to probe and pose follow-up questions. This provides more depth to understanding of the phenomenon that cannot be obtained when a questionnaire is administered. Interviews used in research range from structured to unstructured interviews. Structured interviews are characterised by careful and systematic planning coupled with the use of a skilled interviewer. This means that a list of questions is planned and pre-set such that they provide information about the topic of interest. Phrasing of the questions in a structured interview are more like a questionnaire used in quantitative research with limited responses that do not seek answers that elaborate on feelings and experiences (Swanepoel 1998: 319; Terre Blanche et al. 2006: 298).

However, where participants are required to provide in-depth feelings and experiences semi-structured interviews are conducted. This comprises a set of basic questions and a procedure is provided but all depends on the interviewer; how respondents are treated and how probing is done. According to Chilimo (2009: 159), the interviewer has autonomy to modify the format and the sequence of the questions in an appropriate manner to the interview. In-depth interviews that are unstructured generate more original individual data because of their nature to provide the researcher more flexibility to adapt to each respondent (Mngomezulu 2009: 75).

This impression is supported by draft guiding principles and standards for monitoring and evaluation of public policies and programmes (Republic of South Africa 2006: 38). This source states that interviews are fully conducted to fully understand people's "impressions or experiences, or learn more about their answers to questionnaires". It further provides

advantages of conducting the interviews as giving full range and depth of information, and provides ample time with the participants.

For the purpose of this study both structured and unstructured interviews were conducted with employees of the DOH selected to participate in the study. Interviews with the Managers and M&E Officials aimed at answering the following questions:

- Is the DOH efficiently and effectively managed?;
- Is the Department complying with the basic tenets of the GWM&E system; and of good governance?;
- What are the benefits that had accrued from the Departmental M&E system?
- What are the M&E challenges currently faced by the Department; and how should they be addressed?; and
- What are the essential elements of an Evaluation Framework for an M&E system of the Department?

The following section elaborates on what constituted the structured interviews guide.

4.7.1.1.1 The structured interview guide for managers and M&E Officials

A structured guide with both closed and open-ended questions was developed for use in the interview process for Programme Managers, M&E Managers and M&E Officials. The design of the interview guide was on the objective of the study on which the questions of the study were based. The interview guide was structured as follows:

Section 1 to 4

Sections 1 to 4 allowed the researcher to collect information that would provide an overview of the participants' awareness of the existence of the Departmental M&E System as guided by the Departmental M&E Framework. Issues like governance was

core to their understanding of why M&E system as it is a core element of the Departmental functions based on policies and legislation that underpin crucial elements of governance. This included the extent of the Framework implementation, monitoring and reporting – procedure and data flow at all levels or spheres of the Department. The extent of the manager's involvement and evidence of their programme specific monitoring system of the implementation of the Framework was to be made evident. Moreover, the managers had to show awareness and understanding of the National mandate, the Government-Wide M&E Framework on which the Departmental M&E System was based

This information was important to eventually gauge the extent to which the M&E system of the Department was utilised. Knowing this, would also determine the extent to which the M&E System was supported by being used as a management tool for decision-making and planning (Refer to Appendix 8: Questionnaire for Senior Management Service).

Section 5 to 6

Sections 5 and 6 helped the researcher to collect information on the M&E capacity that the participants had in order to make an informed decision of why the M&E system was implemented or not implemented. This started by exploring the participants' understanding of the concept of M&E and the tenets of the M&E System. It also required more insight on the development of their programme specific indicators and display their knowledge of the mandates that underpin monitoring and evaluation processes in order to elicit compliance (Refer to Appendix 8: Questionnaire for SMS).

Section 7

Section 7 sought information pertaining to reporting. Reporting is a crucial element of a manager's performance as it is closely related to the employee's performance towards attainment of the Department's goals and objectives. Department reporting should be aligned to policies, strategic and performance plans undertaken in an integrated manner. Collecting this information would expose the researcher to the extent to which managers comply with the reporting prescripts and determine the extent to which data quality was considered as crucial in their reports.

Section 8

This section provided information on the efficiency and effectiveness of the Departmental M&E System. Challenges that the implementers were faced with were expressed. This included the overall evaluation of the Departmental System – its importance, its impact and where amendments and changes in the design, introduction to employees, implementation and its monitoring needed to be made. This section also enabled participants to share the experiences of the M&E System and recommendation for future M&E endeavours (Refer to Appendix 7: Focus Group Discussion).

4.7.1.1.2 Semi-structured/unstructured interviews

In practice in-depth interviews that are semi or unstructured generate more individual data as they allow the researcher more flexibility to adapt to the individual participant. Where semi-structured interviews were conducted they were informal so that participants were able to introduce more issues which had not been anticipated by the researcher. In this study, the interview guide used during interviews was based on the issues related to the objective of the study (Refer to Appendix 8: Questionnaire for SMS; Appendix 11: Sample of an Interview).

4.7.1.2 Focus group discussions and Group sizes

Focus group discussions are a method of obtaining data from people in a group. A focus group is a group of people who do not necessarily know each other; but people who share a similar experience according to the criteria set by the researcher on what needs to be investigated (Terre Blanche et al. 2006: 305). Data is collected from several people in a group by means of an interview. In a Focus Group Discussions, questions are not posed to individual members but are asked in a manner that enables all respondents to participate in a discussion talking to one another, exchanging ideas, experiences and point of views on the question posed. The discussion flows smoothly since the group comprises respondents of similar status. The discussion is also focused in that it revolves around a selected topic and it is the responsibility of a researcher to channel it towards the required objective which the question was designed.

Chilimo (2009:161) states that Focus Group Discussions in research are generally used for the purpose of triangulation where other data collection techniques are used. Information obtained from the Focus Group Discussions may be compared to information obtained from other methods of data collection namely, interviews, observations and questionnaires. Focus group discussions are useful in evaluation as they provide common impressions quickly in a reliable manner; and are an efficient technique to get considerable range and depth of information in a short time (Republic of South Africa 2006:38).

In this study, the researcher used Focus Group Discussions to explore the topic in depth. Several factors, which included the decision on group size, group composition, the number of Focus Group Discussions to conduct and the criteria of respondents that would form part of the FDGs were adopted. In the following sections, an elaboration on

the decisions the researcher made regarding Focus Group Discussions that would be used in this study is discussed (Refer to Appendix 7: Focus Group Discussions Interview Guide; Appendix 12: Sample of a Focus Group Discussions).

4.7.1.2.1 Groups' characteristics

Selecting members to participate in focus group discussions was mainly guided by the purpose of the study, which was to review the development of the existing M&E system; the performance of the M&E system; the extent of the M&E information usage to improve performance of the Department and towards reaching its goals and objectives; and the magnitude of good governance as a result. For this reason, a focus group discussion was sampled from the employees of the Department who were actively involved in monitoring, evaluation and reporting activities of their programmes.

Individuals forming part of the groups were either involved in the management of their programmes, designing of systems and processes to monitoring the programme, monitoring the progress of the implementation and or reporting on the progress towards realising the programme's targets.

4.7.1.2.2 Group sizes

Different researchers use different sizes of focus group discussions. The group size for a focus group discussion may range between three to twelve participants. Barbour and Litzinger (1999: 71) contend that a group of three to five participants is sufficient. Researchers that regard a focus group discussion from four to twelve participants are Morgan (1988: 43); and McCellard (1994: 29). Terre Blanche et al. (2006: 304) contend that most focus groups consist of 6 to 12 participants. There are several others that

support any group size between 3 and 12. Determination of the appropriate number of participants may depend on the researcher's discretion based on the discussion guide. Time allocated for a focus group discussion could be between one and two hours also depending on the issues for discussion. It is, nevertheless, recommended that the group should neither be so large that it is uncontrolled or hinders participation of other group members nor be so small that it is unsuccessful to provide significant information than that of an individual interview (Chilimo 2009: 163).

4.7.1.2.3 Identification of the respondents

The key informants comprising the District Offices staff included different managers for different programmes as well as M&E Managers. The final FOCUS GROUP DISCUSSIONS composed of the Head Office personnel who were either involved in monitoring and evaluation in their specific programmes or those capturing data or compiling reports and submitting them to various stakeholders. Table 2 below summarises selected optimal groups sizes and the criteria that the researcher used in this study.

Table 4.2: Focus group discussion sizes

FDG & District	Group size	Group composition in terms of the respondents' occupations	Duration of the FDG
FDG 1: UMkhanyakude	Respondents : 10	M&E Manager, Planning Manager, Quality Assurance and Control Coordinator, Fleet Manager, Tuberculosis and Communicable Diseases Control Coordinator, Finance Manager, Clinical and Programme Manager, District Information Officer, HIV and AIDS Coordinator, and Health promotions and Oral Health Coordinator.	1 hour 30 minutes
FDG 2: UThukela	Respondents : 11	M&E Deputy Manager, M&E Planning Manager, Clinical Coordinator, District Information Officer, HIV and AIDS/Sexually Transmitted Infections and Tuberculosis Coordinator, Primary Health Care	50 minutes

		Coordinator, Mother, Child and Women's Health and Prevention of Mother to Child Transmission Coordinator, Occupational Health Coordinator, Community Care Giver, Programme Coordinator, Infection, Prevention and Control Manager and QUALITY ASSURANCE AND CONTROL Manager.	
FDG 3: UMzinyathi	Respondents : 7	M&E Deputy Manager, Rehabilitation and Disability Manager, Healthy Lifestyles and Oral Health Manager, Infection Prevention and Control Manager, Community Based Programme Coordinator and HIV & AIDS Coordinator, Employee Assistance Programme Manager and Quality Assurance and Control Manager.	1 hour
FDG 4: Zululand	Respondents : 6	M&E Deputy Manager, M&E Planning Deputy Manager, HAST Coordinator, MCWH/ and PMTCT Coordinator; TB Coordinator; Mental Health Coordinator	50 minutes
FDG: 5: UThungulu	Respondents : 5	M&E Deputy Manager, M&E Planning Manager, Pharmacist Manager, MCWH and PMTC Coordinator and HAST Coordinator	1 hour 30 minutes
FDG 6: UGu	Respondents : 08	District Information Officer, Pharmacist, HIV/ART/STI Coordinator, TB Coordinator, PMTCT and MCWH Coordinator, HR Assistant Manager, Healthy Lifestyles and Oral Health Coordinator and Chronic Illnesses Coordinator	50 minutes
FDG 7: UMgungundlovu	Respondents : 9	DIO, MCWH and PMTCT Coordinator, Nutrition Coordinator, Communicable Diseases and Control, PHC Development and Training Coordinator, ART and STI Coordinator, TB Coordinator, HIV and AIDS Coordinator, and Occupational Health Coordinator.	1 hour
FOCUS GROUP DISCUSSIONS 8: Amajuba	Respondents : 10	M&E Deputy Manager, District Clinical Manager, Planning M&E Manager, HAST Programme Coordinator, MCWH Manager, DIO, Community Care Giver Programme Coordinator, HIV, AIDS and STI Coordinator, TB Coordinator and QUALITY ASSURANCE AND CONTROL Manager	1 hour 30 minutes
FDG 9: Head Office	Respondents : 12	Human Resource (HR) Management, Mental Health, Finance Manager, Supply Chain Management, Strategic Planning, Infrastructure, HR Development Manager, MCWH, Corporate Governance, Research, Nutrition and Emergency Services.	40 minutes

4.7.2 Questionnaires

One of the methods mostly used to obtain research data is the questionnaire. Participants are given a questionnaire. This method is less time consuming and less costly in comparison with interviews and focus group discussions. Using this method may result in some of the questions being overlooked and it may not be feasible to ask follow up questions to clarify vague or unclear answers (Swanepoel 1998: 268). It is recommended that the after the questionnaire has been finalised, a pilot study is conducted to check the questionnaire before it is administered to the study sample.

As this study used both qualitative and quantitative methods of data collection the questionnaire used comprised of both open-ended and closed questions. Questionnaires were circulated to some SMS, MMS Managers and the external stakeholders as they receive data from different sources collate and analyse it, and generate reports based on data collected (Refer to Appendix 9: Questionnaire for External Stakeholders). Data collection tools: interview guide and the questionnaire were tested before they were used in the study.

4.7.2.1 Pre-testing of tools

Data collection tools are carefully designed and approved before they are used for data collection. However, to be sure that error does not exist and that the tools are ready for use, pre-testing may be conducted (Peterson 2002: 119).

The designing of the interview guide and the questionnaires for this study was done in consultation with the researcher's supervisor. Before these were used pre-testing was conducted in order to ensure that the instruments were of good quality (Chilimo 2009:

178). The pre-testing exercise was conducted with individuals who are experts in the field comprising an expert in health service planning monitoring and evaluation, a manager in evaluation research, an epidemiologist involved in monitoring disease profile and evaluation of interventions, a professional who is heading a Monitoring Section in the Office of the Premier and a District Manager of one of the well performing Districts. Because of their convenient availability, the participants were also selected on the basis of their ability to provide relevant input on their view of the tools. Table 4.2 below shows participants in the pre-testing of the data collection tools and their field of expertise.

Table 4.3: Participants in pre-testing the instruments

Name	Occupation
Mr. J. Govender	Acting General Manager: Health Service Planning, Monitoring and Evaluation, Department of Health, KwaZulu-Natal.
Mr. X. Xaba	Deputy Manager: Research Department of Health, KwaZulu-Natal
Dr. E. Lugter	Manager: Epidemiology, Department of Health KwaZulu-Natal
Dr. N. Behari	Director: Monitoring, Office of the Premier KwaZulu-Natal
Ms. M. Themba	District Manager: uMkhanyakude Health District KwaZulu-Natal
Mr. S. Gumede	Manager: Works Department KwaZulu-Natal

The participants provided constructive feedback on the tools. Their inputs were mostly on the simplification of the questions on the questionnaires. Recommendations were that, because the monitoring and evaluation concept is not fully understood, to self-administer them would be more productive so that probing is used in order to elicit more responses from the respondents; whereas sending the questionnaires to respondents may yield very limited responses. In this way the questionnaires did not require any changes per se. In consideration of the pre-test inputs, the researcher designed shorter

probing questions for the right channeling of the questions to yield required responses. For the sake of consistency, the researcher prepared side notes derived from the tools to prompt answers that would satisfy the question. This exercise did not require changing of the questions in the tools and for that reason the tools were not taken to the thesis committee for re-approval.

4.7.3. Methods of secondary data collection

Secondary data is data that is collected by "individuals, or agencies and institutions other than the researcher him- or herself" (Welman et al. 2005:140). For the study this data was obtained from several sources as shown in the section below:

4.7.3.1 Document reviews

According to Terre Blanche et al. (2006: 316), documentary sources such as newspaper articles, official documents, books and internet are useful in qualitative research. This goes further to say using documentary sources is much cheaper than using interviews and participants observations as data collection methods.

The Department has in abundance the information relevant to the study, namely: books, articles in journals, magazines, newspapers, archived material, published statistics, Department's quarterly, annual and mid-term reports, Strategic and Annual Performance Plans; the M&E Framework, the internet as well as the Acts of Parliament. The researcher used most of these data sources. Other sources of information used were national and provincial government legislation and policy documents on service delivery; national and provincial reports on workshops and inter-departmental M&E Forum meetings.

4.7.4 Data saturation

A general feature of all qualitative research is that of data collection, data analysis and report writing almost occur simultaneously. Data collection normally occurs up to the point when the researcher stops from acquiring new information/data or because data being collected no longer adds to the unfolding analysis. This means the information being collected has become redundant or has become repetitive. This is referred to as data saturation (Terre Blanche, Durrheim and Painter 2006: 372).

In the study, the researcher collected data using all the data collection methods discussed above until no new information was obtained from the participants. When new thoughts that were considered to add anything new to the understanding already obtained; and when new material and new questions seemed to confirm the account had become redundant data collection was terminated as saturation had been reached.

4.8 Problems encountered during data collection

The researcher was faced with several challenges during the data collection in the field. These challenges included problems of transport to some districts, and terms related to the monitoring and evaluation system. District Offices are sparsely located over the whole province, for instance Amajuba District (Kilometres from Head Office) at the far West of the province in Newcastle; Zululand (Kilometres from Head Offices) and UMkhanyakude District Offices (Kilometres from Head Office) at the far North West and far North of the province respectively and UGu District (kilometers from Head Office) at the South border of the province. As a result much time was spent during travelling to these places.

Another problem encountered was difficulty in obtaining sensitive data from respondents. This was data related to the Managers' knowledge of M&E, managers' performance towards reaching goals and managers' implementation of the M&E system. Data provided with regard to the respondents' performance was clouded with attitudes and there was reluctance in providing such data. The researcher had to work extra hard to probe for more clarification in some areas of discussion.

The researcher also had a problem when respondents did not understand some of the M&E concepts at their work place. It was required that the researcher also make explanations and definitions of some concepts including certain M&E procedures in order to ensure smooth running of the interviews and that the interviews became a success.

The most disheartening challenge was difficulty to obtain ethical approval to enter some of the Districts despite the fact that the Head Office had approved entry into the districts. As a result, a district was left out of the sampling procedure. Some SMS employees could not avail themselves for the study without any concrete reasons. Consequently, it was difficult to obtain some of the information expected from them.

4.9 Triangulation

In research triangulation is a 'methodological approach' that make use of more than a single method of collecting data (Mngomezulu 2009: 85). Chilimo (2009: 175) explains triangulation as involving use of varying sources of data and categorizing of stakeholders or groups according to the topic being investigated. Besides data triangulation that focuses on different data sources, methodological triangulation is also used. This pertains to methodology being used in the study. This could either be multiple

techniques that include qualitative or quantitative methods. There are other methods of triangulations for instance the investigator triangulation and theory triangulation (Terre Blanche et al. 2006: 380).

To ensure data triangulation in this study data from different sources and different stakeholders currently involved in one way or another with data, monitoring, evaluation and reporting activities was used. Responses and contributions of all respondents/stakeholders and groups were scrutinized for consensual ideas amongst them. As a qualitative study, comparing and cross-checking of the consistency of the information obtained at different times was undertaken. This would offer opportunities of deeper insight into the relationship between inquiry, approach and the phenomenon being studied (Mngomezulu 2009: 85).

The study also adopted methodological triangulation by using the case study design, where various data collection methods for both qualitative and quantitative methods were used. For instance, structured and unstructured interviews, focus group discussions, questionnaires and document reviews. Means used in the study included different types of purposeful sampling (choosing of interview participants, FOCUS GROUP DISCUSSIONS of different stakeholders and snowballing). This process of triangulation included cross-checking data/information obtained in private from the in-depth interviews and in public in the focus group discussions.

As the process of data collection progressed the participants consistently uttered the same views of what was discussed. The participants' views were seen from different perspectives, that is, the perspective of the senior managers, middle managers and M&E Officers at a lower category of M&E implementation. The information provided in the

questionnaires also confirmed what was already mentioned in interviews and focus group discussions.

4.10. Validity and reliability in quantitative and qualitative studies

4.10.1 Validity

Validity refers to the extent to which the research findings are sound. Among types of validity there is internal and external validity. Internal validity determines the extent to which conclusions can be drawn; it is about the logic of the design and on whether conclusions follow from the data and procedures followed. External validity is about representativeness and how widely the study results can be applied beyond the context of the study. External validity looks at where the research participants were obtained and if findings based on them can or cannot be generalised to other populations (Terre Blanche, Durrheim and Painter: 166). The explanatory research chooses internal validity over external validity; meanwhile descriptive surveys chose representativeness and generalisability of findings (Terre Blanche, Durrheim and Painter 2006: 90).

In quantitative research, identification of possible validity threats is undertaken prior to the study and measures to control such threats are put in place. To ascertain that accurate conclusions are drawn from the research results tried and tested measures, experimental arrangements and statistical techniques are used (Terre Blanche, Durrheim and Painter 2006: 90). While quantitative research view validity threats as nuisance or extraneous variables that can be controlled and eliminated; in qualitative research it is believed that nuisance variables are an integral part of the real world settings (natural) and instead of eliminating them researchers try to find out what influence they have on the outcomes of the study. If nuisance variables caused impact

and this was not noted, misleading conclusions may ensue. Among other methods this could be done by using triangulation (using different research methodologies) e.g. quantitative and qualitative to find if discrepant findings are provided (Blanche, Durrheim and Painter 2006: 91).

Terre Blanche, Durrheim and Painter (2006: 92) further contend that in qualitative designs, researchers find it impossible to identify specific validity threats in advance. These researchers postulate that research can be evaluated for credibility. Credibility in qualitative designs is established during research. The researchers look for discrepant evidence to the hypothesis they are developing in order to produce a rich and credible account. It is recommended that in order to ensure credibility, the researcher should undergo a process of training on conducting interviews. Such training should also include the researcher's experience, track record and presentation of the researcher (Mngomezulu 2009: 82).

4.10.2 Reliability of the study

Reliability and dependability

Reliability is a degree to which the results are repeatable. This means that the same sets of results will be obtained repeatedly if the same study is replicated. Reliability is important in quantitative research. It is believed that studies are done in a stable and unchanging reality to indicate accuracy and conclusiveness of the findings (Terre Blanche, Durrheim and Painter 2006: 92). On the other hand the interpretive and constructionist researchers do not believe in that reality being investigated is stable and unchanging. They thus do not expect to repeatedly find the same results. They expect that individuals and groups behave differently and come up with different opinions in

different contexts. In this way they propose that findings should be dependable (Terre Blanche, Durrheim and Painter 2006: 93).

Dependability refers to the notion that the findings the researcher presented as have occurred depends on the reader. Dependability is attained by having rich and detailed descriptions, which substantiate that certain actions and opinions are rooted in and developed out of contextual interactions. By providing the reader with a frank account of the methods used in data collection and analysis, dependability is achieved (Terre Blanche, Durrheim and Painter (2006: 93).

Besides pre-testing of the instruments, triangulation and adequate sampling adopted in this study, the researcher included having an open and enquiring mind, being an attentive listener and being generally sensitive and responsive to evidence elicited by participants (Chilimo 2009: 181).

4.11 Data analysis

Data analysis refers to the process of summarising the collected data and organizing them such that they answer the research questions. This is done in order to reach the research conclusions. Data analysis can be separated into quantitative and qualitative techniques. Data analysis in this study was done in order to transform data or information to meet the objectives of the study. Chilimo (2006: 182) adds that the analysis process includes editing, coding, catergorising and manipulating data to find answers to the original research questions.

4.11.1 Analysing qualitative data with thematic categories

Analysis was done to provide information to meet the objectives of the study. The

researcher read through all the interviews and made notes in the margins and the data was then organized into topics and files. From the data, themes or patterns were identified. Several readings were undertaken in order to develop a coding scheme. Eventually, the researcher grouped common data according to experiential themes and sub-themes. This exercise included organizing common and unique data into themes and patterns. This helped her to capture and code the stories of the research participants in a standardised framework to describe what was collected during fieldwork. No computer programmes were used to analyze data collected, but data analysis was done manually by the researcher, using the themes and sub-themes (Mngomezulu 2009: 90).

4.12 Ethical considerations

In research where the human subject will be used showing respect for ethical issues is a requirement. Ethical considerations in research include obtaining approval from the institution's Research Ethics Committee before the research commences. This is based on the requirement of respecting people, maximizing benefits and minimizing harm or risks (Mollet 2008: 48).

Roberts and Yeager (2004: 127) agree with Mollet that the researcher must be concerned with the dignity and respect of the individual participants. Amongst the factors that the researcher should be concerned with are a) ensuring that the participant is mentally sound to give consent; b) The researcher provides adequate information about the research being conducted so that the individual is able to weigh risks and benefit before taking a decision to participate; c) providing enough period of time for the participant to think whether they should participate d) ensure that consent is free and without coercion e) providing information as to what will be done with the information

obtained from research, how will confidentiality be ensured, ensure anonymity in the reports f) ensuring the participants that they may refuse or may withdraw consent at any stage and that there'll be no penalty (Roberts and Yeager 2004: 128).

Confidentiality and anonymity is core to an ethical and authentic research process. In qualitative research it is not easy to ensure these two factors as qualitative methods may require quoting of participants, nevertheless, it is imperative that participants are assured that they will be protected by anonymity. Participants need to be aware that absolute confidentiality and anonymity cannot be achieved. Where participants' quotes have been used authenticity may be edited in a way that protects identification of participants; and may be checked with the participants to clarify content and also check participants' reactions (Roberts and Yeager 2004: 132). For the factors just mentioned, reference is made to Appendices 3 to 7, namely: Appendix 3: a request for "Permission to conduct Research for the Doctoral Degree in Public Administration (DPA)"; Appendix 4: Introduction of the Study to Participants; Appendix 5: Informed Consent for Focus Group Discussions; Appendix 6: Informed consent for Interviews; Appendix 7: Focus Group Discussion Interview Guide;

Verbal and written information must be provided for informed consent. Both verbal and written material should be simple and be available in the language of choice of the participants must be respected protecting confidentiality of participants, following appropriate procedures for gaining access and acceptance into the premises or organisation where research will be conducted (Roberts and Yeager 2004:132).

The research proposal for this study was submitted and approved by the University of KwaZulu-Natal (UKZN) Humanities and Social Science Research Ethics Committee (Reference HSS/1061/0110) on the 26 October 2011 (Appendix 1: University of

KwaZulu-Natal Ethics Clearance). This was on condition that KwaZulu-Natal Department of Health (KZNDOH) and other stakeholders accepted the request to conduct research in their respective areas. Approval from the KZN Department of Health Research Committee was obtained on 12 December 2011 (Refer to Appendix 2 Ethical Approval from the DOH). Copies of both approval letters have been included as appendices to this report.

Research was only conducted when ethical approval to conduct the study in the province was obtained by the KZNDOH Research Committee and when the respective Districts, Programme Managers at Head Office and the external stakeholders accepted that the study be conducted in their areas. Informed consent was obtained from the selected participants after the informed statement was read to them. For informed consents reference is made to Appendices 13 to 20 from the following districts: Appendix 13: UMgungundlovu; Appendix 14: Amajuba; Appendix 15: UMkhanyakude; Appendix 16: UGu; Appendix 17: UMzinyathi; Appendix 18: UThukela; Appendix 19: UThungulu; and Appendix 20: Zululand.

Confidentiality of information was a major consideration for the researcher. The identity of the respondents in the study was treated with confidentiality and therefore only captured the district in the case of focus group discussions. No respondent identifiers (names, identity numbers and home addresses) were captured on the data collection tools. This ensured that the rights of the respondent whose reports/records were reviewed as part of this study were not compromised.

Joining the study was voluntary and participants were free to terminate their involvement if and when they wished or could skip questions that they did not like to answer. The researcher conducted interviews herself and respected the wishes of the participants.

4.13 Conclusion

Chapter Four presented the research design of this study. It provided an elaborate picture of a description of the population and sampling procedures and data collection methods followed, reason given to why each instrument for data collection was selected. Validity and reliability issues and ethical considerations taken were presented. Problems encountered during data collection were presented as well as the data analysis procedures followed. The next chapter, Chapter five will be on presentation, analysis and interpretation of results.

CHAPTER FIVE

PRESENTATION, ANALYSIS AND INTEPRETATION OF DATA

5.0 Introduction

This chapter presents the empirical data obtained from the structured and semi-structured interviews, focus group discussions and documents reviewed. The structured interviews were conducted with the Programme and Component Managers in the Head Office and the Deputy District Managers (M&E) in the selected districts. The chapter also presents what was derived from the focus groups conducted with the Programme Managers from districts and a focus group discussion conducted with the M&E Officials in the Head Office. The chapter also presents how data analysis was conducted using qualitative and quantitative approaches. Data analysis involved attaching meanings and significance to the analysed findings as they emanated from analysis of data collected. The analysis also covers the excerpts elicited by the participants during interviews and focus group discussions.

In the chapter, data is categorised according to specific objectives and research questions that the study attempted to answer. Presentation of data in this chapter does not follow the sequence in the protocol, the questionnaire or the interview guides. Instead data that address a particular theme in accordance with the study objectives and the research questions are presented together.

Simultaneously with the data presentation, the chapter will also present the analysis and interpretation of the data that is presented. Analysis involves giving an account of the phenomenon that was studied using thematic categories. This shows that qualitative designs data analysis involves familiarising with data and breaking it down in the themes and categories and rebuilding it up in order to elaborate on it and interpreting it (Terre

Blanche, Durrheim and Painter 2006: 322). The analysed data presented in this chapter is interpreted.

Some researchers prefer that the chapter for presentation of data is separated from the results so that readers can examine data and come with their own conclusions. There is no hard and fast rule for this; as in any method taken it is only through interpretation of data where the researcher can make relations and expose processes underlying the findings (Chilimo 2009: 286). The process of interpretation also involves relating the findings of the study to the current theories and finding if they are consistent with them or not.

The purpose of this study was to critically review how the KwaZulu-Natal Department of Health M&E System was performing; how the M&E system was used to improve the Departmental performance towards reaching its goals and objectives; and the extent to which good governance had been achieved. The following specific objectives were outlined for the study:

1. Examine the M&E governance arrangements nationally and provincially within the DOH;
2. Critically examine the extent to which M&E is being compiled with in the DOH;
3. Establish the level of commitment of the senior management towards the implementation of the M&E Framework and use it as a management tool
4. Evaluate the M&E capacity of the senior management in the DOH;
5. Explore challenges and remedial actions towards improved utilization of the M&E information policies and their implementation; and
6. Determine facts to consider for the evaluation of the M&E system in the Department.

Based on the above objectives, the study compiled research questions and possible sources of data (Refer to Appendix 10: Research objectives and research questions).
The chapter begins with a discussion of the background of the respondents, though this did not form part of the study objectives. However, for relevance in keeping the flow of the argument in the thesis in Chapter Four, the characteristics of the respondents were presented in order to show if the population was appropriate and more likely to provide the required information that would answer the research questions.

5.1 Characteristics of the respondents

As mentioned above, identifying the characteristics of the study participants did not form part of the specific objectives of the study. Nonetheless, it is necessary to present this data to the reader in order to understand the background of the participants. The discussion of the characteristics of the study participants provides a picture on the suitability of the participants for the study. Understanding the background of the participants would shed some light on the factors that influence their function within the M&E system of the Department. This data was obtained from the participants' profile as the employees of the Department and during the interviews. Characteristics of the participants were discussed in four categories, namely:

1. The age of respondents;
2. Level of education;
3. Occupation of respondents; and
4. Involvement in the M&E activities

Table 5.1 below shows the demographic profile of the study participants of age, gender and their occupation or positions held.

Table 5.1: Demographic profile of respondents

Demographic Data	All Districts	Head Office	External Stakeholders
Respondents interviewed	8	12	4
Focus group discussions	8	2	-
Mean age	35	33	38
Basic literacy and levels of education	Matriculated	Matriculated	Matriculated and graduates
Occupation: N=84	Managers, Coordinators, Officials, DIOs FIOs and Data Capturers	Managers, Coordinators, Officials and Data Capturers	4
Clinical Managers;	68	24	0
Programme or Component Managers	70	10	1
M&E Managers	16	5	3
Involvement in the M&E activities: **Involved in reporting**	All	All	4
Involved in M&E	All	All	4
Involved in M&E and reporting			4

Characteristics of respondents and the implementation of the M&E System

This sub-section discusses the findings on the characteristics of the respondents and the implications of the findings on the implementation of the M&E system in the Department of Health (DOH) based on the study objectives and the research questions of the study. The discussion in this section will show the extent to which characteristics of the respondent that were involved in this study enhanced or hindered their ability to implement and use the M&E system of the Department.

Age of the respondents

Age is one of the characters that may influence the implementation of new complex programmes like monitoring and evaluation systems. The mean age of respondents in the Districts was 35 for the districts; 33 for the Head Office and 38 for the External stakeholders as shown in Table 5.1 above.

Erasmus, Van Wyk and Schenk (1998: 74) state that older people are resistant to change or are conservative. However, this is not the truth in all cases as according to these researchers there is no study that demonstrated a positive correlation between the two variables (age and resistance to change). It may only be physical abilities or deterioration that may impede the function as they approach retirement age. Referring to the mean ages of the respondents in Table 5.1, it could have no effect in implementation of the M&E system.

Literacy and the education levels of the respondents

It has been a widely debated phenomenon that the educated people “are not developed to meet the South Africa’s needs” (Erasmus, Van Wyk and Schenk (1998: 450). However, nurses are no longer admitted into the nursing profession without having matriculation. It is for this reason that more nurses have Nursing Diplomas and Degrees.

In the study all the respondents were matriculated as illustrated in the table. This level of education placed them in a better position to understand any interventions or programmes entrusted to them. This also applies in the other categories of the respondents.

Occupation of the respondents and involvement in new and complex programmes

In the interview guide the participants were requested to provide their occupation and their programmes. This was a closed-ended question and various occupations were provided by the participants. These were later grouped into 3 categories by putting together related activities. This was undertaken for the purpose of coding and simplifying the data. The categories were clinical, non-clinical and monitoring and evaluation. A separate category was created for participants involved in monitoring and evaluation. These comprised M&E Managers, District information Officers (DIOs), Facility Information Officers (FIOs) Data Capturers, and Officials engaged in reporting.

Nurses collect information from patients and write reports. The Data Capturers and other M&E Officials are involved in monitoring, and reporting enabling them to have a good understanding of their function. In this way all the respondents' occupation enabled then to perform in the field of study. They can be described "as both knowledgeable and prepared" to engage in the implementation of any new and complex initiatives (Erasmus, Van Wyk and Schenk (1998: 296).

Involvement of respondents in the M&E activities of monitoring and reporting

As mentioned in the above discussion the respondents were either involved in monitoring of their performance as programmes by collecting, collating and analysing data and or reporting to their supervisors at a level above them (if facility to the district and if district to the Head Office). Though some were not involved in the whole process,

but they were involved in one way or another as mentioned. This made them relevant for inclusion in the study.

5.2 Process of data analysis

Data analysis is a process of bringing order, structure and meaning to the large quantity of collected data. According to Mngomezulu (2009: 105) in qualitative research data "analysis involves consideration of words, the, context, non-verbal cues, internal consistency, frequency, extensiveness, intensity and specificity of responses" This refers to narrative analysis where meanings are attached to experiences; where participants give their own interpretations and explanations of events.

It is necessary to have sufficient data as Ibrahim (2012: 8) states that pertinent data enables "governments, citizens and civil society organisations to assess the impact of policy interventions, guide resource allocation and learn from the successes and failures of others "

Data collected for the study was not much such that a software programme to categorise it was not necessary. No Microsoft programme was used to analyse the qualitative data collected. The analysis was conducted manually. The approach adopted was the identification of descriptive patterns, and looking for relationships and linkages among the descriptive dimensions. Such patterns were categorized into experiential themes for each participant as identified in each interview and focus group discussion. The experiential themes were further sub-categorised into themes and were used in data analysis.

5.3 Thematic presentation, analysis and interpretation of data

These experiential themes and sub-themes are displayed in Table 5.2 below.

Table 5.2: Themes and sub-themes

Experiential Themes	Sub-themes
5.3.1 Governance and M&E arrangements Nationally, Provincially and Departmentally	• Structures effectiveness and efficiency of the Departmental M&E system • Knowledge and understanding of Government-wide M&E system by senior management • Mandates that prescribe the use of the M&E system in the Department • M&E capacity of senior management to efficiently and effectively drive the DOH mandates
5.3.2 Compliance with the M&E Framework	• Opinions on the Departmental M&E system in general • Knowledge of and attitudes towards the Departmental M&E Framework • The M&E Reporting system as based on the M&E Framework • Evidence of the Health Information Teams and their role
5.3.3 Senior Management commitment to implementation of the M&E Framework and use as a management tool	• Management role played in the implementation of the M&E Framework • Evidence of programme specific M&E Implementation Plan and the process followed
5.3.4 M&E information use	• Data quality and measures to ensure data quality • Importance of the M&E information and its usage in a Department
5.3.5 Challenges and remedial action - Evaluation of the M&E System	• Challenges in the M&E system • Review of the current M&E system – elements to include in the revised M&E system

5.3.1 Experiential Theme 1: Governance and M&E arrangements Nationally, Provincially and Departmentally

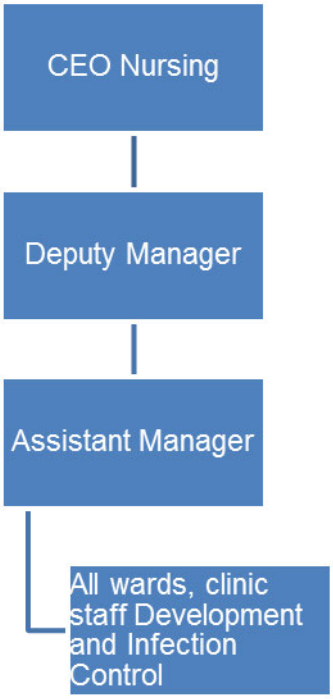
5.3.1.1 Sub-theme: Structures effectiveness and efficiency of the Departmental M&E System

When the manager for Corporate Governance was asked about her opinion of the Departmental M&E System the response was that it was necessary to redefine the role of the M&E Component in the Department. It was stated that almost each Programme or Component had its own M&E staff and that the M&E Component did not have to involve itself in the monitoring of Programmes and Components as it was the Programme Managers' (PMs) responsibility to monitor their own programmes and Components. This respondent added that,

> *"The M&E capacity is not enough to drive the M&E implementation forward; instead you are doing the PMs' responsibility of monitoring their programmes".*

A document review of eight hospitals within eight visited districts supported the report obtained from the focus group discussions conducted in the districts. The eight hospitals had the M&E Managers and FIOs who were responsible for implementing the M&E System. The following diagram shows the hospital organogram that does not mention the M&E structure.

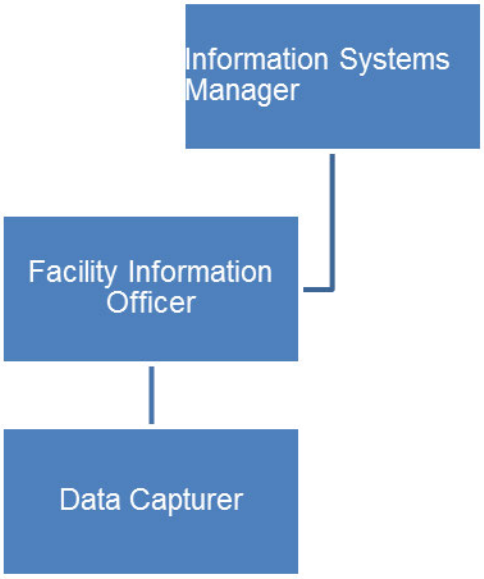
Figure 5.1: Hospital organogram/structure



The above figure shows a hierarchical position, the Assistant Manager (M&E Manager) who is designated to function as an M&E Manager at facility level. As the Assistant Manager is the M&E Manager as well one of her subordinates is the Facility Information Officer (FIO) who also performs the M&E functions. From this diagram, it is evident that the FIO involved in M&E function is not part of the organogram.

Shown in the following diagram is also another structure which is related to M&E but parallel to the one above.

Figure 5.2 Hierarchical post of the Facility Information Officer



The above figure shows a hierarchical position of the Facility Information Officer (FIO) who is designated to function as a data manager at facility level. Like the organogram above it is evident that the M&E Manager is not part of this organogram and the FIO directly reports to the Systems Manager and reporting to him/her are the Data Capturers.

The eight districts' reports showed that there were only three hospitals having a hospital organogram. However, in the hospital organogram the M&E structure was not incorporated. Four out of eight hospitals did not have the M&E structure and in one hospital the participant was not sure what the structure was supposed to look like. It was mentioned in the previous chapter that the M&E Managers in the hospitals were previously Clinical Managers and were seconded to the M&E position without changing their job descriptions of managing the Infection, Planning and Control and the Quality Assurance and Control Programmes. This meant that their responsibilities were not aligned to the M&E function. In addition to this they were involved in Planning, Fleet Management, Infrastructure, Human Resources Management and Finance which were

the Nursing Manager's functions. They also had to perform Data Management functions. This caused them not to fully dedicate themselves in the M&E management function. The mentioned multitasking impacted negatively on the implementation and the effectiveness of the M&E system; the multiple functions were more than what they could manage.

In response to their functionality as M&E personnel, two of the hospitals were not sure of what the M&E functions constituted. One of the eight hospitals did the internal arrangements with the Chief Executive Officer (CEO – the Hospital Manager) and modified the M&E Manager's job description so that the M&E Manager could perform the M&E functions. In the hospitals where this initiative was not taken, the M&E Managers continued to perform the Nursing Manager's functions to the expense of the M&E function.

The job descriptions of the FIOs were comparatively more aligned to the M&E functions. However, the FIOs were placed in the structure of the Systems Management, not in the structure of the M&E Management. Both structures ran parallel to each other though they worked together. The following organogram (Figure 5.3) illustrates this parallel functioning; and shows how the two separate portfolios (M&E Manager and FIO) forged a working partnership in Itshelejuba Hospital, in the Zululand District.

Figure 5.3: M&E Structure in the hospitals

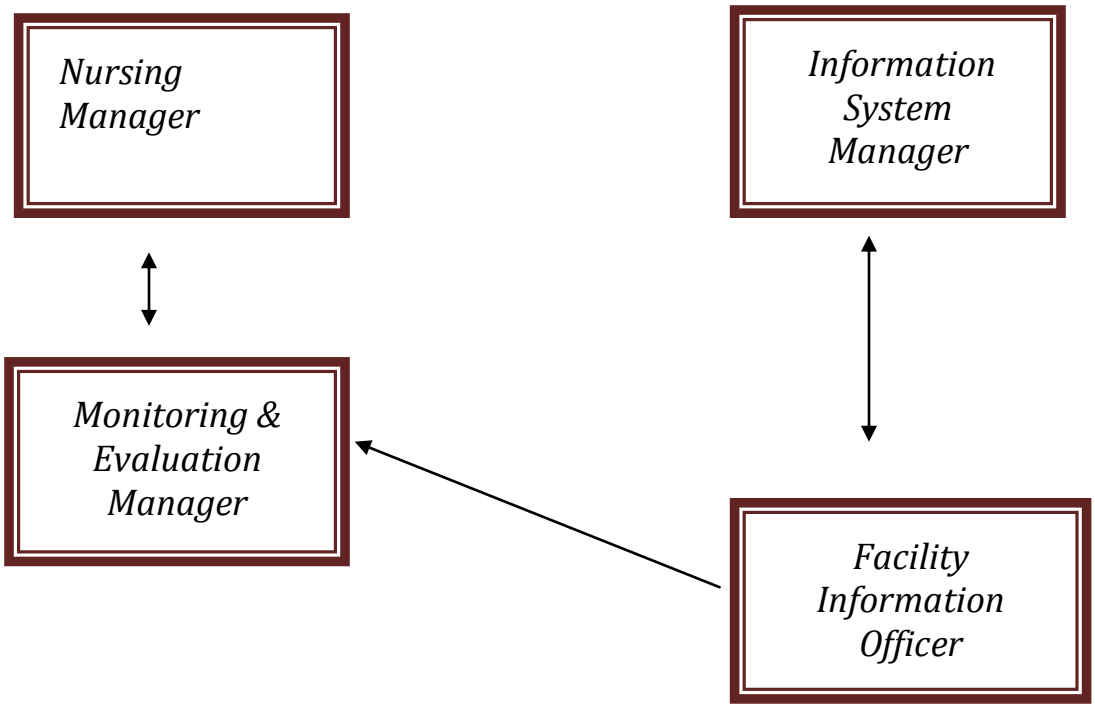


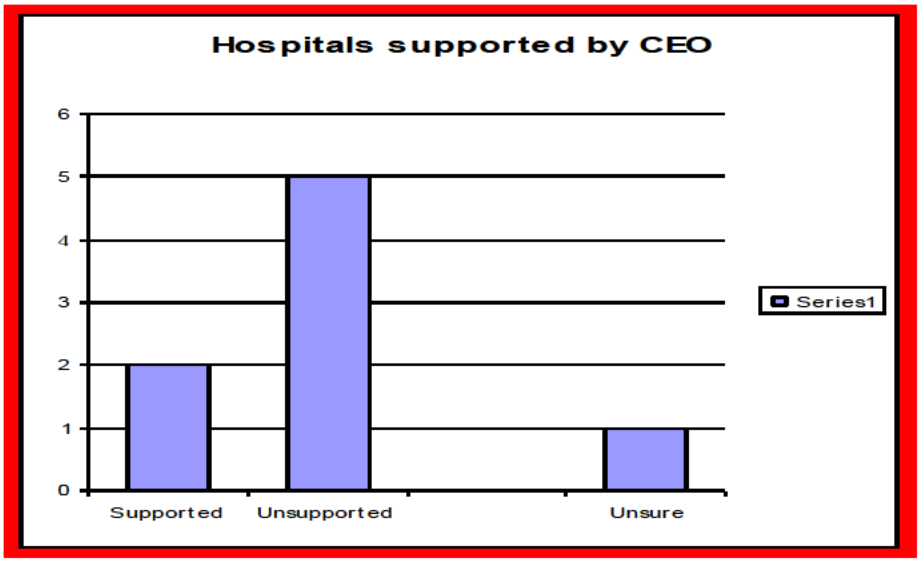
Figure 5.3 above illustrates that the parallel functioning is more vivid at the highest level of the directorates of the Nursing Manager and the Information Systems Manager. It shows that in the next level is the M&E Manager and lower down in the Information management directorate is the FIO who reports to the Information Systems Manager. The line of supervision is such that the M&E Manager is supervised and reports to the Nursing Manager. The FIO on one side reports to the Information Systems Manager and is supervised in this Directorate. On the other side the FIO reports to the M&E Manager for the M&E functions performed yet she/he is not supervised in this Directorate.

What practically happened on the ground with regard to M&E functioning is firstly to note that the focus of the FIO's line of function was on the technical aspects of information systems (computers) and not on the facility data. That is the reason why this structure

caused them to report to the manager in the Information Systems Directorate though they were involved in data information system/M&E as well. The participants expressed that this arrangement affected their supervision on data aspects as their Directorate was not involved in data. In this way, the FIOs found themselves performing the M&E functions unguided and unsupervised. In some hospitals where the M&E Managers showed interest in the M&E function, they 'adopted' the FIOs and worked with them though it was almost a blind-leading-the-blind fashion; as all of them were never trained on M&E. However, the FIOs are trained on the District Health Information System (DHIS) into which the Department data is captured and so have the understanding of data management (but not the M&E Managers).

The hospital CEOs are accountable for data collected in their facilities. They are then required to check their reports for accuracy and relevance and sign them off before sending to the districts. The following diagram shows hospital support from CEOs.

Figure 5.4: Hospitals supported by Chief Executive Officers



Evidence in Figure 5.4 above shows that out of eight hospitals only two hospitals were supported by the CEO; even though the reports from all the eight hospitals were signed

off. This means that the reports in six hospitals were signed without checking for accuracy and relevance. With regard to the M&E support provided to M&E staff, five hospitals reported not being supported and one was not sure because the hospital was not fully involved in the M&E activities.

One of the District M&E Managers said:

"The M&E structure does not only lack at facility level; it also does at district level"

Efficiency and effectiveness should normally involve the identification of gaps; developing interventions or plans of action to address gaps; drawing of monitoring plans and implementing their Plans of Action to address the gaps identified. One of the districts clearly outlined that though remedial actions were drawn for challenges or gaps identified, implementation of the plans was promised but monitoring of the interventions was not done. In the following reporting quarter the same challenges still existed and no progress was mentioned about them. The reason given for this kind of behavior was that monitoring and evaluation of indicators was regarded as the responsibility of the M&E personnel. Additionally, where the Programme or Hospital manager was supposed to monitor weekly, it was not done. They only monitored at the end of the month when it was already late to rectify deviations and provide outcomes for the next report. When quarterly reviews were organized and Programme Managers were invited to attend, they either did not attend or when they did, they showed lack of interest and did not partake in the discussions.

To explain this behaviour, one of the districts announced that they did understand that they should monitor their performance as a district, but that did not occur. They mentioned the lack of commitment as the cause where the relevant people did not do what was expected of them. At the same time, it showed that districts were not able to

ensure that monitoring of interventions was done, as the District Managers did not get fully involved – did not support the M&E Managers in monitoring of implemented strategies or interventions. This supported the fact that the staff members perceived that performance monitoring and evaluation belonged to the M&E Component and that it was this Component's responsibility to monitor what had been implemented.

Trends of the same challenges reported overtime

It has been mentioned that reporting is one element of the M&E System that has been followed to the book as reporting was done even before the inception of the M&E System in the Department. However, it is important to find out if the SOP for reporting according to the templates provided is closely adhered to. The following passage shows what deficiencies the reporting had in Q3 2009/10 – Column A. Simultaneously this is compared with what happened in Q3 2012/13 reporting – Column B three years later.

Table 5.3: Trends overtime

Column A: **Feedback on reporting in Q3 of 2009/10**	**Column B:** **Feedback on reporting in Q3 of 2012/13**
Targets • There were no targets (targets are crucial for monitoring performance); • Significantly exceeded targets – even 100% (150% etc.); • Too high/low targets that need to be adjusted according to performance in the previous Financial year (FY) using the achievement as baselines; too ambitious targets that cannot be achieved within a given timeline; • Missing data; • Too high achievements suspicious of inaccuracy.	To date some indicators are still having no targets even though there are baseline on which to develop new targets; Still having too ambitious targets that are not achievable; Data is still missing and no explanation provided; Achievements are still too high raising suspicions of inaccuracy or deliberately inflated data.

Column A: Feedback on reporting in Q3 of 2009/10	Column B: Feedback on reporting in Q3 of 2012/13
Narratives for data • There are still lots of blank spaces in some districts, i.e. no narratives provided; • Reasons for deviations from target were not spelt out - not even the under-performance; • Discrepant comments e.g. facility was 100% compliant but the comment says "elbow-controlled taps missing"; and • Should explain what is meant by "status quo remains same as previous"	Blanks spaces are still a problem as mentioned elsewhere in this chapter that data completeness is still a challenge; It is expected that deviations from the target either below or above target be explained, however, this is not always the case; Limited understanding of data elements/indicators still persists; There are still statements that do not tie up to the previous reporting.
Remedial actions • For some underperforming indicators remedial actions/plan were not provided; • The space also provides reporting on the progress of the previous remedial action planned or implemented; • Remedial actions for challenges are not entered; • Follow up on previous challenges are not made; • Incorrectly phrased remedial actions e.g. "Motivate to fill posts" – this is just a statement not an action plan; • For example, a comment on women with complications on delivery it was said: "Strengthen health education" – this is scanty information that does not tell what action to take, while action plans need be drawn and given timeframes for feedback.	To date the same challenge in reporting is still encountered – staff do not account for underperformance and do not explain measures that were taken or will be taken; Nothing is said about the progress on the remedial actions planned in the previous report – whether they were implemented and the progress; but the same challenges are reported over and over again. This means that the follow-up to the interventions or even the implementation are not undertaken. To date, phrasing of the remedial action that will be undertaken is not according to the SOP despite several feedbacks given to the Managers on this issue.

Column A: **Feedback on reporting in Q3 of 2009/10**	Column B: Feedback on reporting in Q3 of 2012/13
Reporting • Reporting should be made in context: multivariate analysis should be practised e.g. increase in sexual assault cases; age of survivors of sexual assaults; whether prophylaxis was given; report on availability of trauma centres to help survivors; most affected geographical areas; living conditions in these areas and availability of resources, e.g. South African Police Services and other Departments/organisations. **Examples of ongoing challenges** • PHC structure and restricted resources • There is a general increase in incomplete abortions against observed reduced contraceptive intake - what to do?; • STI partner treatment rate is still significantly low – what to do?; • Sexual assault cases are escalating by the quarter including children under 2 years – what is being done?; • Prophylaxis is comparatively lower than the survivors – what is the cause? What to do?; and • Development of a system of Early Warning Signs from the common adverse events.	Reporting still shows lack of insight in analysis. For instance the majority of district PMs still provide reports on data elements in silos – not in relation to the bigger picture (multivariate reporting) as shown in Column A; The same challenges are still reported without providing the actual remedy to combat the problem; and The same challenges that were there in 2009/10 given in Column A of on-going challenges still prevail even today and no very minimum, if any, interventions are planned to address them;

The above table shows that the trends of challenges that were experienced since 2009/10 have not changed even in 2012/13. This emphasises the fact that there are some deficiencies in adhering to the requirements of the M&E Framework. Feedbacks are one of the incentives the M&E System normally uses to improve performance. If in three years down the line things have not changed could it be said that the M&E System of the Department is effective?

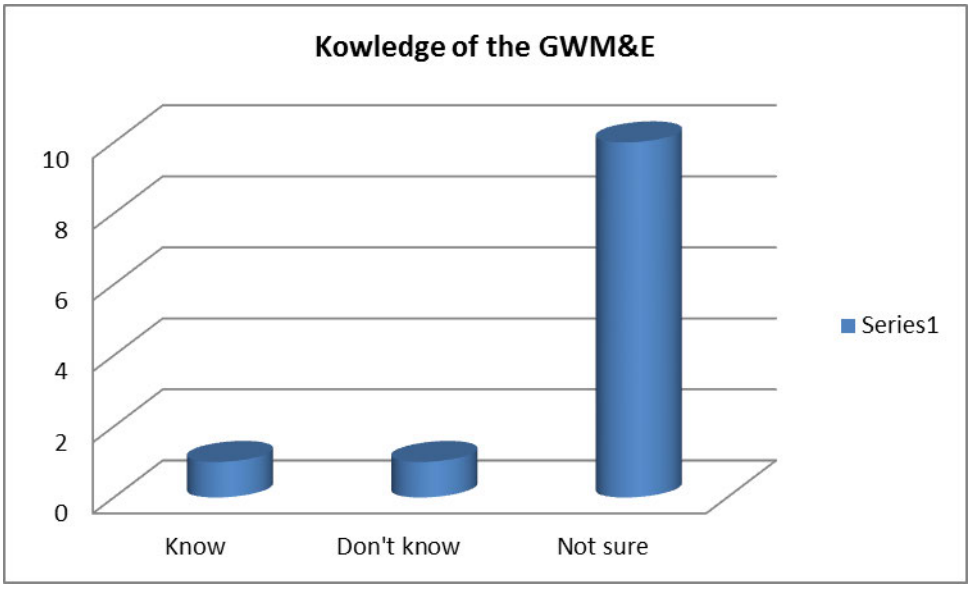
5.3.1.2 Sub-theme: Knowledge of the Government-Wide M&E System its tenets/assumptions.

Some elements of good governance used to check knowledge and understanding of the Government Wide Monitoring and Evaluation Policy Framework (GWM&E); its principles and application to the work environment were accountability, transparency and consultation or inclusion. These do not only apply to the customers but also to service providers particularly at management level. During data collection lack of consultation was mentioned by all districts as one of the challenges that affected proper M&E functioning. For instance, indicators collected for programmes were monitored at district level but a complaint raised by districts was that when indicators and data elements were changed at provincial level there was no consultation or they were not involved in the process by the Province. The blame was aimed at the M&E Component at Head Office.

Apparently there was confusion of processes where the blame was aimed at the Provincial M&E Component. This blame showed the lack of understanding of processes and procedures, as owners of programmes (That is, Programme and Component Managers at Provincial level) had ownership of the programmes and were, therefore, the ones who could make additions or omissions to their programmes. Another mentioned confusion raised by the district respondents was that the M&E Component did not provide indicator definitions together with the new indicators. Once more this was a mistake as there had been a trend that when PMs at provincial level added new indicators they did not provide definitions for the new indicators with the result that the new indicators were listed without proper indicator definitions and calculation methods. It was the responsibility of the PMs at Head Office as the programme owners to provide a facilitative role in this process, but such processes and procedures were not communicated to the PMs at lower levels; hence the blame to the M&E Component.

When the twelve managers were asked about the GWM&E System Framework ten had heard of it but they were not sure what its purpose was and they could not mention its tenets or assumptions. One manager admitted having never heard of it and one did know the GWM&E though could not mention its principles or tenets. The following figure complements this analysis.

Figure 5.5: Knowledge of the Government-Wide M&E Framework Policy



This picture shows that the respondents had never bothered to read it as some were even asking where to find it and about its relevance to the Department. Having never read the GWM&E Framework implied that they had never read the Departmental M&E Framework either, as the latter made references to it.

This confirmed that training or workshops to introduce the Departmental M&E Framework were never conducted. Otherwise the staff would have been oriented on the GWM&E Framework simultaneously.

5.3.1.3 Mandates that prescribe the use of an M&E system in the Department

When the Manager for Corporate Governance was asked about how Governance was ensured in the Department in response she gave the governance structures that existed in the DOH, namely: the Hospital Boards, Clinic Committees, Legislation or legislative mandates: Health Act, Mental Health Act; District Council Provincial Health Council, Provincial Health Technical Committee, Audit Committee, Audit and Risk Committee – for Finance, the Standing Committee on Public Accounts,, Health Portfolio Committee to mention but a few.

Accountability: The employees account to all of the mentioned structures and adhere to all their prescripts. Boards are included in the Standing Committee on Public Accounts meetings work with District Management Committees; regarding inclusion of the Boards/Committees – regular meetings are held with the hospital management and there are prescribed activities that they need to follow; they are also trained in order to help them with governance issues. They are also invited to the annual Health Summits, invited to the MEC's Budget Speeches and need to adhere to all legislation.

In response to the question of how compliance was monitored, the response was that the Component does not monitor the implementation but monitoring was supposed to be conducted by the Quality Assurance and Control Component, which is under the Hospital Services Unit.

The mandates that guided the function of the Department included Chapter 10 of the Constitution of the Republic of South Africa of 1996. The Department of Health Workplace Good Governance and Ethics document (2009: 42 and Rossouw 2012:16) imply that the Batho Pele Principles should be applied in day-to-day functioning of the Government Employees. These include but are not limited to consultation where clients

Are asked what they want and finding out how their needs can be met. The Service standards for rendering the services accordingly based on the clients' needs are followed. All the people need to access services including the disabled children the aged and those living in the remote areas.

When asked to describe her Component's role in the implementation of the M&E System, the answer was as follows:

> *"Which M&E - your M&E?"* and continued *"There is no direct involvement as M&E focuses on the clinical side and monitors the clinical indicators. I don't know how I need to interact with you"*

When asked about the quarterly report submission her programme was submitting every quarter (To the M&E Component), she did not even know that the template she used quarterly for reporting was from the M&E Component; and that she was reporting to the M&E Component. What she knew was that the report she submitted quarterly was to the Strategic Planning Component. She said:

> *"I report towards the APP"*

Checking this in the Quality Assurance and Control Report the template that had the indicators monitored by this Component had no indicators to monitor compliance to any other policies either than Compliance to Infection Prevention and Control; Client satisfaction Survey, Waiting Times Survey and Compliance to the National Core Standards and the Complaints resolved. Additionally the Quality Assurance and Control Component was expected to monitor the established Hospital Boards and the Clinic Committees. Evidence of these was monitored but their functionality was questionable As there was no reporting on the content of their meetings let alone the follow ups on any plans or resolutions that might have transpired during such meetings.

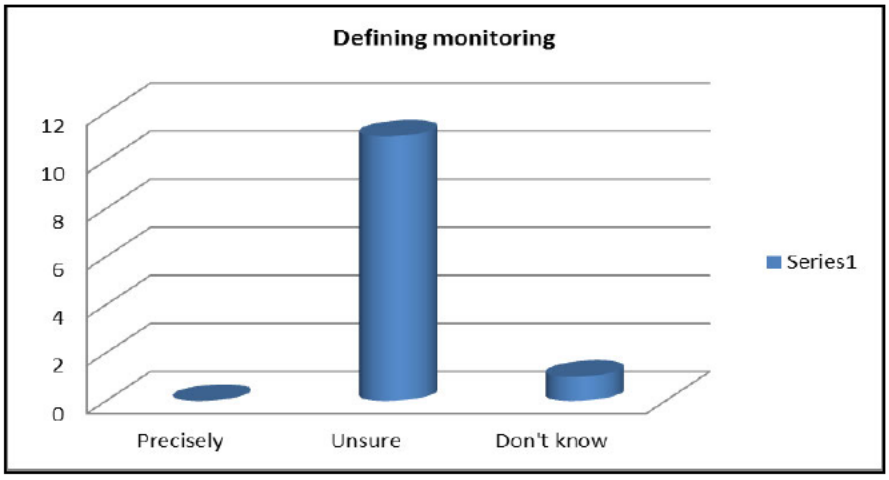
The Manager mentioned several policies regarding corruption, use of official transport and subsistence and travel, use of resources - equipment and stationary (computers, telephones, stationary, absence from duty), whistle blowing, exiting from the service and others, as existing but their monitoring was not undertaken.

5.3.1.4 *Sub-theme: M&E capacity of efficiently and effectively driving M&E*

It was discovered that in order to build or strengthen the M&E capacity amongst the district M&E staff the Provincial M&E Component conducts quarterly meetings. This was according to the M&E Framework. The District Deputy (M&E) Managers, M&E Planning Managers and the District Information Officers were summoned to assembly in a district venue of their choice and the agenda for the meeting was jointly decided by both the Districts and the Head Office M&E Staff. The M&E quarterly meetings provided an opportunity to mentor the District M&E Staff. The challenges they encountered during their M&E function and solutions thereof were discussed.

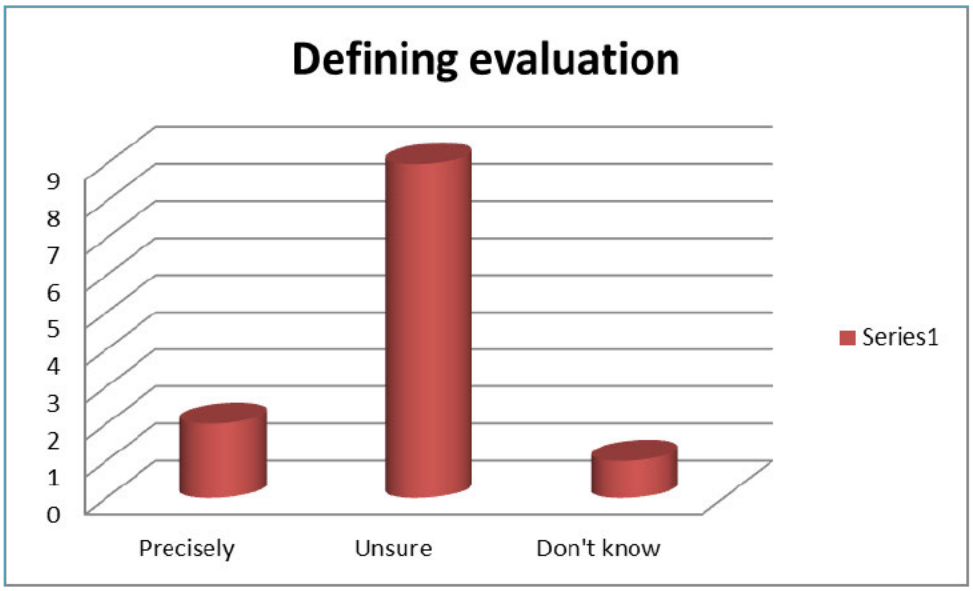
The following diagrams show how much the Managers understood the M&E concepts of 'monitoring' and 'evaluation'

Figure 5.6: Defining monitoring



Out of 12 respondents interviewed no one precisely defined monitoring; though 11 mentioned several words but they were obviously not sure of the definition; one respondent said outright that he did not know what monitoring meant.

Figure 5.7: Defining evaluation



In the above diagram the understanding of evaluation was comparatively better than the understanding of monitoring. Two respondents precisely defined evaluation while nine were not sure and one did not know.

In response to the question on capacity one of the respondents in one district in a focus group discussion mentioned that capacity starts with the programme Managers to look at themselves and answer the question:

"Do I have capacity to develop tools to assist me in my programme?"

Apparently there was only the basic understanding of M&E as most managers at facility level did support reporting (as one aspect of M&E). Reported was a lack of detailed conceptual understanding of M&E coupled with no understanding of indicators, their definitions and measuring of performance against targets; how the M&E tools are developed and their relevance to their programmes. It was admitted that there was a gap between knowledge and practice as the little M&E knowledge they had could not be put into practice. To address this it was stated that training needed to be conducted before people were expected to monitor such indicators.

It was also reported that there was never any training on data collection tools. As a recommendation the Zululand District echoed what was said by other districts that training was required at all levels; that it was required to identify the people who would be responsible for training and be made part of the planning team; that adequate number of people needed to be allocated to drive the M&E forward. The CEOs must be trained on M&E; it must be formalised that the M&E Managers and FIO have appropriate job descriptions and the structure be correctly aligned. The M&E should be made one of the training modules in training colleges. This meant that the training manuals in the colleges be aligned with Public Administration Leadership and Management Academy PALAMA - a National official training body for the government. It was also recommended that the key results areas (KRA) at all levels should include M&E. Evaluation of each institutional performance should be conducted by a provincial body that would work with a district Team where a few data elements are selected for performance evaluation. It was also recommended that benchmarking on best practices from the Department of Education be undertaken, for instance, benchmarking on the DOE Policy for incentivising for best performance; and sanctioning for non-compliance.

In the focus group discussions all other districts confirmed that the M&E capacity was limited as M&E training had never occurred at any level. That is, senior management and data collectors at clinic level were never trained. Those who admitted having been trained on M&E reported that they were not trained by the M&E Component from the Province or district but obtained the basic knowledge from modules from their degrees or diplomas. They agreed that, that kind of knowledge was too general and therefore different from training that one could obtain in relation to their jobs. It was evident that applying the knowledge obtained in this manner was not easy for them making it difficult to apply the skills that they obtained somewhere else years ago. They explained that they were currently exposed to the M&E functions, which did not even have the adequate M&E processes. It also experienced more confusion when they were expected to monitor the indicators without even understanding their meanings and the method of data collection.

In addition to the above, these respondents felt that it was crucial to know why data was being collected, what the desired outcome was and the rationale for collecting such data. They said it would be encouraging to collect data knowing why it was important to do so. It was also mentioned here that training had not been carried out and it was a challenge for them to ensure that there was accuracy in data; and if collected data would make any sense. Besides the lack of training on tools and processes they had never been trained on data collation, analysis and interpretation so that people could see the variations in their performance. In this case, they captured the data that they could not analyse.

One of the respondents announced that in general the same people were sent for training over and over again. On their return they did not come up with implementation plans for what they were trained for – not even a report on the content of the training or training material. When asked them about the training policy and the training procedure which stated that they needed to come back and present what they had leant and

provide the material obtained, it was revealed that to their knowledge there was no such policy; and if it was there it was not followed. It was clearly stated that it was the responsibility of the M&E Component to monitor the implementation of policies within the Department and that the structure and the environment within the clinics was not conducive to people complying with the legislature. Some agreed that the Quality Assurance and Control Monitoring Component should also be looking at compliance with the policies and the M&E. It was expressed that:

"In facilities they do not understand – they need to be made to understand M&E".

This was expressed by a Programme Manager in the District. The Districts Programme Managers did not see it their responsibility to capacitate the staff at facility level; rather they saw it as a responsibility of the M&E Component at the Provincial level. It was evident that there was no overall understanding of policies: how to apply and monitor their implementation.

5.3.2 Experiential Theme 2: Compliance with the M&E Framework

5.3.2.1 Sub-theme: Opinions on the Departmental M&E system in general

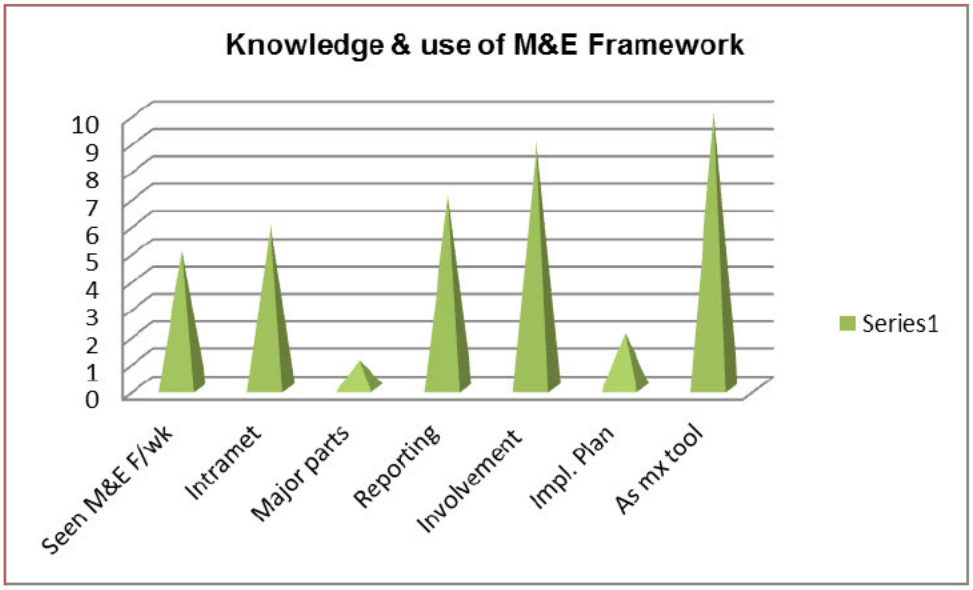
A focus group discussion held with the Middle Management Service (MMS), and Assistant Managers and other staff members involved in data and reporting in the Head Office, had utterances that had an attitude with the following meaning:

"W*hat is this Departmental M&E System about as it is not known?*"

The respondents said that the Departmental M&E system was never introduced to them; and that it was not aligned to other Components in the Department. They did not know its plans and principles; and they did not understand the M&E concept. They said there was a gap between theory and practice, which in turn caused a gap in the M&E implementation.

In the following diagram several variables were used to explore the respondents' knowledge and use of the M&E Framework.

Figure 5.8: Knowledge and use of the M&E Framework



Out of 12 respondents five had seen the M&E Framework; 6 out of 12 said it could be accessed in the intranet; only one respondent could mention at least three major parts of the Framework; out of nine respondents who said were involved in reporting only seven followed the reporting system outlined the Framework; two respondents had their programme M&E Plans based on the Framework; ten out of all managers interviewed said they regarded the M&E System as a management tool.

Furthermore, five out of twelve Senior Management Services (SMS) Managers interviewed repeated what the Provincial and other focus groups have said – that they had never heard of the M&E Framework being referred to at any level. To them, the staff just saw their daily work as routine work – with no relation to the implementation of the M&E Framework. They said:

"The staff members detach themselves from implementing the M&E system. They perceive it as "theirs and not ours"; and therefore not seeing it as a guideline to their routine functions. They also did not see the problems identified as being related to M&E; for advice people have a 'do not care' attitude towards their wrong actions"

One of the Programme managers who had seen the M&E Framework said that in his opinion:

"The Department was not ready to implement it yet and that the Framework and the M&E System should be disposed of as it is abstract – it is too far-fetched, so that a very simple and practical M&E Framework be developed – which would be closer to what is happening; An M&E Framework that would provide guidance to what needs to be done in the KZN DOH; that would motivate thinking on moving from monitoring to evaluation in achievable milestones".

The same question about their opinion on the mainstreaming of the Departmental M&E system in the districts was asked. The Programme Managers in all districts unanimously said that the system was not well structured; there was poor introduction of M&E from the onset resulting in both the clinical and the non-clinical staff not knowing what was expected of them. They did not know their M&E roles and responsibilities. Six out of eight districts said that the whole concept of M&E was not understood, which was detrimental to the buy-in from all concerned. They said that the M&E concept must be clarified. As it was, they felt that they had been pushed into a "fast moving car".

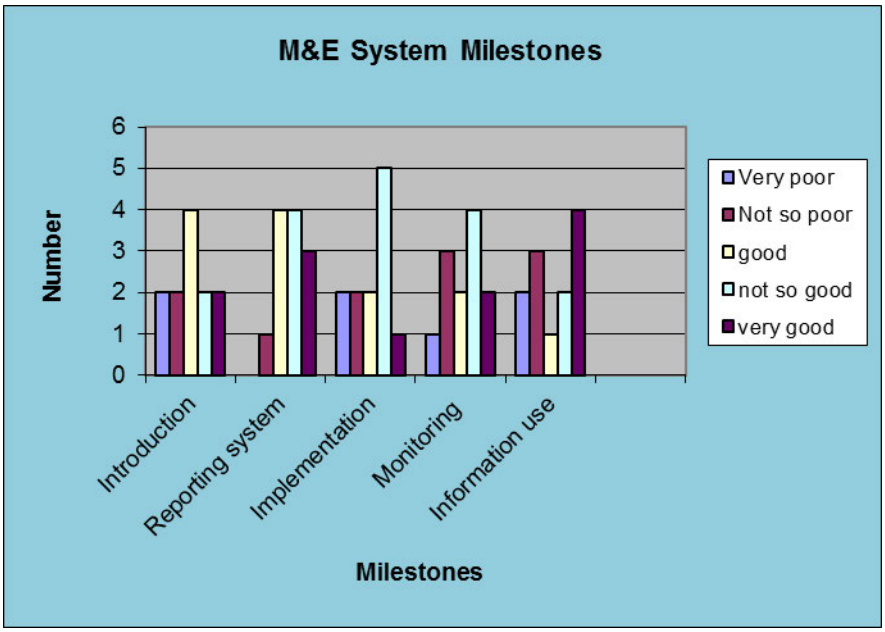
"There is no synergy between the districts and the facilities such that problems arising at facility level are not addressed. This is due to M&E not having cascaded to the facility level"

It was also mentioned that:

"The focus was to the districts while sidelining excluding the facilities".

The emphasis was that this approach resulted in having no buy-in from the majority of the managers.

Figure 5.9 Milestones on implementation of the M&E System



All the respondents suggested that before implementing the M&E, they should be fully capacitated so that they are able to implement correctly. They said:

"As for us (at the Province) we are not sure of our role; we need guidance from the M&E Component"

One of the Programme Managers said that she was not proud of the quality of the reports they generated. It was also mentioned that the Programmes in the districts and facilities collected scanty data that did not give the full picture of the programme performance. It was expressed that they did not understand the role of the Strategic Planning and M&E Components. There was also confusion to understand the communication lines between the provincial M&E Component and the National M&E Component.

The Mental Health Programme is an example of the few programmes that expressed their dissatisfaction with the number of data elements that they monitor, complaining that these do not give a picture of what is happening on the ground. The following diagram shows the only indicators that the Mental Health Programme is monitoring.

Table 5.4: Programme with scanty data

Mental Health Programme
Number of Provincial Hospitals with Psychiatric Units (Defined as a separate ward with 25 – 30 beds)
Number of District Hospitals providing 72 hr assessments
Number of hospitals (regional/district) with seclusion rooms
Number of mental clients staying more than 72 hours

The Mental Health Programme mentioned that these data elements do not provide the number of suicides committed and their causes; intoxicating substances use and their types; proportion of clients rehabilitated and more. They expressed the importance of monitoring all the data elements and indicators as they are the source of most unrest in the community.

The M&E Component stated that as much as their concern was valid but this was merely passing the buck again as the programmes belonged to the PMs; and they are the ones who should decide on what they wanted to monitor and report. In all it showed that the PMs in the Province were not working closely with the PMs in the districts. Their role as PM at Head Office was to communicate with the District to guide them as to what data was required for collection. They should not depend on the M&E Component to guide

the PMs on what data they needed to collect as programmes were managed by PMs not the M&E Component.

5.3.2.2 Sub-theme: Knowledge and attitudes on the Departmental M&E Framework

Understanding of M&E as a discipline and the buy-in of CEOs was poor because the M&E System was least recognized as a discipline owing to lack of its understanding. When given feedback the staff became defensive. In one hospital the District M&E staff were not welcome. They had to return to the district having not met with the relevant hospital staff as they did not show up for the meeting which was prior arranged and acknowledged. When asked for the reason for not attending, the response they received was that "they were busy". In interpreting this deed the district giving this report said that "it was clearly not only about the lack of insight but it was also the attitude"

The knowledge of the M&E Framework cannot be overemphasized as it was also presented in Section 5.6.1.2. One respondent at UGu District mentioned that she did understand the generic framework but did not understand why they were required to monitor such confusing data elements. She made an example that in the Mother, Child and Women's Health (MCWH) Programme the Paediatric World Health Organisation (WHO) provides the guidelines for which the Province does not give clarity on why reporting needed to be made on such indicators and how to monitor them. It was expressed that:

> *"We need a dictionary that clearly defines the data elements – we need training"*

The district kept on mentioning that the Programme Managers in districts and facilities did not know their M&E roles and responsibilities as they had never been told. Their attention was drawn to the relevant section in the M&E Framework – that have roles and

responsibilities of all levels in all components and at all spheres of the Department. They admitted that they had never read the Framework. As this was mentioned by the districts it meant that even at this level the people who were fully involved in the development of the M&E Framework did not read after it was finalised. The Districts provided Quarterly Reports on the Implementation Plan but they did not even know that the mere Implementation Plan they reported on was the Annexure 1 of the M&E Framework. It showed their state of mind regarding M&E as they requested that training on the Framework should be undertaken. Furthermore, the M&E System was accused of causing tension so that the working relations amongst workers had soured because of the existence of the M&E System and its Framework.

In this regard it was evident that there was little compliance to the prescripts laid down in the Framework. For instance, how could people comply with something they had never seen or read and obviously did not understand? The only part of the M&E Framework that they complied with was the reporting. The clinics reported to the hospitals, which in turn reported to the districts. The districts reported to the M&E Component and their respective Components at Province. At the Provincial level reporting to the M&E Component was not done by all Programmes/Components though.

When reviewing the reporting documents, it was evident that the status of reporting of the 30 Programmes over the last six months was not according to the requirements of the M&E Framework. For instance regarding frequency, out of 30 Programmes and Components only seven reported regularly, timely and without being prompted. The rest of the PMs and Component Managers either reported after being prompted or ended up not reporting at all; or reported when they wanted to. Reports that were submitted by some of the PMs lacked necessary narratives and they blamed the districts for not explaining their performance.

On the other side the response from districts clearly showed that they did not read the guidelines on reporting. Their reports lacked narrative explanations which could be due to lack of understanding of some of their data elements or lacked calculation skills. However, it was discovered that there are guidelines that come with definitions and all explanations regarding the data elements, how to measure them and why it is necessary to collect and monitor such data elements and indicators.

When their attention was drawn to this they said that this occurred because of lack of supervision due to lack of clear roles and responsibilities. There was lack of communication caused by the existence of two structures with FIOs reporting to both the Systems Manager and the M&E Manager was said to have caused this confusion.

> *"If the two parallel structures can sing the same song - they can work well together; but as it is now they are working parallel"*.

It was also mentioned that other nurses were not interested to know what M&E was about; they do not ask for clarity when having challenges. Though this point was presented in Section 5.6.2.1, it required mentioning here as it causes negative attitudes towards the implementation of the M&E System in this Department. Seemingly, there was a red thread that ran through most of the challenges and which went back to the way the M&E System was introduced (having had no workshops on the M&E Framework) and driven through all the Departmental spheres.

When asked if they had seen the M&E Framework, some agreed, some seemed confused and a few denied having seen it. When asked about the parts of the Framework they think were more crucial to their work, none of them seemed to know. They supported themselves by saying there was no formal training on the M&E Framework. Some agreed that to them the M&E Framework was as if it belonged to

certain people – mentioning the M&E Manager by name. They agreed that this picture trickles down to the lowest levels where M&E was seen as the responsibility of certain people.

When asked about the implementation plan which they monitor and report on quarterly the response was:

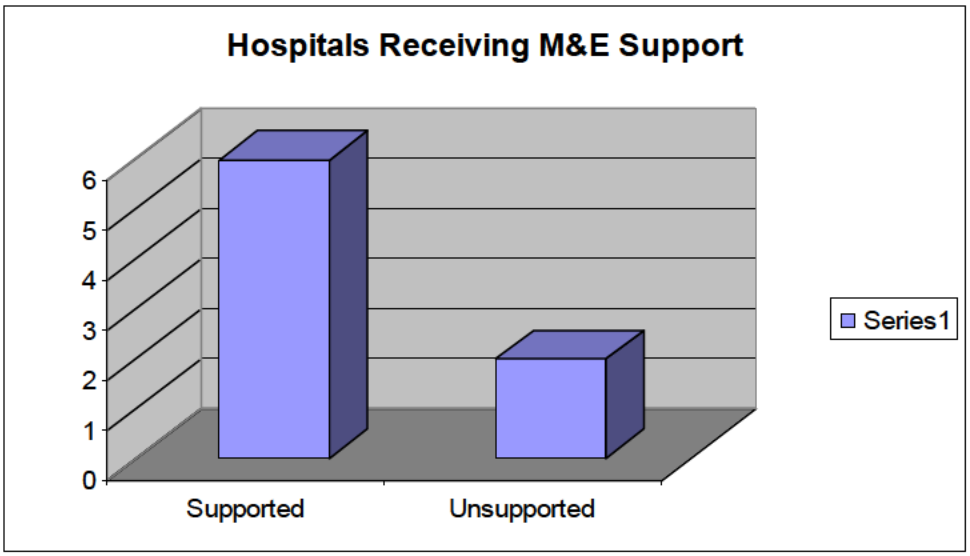
> *"There is not enough understanding of these processes. There must be training in order to make people understand them"*

This clearly showed that though there were attitudes towards M&E system, knowledge on this system, its process and procedures was inadequate. This caused one to think of the accuracy in the reports they generated on the Implementation Plan.

When the respondents were asked which parts of the M&E Framework were helpful in managing their programmes, it was not easy to answer as the majority had not seen the M&E Framework. There was, however, a general understanding that the reporting system formed an integral part of the Framework. On further probing there was an assumption that at all levels support and the existence of the Health Information Teams (HIT) were crucial. The M&E Managers in the districts stated that there was very minimal support from the no-clinical Programme Managers as the perception was that the M&E System was only meant for the clinical programmes managers – not both the clinical and the non-clinical programmes.

Regarding M&E support provided to the Facilities by the Districts the following diagram shows this information.

Figure 5.10: M&E support to hospitals



The reports showed that out of eight hospitals, the district M&E support occurred in six of them. These hospitals admitted having regular support visits from the districts. However, when prompted for the purpose of the visits and their content, it became evident that these were just routine visits - not necessarily the visits aimed for M&E support. This was supported by seven hospitals that reported having never had any M&E training from the districts. It was only one hospital in one district that admitted having been trained on M&E by the district. This then means that the District M&E support to the Facilities is very scanty and because of lack of M&E knowledge the facility personnel visited could not distinguish between M&E discussions and the routine discussions. It also reflects back to the District M&E staff that the objective of their visit is not made clear to them.

With reference to the introduction of the M&E System in the Department respondents at both the Head Office management and in the focus group discussions in the district revealed that the introduction of the system was poor from the onset. This resulted in employees not knowing their role as they did not understand even the M&E concept; tools keep changing and there were no Standard Operating Procedures (SOP) as to how

to use the tools as well as the lack of clarity of procedures. It was also said that the M&E System was also not functional.

5.3.2.3 Sub-theme: Reporting System based on the M&E Framework

Reporting

The Submission rate of the Districts Quarterly Progress Reports (DQPR) was observed for Q3 of 2012/13 from the records. Reporting was due on the 25th January 2013. It was critical to have these reports on due dates as the Provincial Report to Treasury has tight deadlines that are not negotiable. The following table is the DQPR Reporting Template:

The selected districts were reviewed against the following data quality assessment criteria:

1. Timeliness; whether data was submitted according to the required timeline in the schedule and frequency in order to meet programme management needs. Reporting was expected by the end of the month after the reporting quarters.
2. Completeness: There are a number of indicators or data elements for monitoring and reporting. These are submitted together with narratives that provide the qualitative data analysis. A complete report has all the data fields entered and the narratives provided accordingly
3. Accuracy: this is about identifying the incorrect data and deviations that are way above or below the expected performance against the set target. Amongst other methods to ensure accuracy, it is to compare the performance with the targets the trends overtime and then note the deviations as mentioned.
4. Frequency: this refers to regular reporting as per requirement of the Department, which is quarterly in this case.

Compliance to the above criteria is demonstrated in the table below:

Table 5.5 Reporting criteria

Reporting	Zululand	Umzinyathi	Ugu	UThungulu	Umkhanyakude	UMgungu-ndlovu	UThu-kela	Amajuba
Timeliness	28th	30th	26th	25th	25th	24th	25th	25th
Completeness	80%	85%	90%	92%	92%	95%	88%	97%
Accuracy								
Frequency	Qrtly	Qrtly	Qrtly	Qrtly	Qrtly	Qrtly	Qrtly	Qrtly

There were challenges experienced during quarterly reporting that included delayed submissions by some districts. Some of the districts that submitted their DQPR on time, later made changes to the initial reports and thus submitted 2 or even 3 versions of the report. Incomplete data on the expected indicators were also a challenge. The above table (Table 5.5) shows the following:

a) Four Districts were able to submit the QPR Reports by the due date.

b) The majority of Districts reported on most indicators but none reported 100% on all indicators. The districts provided sound reasons (No tools in place; not collecting data on certain indicators and newly developed indicators for which data was not collected yet) for not reporting and these were mainly beyond their control. For new indicators, it was reported that Programme Managers are currently engaging with Data Management for development of data collection tools.

c) In order to measure accuracy in all the district reports the same programme was selected, namely MCWH. Among other programmes MCWH was selected because of challenges that most districts show when reporting on it. Accuracy was measured by comparing the current data with the data in the previous

reports, that is trends and recalculate the suspicious data that had remarkable deviations.

d) What was discovered in this regard was that there was one or two discrepancies in all of the reports. This means that there was not one district that did not have an inaccurate data. This was rectified by the respective PMs with the respective districts.

e) With regard to frequency, all districts reported frequently on quarterly bases as required, though timeliness was still a challenge with some districts as illustrated above.

In general, reporting had improved in the second quarter of 2012/13 when comparing it with second quarter of 2008/09; and it was even better in Q3 2012/13. Almost all the Districts managed timely reporting. This includes data completeness, though data accuracy was a problem even before the inception of the M&E System. At that time it was expected that the revision of the DHIS from Version 1.3 to 1.4 would be a remedy to the quality of data but when Version 1.4 was introduced there was no change and the tune changed from blaming the DHIS Version 1.3 to saying Version 1.4 was even worse than the previous version.

Reporting Tools

The Data Management, Strategic Planning and the Monitoring and Evaluation Components routinely engage with Programme Managers to determine the core indicators for reporting for each programme based on the Annual Performance Plan (APP). However, the entire programmes' core indicators are selected by the respective PMs. The reporting tools are thus developed according to the reporting guided by these processes. The M&E Component designs and distribute to the relevant personnel the reporting templates or tools.

The District Quarterly Progress Reporting Spreadsheet (DQPRS)

According to the documents reviewed, the National Department of Health sets National priorities and goals and these are implemented by the Provincial DOH. In terms of the KwaZulu-Natal Health Care Bill Draft 11, 2007, Section 85, the Member of the Executive Council is required to prescribe minimum norms and standards for the delivery of health care services that all programmes are subject to monitoring, evaluation, assess impact assessment and report submission. The Districts' Quarterly Performance Reports (DQPR) is being used as a monitoring and reporting tool.

Table 5.6: DQPR Template

	Programme / Sub programme / Performance Measures	Q1 Total Provincial Target	Provincial Total	Zululand	UMzinyath	UGu	UThungul	UMgungun	Mkhanyak	Uthukela	Amajuba
	General - Fixed Data										
1	Number of Health Posts	57	44	37	2	0	0	0	0	0	5
2	Number of PHC Mobile service stopping points	2655	1644	174	230	298	173	213	254	208	301
3	PHC Mobile Bases	53	44	10	3	7	3	4	3	6	8

The Quarterly Treasury Report

The Provincial and the National Department of Health Treasury reports are informed by the Districts and the Components Reports. After populating the Treasury reporting Templates (qualitative and quantitative templates) and providing a narrative based on the data provided the report is submitted to the Provincial and National Treasury.

Table 5.7: Treasury Reporting Template

NON-FINANCIAL PERFORMANCE NARRATIVE PUBLIC ENTITY: KZN DEPARTMENT OF HEALTH QUARTER: THREE 2012/13			
Programme/Sub-programme/business activity as tabled	**Performance Measure**	**Challenges**	**Responses**
PROGRAMME 2: DISTRICT HEALTH SERVICES			
2.1 Clinics and Community Health Centres (CHC)	1. Provincial PHC Expenditure per uninsured person	Above target.	PHC Budget allocation has increased to enhance service delivery and access. This is evident in the investment in Tuberculosis (TB), School Health Teams and PHC Family Health Teams
	2. Utilisation rate - PHC	Target met	

Head Office Component Spreadsheet

The Head Office designed a reporting template for all the Head Office Components and Programmes. The template requires reporting on the indicators based on the strategic objectives and targets. Frequency of data collection and analysis is also entered into the template and the actual achieved against a given target. Explanation of the status of data achieved is provided. For instance where there are raw data, explanation of what the data mean is provided. Where there are deviations from target – under-performance or over-performance - by 5% either side; reasons for such deviations are provided as well as planned interventions/remedial actions; with timeframes and monitoring and reporting plans given. When reports were compared with the expected performance it was evident that filling in of templates was not done accordingly. Not one template was fully completed according to expectations.

The following table shows the reporting template used by the PMs after they have collated data from the District and the DHIS. The report is submitted to the M&E Component to compile a composite Provincial Report. It will be noted that column 5 on

the table – 'Contextualise Indicator Value – Concise' seeks an explanation of actual value in terms of calculations, outputs and activities.

Table 5.8: Head Office Reporting Template

Key Activities/ Measurable Objectives	Indicators	Data Source	APP / Program Target	Quarter	Actual Value	Contextualise Indicator Value – Concise	Reasons for Deviations from target (Key Challenges/ Achievements)	Remedial actions for challenges (Implemented or planned)
To scale up implementation of the integrated TB Crisis Plan to improve the TB cure rate to 70% by 2014/15	TB Incidence Annualised	Programme Manager / Data Capture Tool	1160/100 000	Q1				
				Q2				
				Q3				
				Year End				
	New smear positive PTB cure rate	Programme Manager	78.9 %	Q1				
				Q2				
				Q3				
				Year End				

As mentioned that reporting is done quarterly, recording of reporting is undertaken as soon as reports from Programmes and Components are received. As with the DQPR the Head Office Reports are checked for timeliness, completeness and accuracy. Where the reporting date passes a reminder is sent to those that have not yet submitted their reports. This is done through e-mails or by phone.

After five days of receiving the reports from either the districts or Head Office the M&E Component staff scrutinise them, make comments and send feedback to the sources. Feedback to the districts is undertaken on the DQPR by highlighting where the discrepancies are, making comments and sending the spreadsheet back to the sender. The same procedure is followed with the Head Office Reports. However, it was noted

that it is not all the Head Office PMs that receive feedback from the M&E Component. When this was probed, it was explained that it is due to the staff shortage in this Component and the workload which affected the request for a report.

Data analysis of reports

The districts performance is measured against the Provincial target to determine how close to or away from the target they have performed. Where possible, a comparison with previous quarters to determine changes in performance at 5% below or above target was accepted. The inter-district comparison in performance is also determined to show which district has performed the highest on a particular indicator against the one least performing on the same indicator.

Reporting

Reporting directly to the M&E Component went through the DHIS. There were remaining Programmes that still report vertically. That is, they have their own reporting systems. These are as follows:

1. The Electronic Tuberculosis Register;
2. Communicable Disease Control Register;
3. Malaria; and
4. 3 TIER Register.

The fourth system above was recently established. Most indicators and data elements of the Anti-retroviral Therapy Programme were always in the DHIS since the inception of the Programme but because of the nature of the HIV and AIDS the 3 Tier Register (System) was introduced.

Surveys

Surveys are other forms of data collection and reporting used by some programmes in the DOH. For instance:

HIV and AIDS Survey – Strategic Programmes Unit

It is a National mandate that all the Provinces conduct the HIV Survey. Therefore the KwaZulu-Natal Department of Health conducts the HIV Survey where the Epidemiology, the Data Management and the HIV and AIDS Component work hand in hand. This survey involves all the 11 Districts of KwaZulu-Natal. The survey results are sent to the National Department of Health where analysis and report writing is done after consolidation of all the results from all the provinces. The publication of results is undertaken by the National DOH. Reference is made to the National HIV and AIDS when compiling any DOH report that needs reporting on HIV and AIDS.

Client Satisfaction and Core Standards Surveys - Quality Assurance and Control Component

The Quality Assurance and Control Component monitors the Department's performance against the National Core Standards through the Client Satisfaction Survey and the Waiting Times Survey. All the districts conduct these annual surveys from Q3 of the Financial Year so that by the end of the year reports on findings are submitted to the relevant Component in the Head Office. This Component in turn compiles a Provincial report of the survey and submits to the M&E Component to compile a Provincial report.

Table 5.9: Quality Assurance and Control Reporting Template

CLIENT SATISFACTION							
Number of PHC facilities conducting annual Patient Satisfaction Survey (report only once)	152	60	0	12	11	24	13
Number of CHCs conducting annual Patient Satisfaction Surveys (report only once)	6	3	0	1	1		

Process of reporting

Taking from what respondents reported on data collection it was evident that there was a lack of understanding of what reporting entailed. For instance, the understanding of most respondents in all districts reporting was about providing raw data. If a report was required by any stakeholder (or M&E Component) at Provincial level for instance, they informed the stakeholders that the report was available in the DHIS. They may also inform the DIO to extract and submit it to the stakeholders as if that was all about reporting. They did not consider that figures alone do not give the full picture; but an accompanying narrative is required to make sense of the raw data. Apparently they did not like to provide the narratives and yet they were the people knowledgeable about what was happening in their programmes: why targets were not met, what challenges they were experiencing and how best they could address such challenges.

Respondents from the eight districts complained of rapid change of the data collection tools (registers, tally sheets and monthly summary sheets) caused by continuous change of data elements. These changes were reported as a challenge that resulted in the use of different versions of tools by different facilities. It was also reported that for M&E to be effective, data collection should be undertaken properly. They explained that proper data collection would be achieved only when they were involved in making the changes; for

example, being involved in the introduction of new indicators and in the discussions on the purpose of collecting certain data. They expressed that the exclusion made them, *"Feel treated as objects"*

They added that the changes that were made did not come with proper tools, which caused more confusion. One of the respondents said:

> *"Things are being imposed on us as there is no consultation at all levels. National, Provincial and Districts do not consult the levels subordinate to them"*

In addition to the issue of standardisation of data collection tools, some facilities did not have the tools at all, which resulted in the use of notebooks for the purpose of collecting data instead of registers. Some used older versions of the tools – tools that were no longer used as they were never taught how to collect data using new tools (i.e. there was no training on data collection tools). Reporting tools and the monthly summary forms ended up not tallying. This caused a challenge when compiling quarterly reports.

UGu District, which was the second best performing district in terms of reporting, agreed experiencing a similar problem resulting in having the data collecting tools not corresponding to the data being collected as a result they had to use note books for data collection. This district reported that a certain Professor from the University of KwaZulu-Natal who was conducting the outreach programme assisted them. A need for a data definition 'dictionary' and training before starting collecting data was raised.

> *"The Programme Manager from the Province did not help us instead a Professor from UKZN did".*

The existing division between the Province and the Districts was emphasised. When asked about the conduct of the Provincial Programme Managers' unwillingness to assist the districts, in reply they said that it showed lack of accountability:

> *"At all levels there is lack of understanding of what M&E is about; supervision also lacks because of this"*

The minutes from District M&E Meeting held in November 2012 showed that some indicator definitions in the DHIS and the APP were completely different. Some did not have numerators and denominators, which showed that there was poor alignment between the DHIS and the APP.

5.3.2.4 Evidence of the Health Information Teams and their role

According to the M&E Framework, there should be M&E Health Information Teams (HITs). These are structures responsible for data verification, or interrogate data in order to ensure accuracy and monitor trends and under-performance against targets. HITs need to be established at all the spheres of the Department. The Implementation Plan of the Framework prescribes that at Provincial level the Information Systems Manager should create and drive the functioning of the Provincial HIT. When asked about the existence of the HIT at this level, managers who were interviewed stated that this team was non-existent. The Annual Report (2011/12) confirmed that the HIT did not exist at the Provincial level.

Two of the eight districts reported having functional HITs. One of the districts which had the HIT before the study reported that the HIT had been non-functional for over a year because of lack of commitment from the non-clinical programmes that did not attend meetings, and was ended. It was mentioned that the HITs were there only in name and that there was a need for a workshop on how the HITs should look at their data as there

was no understanding of data. The M&E Planning Manager in the same district expressed that:

> *"They go for quantity not quality; they are not able to interpret their own data; data interrogation is not done"*

When asked about the reasons for the HIT to become non-functional, the reasons given were the skewed M&E System that focused on clinical staff neglecting other programmes; lack of guidance as to what to discuss in the HIT meetings; no standard operating procedures; and no mentoring from the M&E Component from the Head Office.

In the documented report only three out of the eight hospitals reported having the HITs; four had no HIT at all; and one hospital was not sure of what the HIT was. However, out of the three reporting to have HITs only two of them produced minutes of the meetings. The minutes showed that 90% of the content of the meeting was on general facility issues not on data being collected and its accuracy. It also showed that the planned interventions and the time frames set to address the M&E challenges were not monitored to assess the progress. The feedback on the progress in the subsequent meetings was also not provided. One of the managers who tried to make meaning of the whole situation said that it was not everyone who followed the reporting lines or data flow in terms of the Framework. This was also attributed to lack of accountability. She suggested that:

> *"There must be a circular strongly stating the M&E Framework be followed".*

In summary, all the above reports on the existent of the HITs showed that there were no HITs; if there were any they were non-functional. This presentation showed that even the parts of the M&E Framework that the respondents saw as crucial in the implementation

of the M&E System, they were not applied practically. This, therefore, raises doubt if the M&E implementation was effective and sustainable.

5.3.3 Experiential Theme: Management commitment in implementing the *M&E Framework*

5.3.3.1 Sub-theme: Management role played in implementing the M&E Framework

M&E Support to Districts

In a focus group discussion conducted with the employees in the Head Office, the Human Resources and the Risk Management Assistant Managers complained that data from the facility registers and the tally sheets did not correspond to the data in the DHIS. One of the managers said that the discrepancy was due to data verification at facilities and validation at district levels being not conducted. They agreed with each other that the M&E system is not used to change the situation, as they have never been trained on how M&E was a management tool. One of the managers, however, argued that the M&E Component is just to play a facilitation role, but the onus is on each Programme Manager to implement the M&E System in their programmes. The group suggestion that the standard operating procedure of how to conduct the programme review meeting - stating what was expected of them need to be developed; and that everybody should be involved during its development. Benchmarking the best Practices from other districts was also suggested.

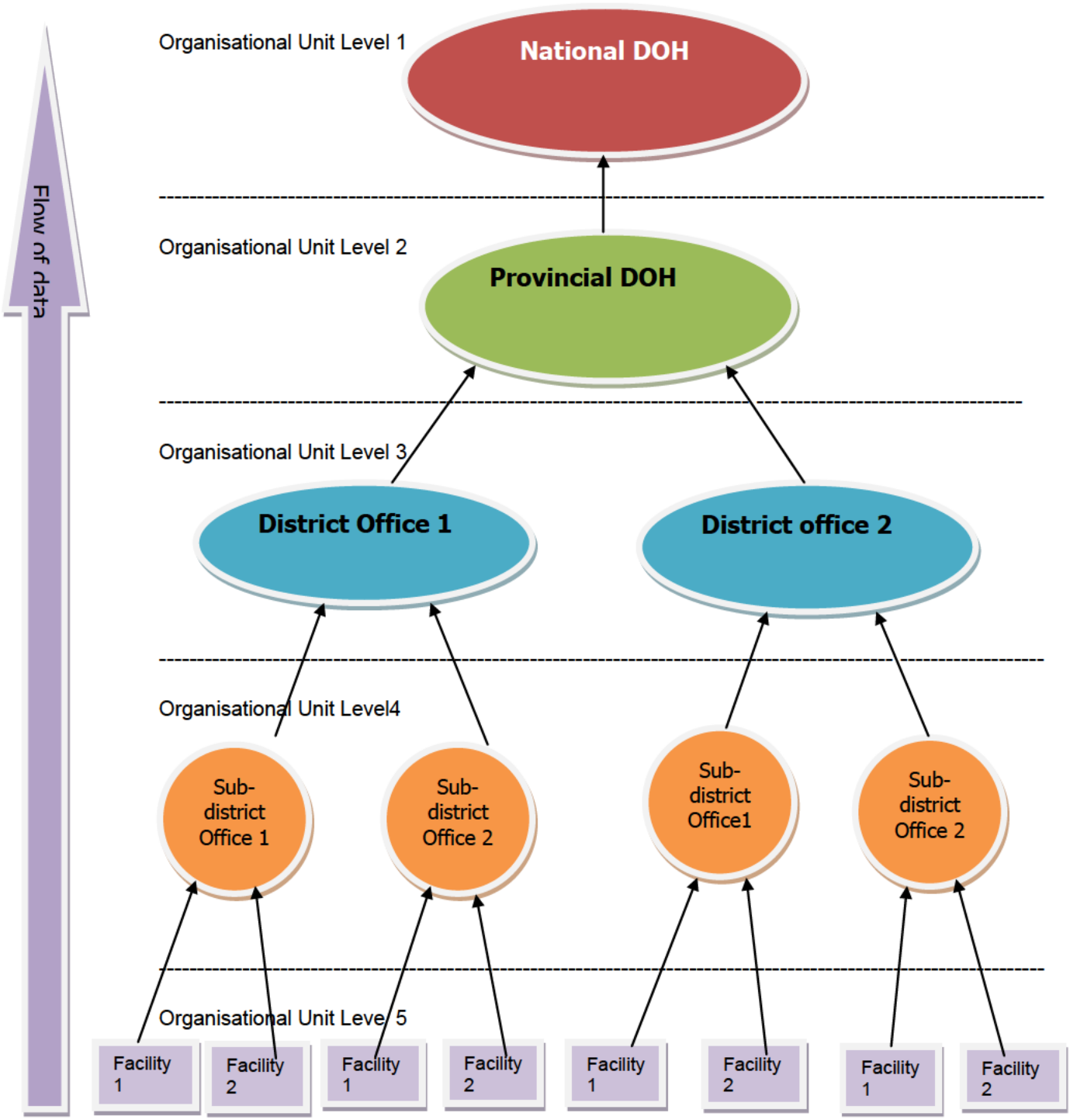
It was discovered that in their documented visit report the EThekwini District blamed the district size for its inefficiency to implement the M&E System as it is enormous in comparison with other districts. This coupled with the scarce resources where there were not enough data capturers impacted negatively on other staff members who were expected to perform data capturing duties.

The lack of consultation was echoed by all other districts and facilities. This was substantiated by the issue of Data Capturers that were employed by the department without consulting the districts. These were deployed to districts without consulting the District Deputy Managers who were expected to supervise them. Regarding this action, proper procedures were not followed in their placement. It was also not done according to the needs of the districts as their number did not match figures required per district (ratio). There was vertical staff still being employed by the Province and placed in the districts whose reporting was directly to the Province while they need to report to the M&E Managers in district in order to secure integration.

One of the senior staff members interviewed for the study raised a question regarding the existing manager who conducted the expenditure budget monitoring asking where he fitted in the whole M&E structure and his role and function. This showed how uncoordinated the M&E function was – when senior management did not exactly know the role of another senior member who played such a pivotal role.

As much as the DHIS is generally used in capturing data for all programmes, a report in November 2012 revealed that some programmes stopped capturing into the DHIS to capture their data into different tools. One of these programmes was the Emergency Services Programme, which reported awaiting training of FIOs on DHIS. This showed that uniformity is not followed by the DOH. Confusion in reporting still existed with some programmes having the PMs not willing to come and address the District Deputy Managers regarding their reporting system and what monitoring was expected for the programme. The process of data flow was not clear to them; they did not have a clear data flow diagram in terms of data collection, reporting and feedback loop. However, data flow was clearly illustrated in the M&E Framework as shown in the following diagram.

Figure 5.11: Data Flow Chart (Sourced from the KZNDOH M&E Framework (2010)



There was an issue of the DHIS data not matching with the data in the districts and facilities. In essence, this was due to data being verified and changed at the lower level

and not communicating the changes made to the provincial level. This discrepancy impacted on the accuracy and reliability of data, which in turn resulted in questionable reports. The feedback provided to the District Deputy managers is mostly not taken into action by the PMs in this level. This is evidenced by very little improvement in performance. For instance, reviewing the feedback reports provided to the districts in 2010 and comparing them to the present feedbacks recently (2013) sent to districts showed no changed in performance.

Proper tools are still a challenge – some facilities still use a paper based system as there are no computers. Some computers were stolen from the clinics; where computers were not stolen they were still packed in boxes without being installed for years because of lack of installation accessories for example points. Where installation of computers took place, there was no capacity for the staff in the clinics to use computers; initiatives to install are very slow. In some clinics there is a network problem owing to terrain of the areas.

There was a circular posted to all institutions addressing the backlog on computers. It stated that there would be no new requests for the new computers until the backlog was cleared. There was an Electronic System known as the E-Health Tool which was proposed for which a pilot was already started in some clinics in UMgungundlovu District. This system proposes the introduction of a system where each clinic would have four computers and two data capturers. This implied that there would be a shift from the information being captured in hard copies to data capturing electronically from the source. Funding already existed but rolling out commenced with capturing of the National Health Insurance data from the pilot sites.

According to the District Deputy Managers, the system was not introduced to them – they just heard from different sources without its being introduced to them as the people

responsible to monitor any data related system. In analysis, it is apparent that the DOH is too ambitious: there is a general shortage of computers coupled with insufficient computer skills at the clinics and yet the plan was to suddenly have four computers per clinic. To the District Deputy Managers, the effective implementation of this system was questionable, particularly as they knew little about it. The same was also apparent in the M&E Component – the role of the M&E component regarding the new developments was not clear as the Component was not involved in the National Health Insurance planning discussions.

Engagement of the Provincial PMs in training/data collection issues related to their programmes was not reported as it was supposed to. A complaint raised was that the Province organises workshops and meetings during the hectic reporting period, which affects data quality and times of reporting.

5.3.3.2 Sub-theme: Evidence of programme specific M&E Implementation Plan

The Monitoring and Evaluation Framework has a monitoring Implementation Plan to monitor its implementation. The M&E Framework Implementation Plan has objectives, indicators, roles, responsibilities and timeframes. Monitoring is undertaken against these prescripts and reporting on a quarterly basis is expected from each district. The districts have their District Health Plans (DHP) and the Operational (OPS) Plans but the Implementation Plan is not to monitor these tools but is solely for monitoring the implementation of the M&E Framework. During the interviews of the senior managers it was also apparent that the programmes did not have the Implementation Plans to monitor their Operational Plans at the Provincial level. The districts produced reports on the Provincial M&E Implementation Plan but when asked about their own Implementation Plans to monitor their Operational Plans according to their respective

District Health Plans, they admitted that they did not monitor these tools (Operational and District Health Plans), except for Amajuba District. This was the only district that had the Implementation Plan for its DHP and the OPS Plan.

Asked for the reason for this they complained that the M&E System did not empower them to monitor their OPS Plans and asked for a template to use for this purpose. These tools have all the indicators the districts need to monitor as they are based on the DHPs that respond to the APP and the Strategic Plan of the Department.

Another defect in implementation of the Departmental M&E system was having the Head Office Programme and Component Managers not monitoring their own OPS Plan at a Provincial level. It cannot be said that they did not comply as they explicitly mentioned that they did not know that they should be monitoring the implementation of this tool.

Table 5.10: Analysis of the checklist on monitoring of the M&E Implementation Plan (2011/12)

Departmental Levels of implementation:	Amajub		UGu		Umkhany.		UMzinyat		UThukela		Zululand		UThungul		Umgun	
District Level	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is there a functional Health Information Team?	√		√			√	√		√			√	√		√	
Does the Team have a mandate or Terms of Reference?	√		√						√							
Do all members understand their roles and responsibilities as part of the Team ? Mention them.	√		√						√							
Are meetings held regularly? Q = Quarterly, M = Monthly)	√		√					√	√			√	√		√	
Are minutes available?			√				√		√						√	
Hospital Level																

Do all hospitals have a functional Health Information Team?	√		√		√		√		3	√		√		√	√	
Does the Team have a mandate or Terms of Reference?	√		√ 2/5						1	3						
Do all members understand their roles and responsibilities as part of the committee? Mention them.	√		√						3	1						
Are meetings held regularly? How often? M=Monthly; Q: Quarterly	√		√ M		√ M			√	1	3		√	√ M			
Are minutes available? Please attach.			√					√	√			√				
CHC Level	N/A		N/A						N/A		N/A					
Is there a functional Health Information Team in all CHCs?					√		√						√		√	
Does the Team have a mandate or Terms of Reference?																
Do all members understand their roles and responsibilities as part of the committee? Mention them.					√											
Are meetings held regularly? Q = Quarterly, M = Monthly					√ *M*			√					√ *M*			
Are minutes available? Please attach.						√	√									
All hospitals publishing (on the intranet) quarterly health bulletins. Mention reference on the intranet.	√			√		√		√		√		√	√			

The above table is a checklist used by the districts as a monitoring tool to monitor the Implementation Plan of the M&E Framework of the Departmental M&E System. The checklist was used at District and at Facility levels (Hospital and Community Health

Clinics - CHC). This was in response to the Annexure 1 of the Implementation Plan of the M&E Framework. The M&E Component monitors performance towards achieving the set objectives. For the purpose of the study, only the above portion of the checklist that focused on the formation and functionality of the Health Information Teams (HITs) was extracted.

From this record review, it is apparent that in the first quarter of 2011/2012 there were some institutions that still had HITs. Out of the selected eight districts six had them and three out of them had the terms of reference (TOR). Those having the TORs agreed that the members understood their roles and responsibilities. Frequency of holding the meetings was not uniform as some met quarterly and some monthly.

Assessing the status in the facilities, apparently the implementation was even poorer. Though the checklist shows that there were CHC having the HITs if no team member understood their roles their functionality is doubtful. Though UMkhanyakude District, as an example, did not have the HIT at the district level, they were reported at facility level. Even so, there were no minutes for the HIT meetings, which refuted their existence as functionality is monitored through evidence of minutes. As mentioned elsewhere in this chapter that even the Institutions which reported having HITs, the minutes submitted were not specifically the M&E minutes or data related minutes but were minutes for routine visits.

It is important to mention that a year later, in the first quarter of 2012/13, already the HITs had died out. Making a comment one of these the district's M&E Manager stated that in her district previously the committees formed part of the management meeting. The FIOs who had to present data became uncomfortable displaying problematic indicator performance and incorrect data at the meetings because they were at the

mercy of the management that protected their terrain. Therefore, they started displaying only the clean data. Later most of the PMs in this district only wanted to concentrate on their unit data and not on all data presented and therefore they only sat for their unit data and left the meeting.

This could be the one of the causes why people lost interest in the data review meetings and therefore there were no more functional HITs.

5.3.4 Experiential Theme: M&E information use

5.3.4.1 Data quality issues and measures to ensure data quality

Data quality

When asked about the status of data quality and the measures taken to ensure that data was of good quality the respondents said that data was of poor quality. Several reasons given included the existence of several parallel data requests from different stakeholders they had to provide. For this reason they were compelled to thumb suck the data submitted. It was also mentioned that this affected dedication to their work. The District Health Information System (DHIS) was also suspected as causal to poor data quality. The explanation was that data in the system changed rapidly causing suspicion that Version 1.4 of the software was having problems.

According to the M&E processes the stakeholder/audience analysis should be undertaken so that there is a list of known stakeholders and their report requirements. This included the format of the reports and the frequency of reporting. The respondents reported having never conducted the stakeholder analysis in order to find this out. When the M&E Framework was examined, there was no mention of this analysis in it. This meant that the people expected to produce the reports did not know who were the

stakeholders to receive the reports, the kind of reports and how often and the templates for such reports. However, the only stakeholder that had these details was the M&E Component.

The FIOs at facility level overlooked data validation rules so that data captured was of poor quality; tight deadlines also affected accuracy of data as it affected the conducting of the verification of data. After submitting the reports the facilities made changes to the submitted data without notifying the Districts so that the Province ended up having data that was outdated and discrepant to the one at hospitals. These gaps were not updated until the end of the Financial Year. When asked about the possible reasons for this they said it was due to lack of relevant SOPs to guide them so that facilities wrote what procedures they should follow when reporting. What they said was that:

> *"We give them whatever comes to mind – we thumb suck. The timeframes and the staff shortage also affect data verification as there is not enough time to verify"*

It was suggested that mainstreaming of the M&E System should start with rigorous training on new versions of tools when the old ones have been destroyed; and with their SOPs also reviewed.

It was reported that when counting, some statistics proved inflated because of not following calculation definitions; training of employees on tools not conducted and SOPs for data collection tools and for data verification procedures were not available; remedial actions were not followed and therefore were not implemented. Their complaint was that the problems continued over time such that trends were developed but no interventions to address them and that the M&E Component was not doing anything about it.

The demographic data had challenges on population estimates which affected the calculation of for instance, data on the under 1 year's denominator which was either inflated or deflated statistics. Reports showed that out of eight hospitals data verification at facility level was only done monthly in only three hospitals while the rest did not do data verification. Those that conducted verification had neither verification tools nor Standard Operating Procedures (SOP) to follow. Where verification of data was done it was discovered that the tally sheets and registers were being used without any SOP in place which resulted in the verification being done haphazardly without following any particular method or procedure.

In the review of a report compiled by the National Department of Health (NDOH) on verification of data conducted at the health facilities against the data reported at the NDOH undertaken in 2010. This process commenced with the briefing sessions to the District and Provincial management staff in order to outline the purpose of the project, plan facility visitation and proposed visit to the identified facilities. After each visit a feedback session was conducted to the District and Facility Management Teams where presentation of the findings was undertaken. The methodology adopted was the interviews using questionnaires from the South African Statistical Quality Assurance Framework (SASQAF Tool) to Information Management officials in facilities who were the Data Capturers, Facility Managers, Chief Professional Nurses and Facility Information Officers in hospitals/sub-districts. Data verification comprised scrutinising documents used in data collection, verification/validation and reporting. Reported data was recounted, cross-checked with other data sources, namely, tally sheets, patients' registers, weekly and monthly input forms against DHIS at National, Provincial, District and Sub-districts. Data flow policies, concepts and definition manual guidelines on how to calculate for indicators and supervisor's manual, were also reviewed. In this endeavor

four districts were visited in the KZN Province against fourteen selected from other Provinces.

The NDOH report showed that there were gaps in the monthly input form and that there was recoding of the same data on different registers which made the data reported questionable. The facilities were not updating their figures in the DHIS making it discrepant with what was reported. There was also poor record management due to poor filing system resulting in facility records going missing; supervisory visit tool/manuals missing and monthly input forms not signed by supervisor. There were also arithmetic errors and data capturing errors. Poor phrasing of National Indicator Development System (NIDS) data elements; and the addition of data obtained from campaigns to the routine data made the routine data inflated. This also affected filling out of the data collection tools causing system errors. Finally, the inconsistency in data submission dates was an additional challenge observed by the NDOH Team.

Regarding measures to ensure data quality, the Data and Information Management Component said that the DHIS had the data validation rules. This means that after capturing data into the DHIS the FIO from hospitals was required to 'run the validation rules' to check if the data captured into the system was of good quality. However, as mentioned somewhere in this report, this procedure was not followed. It was brought to the attention of this Component that errors may have occurred at the source, that is, at clinic level during collection and tallying of data collected and if there were any means done at that level. The response was that the staff knows what to do but did not do as per requirement. During this interview it was evident there were no data verification tools at clinic level and there were no SOPs to guide the data collectors or managers how they should verify their data.

The DIOs at the district level were also expected to validate data that was sent to them by the hospital. When investigating, validation was not done. The record reviews also showed that the FIOs in hospitals did not conduct verification on the data collected and submitted to them. Reasons provided by the districts were that the workload at both levels was beyond the staff to carry; and that there was an on-going challenge of staff shortage, which caused them not to do their work thoroughly. The M&E Managers were asked about their role of supervision in this regard, the same reason was provided and in addition they said that they do not know how to run validation rules as they were never trained on the DHIS. That way they could not supervise the responsible people on procedure.

What was discovered by the NDOH was not different from what transpired in the districts as already presented in this study. This points out that the data quality issue was a real challenge in the Department. However, this does not solely imply that the M&E System was inefficient; on the contrary, it implies that all the data management system of the Department is lacking.

5.3.4.2 Sub-theme: Importance of M&E information; its usage in the Department

In order to address this sub-theme a discussion on the feedback provided to the data providers was undertaken and the following input was obtained.

Feedback to data providers

The District Programme Managers did not know who used their reports because there was no feedback provided. Eighty (80%) percent of Programme Managers in the visited districts said proper planning and consultation with all managers when the Implementation Plans were drawn would have brought awareness in this area. It was

recommended that appropriate tools and resources should be in place for proper implementation and functioning. The general feeling was that the Departmental M&E System was not conducive to data collection at the grassroots.

Regarding the HITs and quarterly reviews of the reports submitted by the facilities it was reported that when quarterly reviews were conducted in some districts data collectors (PMs in districts, hospitals and facilities) became defensive when their under-performance was highlighted. They did not want to accept feedback positively and own their mistakes. This was attributed to lack of capacity for M&E supervision and management; lack of initial and on-going training – not even when there were changes; Employment Performance Management and Development System (EPMDS) not conducted accordingly; performance management and monitoring not aligned to individual performance; at employment close scrutiny not done to distinguish whether or not employed people really qualified for the job; attitudes that people had compounded with lack of commitment; information not being cascaded to lower levels and no link between the government/department spheres.

It was expressed that the report submitted by the District Information Officers (DIO) had data errors. They did not examine data deviations and just sent incorrect data. When asked about the reason for this, the response was that there was lack of accountability at all levels owing to lack of understanding of M&E:

> *"Supervision also lacks because of lack of M&E understanding. Reporting this challenge to National and to Data Management in the Province was unfruitful. With regard to data management processes, the managers do not know data issues and therefore cannot supervise the DIOs"*

One of the respondents added:

> *"The indicators are imposed on to us - we are not told why we should collect such indicators – there is no consultation of the staff at lower levels"*

What was mentioned showed the existence of communication breakdown between National and Provincial; between Province and District, between components at Provincial level; and between M&E Managers and Programme Managers within the Districts and between the Districts and Facilities. The reason mentioned was that the lack of inter-Provincial integration caused several Provincial Managers not talking the same language. In addition to this, the junior staff was sent for training on data issues but the PMs were not sent so that knowledge gap existed making it difficult for the PMs to guide and supervise the junior staff. This was identified as a gap on M&E implementation including the lack of feedback to Programme Managers on data specific issues by the M&E Managers in the Districts.

This is also a data management issue as the DIOs are sent for DHIS training by Data Management Component. Confusion was noted on the role of Data Management and M&E Components and it is a shortfall of the Department.

M&E information usage

When asked about the importance of the M&E information, and its usage in the Department the following transpired:

- All agreed that because of the Departmental M&E System they were able to assess the progress of and review their programmes;
- The M&E System provided baselines in order to develop appropriate targets;
- It provided awareness of the early warning signs for outbreaks and plan interventions;

- They were able to zoom in on specific poorly functioning facilities so as to intervene accordingly;
- M&E System was good for resource allocation e.g. budget, staff, ambulances, equipment and building of new facilities;
- It enabled them to improve services by looking at abnormalities in data – deviations (all errors in data collected) and trends.
    - An example given in this regard was that they had recently placed more Roving Teams in the districts in order to enhance the initiation of patients on Anti-retroviral Therapy - ART) where there was a need;
- The M&E System was good in informing planning and decision-making; and
- It also fed into the next cycle of the Strategic Plan of the Department.

5.3.5 Experiential Theme: Challenges and remedial actions – evaluation of the M&E System

5.3.5.1 Sub-theme: Challenges which the M&E System is faced with

Lack of integration

One of the Programme Managers showed a concern saying that the Departmental M&E System had a 'silo function' and was not generally accepted as each unit had its own M&E staff:

> *"There is no buy-in for the Departmental M&E. The Province is therefore not talking one language which results in districts being confused"*

One respondent said that comparatively there was a considerable difference in the understanding of the Departmental M&E System between the Districts and the Provincial staff, such that the district understood it better than the staff at the Province. According to them, this was expected as the M&E focus was on districts while sidelining the Province.

Record review showed that the disintegration between the Province and the districts as well as the facilities really exists. This was also echoed in a Districts M&E meeting (for District M&E Managers) held in November 2012 at Wentworth Hospital where participants reported that the issue of integration should be addressed as a matter of urgency. One of the suggestions put forward was to develop an M&E Information Team (HIT) at Provincial Level.

One of the reasons for a very minimal or lack of acceptance of the M&E System was identified as due to lack of political will and therefore no buy-in from the Programme Managers. In order that the M&E System is well accepted it was suggested that there must be a sense of ownership. Lack of capacity at all levels of the staff. For instance, in EThekwini district it was established that the Medical Managers (doctors) themselves were not able to develop remedial plans for the challenges identified. It was suggested that information management skill be included in the job descriptions of the Medical Managers.

Already mentioned in this presentation is the lack of understanding and knowledge of the M&E issues in general. This includes lack of knowledge of the M&E Framework because it was never formally introduced to all the Department spheres. The understanding of the M&E Framework in particular and the M&E System in general was also seen as a challenge that impeded the buy-in from the all the staff member especially the managers and the mainstreaming of the System.

The above challenge led to people having an attitude towards the M&E System ‘detached’ themselves to the implementation of its Framework. The issue that aggravated the staff attitudes was non-inclusion in decision making relating to data

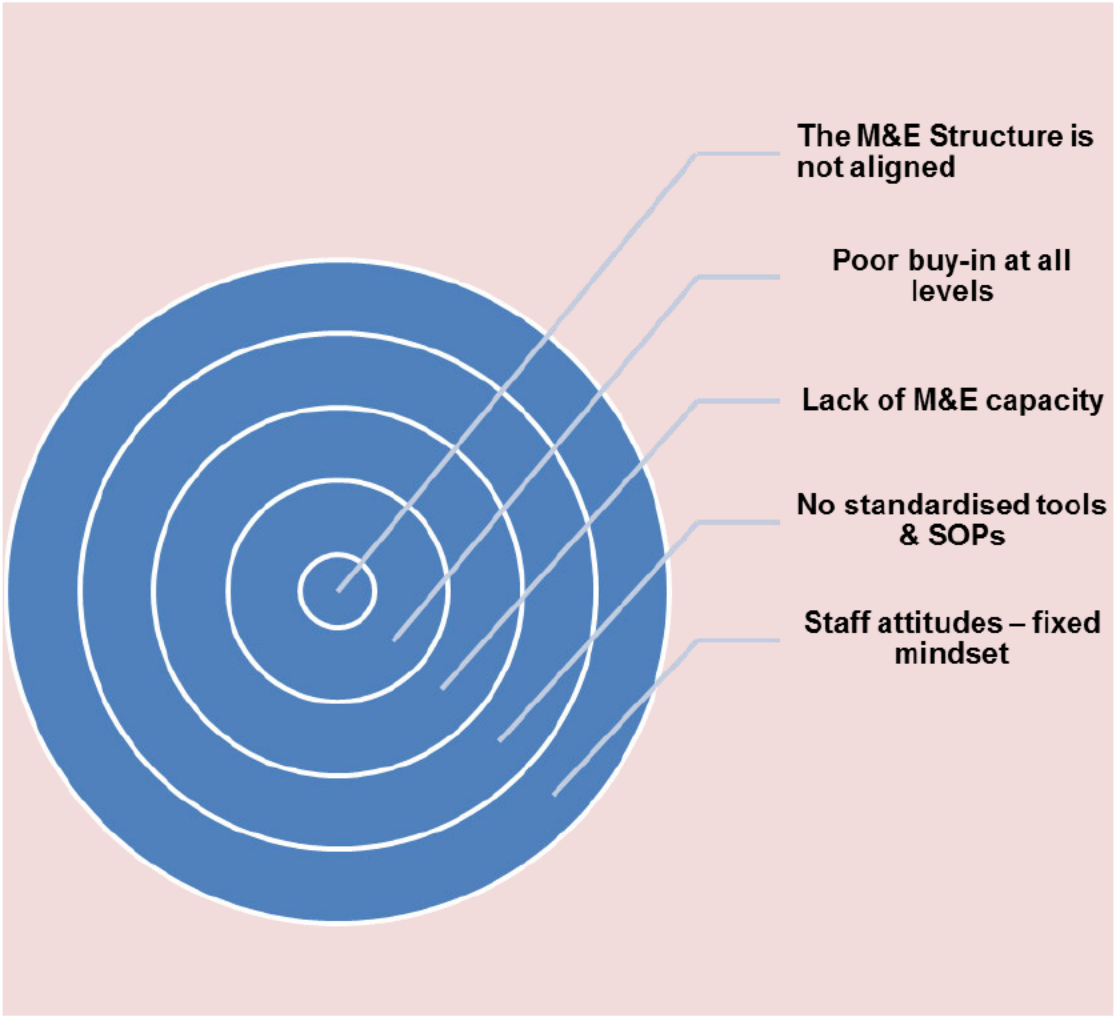
collection and tools. These were changes undertaken in the Head Office level; such that they made them feel they were treated as objects. Having such negative attitude resulted in the staff becoming defensive when given feedback on the data they submitted.

Lack of capacity on M&E also proved a challenge. There was no training on the data collection tools. The multiple versions of such tools resulted in people collecting data not knowing which tool to use and therefore using notebooks. Ever changing of data elements and indicators also added to the dilemma with no renewal of data collecting tools. As a result the data collected did not tally with other data collecting tools (tally sheets and monthly summary forms) causing data errors and inaccuracy. Data collection tools (and other tools) used had no SOPs resulting in the users having no direction or adequate guidance to use them.

One of the main challenges at facility level though, was the structure that did not accommodate M&E functions. For instance the staff that was tasked with M&E function (M&E Manager and the FIO) were placed on different structures so that the Manager could not supervise the FIO while the latter reports to another manager. This also involves the job description of the Manager which says very little on M&E responsibilities but centers around the clinical management function.

Data quality was a major issue that occurred as a result of almost all the above-mentioned challenges. This was compounded by the lack of data verification tools at the grassroots; and lack of adherence to the validation rules coupled with lack of supervision. Reporting to multiple stakeholders without having stakeholder analysis procedures and processes in place also proved a challenge resulting in producing thumb sucked reports.

Figure 5.12: 5 Top challenges in M&E mainstreaming



Remedial actions

In response to the above challenges the respondents at Head Office in particular suggested that the silo functioning in the implementation of the M&E System should be done away with and integration exercised; and the participatory approach be adopted where all the stakeholders are involved in driving the M&E System forward. This would happen if all the Units/Components work together; by having the separate M&E sections coming together and reporting to the Departmental M&E Component as this would help them follow one M&E Framework. It was also suggested that even if several M&E

personnel in each Programme or Component did not report to the Departmental M&E, they should hold regular meetings with all M&E personnel. This means a platform for information sharing should be established.

Some respondents suggested that there should be a specific M&E Manager who should assist the programmes in M&E issues. To have additional staff was also mentioned as a remedial action to take in order to successfully implement the M&E System to all levels. In this regard the dire need was put on the data source, on people who collect data, as it was felt they were somewhat neglected. The respondents said that these should be 'made to love M&E' so that they cannot take it as a means to 'police' them.

Remedial actions included proper introduction of the M&E System where all the staff is brought on board. M&E training on all data processes including data collation, analysis and proper report writing. It was also mentioned that M&E training should be included during the induction of the newly employed staff throughout the Department; and should also be an on-going exercise for the entire Department employees. They said that this could be effective if an M&E Training Handbook is developed.

Job descriptions of the M&E staff, as well as the M&E structure should be corrected so that the respective people are able to function accordingly. It was further stated that the job description of all the employees should be inclusive of the M&E functions by adding them in the Key Results Areas (KRAs) of the employees which will in turn strengthen the EPMDS.

The HIT in districts should be revived and established at Head Office. Together with this activity there should be terms of reference developed for the operation of the HITs at all

levels. Together with this activity the M&E Component should provide support and guidance in order to ensure that the HITs survive and sustain.

One of the M&E tools to reinforce performance in M&E is the provision of incentives to the best performers. One of the Managers in Amajuba District mentioned that they used to have floating trophies for the best achieving programmes.

It is also recommended that the health bulletin newsletter should not be limited to the general events that occurred in facilities (entertainment, bereavement and graduations) but should also be used as an opportunity to disseminate M&E information. Social networks were also mentioned as one of the channels that can be used to provide relevant M&E information to the stakeholders including the communities.

5.3.5.2. Reviewing the current M&E System: changes and additions to the current system

Deducing from some of the information provided in this presentation, it was required to have a model with a core team at the Province and at district levels with their KRAs including the M&E; and indicators that would be monitored. The Manager interviewed in this regard expressed that the M&E report should feed into the internal control (Risk Management):

> *"The M&E System should have a Framework or policy with an operational plan. It should adopt a multi-disciplinary approach that works with Risk Management Unit".*

She added:

> "*The M&E Framework should include all the required M&E elements and be formally introduced at all levels. There must be a multi-disciplinary approach with*

methodology that would allow networking with all the different units. We need a Departmental M&E not a silo M&E; it should cut across all Units - QUALITY ASSURANCE AND CONTROL, Human Resources Management, Finance, Emergency Services (EMS), Supply Chain Management (SCM) and other Units and Components"

It also further stated that the M&E System should prescribe and guide how to monitor reporting, compliance, efficiency and effectiveness through selected indicators that are core to the all Programmes and Components - not just the clinical indicators. It is required to have a multidisciplinary model that it will follow. For instance, a semi-decentralised Provincial and District Team working with Audit and Risk Management to address issues like fraud.

Asking about the evaluation model that the Department would follow in order to evaluate its M&E System, it was suggested that the M&E System should select a separate Evaluation Team or Committee. This Team should set indicators based on the baselines to monitor the outputs and outcomes. This Team should meet once quarterly.

"People spearheading the evaluation process of the evaluation of the M&E System should work according to the Public Service Commission Manual on the implementation and mainstreaming of the M&E Systems"

5.4 Generalisability of the study

According to Strydom, Fouchè and Delport (2002: 339), data should be solid enough to make the reader to understand the meaning of the experience and the phenomenon being studied. In qualitative studies the external validity known as transferability is an element of generalizability where it refers to the applicability of the study findings to

another context, setting or population group. These researchers propose that determining the applicability of findings in this regard solely depends on the researcher who wants to make the transfer so as to determine generalizability to other settings.

The dominant paradigm applied in conducting this study was qualitative research. Samples used in the study were not randomly selected and reference was made to several theories within the M&E Systems and how they applied to the present study in order to provide the theoretical framework. There was an elaborate description of the social group and the setting used in the study. The methodology and the whole process followed from data collection to data analysis was provided. The study used multiple sources to obtain data, now the question would be: can this study be generalised?

According to Strydom, Fouchè and Delport (2002: 352), triangulation, where multiple data sources are used, can strengthen generalisability or the study's usefulness to other settings. However, before making any conclusion with regard to generalisability of this study it will be noted that other variables may have come into play in this study. For instance, in the selection of the study participants purposive, convenience and snowballing sampling methods were used. These methods of sampling affect the external validity of the study and therefore the study cannot be generalised to other settings.

5.5 Conclusion

Chapter 5 presented and analysed data in accordance with research objectives and research questions. These were presented by means of categorizing data into themes and sub-themes. It also provided a summary of the research findings and formed the basis for a summary of findings, conclusions and recommendations presented in Chapter Six.

The key themes that emerged from data presented showed that, although there are some developments in the M&E System of the Department of Health at the district sphere, significant barriers for its effective implementation, mainstreaming and utilisation still exist. At the Provincial sphere this predicament is more evident. This is especially true in terms of lack of adequate capacity drive and political will as it prevails in most of service delivery initiatives.

With regard to the quality of data and usage of the M&E information in the Department, the results showed that data quality is still a dilemma which impacts on the reliability of reports generated by the Department. Data verification and validation processes are non-existing and where available are not followed by the relevant staff. The HITs, which are responsible for data reviews are non-functional and have lost direction and perished.

The M&E implementation faces grave challenges for which remedial actions were laid down. It was apparent that such challenges require strong leadership that would guide the implementation of the M&E System in the entire Department. What came strongly from the respondents' contribution was that a review of the existing M&E System is required as a starting point. The next chapter provides a summary of the findings, conclusions and recommendations.

CHAPTER SIX

GENERAL CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

Chapter Five discussed findings of the study; data presentation, analysis and interpretation. The aim of this chapter is to provide the general conclusions and recommendations of the study. Before these are provided, it is important to provide the purpose and the research questions of the study. This will be followed by the summary of findings, which will be presented on the basis of the themes and sub-themes of the discussion in the previous chapter. The summary of findings will be followed by general conclusions based on the findings, the recommendations and suggestions for future research. Amongst the recommendations will be a summary of facts to consider for a framework or a model for the evaluation of the M&E system of the Department.

6.1 Purpose of the study and the research questions

This section restates the purpose of the study and the research questions that guided the study. The purpose of the study was to critically review how the KwaZulu-Natal Department of Health M&E system was performing; how the M&E system was being used to improve the Departmental performance towards reaching its goals and objectives; and the extent to which good governance had been achieved. The following specific objectives were outlined for the study:

1. Is the DOH being efficiently and effectively managed?;
2. Is the Department complying with the basic tenets of the GWM&E System and of good governance?;

3. What are the benefits that have accrued from the Departmental M&E System?;
4. What are the M&E challenges currently being faced by the Department and how should they be addressed?; and
5. What are the essential elements of an Evaluation Framework for an M&E System for the Department?

The following section presents the summary of findings of the research.

6.2 Summary of the key findings

As a reminder of what transpired during data collection, it is convenient to provide the summary of findings before conclusions and recommendations of the study are made; and before the outcomes of the analysis are presented. The following sections present the key findings of the study, conclusions and recommendations.

6.2.1 Governance and M&E arrangements at all the spheres of the Government

6.2.1.1 Structures, effectiveness and efficiency of the Departmental M&E system

It is crucial to have relevant structures to ensure effective implementation at all levels. In this study this was explored and conclusions based on the findings in this regard are listed below.

1. Evidence showed that the M&E Component was located under the Directorate of Health Services Planning, Monitoring and Evaluation. The Director headed the M&E Component at Head Office and was assisted by two Deputy Directors, an Assistant Director and an Administration Support Assistant. In the districts the Deputy District Managers managed the M&E functions assisted by the M&E Planning Managers, the District Information Officers and the data capturers. At the facility level the M&E

Managers were supposed to run the M&E initiatives assisted by the Facility Information Officers. The clinics did not have an M&E structure but there were clerks and data capturers who were responsible for data related functions, and supervised by the Clinic Managers. This gives an overview of the M&E structure in the Department.

2. The respondents in the Head Office did not have a clear understanding of the role of the M&E Component in the Department;
3. The hospital organogram did not incorporate the M&E structure such that there was no M&E directorate in the hospital organogram. Initially, the M&E Managers were employed as Clinical Managers. They were seconded to the M&E positions without changing their job descriptions of managing the Infection Prevention and Control and the Quality Assurance and Control Programmes. As a result, their responsibilities were not in line with the M&E function;
4. The job descriptions for the Facility Information Officers' (FIO) were comparatively more aligned to the M&E functions than the job descriptions of the M&E Managers. However, the FIOs were placed in the Systems Management structure, which was not in line with that of the M&E Management. Both structures (that of the M&E Manager and of the FIO) ran parallel to each other though they were supposed to work together. One of the eight hospitals made internal arrangements with the Chief Executive Officer (CEO – the Hospital Manager) to modify the M&E Manager's job description so that the M&E Manager could perform the M&E functions;
5. One of the M&E responsibilities of the CEO was to sign off the reports for data accuracy and relevance before sending them to the districts. This function aimed to ensure accountability. However, evidence showed that the reports were signed off without being verified for data accuracy and relevance. The respondents

described this as the lack of commitment and M&E capacity where the relevant people did not do what was expected of them;

6. Though the remedial actions were drawn to address challenges or gaps identified, the implementation of such actions was neither executed nor monitored for progress. This resulted in continuation of the same challenges. Additionally the M&E system was not aligned to the DHPs and the Operational Plans of the Programmes or Components at the Provincial and the District levels. These particulars placed the effectiveness and the efficiency of the M&E system in this Department questionable.
7. To support the last statement the respondents had a minimal M&E capacity, which was not enough to enable them to drive the M&E implementation forward. Over and above, they regarded the M&E system as belonging to the M&E Component and for this reason its mainstreaming and implementation was seen as a responsibility of the M&E Component. It was also this Component's responsibility to monitor the progress. The relevant PMs demonstrated this by showing lack of interest and by not partaking in the discussions when they were called to discuss the data they collected and the reports they submitted.

The above exposition explicitly provided relevant understanding of the structural context in which the M&E system is being implemented. Perhaps the issue of correct structuring of M&E within institutions forms the basis of all the other factors that influence the mainstreaming of the M&E system in this Department.

6.2.1.2 Knowledge and understanding of Government-wide M&E system

It is a fact that in order that an intervention or a programme is successfully implemented the people implementing should have adequate knowledge and skills of the programme

of intervention. Findings below show the extent to which the Department employees knew about the basic policy framework on M&E implementation.

1. The respondents had heard about the Government-wide M&E System Framework (GWM&E). However, they had never seen or read it; they did not know its purpose and could not mention its tenets or assumptions. Their ignorance of the GWM&E showed that they had never read the Departmental M&E Framework either, as it made reference to and was based on the GWM&E; and
2. The respondents revealed that training or workshops to introduce the Departmental M&E Framework were never conducted, at the onset of the System; hence they had no knowledge of the GWM&E Framework.

These concluding remarks on the knowledge of the GWM&E Framework make it possible for one to consider the impact this could have had on the attitudes and opinions of the staff that was expected to implement the M&E system.

6.2.1.3 Mandates that prescribe the use of an M&E system in the Department

The Government and the Departments draw legislative mandates within which the public servants may function. The mainstreaming of the M&E system also follows the same process – they abide by the framework policies that guide its mainstreaming. The implementers should have adequate knowledge of such frameworks and the guiding legislation in order to follow them and implement accordingly. The findings on this topic resulted in the conclusions elaborated on below.

1. The respondents demonstrated adequate knowledge of the legislation or legislative mandates that prescribed the use of and reporting based on the M&E system of the Department. The National Health Act 61 of 2003; Mental Health

Care Act 17 2002; and the Constitution of the Republic of South Africa of 1996 were amongst the mentioned legislation;

2. A list of the governance structures that existed in the DOH was provided; and the respondents mentioned that in order to ensure accountability, the employees accounted to all of the mentioned structures and adhered to all their prescripts;

3. Hospital Boards and Clinic Committees are included in the Standing Committee on Public Accounts meetings where they worked hand in hand with the District Management Committees. Inclusion as an important element of governance was attended to as the Hospital Boards and the Clinic Committees conducted regular meetings with the hospital management and therefore follow prescribed activities and were also trained in order to help them with governance issues. They were invited to the annual Health Summits and to the Member of the Executive Council's (MEC) Budget Speeches and were required to adhere to all legislation;

4. The relevant policies with regard to corruption were mentioned, namely: use of official transport and subsistence and travel, use of resources, equipment and stationery (computers, telephones, stationery, absence from duty, whistle blowing exiting from the service and others. Though these existed, their monitoring was not undertaken;

5. The Corporate Governance Unit that ensured adherence to prescribed mandates reported being not responsible for monitoring the implementation and compliance, as monitoring was the responsibility of the Quality Assurance and Control Component. This function was not carried out as the responsible Component was wrongly placed in the Hospital Services Unit instead of the M&E Component. Instead of monitoring compliance with policies, the Quality Assurance and Control Component only monitored the Patients' Waiting Times and Patients' Satisfaction Surveys. Even at facility level some respondents

agreed that the Quality Assurance and Control Monitoring Component should also be looking at compliance with the policies as well as compliance with the M&E Framework.

6. The Programme Manager in the Corporate Governance Component reported having no direct involvement with the M&E Component as the latter focused on the clinical side by monitoring the clinical indicators. They, therefore, did not see the need to interact with the M&E Component; and

7. Some managers in the Head Office did not even know that the reporting template they used quarterly was from the M&E Component; and that they submitted quarterly reports to this Component. They thought that they were submitting the reports to the Strategic Planning Component.

Evidence in the previous chapter led to the above-mentioned deductions that show a disjuncture between the respondents and the M&E system in the Department where the M&E system seems to have its own life that is not related to their performance.

6.2.1.4 Capacity of management to effectively and efficiently drive DOH mandates

It was mentioned above that without adequate knowledge and skills it is not possible to successfully execute an intervention. The senior management in particular should have such capacity. Findings below show the M&E capacity of the management staff:

1. The District Deputy (M&E) Managers, M&E Planning Managers and the District Information Officers met regularly with the M&E Component to address their concerns and iron out misunderstandings regarding their M&E functioning. This exercise did not include other relevant stakeholders like the Programme Managers and the CEOs who had poor understanding of M&E;
2. Most managers in facilities had their M&E understanding limited to reporting which they did regularly to the districts. However, their reports lacked depth due

to limited conceptual understanding of M&E coupled with limited understanding of indicators, their definitions and measuring of performance against targets; how the M&E tools were developed and their relevance to their programmes. It was admitted that there was a gap between knowledge and practice as the little M&E knowledge they had could not be put into practice;

3. It was also reported that there was never any training on data collection tools and that there was limited M&E capacity as M&E training had never occurred at any level. That is, senior management and data collectors at hospital and clinic level were never trained.
4. Some PMs who admitted having received training on M&E reported that they were not trained by the M&E Component from the Province or district but obtained the basic knowledge from modules from their degrees or diplomas. They said that, that kind of knowledge was too generic and therefore different from training that one could obtain in relation to their jobs - Departmental M&E functions, which did not even have the adequate M&E processes;
5. The respondents experienced more confusion when they were expected to monitor the indicators without even understanding their meanings and the method of data collection. The general feeling was that that it was crucial to know why data was being collected, what the desired outcome was and the rationale for collecting such data;
6. The respondents also said that they had never been trained on data collation, analysis and interpretation to be able to understand the variations in their performance. They, therefore, could not make out what their data meant. They reported that they have never seen the training policy and said that if it did exist it was not followed.

The above clearly shows that the little M&E capacity the respondents had was only derived from the relevant training and on the job experience. The M&E is a new concept which many people are not familiar with. It shows that both the M&E knowledge and skill were lacking in this regard.

6.2.2: Compliance with the M&E Framework

6.2.2.1: Opinions on the Departmental M&E System in general

Frameworks and policies are put in place and compliance to them is monitored. However, people will always have their own opinions that are influenced by their values and belief system, as well as the environmental factors regarding new interventions. Unravelling these may assist in finding the direction that should be followed.

1. The respondents in the Head Office said that the Departmental M&E system was never introduced to them and that it was not aligned to other Departmental Components; they did not know its plans and principles; they did not understand the M&E concept such that it was not implemented. Consequently, there was a gap between theory and practice. Furthermore, the respondents revealed that they had never heard of the M&E Framework being referred to at any level. To them, the staff just saw their daily work as routine work – with no relation to the M&E Framework;

2. They stated that they detached themselves from the M&E system and had no ownership of it as they take as its belonging to “others” not themselves. In this way, they did not see it as a guideline to what they routinely should do. They also did not see problems identified being related to M&E. They have a ‘do not care’ attitude to whatever was wrong in their performance;

3. One respondent interpreted this attitude as being due to lack of readiness by the entire Department meaning that the staff was not ready to implement the M&E system;

4. They felt that the M&E Framework should be disposed of as it was abstract to them – *"too far-fetched"* and be replaced by a simple and practical M&E Framework that would be closer to what was happening; the M&E Framework that would provide guidance to what was needed to be done; that would motivate their thinking towards moving from monitoring to evaluation in achievable milestones;

5. They also felt that the system was not well structured, as there was poor introduction of M&E from the onset which resulted in both clinical and non-clinical staff not knowing what was expected of them. They did not know their M&E roles and responsibilities. This overall lack of M&E understanding was detrimental to the buy-in from all the stakeholders. They stated that the M&E focus was to the districts while marginalising the Head Office and the facilities. Again, this was said to have resulted in having no buy-in from the majority of the managers;

6. They also mentioned that the Programmes in the districts and facilities collected scanty data that did not give a full picture of the programme performance. It was mentioned as a technical problem that the PMs in the HO were not working closely with the PMs in the districts: to communicate with them and to guide them on data related issues.

The above-mentioned conclusions of the study findings shows the challenges encountered in trying to move from the known to the unknown. This is due to fixed mind-set that people tend to have.

6.2.2.2: Knowledge of and attitudes towards the departmental M&E Framework

In order that implementation becomes a success people need to be fully involved. However, certain factors tend to deter this from happening. The following conclusions drawn from the findings show how such deterrence influenced implementation of the Departmental M&E system.

1. The facilities did not welcome them during support visits. In one district they even boycotted the planned meetings reporting being very busy to meet with them. The M&E Managers in the districts stated that when giving the feedback on the data submitted by PMs at any level the recipients became defensive;

2. Respondents expressed their lack of understanding why they were required to monitor such confusing data elements, saying that the Province did not give clarity on why reporting needed to be made on such indicators and how to monitor them. They reported that they needed a dictionary that clearly defined the data elements; and be trained on the tools;

3. Even the districts PMs never read the M&E Framework, which meant that the very people who were involved in the milestones of its development did not read it when it was finalized. The districts provided Quarterly Reports on the Implementation Plan but they did not even know that the mere Implementation Plan they reported was the Annexure 1 of the M&E Framework. The point made above proved that they did not comply with the prescripts laid down in the Framework because they did not know it;

4. The only part of the M&E Framework that they complied with was the reporting. The clinics reported to the hospitals, which in turn reported to the districts. The districts reported to the M&E Component and their respective Components at Province;

5. At the Provincial level only a few Components submitted their reports to the M&E Component. Though some complied with reporting they did not read the guidelines that are in the reporting spreadsheet as it provides guidelines on all the indicators (definition and calculation methods);

6. Other nurses were not interested to know what M&E was about as was observed from their unwillingness to ask for clarity when having challenges. Some agreed that to them the M&E Framework was as if it belonged to certain people – mentioning the M&E Manager by name. The statements made above brought doubt about the accuracy of the reports generated on the Implementation Plan;

7. The M&E Managers in the districts stated that there was very minimal support from the non-clinical Programme Managers as the perception was that the M&E System was only meant for the clinical programmes managers – not both the clinical and the non-clinical programmes. The districts visits to the facilities were not seen as the M&E support visits, as most hospitals reported having never been trained by the districts during such visits. Only one hospital in one of the districts admitted having been trained on M&E by the district. This shows how M&E support visits were confused with regular or routine visits;

8. The respondents reported that from the onset the system was introduced poorly, which resulted in employees' ignorance of what was expected of them; they even did not understand the M&E concept. The respondents complained about the data collection tools that kept on changing and lack of the Standard Operating Procedures (SOP) on how to use the tools. Lack of clarity on procedures added to the confusion. The respondents at HO level unanimously agreed that the M&E System was also not functional.

Paying attention to the above-mentioned conclusions on the topic brings light to the general attitudes of the people involved in the rolling out of the system. A thin line seems

to exist between knowledge and attitude in the above list. Attitudes may also emanate from having or not having adequate knowledge about the subject.

6.2.2.3: The M&E reporting system as based on the M&E Framework

One of the prescriptions provided by the M&E Framework was the reporting system. Guidelines for reporting were laid out in the framework. The extent to which this was followed is provided below.

1. The M&E framework includes the whole process of developing the indicators reported on and the reporting templates. This process was not understood by most respondents. This involved the stakeholders who should receive the reports; prescripts in this process as well as the role of the M&E Component in this regard;

2. More confusion was when changes made to indicators or data elements did not come with proper tools. The respondents expressed a need for having an indicator dictionary (definitions); and training before they started to collect data;

3. Some indicator definitions in the DHIS and the APP were completely different. Some did not have numerators and denominators, which showed that there was poor alignment between the DHIS and the APP.

4. The Provincial and the National Department of Health Treasury reports are informed by the Districts and the Components Reports. After filling in the Treasury reporting Templates (qualitative and quantitative templates) and providing a narrative based on the data provided the report is submitted to the Provincial and National Treasury;

5. Some of the districts that submitted their District Quarterly Progress Reports (DQPR) on time, later made changes to the initial reports and thus submitted 2 or

even 3 versions of the report. The districts reports feed into the reports generated at the Head Office. The different versions sometimes resulted in having other reports not capturing the inputs in the later versions;

6. Feedback to the sources of the reports is undertaken and comments in the original spreadsheet are sent back to the sender. Reporting is also done through monthly data capturing into the DHIS. A few Programmes still report vertically that is, they have their own reporting systems;

7. Respondents responsible for reporting did not provide the narratives that supported their data or give explanations on the status of their programmes and reasons or challenges for not achieving the targets. In principle, where there are raw data, explanation of what the data means should be provided; and where there are deviations from targets, reasons for such deviations are provided together with planned interventions/remedial actions;

8. The respondents' experienced feelings of exclusion and being treated as objects; they felt that decisions are imposed on them as they were not consulted at all the three spheres of the Department;

9. Some districts mentioned that the Provincial PMs neglected them and that they received support from the Outreach Programmes in the University of KwaZulu-Natal;

Reporting involved several aspects as shown in the findings in the previous chapter. The above conclusions clearly show what transpires in the reporting scenario. For instance there was a process of indicator development which the respondents did not fully understand and reporting itself as some raw data had no narratives. These specific conclusions will also contribute to the general conclusions of the study.

6.2.2.4: Evidence of the Health Information Teams and their role

Like any intervention in an organisation the M&E implementation can never be a one-man show; on the contrary, implementation is a group effort. It is for this reason that the relevant stakeholders should be involved in order to enable them to engage in processes to assess and review the progress. Conclusions on the findings explicitly show if this is the case in this Department. In essence the HIT were expected at all levels: at the Head Office, District and Facilities. The discussion below shows if the expectation was met.

1. There was no HIT at the Provincial level of the Department;
2. Most HITs that previously existed in the districts no longer existed. The one district that said it had a HIT reported that the District HIT had been non-functional for over a year because of lack of commitment from non-clinical programmes that did not attend meetings and was ended;
3. Reasons given were that the M&E system was skewed - focused on the clinical staff while neglecting the staff in the other programmes; and did not provide proper processes, tools and procedures;
4. Even when HITs were functional, ninety percent (90%) of the content of the HIT meetings were on general facility issues - not on discussing data being collected, its accuracy, planned interventions and monitoring of previous interventions that were implemented. The respondents felt that there must be a policy enforcing the implementation of the M&E Framework;
5. The above-mentioned facts therefore posed doubt if the M&E implementation was effective and sustainable;

Based on the findings, the illustrated conclusions show that as much as the policies and frameworks provide guidelines, the relevant Standard Operating Procedures strengthen and provide guidance to the implementation processes. Integration of services and

integrated monitoring is important for implementing policies, frameworks, processes and procedures.

6.2.3 Management commitment to the implementation and use of the M&E Framework

6.2.3.1 Management role played in the implementation of the M&E Framework

The knowledge and skills mentioned elsewhere in this section should be coupled with enthusiasm to perform. However, even if these elements could exist the success of the implementation depends on the leadership involvement and ability to lead. From the findings below, this statement will either be supported or refuted.

1. The documented information reported that the EThekwini District blamed the district size for its inefficiency to implement the M&E system as it is enormous in comparison with other districts. This coupled with the scarce resources where there were not enough data capturers impacted negatively on other staff members who were expected to perform data capturing duties;

2. The lack of consultation was echoed by all other districts and facilities as they reported that Data Capturers were employed by the department and deployed without consulting the districts; yet they were expected to supervise them. There was vertical staff still being employed by the Province and placed in the districts whose reporting was directly to the Province while they needed to report to the M&E Managers in districts in order to secure integration and ensure supervision;

3. One respondent enquired about the role of the manager who conducted the expenditure budget monitoring as to where he fitted in, in the whole M&E structure and his role and function;

4. Certain data in the DHIS sometimes did not match with the data in the districts and facilities owing to data being verified and corrected at the lower levels and not being communicated to the provincial level. Lack of verification and validation systems and procedures resulted in questionable reports because of the discrepancies that impacted on the accuracy and reliability of data;

5. The same problems continued as feedback provided to the District Deputy managers was not taken into consideration when planning the interventions; and the planned interventions not monitored;

6. The respondents in the Head Office said that another defect in implementing the Departmental M&E system was to have the Head Office Programme and Component Managers not monitoring their own OPS Plan. These respondents explained that this behaviour could not be called non-compliance as they did not know that they should monitor the implementation of these tools.

Findings led to the conclusions that showed that focused and strong leadership on the implementation of the M&E system could have played a crucial role. This coupled with other environmental factors like the existence of proper tools and direction being provided by the principals of the intervention would have produced the expected outcomes.

6.2.3.2 Programme specific M&E Implementation Plan and the process followed

Planning is the first step before implementation; hence the implementation plan for programmes or interventions. The framework implementation plans developed is a guideline for implementation. It is required that the people implementing develop their own implementation plans that are programme specific in order to monitor their own implementation progress. The discussion below is about conclusions drawn from the findings on this topic.

1. The Senior Managers said that the programmes did not have the Implementation Plans to monitor their Operational Plans for their own Programmes and Components at the Provincial level;
2. The districts produced reports on the Provincial M&E Implementation Plan but admitted that they did not monitor their Operational Plans based on their respective District Health Plans mentioned tools, except for Amajuba District;
3. The perception is that the M&E Component should have capacitated them to monitor their OPS Plans and provided a template to be used for this purpose. These tools have all the indicators the districts need to monitor as they are based on the District Health Plans (DHP) that respond to the APP and the Strategic Plan of the Department;

Deducing from the conclusions it is not clear how the respondents would have been able to successfully monitor the success of their programmes as they did not have their programme specific M&E implementation plans based on the Implementation Plan of the M&E Framework. This shows that the managers were not capacitated to conduct monitoring even of their own programmes.

6.2.4 Monitoring and evaluation information usage

6.2.4.1 Data quality and measures to ensure data quality

Good quality data ensures good and reliable reports and the contrary is obvious. It is, therefore, crucial to note the following conclusions that were based on the findings on the study regarding data quality.

1. The problematic issues that surrounded the process of implementing the M&E system influenced the quality of data produced. These included lack of data collection tools or having outdated and inadequate reporting tools.

2. Lack of data verification systems including tools and standard operating procedures at the grassroots; lack of adherence to the DHIS validation rules; and lack of supervision.

3. The Programme Managers in the districts did not know who used their reports because there was no feedback provided to them by any stakeholder. Reporting to multiple stakeholders without having stakeholder analysis procedures and processes in place also proved a challenge resulting in the compilation of thumb sucked reports. In addition, shortage of staff to adequately execute all M&E functions intensified poor data quality;

4. Inadequate understanding of the M&E concepts in particular and M&E System in general affected data collected. This was due to lack of relevant training particularly in data quality management.

Good data quality involves several factors which should be taken into consideration when collecting, collating analysing data and generating reports. If such factors are not considered, the quality of data or reports will be compromised. This may affect future planning and decision-making. Therefore, M&E should be involved in all the stages of working with data.

6.2.4.2 Importance of the M&E information and its usage in the Department

It is of no significance to have M&E information in abundance if it is not used for planning; and if it is not used for reaching the goals of an organisation. This is the case as the M&E System is generally regarded as a management tool. The following conclusions on the findings establish the extent to which this is true for the DOH.

1. Programme Managers in the districts did not know who used their reports, as they did not receive feedback. This meant that they also did not know if and how their reports were used;

2. The Senior Managers admitted that the M&E system was appropriate for planning, decision-making and that it fed into the next cycle of the Strategic Plan;

3. All other respondents agreed that the M&E system enabled them to assess the progress of their programmes and were able to review them; it provided baselines in order to develop appropriate targets; it provided awareness of the early warning signs for disease outbreak and plan interventions; they were able to identify specific facilities that functioned poorly; and could plan accordingly;

4. The respondents said that the M&E information was good for resource allocation: be it human, financial or human resources. It also enabled the PMs to improve services by looking at abnormalities in the data collected, identify errors and do trend analysis.

The above-mentioned conclusions clarified the extent to which the M&E information is used in the Department. Considering this, one would easily come to the conclusion that the M&E system is successfully implemented in the Department. This conclusion, however, should be made with the findings regarding the employees' involvement in the M&E implementation process. Would this not give an idea of how the same employees may conveniently utilise ready-made products without 'making their hands dirty'?

6.2.5 Challenges and remedial actions – evaluation of the M&E system

6.2.5.1 Challenges which the M&E system is faced with

Like any new intervention, the mainstreaming of the M&E system seems to have inherent challenges. Whereas this section illustrates the challenges, simultaneously it provides strategies or ways to address the challenges.

1. One of the respondents said that the Departmental M&E system had a ‘silo function’; that it was not generally accepted, as each Unit in the Department had its own M&E staff; and that there was no talking of one language in the entire Department which resulted in confusion in the districts;

2. The understanding of the M&E Framework in particular and the M&E system in general was also seen as a challenge that impeded the ‘buy-in’ from the all the staff members especially the managers and the mainstreaming of the system. The lack of knowledge of the M&E Framework in particular was due to the fact that it was never formally introduced to all the Department spheres;

3. Districts, however, had a better understanding of the M&E system in comparison with the Head Office staff, though it was not enough;

4. Lack of full understanding and knowledge of the M&E concept in particular and M&E issues in general at all levels of the staff was evidence of lack of capacity even in the leadership. For instance, in EThekwini district, it was established that the Medical Managers themselves could not design the interventions that would address challenges and improve performance ;

5. The above challenge led to people having an attitude towards the M&E system - ‘detached’ themselves from the implementation of its Framework. As a result the data collected did not tally with other data collecting tools (tally sheets and monthly summary forms) causing data errors and inaccuracy;

6. Data collection tools (and other tools) used had no SOPs resulting in the users having no direction or adequate guidance to use them; poor data quality was a major issue due to lack of data verification tools at the grassroots; lack of adherence to the validation rules coupled with lack of supervision;

7. Reporting to multiple stakeholders without having stakeholder analysis procedures and processes in place also proved a challenge resulting in producing thumb sucked reports; and

Below are the remedial actions for the above-mentioned challenges mentioned above:

1. Revising the M&E structure at all levels and ensuring adequate dedicated staffing for the M&E mainstreaming and correction of job descriptions of the M&E staff at facility level;
2. including the M&E role in each employee's KRAs and strengthening the Employee Performance Management and Development System (EPMDS);
3. Revival of the Health Information Teams (HIT) in district and establishing a Provincial HIT; strengthening of M&E support at all spheres;
4. Proper introduction of the M&E system at all levels; integration of Units and programmes at all levels, engaging them in the M&E processes; having adequate tools for data collection and providing M&E training;
5. The M&E module should be included in the induction programme for the newly employed and for the entire Department employees; and an on-going training on M&E should be provided.

The weight inflicted by having the above-mentioned array of challenges in the M&E mainstreaming is uplifted by the corresponding remedial actions that may be taken in order to address them.

6.2.5.2 Reviewing the current M&E system; elements of the revised M&E system

One specific objective of this study was to review the existing M&E system and determine facts to consider when planning evaluating it. This section provides points to

consider in revisiting the Departmental M&E system. Conclusions on findings showed the importance of the following aspects:

1. Introduction of a new model with a core team at the Province and at district levels; M&E should be included in the employees' KRAs. The new model should adopt a multi-disciplinary approach that has a methodology that would allow networking with all the different units;

2. People spearheading the evaluation process of the evaluation of the M&E system should work according to the Public Service Commission Manual on the implementation and mainstreaming of the M&E Systems;

3. The M&E Framework should include all the required M&E elements and be formally introduced at all levels. This means that the M&E system should have a Framework or policy with an operational plan;

4. Needed is a Departmental M&E not a silo M&E; it should cut across all Units not just clinical programmes;

5. The M&E system should prescribe and guide how to monitor and report; ensure compliance, efficiency and effectiveness through selected indicators that are core to all Programmes and Components - not just the clinical indicators; The M&E report should feed into the internal control (Risk Management); that is, it should adopt a multi-disciplinary approach that works with Risk Management Units;

6. As there was a considerable difference in the understanding of the M&E system between the District and the Provincial staff - with the districts having more understanding – one respondent suggested that a plan to mainstream the M&E system should clearly be outlined in the Framework;

7. Means to enhance acceptance of the M&E System should be identified in order to gain political will and therefore 'buy-in' from all the Programme Managers;

8. A sense of ownership should be developed within employees; and M&E training work plan be included in the framework policy included.

The conclusions above emphasise the fact that the implementation of an intervention in an organisation is a team effort. Similarly, it is important to have a special team(s) that would have its focus on monitoring and reviewing the implementation of the M&E Framework in all spheres.

6.3 General conclusions on findings

As the above discussion outlined findings of the study, it is appropriate to present the general conclusions on the findings in this section. These conclusions are mainly based on the statement of the problem, primary objectives of the study and at the same time attempt to answer the research questions of the study. For instance, this was a case study of the KwaZulu-Natal Department of Health with regard to monitoring and evaluation in public governance. The study aimed to critically review how the existing M&E system had developed; how well it performed; the degree to which the M&E information was used to improve performance of the Department towards reaching its goals and objectives; and the extent to which good governance was achieved. The following is one of the excerpts from a local newspaper that highlighted the extent of the research problem:

> *"The (KZN) Department 10-Point Plan is just rhetoric – an increasingly ineffective initiative to hide the consequences of the profound incompetence of the management of the KZN DOH" (Mercury 18 January 2010:7).*

The study was also based on particular assumptions that would be supported or refuted by the findings. Though the study has a quantitative element it is mainly qualitative. In this regard the response to the assumptions will be provided in a qualitative manner

based on the findings and the conclusions. For clarity and logic the presentation is arranged in themes as follows:

6.3.1 Examining the M&E governance arrangements nationally and provincially

This objective also answers research question one on the DOH M&E system being effectively and efficiently managed. At National level there is an M&E structure in the Department of Performance Monitoring and Evaluation (DPME). However, there is no line function between this structure and the Departments at the Provincial level. The DPME is embedded in the Presidency and its line of function is in the Offices of the Premiers in the Provinces. The M&E Unit in the Office of the Premiers coordinates the M&E functions in the Provincial Departments. The DOH Official in the DPME does not coordinate the M&E functions of the DOH in the Province.

Findings showed that at the provincial sphere of the DOH there was a defined M&E structure situated within the M&E Component in the Health Service Planning, Monitoring and Evaluation Unit. The M&E Component had dedicated personnel whose primary focus was M&E functions. The findings of the study also indicated that the M&E structure polarity was evident at the lower levels of the Department.

The structure at district level was not well-defined as the District Deputy Managers generally known as the M&E Managers also performed the duties of the District Managers in their absence. Reporting directly to the District Deputy Managers was the Deputy Manager: Health Service Planning, Monitoring and Evaluation; The District Information Officer and the Assistant Manager: Quality Assurance and Control and Infection and Prevention Control. The District Information Officers (DIOs) worked with the M&E Managers on data issues. The DIOs were an extension of the Data

Management Component in the Province and worked harmoniously with the M&E Managers on data issues.

At another angle, the M&E structure showed incorrect placement of the Quality Assurance and Control Component that was said to have the responsibility to monitor compliance. It was not placed under the M&E Component but was under the Hospital Services Unit. On investigation, the Quality assurance and Control only monitored the Patients' Waiting Times and Patients' Satisfaction surveys. It did not monitor compliance with other governance policies. In this regard, the M&E system of the Department showed lack of coordination and the Programme Managers also supported this conclusion.

At hospital level the M&E line function was completely unclear as data issues at this level were taken care of by the personnel from two uncoordinated structures. The structure comprised the M&E Manager who reported to the Nursing Manager; mostly involved in clinical functions and less committed to the M&E functions. There was also the Facility Information Officer (FIO) who reported to both the Information Systems Manager and the M&E Manager. The Information Systems Manager had nothing to do with the data issues but had everything to do with the computer system of the hospital. The FIO dealt with data and was thus compelled to report to the M&E Manager on data related issues and reported to the Information Systems Manager on computer related issues. The FIO sometimes neglects the M&E function and was assigned to take care of the duties for the Information Technology User-consultant. This in turn became detrimental to the M&E and data issues. This kind of structure disrupted the effective and efficient implementation of the Departmental M&E system in the whole Department.

In trying to correct this confusion, Itshelejuba Hospital in Zululand District devised an informal M&E structure by making an internal arrangement where the FIO worked closely with the M&E Manager; almost doing away with the IT duties. The FIO reported to the M&E Managers so that the M&E system functioned efficiently in this hospital. However, though reporting to the M&E Manager, the FIO was still required to attend to the computer problems as no one had been employed in his place, and because the job description still indicated that was the responsible personnel for IT.

The M&E structure at hospital level also did not include the CEO as an accounting officer. In reality the Hospital CEO was directly part of the M&E structure as she was expected to play a major role in providing support to the M&E Manager and the FIO by engaging in the data collected and sent to the district. Therefore, the CEO of the hospital was expected to check data for accuracy and relevance before it was signed off.

At clinic level the M&E structure was non-existent. There were nurses, clerks and data capturers who were responsible for data collection. In some clinics where there were no clerks and data capturers, lay counsellours were involved in data collection. The data capturers or the clerks were also responsible for data capturing into the computers. They collated the data and sent it to the hospital FIO as well. The clinic nurse in-charge signed off the collated data before sending it to the hospital.

With all this information it could be concluded that the M&E governance structure was not completely developed, coordinated or managed effectively and efficiently; which affected the smooth implementation and mainstreaming of M&E through all the spheres of the Department in the Province.

6.3.2 Examining the extent to which M&E is complied with

Compliance with the GWM&E

This section also answers research question two on the Department compliance with the basic tenets of the GWM&E System and of good governance. Findings showed that the M&E system was not generally accepted by all the staff as an intervention from its inception, as there was no ownership, which resulted in the lack of commitment or political will amongst the staff. This in turn resulted in the absence of accountability towards the collected data and the generated reports.

Lack of interest in M&E, inadequate knowledge and understanding of the Government-wide Monitoring and Evaluation Framework Policy, and minimal involvement of staff in its implementation was among the findings. Respondents had never seen the GWM&E; never read it; did not know its purpose; and could not mention its tenets or assumptions though the Departmental M&E Framework made references to and was based on it. Conclusions can be made that from its inception the M&E was poorly implemented – as training or workshops to introduce the Departmental M&E Framework were never conducted and, therefore, no orientation was conducted on the GWM&E Framework.

The DOH staff had adequate knowledge of some legislative mandates that prescribed use of the M&E system and reporting in the Department. The Health Act, Mental Health Act and the Constitution of South Africa were amongst the mentioned legislation. A list of the existing governance structures and legislation that ensured accountability in the DOH was provided.

Regarding inclusion and transparency as elements of governance, there were Hospital Boards and Clinic Committees in place. These structures were included in the Standing Committee on Public Accounts meetings where they worked with District Management

Committees. They attended regular meetings with the hospital management and were also trained in order to help with governance issues. They were invited to the annual Health Summits and to the Member of the Executive Council's (MEC) Budget Speeches and were required to adhere to all the legislation.

The Corporate Governance Component mentioned that there were relevant policies with regard to corruption. These policies included the use of official transport, subsistence and travel allowances, use of resources, equipment and stationery (computers and telephones), absence from duty, exiting from the service and whistle blowing. Though compliance to prescribed mandates was reported, monitoring of compliance was not certain as this Unit was not responsible for monitoring; but it was the responsibility of another Component - the Quality Assurance and Control Component.

The above exposition reveals that evidence of compliance was not ensured as the monitoring of compliance to the mandates was not demonstrated. It can be concluded that the Department of Health demonstrated a gap between theory and practice. The M&E Framework also fell under the same stereotype – of being a good policy that was poorly implemented. Therefore, compliance by this Department to the GWM&E was questionable.

Compliance with the Department M&E system

From the unsupportive attitude shown by the respondents when asked about their opinions of the Departmental M&E system, it can be concluded that the staff did not entirely own the M&E as the tool to use in their daily duties. This was substantiated by the respondents who revealed not knowing about the principles of the Departmental M&E system; its plans and complaints that it was not aligned to their Components. Some managers also reported having no direct involvement with the M&E Component. Though

these Managers reported quarterly to the M&E Component using the template developed by the M&E Component, they thought it was the Strategic Planning Component that they reported to. This was also indicative of the confusion of the M&E and the Strategic Planning Components; and the disregard of the M&E Component.

The readiness assessment is an approach that is promoted by the National Department to encourage assessment of whether people are ready or not to implement an intervention. The findings of the study indicated that this process was never undertaken prior to the implementation of the M&E system in the Department; and it could be concluded that this could be the cause of the respondents being detached and having a negative attitude towards the M&E system in general. To them it belonged to 'others'; and they had adopted a 'do not care' attitude. Compliance therefore, could not be expected from people who had "never seen" the M&E Framework.

Since the Departmental M&E system was unstructured and uncoordinated, it can be concluded that it was for this reason that the majority of the respondents suggested a fresh start so that the 'right thing is done right the first time'. Findings showed that the M&E Component did not fully involve all the Head Office Components and Programmes. It developed definitions for their indicators and filled in gaps in their poorly formulated reports. In terms of capacity they were marginalized while giving more focus to the districts. By doing this the M&E Component committed a serious mistake as it caused the Head Office managers to be passive. Therefore, it is appropriate to conclude that the M&E Component failed to empower and capacitate the Head Office Components and Programme Managers to take up their M&E roles and responsibilities and become self-reliant. This caused dependency on the part of the PMs as they took 'a back seat' in matters that concerned their programmes.

The Department lacked an integrated function as it had adopted a parallel system of M&E where on one side there was monitoring targeted to data, and on the other side there was monitoring targeted to the budget. In reality there was nothing wrong with this system as it addressed the question of effectiveness and efficiency. However, the two approaches adopted a silo function as one did not 'talk' to the other. Respondents voiced out that they did not understand the role of the Manager who performed budget monitoring as he only attended the M&E Managers' meeting once in a while to comment on budget spent or allocated to the programmes. This is another proof of lack of integration in the Department.

The uncoordinated function was also evident between the clinical and non-clinical Programmes at the district level. The District Health Plans and the Operational Plans were not aligned to the Departmental M&E system. The respondents did not integrate their daily routine with M&E which resulted in its poor implementation and mainstreaming. To some extent this also showed the degree of lack of coordinated functioning of the M&E system.

It is reasonable to conclude that the M&E Component confused the managers as on one hand it required that the Programmes submit their indicators for inclusion in the reporting templates; on the other hand the M&E Component chose core indicators as per APP and removed extra indicators submitted by the programmes as per Programme requirements if they did not confirm that they still needed them for the following Financial Year. As this was not well communicated to the Components and the Programme Managers, it created more confusion. There were no clear processes which affected the implementation of M&E and compliance of the staff.

The situational analysis on which the M&E system was based, mentioned that there was a plethora of information systems in the Department which should be consolidated into

one; with one reporting system. On one hand the M&E system claimed to discourage parallel reporting from the district and yet new parallel reporting systems were introduced, for example: the 3-Tier.net System for the Anti-retroviral Treatment Programme; and the proposed National Health Insurance System (adding to the District Health Information System – DHIS, TB.net System for the TB Programme and the Communicable Diseases Registers (which still existed as parallel systems). This added to reduced interest in managers and less compliance to M&E as it did not benefit them much.

It is mentioned in the above discussion that some managers did not want to sign for the reports as they evaded accounting for the inaccurate data. When feedback was provided on the data that they had submitted, they became defensive when poor performance was pointed out. This led people not taking into consideration the comments and corrections given. Their attendance at the meetings was poor and when they did attend, they were passive and did not partake in discussions. For this reason, the remedial actions decided on were not implemented, resulting in the same challenges continuing over time. It can be concluded that the M&E system did not contribute much in improving the performance of most programmes. Data accuracy was mentioned as a requirement for data quality in the M&E Framework but there was no standard operating procedures to help monitor compliance. Therefore, compliance was also lacking due to lack of M&E processes and procedures in place.

It can also be concluded that the attitudes of the staff also contributed to poor implementation of M&E in this Department. For instance, some respondents were reluctant to collect the required information querying why it was necessary. This attitude was caused by ignorance of the meaning of the indicators for which data was collected; and the reasons why they were monitored and reported on. It could be said that this

attitude emanated from ignorance; and could not have been the case if training was conducted. This was demonstrated when the respondents wanted a dictionary for the indicators not aware that the Annexure E of the APP posted in the intranet had all the national indicators to be monitored and their definitions; the DHIS also had some indicator definitions that were not the APP; other guidelines from several National Programmes for instance, the World Health Organisation Guidelines (and others) were sent with indicators and data elements that had definitions and methods of calculation.

The Department lacked information and a reading culture. For instance, the lack of an information culture identified in the situational analysis still existed after five years. This was aggravated by lack of the reading culture from staff as they did not know some important existing policies including the M&E Framework. In conclusion, the employees of the KwaZulu-Natal DOH did not take their work seriously; and the managers driving the M&E system did not drill the M&E system well enough for the employees to internalise.

It cannot be concluded that reporting was complied with the implementation of the M&E system as, according to the nursing profession, nurses already produced reports irrespective of whether or not there were standardised or correct tools. In that way reporting can be regarded as the culture in the nursing profession. It is a fact that reporting towards the M&E system was more structured because of the standardised templates and procedures; but it cannot be concluded that reporting was reinforced solely by the M&E system as there were other contributory factors.

There was poor compliance with the reporting system to the M&E Component at the Head Office. For instance, less than 50% of the Components/Programmes submitted regular reports to the M&E Component. Some disregarded this responsibility of the M&E

Component and by-passed it to report directly to the HOD. This procedure was reinforced by the fact that most Components had their own M&E Officers and, therefore, saw no reason to report to the M&E Component. Compulsory reporting occurred when the HOD or the MEC or the Office of the Premier wanted reporting on particular indicators that the report would be demanded from non-complying Components.

Filling out the prescribed reporting template and following the guidelines were not adhered to resulting in gaps in the reporting template. The raw data was always provided but the qualitative narrative to explain the data, give reasons for not achieving the targets, stating the remedial actions and giving progress of the actions taken for previous low performance were not followed to the core. This confirmed that the information culture was lacking as mentioned earlier and that compliance to reporting was a challenge.

The majority of the DOH employees did not know their M&E roles and responsibilities though these were well tabulated for every Unit in the Department - from Management Committee at Head Office down to the CEOs in the Facilities. It can be concluded that this is both the M&E system's shortcoming and the employees' avoidance to account.

The M&E Framework also prescribed that there should be Health Information Teams (HIT) at all spheres of the Department that would actively interrogate data and the reports. The findings indicated that at HO level the HIT had never been established, as this was the responsibility of the Information Systems Management Directorate. The findings also referred that this Unit was solely responsible for Computer related issues not data. Because of wrong placement of the M&E functions, there was no effort to establish the HIT. Therefore, there was no compliance with M&E.

The conclusion on the lack of procedures and processes is strengthened by having no clarity on procedures and processes to develop and run the HITs. It was for this reason that even when the HIT still existed at lower levels discussions were on general issues and not on data issues.

The assumption that *compliance to the M&E Framework will have a positive effect on performance (efficiency and effectiveness) of the Department* is not justified as compliance was observed only on the M&E Managers at District level. The clinical PMs detached themselves from the M&E exercises and the non-clinical Managers did not partake fully in the M&E processes. It can thus be concluded that the effectiveness and efficiency of the M&E system was questionable.

6.3.3 Commitment of management to implement and use the M&E Framework as a management tool

With regard to commitment to implement the M&E Framework, findings indicated that the management lacked adequate knowledge of the M&E roles and responsibilities, which implied lack of commitment. In conclusion the above mentioned theme leads to the conclusion that the management in the Department was not fully committed to the implementation of the M&E system.

Shortage of staff mentioned in the problem statement of this study was supported by the findings. This warrants a conclusion that the staff shortage in the Department contributed to lack of commitment from the employees.

The political arena clouded the decision of the Department and affected the implementation of mandates. To substantiate this statement, findings showed that without consultation some staff was deployed to certain districts that did not have such

need. The respondents announced that this was undertaken for political reasons (as it was a mandate from National Government) where the number of youth employed was seen as more important than the needs satisfaction. Based hereon, it can also be concluded that the Departments tended to demonstrate the conflict of interest.

The findings showed that the staff did not know the stakeholders to whom reports were sent, as they did not even receive feedback. The respondents were flooded with report requests in different templates causing them to provide data that was 'thumb-sucked'. A conclusion can be drawn that having no stakeholder analysis in place; and no provision of feedback from the recipients of the reports demotivated the staff and diminished their integrity.

Another conclusion that can be drawn from several factors already mentioned above is a questionable M&E aptitude of the managers driving the M&E system. For instance, together with other shortcomings in implementing the M&E, the stakeholder analysis and the report thereof was not conducted at its inception. A standard operating procedure (SOP) for reporting to stakeholders was not developed or included in the M&E Framework. Furthermore, Amajuba, the only district that had developed its own Implementation Plan to monitor the OPS Plan, requested the M&E Component for further input but was never provided. Other districts requested a template of the Implementation Plan for their District Health Plans, which was never provided. This added to the doubt of the competency, capacity and dedication of the M&E Component itself.

In answering the research question on benefits of the M&E to the Department it can be concluded that if the stated benefits were used in practice, the M&E could be a real benefit to the Department. Some mentioned benefits in the findings were that M&E was

good for planning, decision-making and feeding into the next cycle of the Strategic Plan; that it provided ability to assess the progress from the baselines and targets; and were able to review their programmes - and others stated in the findings. In theory, almost all the uses of the M&E information were mentioned by the respondents. However, as previously concluded, there was a gap between theory and practice - little was done in terms of reviewing their programmes and implementing interventions that had been planned to address the challenges they encountered. Therefore, the M&E provided minimal benefits to the Department.

Regarding the assumption that *The level of commitment of the senior management towards the implementation of the M&E Framework in the Department will contribute to M&E information use (as a management tool for planning and decision-making),* to an extent the M&E information derived from the M&E reports was not entirely used to improve the programmes and the service delivery status in the Department because of minimal commitment of the staff at all spheres of the Department. Among other facts, this was evident when some PMs did not put to action the remedial actions decided upon; and the lack of commitment showed when they were given feedback on their reports.

6.3.4 M&E capacity of the management

The Management in the DOH lacked adequate capacity to effectively and efficiently drive or mainstream the M&E system. This conclusion is made because the respondents admitted that their M&E knowledge was limited to reporting only. This conclusion is appropriate because they did not know how to develop indicators and targets, analyse data and monitor progress; they could not identify data errors and follow trends. They were also frustrated that they had never been trained on either the DHIS or on M&E. This lack of capacity resulted in programme managers not knowing the meanings of

indicators and data elements, to poor quality data and unreliable reports. In this way they could not understand their own data, let alone identifying errors and discrepancies.

The Department poorly demonstrated some governance principles of inclusion and transparency. For instance, involvement of relevant stakeholders when developing the policies was not all inclusive; the developed policies were either not distributed to all spheres of the Department or there was no awareness that policies were posted in the Department website. An example in this regard was the training policy (and the M&E Framework), which was not known to the respondents. Consequently, when the same people went for training they returned without material or proof that they indeed were exposed to such training – showing that the training policy was not known.

About the assumption that *the M&E capacity of senior management in the DOH will determine successful implementation of the M&E system (efficiency and effectiveness),* the findings showed that as a result of the lack of M&E capacity amongst the senior management the M&E System has not been successfully implemented in the Department. This affected its effectiveness as well as its efficiency.

6.3.5 Challenges and remedial actions on implementing M&E

This section also answers research question four of the study on the current M&E challenges and the interventions to address them. Concluding on the findings of the study, it is apparent that the Departmental M&E system had an array of challenges related to the M&E governance and structure, the job descriptions; its disjointed function - 'silo function'; capacity and commitment of management; mainstreaming at Head Office and to lower levels of the Department; alignment to other programmes; processes and systems of reporting and information usage including poor data quality. The system failed to develop M&E skills to most of the relevant people in order to drive forward the

system. They had limited knowledge of M&E concept in general and particularly understanding of their M&E functions; the Standard Operation Procedures (SOPs); M&E concept; developing M&E Implementation Plans, indicators, targets, dictionary, data verification tools and how to follow the validation rules; negative attitudes that prevailed among the staff became a deterrent to the smooth mainstreaming of the M&E system as they 'detached' themselves from the implementation of the M&E Framework.

In addressing the above challenges some remedial actions were mentioned. These are inclusion of the M&E training in the induction programme for the newly employed staff in the entire Department; on-going training on M&E processes in general; the correction of job description as well as the structure and proper introduction of the M&E; inclusion of the role of M&E in each employee's KRAs and strengthening the EPMDS; revival of the HIT in district and establishing a Provincial HIT; strengthening of M&E support to all spheres and having enough staff to drive the M&E mainstreaming forward.

The assumption that *identifying the challenges and applying the remedial actions will result in improved utilization of the M&E information policies and their implementation* cannot be supported as the above evidence showed that the remedial actions that were identified by the M&E Components for the relevant managers to implement in order to improve their programmes were not implemented despite several challenges the Departmental M&E system had experienced. This resulted in trends of the same challenges over the years.

6.3.6 A framework model for the evaluation of the Department M&E system

This section also answers research question five on the essential elements of an evaluation framework of the Department M&E system. It was established from the

findings that there is a need to introduce a model for the evaluation of the M&E system of the department of Health. Different elements of the Model were provided. These will be presented as the recommendations of the study.

The assumption *to improve the M&E system requires determining facts or input the evaluation of the M&E system in the Department* was supported by the findings of the study. The need to review the M&E system of the Department was mentioned by all the respondents and inputs were provided. The M&E system's proposed framework for evaluating the M&E system was, therefore, developed as illustrated in Chapter Six.

6.4 Conclusions on the study

It can be concluded that for the KwaZulu-Natal Department of Health, the process of mainstreaming the M&E system was a cumbersome exercise. This statement is based on the findings and conclusions obtained from all levels of this Department. The problems encountered by the DOH in this endeavor were related to the M&E structure and its alignment, staff attitudes, M&E knowledge and skills, lack of integrated function between and within all levels of the Department; lack of appropriate data collection and verification tools; lack of SOPs; limited training on the new tools; lack of consultation or involvement of the staff on changes made; poor data quality; late reporting, unrealistic deadlines and poor quality of data.

In the above-mentioned factors poor quality data was profound. Though all Districts reported as per the requirements, only 50% of the Provincial Programme Managers submitted their reports on a regular basis to the M&E Component. This showed detached attitude; running away from responsibility; and lack of accountability. This evidence also suggests that readiness-assessment and training of all the stakeholders

on any policy or framework should be conducted before the implementation process begins; because these were not undertaken. In the study the power of impartiality that influenced the attitudes was recognised at all levels. Working in silos, as identified by Cameron (2008: 11), still persists.

When assessing the progress since the mainstreaming of the Departmental M&E system in 2008, all the participants agreed that the existence of the M&E system helped in improving strategies to advance their programmes as well as the coordination of the M&E system of the Department, though a gap between theory and practice is rife.

This research report is not more than just a preliminary study. Further research is required to develop and modify a number of arguments. Nevertheless, a number of broad points can be made. Neglecting or not capacitating the stakeholders, leads to lack of political will, buy-in or ownership of the intervention. This is evident in the conclusions made above on the research questions and the assumptions of the study.

An outline of the mentioned concerns of M&E mainstreaming (for good governance), is not only the interest of implementing the M&E policies; it also helps rebut ideas that M&E mainstreaming is just one linear exercise of monitoring performance towards achieving the objectives of a Government or a Department. It reflects a view which suggests that the political will and readiness, the political environmental, organizational culture and a positive mindset are impetus for the successful implementation of any legislative policy. The results of the study will ensure that the correct M&E system is developed and implemented appropriately.

6.5 Recommendations

Recommendations discussed in this section emanate from the findings and the conclusions presented above. The discussions on the recommendations are also based on the primary objectives of the study in order to determine if the study met its objectives.

6.5.1 Monitoring and Evaluation Governance Arrangements within the DOH

It is recommended that the structure that exists at National level continues through to the Departments at the Provincial level. The connectedness between the National DPME and the Departments in Provinces is recommended in order to ensure the smooth mainstreaming of M&E through the Provinces down to the facilities. **That is, the M&E Components within the Provinces should in reality be an extension of the DPME structure that connects it to the Departments;** it should provide guidance to these M&E Components at Provincial Departments as the Office of the Premiers do not mentor the Departments through their endeavours to mainstream M&E through all department spheres.

Reviewing of the erroneous M&E structure within the Department is recommended from the Head Office down to the facility level. Correct placement of Components such as the Quality Assurance and Control **should be undertaken and the M&E pockets eliminated.** This means that Quality Assurance and Control placed in the Hospital Services Unit should be placed in the Monitoring and Evaluation Component as their function is to monitor compliance to the National Core Standards, the Departmental policies and frameworks. This will facilitate monitoring of functions, provide guidance to the staff and in turn this Component will receive proper direction from this Directorate.

The Head of Department is the accounting officer of a department. **It is recommended that he or she takes the initiative to be fully involved in the M&E processes so as to account for the reports that are generated by the M&E Component.**

It is recommended that the District Deputy Managers do not perform the duties of the District Managers but concentrate on the mainstreaming of M&E, develop appropriate tools, train the staff on M&E, provide full M&E support where required without being overloaded by other District responsibilities and ensure integration between the clinical and the non-clinical officials or managers. The **M&E Component at this level should concentrate on data and M&E issues by providing M&E and data management training including data quality assessment training on how to verify data and also be involved in data validation.**

The recommended structure should also prevail at grassroots (hospitals) where the M&E Manager's portfolio focuses on M&E and data. The FIOs should report directly to the M&E Manager and be supervised by them. They should not function simultaneously as Information User-consultants; this disrupts the M&E functions. User-Consultants that would perform this function should be employed. The M&E Manager should not be a Clinical Manager as this will cause them to continue doing the clinical duties disregarding the M&E functions. The current M&E Manager should choose between being an M&E manager and leave the clinical duties; or revert to being Clinical Managers if they want to receive the Occupation-Specific Dispensation.

Alternatively, new M&E Managers who have a clinical background should be employed, as moving them from nursing over to M&E is not working. This means that there should be a complete move away from the Clinical Manager who is still doing clinical duties to an M&E Manager who fully focuses on M&E. **This reform should be**

supported by a revised job description that solely focuses on M&E functioning. The arrangement made at Itshelejuba Hospital (discussed in Chapter Five and elsewhere in this chapter) in Zululand District is a model to follow in this regard. This, however, needs to be officiated and rolled out to other hospitals in the Province. **A hospital CEO is part of the M&E structure and should also be part of M&E be accountable for the quality of data that the hospital produces and the report it generates.** All staff should be trained on the Departmental M&E Framework. Continuous training and technical support should make them accountable when signing off their reports.

Clinics should also have a person dedicated for data processes and reporting; and clinic staff trained on computer skills. They should also be trained to develop their own verification tools while waiting for the standardised tools (which sometimes never come) from the District or Province. Having developed their own tools, they can seek support and a go-ahead from the next supervisor.

A recommendation of Integration of the M&E system in the entire Department cannot be overemphasised. The silo function of the Departmental Units, Components and Programmes should be done away with. The skewed M&E system that focuses only on the clinical and disregarding the non-clinical programmes should be done away with. This would bridge the gap between the two 'groups' evident at District and lower levels where non-clinical PMs do not see the M&E system as their management tool. Budget monitoring and data monitoring should somehow work together; there must be dialogue between them. An explanation of how they function should be made transparent so that the presentations of budget monitoring do not come as a surprise to the M&E Managers during the meetings.

As mentioned in the above discussion, the 11 districts of the province vary in size. It is recommended that the M&E staff is provided per population catchment of the district as this is influenced by the number facilities (clinics Community Health Centres and hospitals). **This means that there should be adequate staffing at all levels to mainstream and provide adequate M&E support.**

Close functioning between the Data Information and Management and the M&E Components should be strengthened as these two Components do more or less the same function of dealing with data and reporting. Their coordinated function should be more vivid in districts for mainstreaming at district and facility levels if good results are to be achieved. Working in an integrated manner of the two components will also iron out the confusion amongst the staff on these (components) and the Strategic Planning Component.

6.5.2 Knowledge and understanding of M&E

With reference to the findings on the lack of knowledge and skills of the staff, it is recommended that mandates both from National or Provincial Health Offices should be known and complied with by all health workers at all levels. To ensure this, in-service training should be conducted at District and Facility levels. **The Training Manager at these levels should work together with the Quality Assurance and Control Component as it monitors compliance with policies.** This should inculcate an information culture amongst the staff so that it is internalised into seeking new information and reading any material that they come across in order to grow. This will also help bridge the gap between theory and practice; the legislative mandates and policies will not just be theory but will also be implemented.

The M&E Component should create information sharing platforms and see to it that these platforms are functional. For this, relevant tools and relevant indicators or data elements; and terms of reference should be developed to ensure that there is performance monitoring on progress towards attainment of targets and objectives as per discussions and developed action plans. As an example, to monitor functionality of the Hospital Boards and the Clinic Committees minutes of their meetings and execution of decision made during the meetings should be rigorously monitored in order to say these structures are functional, that is to confirm functionality of these structures.

Health Information Teams should be revived in the districts and established at the Head Office. As the M&E Implementation Plan prescribes that it is the responsibility of the Information Technology – Informatics (IT) Directorate to establish and chair the Health Information Teams in the Head Office, this Unit should establish and ensure the smooth running of these teams. Alternatively, **this function should be driven forward by the M&E Component as the IT Unit is mainly responsible for computer functioning.** As a recommendation the M&E Component should follow up with the IT Component on this; and give direction or SOP as to how to develop the HIT and terms of reference. This should be cascaded down to the other levels of the Department so that the same procedure is followed as well. Close monitoring and support should be provided and dialogue platform created at all levels.

All the three Components – the M&E, Data Management and Strategic Planning should work together to train the staff both on M&E and data management issues. Training should encompass the DIOs, FIOs and their supervisors so that the supervisors develop confidence to supervise their subordinates.

It is recommended that an M&E module is developed on which formal training is conducted through in-service and during induction of the newly employed staff; and as an additional module in the Nursing Colleges to ensure that as nurses qualify they are fully capacitated on M&E mainstreaming. A record for monitoring purpose of the extent to which the workshops have reached the facilities should be kept. The M&E Component should monitor this process through quarterly reports from the districts.

The content of the M&E training should also include though not limited to the following M&E areas:

- Developing the M&E Implementation Plan;
- Capacity to align M&E Plans; to monitor the implementation of their own OPS Plans; and the DHPs (The M&E system should be incorporated or integrated into the DHPs so that it is not viewed as a separate function from the DHP/functions of the district as a whole);
- Develop indicators, indicator definitions and targets;
- Validation rules to the supervisors so that they can supervise their subordinates;
- The nurses' curriculum should have an M&E module for nurses in Nursing Colleges;
- M&E should also be included in the Induction Programme so that the new employees receive training when they are employed;
- Development of data collection tools and how to use them;
- Data processes: collection, collation, analysis, reporting, usage and dissemination;
- Development of SOP and how they are applied;
- Data verification and validation (data management system);
- Indicator and target development; calculation and trend analysis;
- Both quantitative and qualitative report writing; and

- Data quality assessment or data audit trails.

6.5.3 Extent to which M&E is complied with

In order to do away with negative attitudes, it is recommended that readiness assessment as an approach promoted by the National Department is followed to assess if people are ready to implement an intervention. Readiness assessment can also be integrated into the review or evaluation of the M&E system of the Department so that recommendations are included in the evaluation report. As a principle it is, therefore, imperative to conduct the readiness assessment before any new intervention is implemented. The readiness assessment will determine capacity; human, material and financial resources; the political will of the staff in general and other tools necessary for the implementation. Simultaneously, the readiness assessment will have played a role to sensitize the staff and develop ownership of the proposed intervention (for example, the reviewed M&E system) and ready to take it forward. This exercise would also develop the skills to integrate their daily function with the M&E system in a coordinated manner.

In order that the staff are accountable for the reports that they generate the M&E Framework should include a standard operating procedure on reporting which covers all aspects related to reporting accountability and feedback: what it means and how it should be taken - as people take it as accusation and subordination or naming and shaming - and so become defensive. The facilitators of M&E implementation should develop the will amongst the staff to enjoy such meetings and take them as an opportunity for information-sharing and not of being ‘attacked’.

6.5.4 Commitment to implement the M&E Framework

Management lacked commitment to implement M&E claiming ignorance of their M&E roles and responsibilities, which are illustrated in the M&E Framework. It is recommended that **the Framework is formally introduced to the management and**

the staff at large in workshops so that they are aware of their M&E roles and responsibilities of different categories at any level of the Department.

In the previous section, it was demonstrated that the staff shortage contributed to the mentioned lack of commitment. It is, therefore, recommended that together with implementation of new protocols, frameworks or policies, if such would require added responsibility from the staff, **additional workers should be employed to meet new challenges.**

The findings of the study showed that employees tend to generate unreliable reports ("thumb-sucked") if they did not know the stakeholders and how their reports were used. **It is recommended that the stakeholder analysis is made** with the District Managers where clarity is provided of what data is needed, the frequency, the format in which it should be presented; and the medium of dissemination. **Feedback thereof should be made as soon as possible after data is submitted;** turn-around time for feedback should also be clearly stated and adherence monitored.

The Employee Performance Measurement and Development System (EPMDS) should be followed and implemented as per requirements. **The M&E role should be added to each employee's KRAs in order to strengthen the EPMDS engagements.** The M&E Component should entrench into the employees' minds that the Departmental M&E System is for the entire Department despite the fact that programmes have their own M&E personnel. **Capacitating of the staff should also include how to monitor their own OPS plans through the Implementation Plan for monitoring the OPS Plans.**

Based on the findings, the job descriptions, the structure and proper introduction of the M&E system should be undertaken in order that the staff is committed to the M&E function.

6.5.5 Determine factors to consider in evaluating the M&E system.

It has been mentioned elsewhere in this report that though there are various models for the M&E systems in most countries Governments and Departments do not use the evaluation systems to monitor their performance against indicators whether goals and objectives are being achieved within prescribed timeframes; let alone the evaluation of whether the achievements were the expected outcomes and whether the resources utilised were according to expectations as based on the goals and objectives.

However, this tendency does not mean that the models are irrelevant. The question would be: do the models offer a piecemeal on how evaluation may be conducted on the M&E systems? It may be easier to respond positively because none of the models discussed in Chapter Three provide an effective framework (in their own right) to use to develop an evaluation model of the M&E systems. Reason for the ineffectiveness of these models is the deficiencies that are inherent to them. This means that these models have failed to make a significant contribution to effectively making a connection between the implementation of the M&E system, its effectiveness and its evaluation. It cannot be denied that they make a significant building block for those interested in implementing the M&E systems for performance improvement. They all discuss issues to consider when implementing the M&E system (Chilimo 2009: 365).

According to this notion, the model for the evaluation of the M&E system suggested in this study is based on the ideas that were extracted from the Public Administration and Management Theory, the New Public Theories and the Monitoring and Evaluation

Theories discussed in Chapter Three. A brief discussion of these models is provided in Section 6.1 of this chapter. The above-mentioned theories play a crucial role in development of and ensuring that performance elicit expected outcomes that would enhance the M&E systems or intervention of any Programme.

By combining the ideas from the previously discussed models, the proposed Evaluation Model (see Figure 6.1) aims to explain the relationship between mentioned models and improved implementation or sustainability of the M&E systems. Put differently, the proposed model combines the ideas of the selected models to establish an evaluation framework that includes the best concepts of all the discussed models.

In this study the implementation-impact evaluation was adopted. The implementation assessed whether the M&E system of the Department achieved the objectives of its framework or not and why. The in-depth approach with field work and document reviews was applied. The impact evaluation was used in order to measure changes that could be attributed specifically to the implementation of the M&E system. This approach seeks to inform the management of the effectiveness of the system, where to improve and what modifications can be made. This information will form the baseline of the reviewed M&E system and bases for subsequent evaluations, hence the proposed new model.

In developing the Departmental M&E Framework the Ten-Step Model by Risit and Kusek (2006), were followed as discussed in Chapter Three Section 3.7. However, not all the steps were followed. Step 7 on the Role of Evaluations was not discussed as it required drawing up of the evaluation plan to follow when performing the evaluation of the M&E system. Step 10 requires sustaining of the M&E system within an organisation, which was also not followed to develop means to sustain the M&E system of the Department.

This means that the evaluation process was not outlined as per requirement; hence the need to develop and propose a model to evaluate the M&E system of the Department.

Question five of the study reads: What are the essential elements of an Evaluation Framework for an M&E system for the Department? Additionally, the objective seeks to determine important facts to consider when planning an evaluation of the M&E system in the Department. The relevant theme as per thematic categories in Chapter Five was developed (Theme 5.3.5): Evaluation of the M&E system. The information obtained from the study findings was used as input to feed into this section.

6.6 Contributions towards a proposed model for evaluating the M&E system

This Section presents contributions that were provided by the participants towards developing a new model to review the M&E system of the Department. Based on the above findings and the conclusions are the following recommendations to consider when evaluating the M&E system.

6.6.1 Recommendations on evaluating the M&E system of the DOH

- There should be a **framework that follows the prescriptions laid down by the National Evaluation Framework Policy developed by the DPME (2011).**

- **The M&E system should prescribe and guide how to monitor and report; ensure compliance, efficiency and effectiveness through selected indicators that are core to all the Programmes and Components.** A plan to mainstream the M&E system should clearly be outlined in the Framework; as well as contents of the evaluation framework. Means to enhance acceptance of the M&E system should be identified in order to gain political will and, therefore, buy-

in from all the Programme Managers so as to build a sense of ownership within the employees.

- **The M&E training work plan should be included in the framework policy;** the M&E Team should monitor the implementation of the M&E Framework at all spheres; and it should also monitor reporting, compliance, efficiency and effectiveness though selected indicators.

- **Separate evaluation Team/Committee established should draw the terms of reference** and meet at least once a quarter to monitor outputs and outcomes. People spearheading the evaluation process of the M&E system should work according to the Public Service Commission Manual on the implementation and mainstreaming of the M&E systems (2011: 12). Above this, there must be a baseline to work from and this will facilitate working forward. According to the Public Service Commissioner Manual the M&E should be everyone's KRA and this should be followed as mentioned above. The M&E system of the Department should have resources allocated to it and be slotted for reporting to the Head of Department and Management Committee for recognition.

- **The framework that includes a core team at the provincial and the district levels should adopt a multi-disciplinary approach that works with Risk Management Unit and either do away with the pockets of M&E in the different Units/Components or incorporate them so that they are coordinated by the M&E Component.** The framework or model should adopt a multi-disciplinary approach and should have a methodology that would allow networking with all the different units. This will eliminate the silo functioning that is characteristic of the Departmental M&E; will cut across all Units and not limits

itself to clinical programmes. The M&E system should have a Framework or policy with an operational plan that includes all the required M&E elements, processes and procedures; and be formally introduced at all levels and to all stakeholders.

- **The M&E Framework should prescribe and guide the reporting system, that is, all data collection procedures and processes, templates, tools, SOPs; data flow, timelines and frequency of reporting; verification, validation and data audit trails.** This should also include ensuring compliance, efficiency and effectiveness through selected indicators that are core to all Programmes and Components (not just the clinical indicators).

- **People spearheading the process of evaluating the M&E system should work according to the Public Service Commission Manual** (2000:7) on implementing and mainstreaming the M&E systems for good governance.

- Techniques to enhance acceptance of the M&E system should strengthen the political will and buy-in from all the Units, Components and Programme Managers and should be devised to build a sense of ownership. **It is also recommended that the M&E training is primarily conducted by the M&E Component working in collaboration with the Human Resource Development Section of the Department.** This way training will be tailor-made to suit the employees at all levels. The M&E training work plan should be included in the framework policy. Finally, the M&E Team should monitor the implementation of the M&E Framework at all spheres.

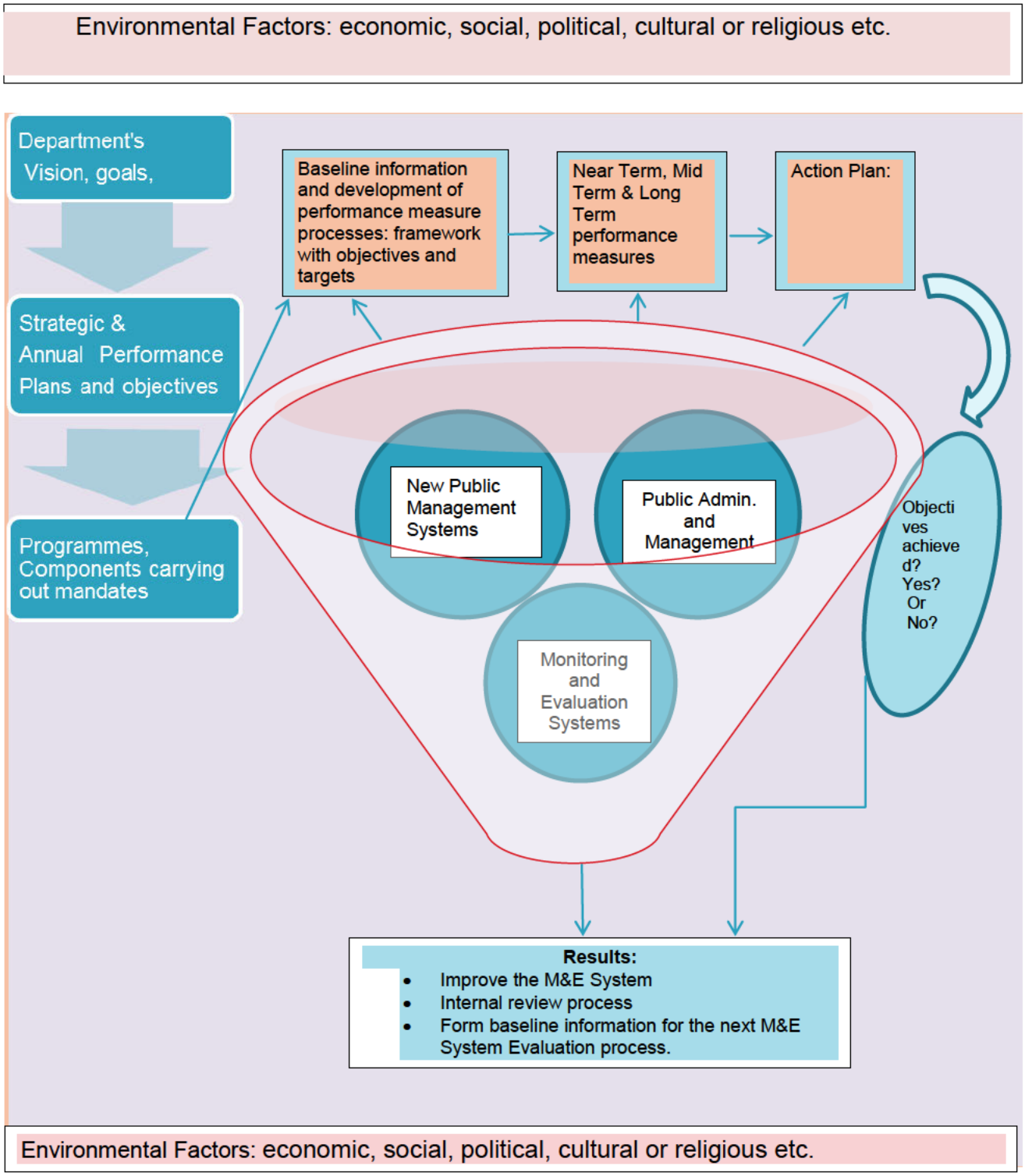
- The Department in particular and the Government in general are the intended beneficiaries of proper M&E. For this reason, it is important to understand the demands and needs for the successful M&E systems; some of which are the enabling environment, the availability of data the information that has to be monitored. The focus should be on the products rather than on processes alone. After understanding the situation at all the spheres of the Department, it is important to determine how M&E system can be improved and utilised as the management tool to meet the objectives and enhance the improvement of capacity which may in turn result in the improved quality of reports. This will then ensure that supply meets demand. The empirical evidence supports this study.

Figure 6.1 below shows how the above-mentioned factors on evaluation of the M&E system in the KwaZulu-Natal Department of Health should be applied.

6.6.2 The Proposed process for evaluating the M&E System

The following diagram is for the recommended evaluation process. Its presentation is divided and discussed according to its levels. This means that each part of the diagram is dissected, and explanation of how it fits to the whole is provided. This is undertaken for easy understanding of how the model can be applied in real situations. Like the pieces of the jigsaw puzzle, by the end of the discussion it will be understood how each part connects to the other; and how all parts connect together in order to give a (whole) model that is readily available for use.

Figure 6.1: Proposed process for the evaluation of the M&E system



The results are reported to improve Monitoring and Evaluation systems and setting a baseline for future exercises.

Figure 6.1 above is a process designed and recommended for use in the Department of Health to evaluate its M&E systems for progress towards the achievement of its objectives in general and of the Departmental M&E Framework in particular.

6.6.3 Explanation of the proposed evaluation process and its levels

As mentioned above, the proposed process in Figure 6.1 can be explained in six levels which suggest that the way these play a part in achieving the optimum goal of quality life for all should be taken into consideration. The process suggests that the focus should not be limited to the reviewed M&E system but it should also encompass other factors. This is congruent with the national guiding principles and standards for M&E, which prescribes that evaluators should have a "comprehensive understanding of the contextual factors of the evaluation as they may influence the results of the evaluation" (The Presidency 2006: 28). These factors include but are not limited to geographical location, timing, political and social climate, economic conditions and other relevant activities occurring simultaneously. Another important factor comprises abiding by the current ethics, standards and regulations on risks of the participants. Other factors to be taken into consideration are discussed below:

The diagram in each level is extracted from the main diagram to facilitate understanding of each level and eventually the entire diagram.

6.6.3.1 Level 1: The organizational culture

Before embarking on this exercise it should be considered that at macro-level any organization functions within an organizational environment or culture. The organizational culture can be explained as shared understanding which exists amongst

employees of all levels regarding how things should be done in that particular organization. According to Erasmus, Van Wyk and Schenk (1998:91) the organizational or environmental culture may be a system of “shared features such as beliefs, values, assumptions, expectations, norms, sentiments, symbols, rituals and so forth”. These factors may be influenced by other environmental factors at a higher level such as economic, social, and political factors. It is within this context that the visions and operational plans of an organization are crafted. In the figure the environmental factors are presented as a surrounding environment within which the Departmental prescripts are crafted.

It cannot be overemphasised that in order that the expertise, resources and processes work in harmony, there should be an enabling environment in terms of policies, the legal and guiding frameworks, political factors, appropriate locally developed content and necessary structures. These structures include the warm bodies and the proper alignment of responsibilities with the relevant portfolios. This kind of a framework is likely to facilitate use of the M&E system for improved performance, data collected and the reporting system at large.

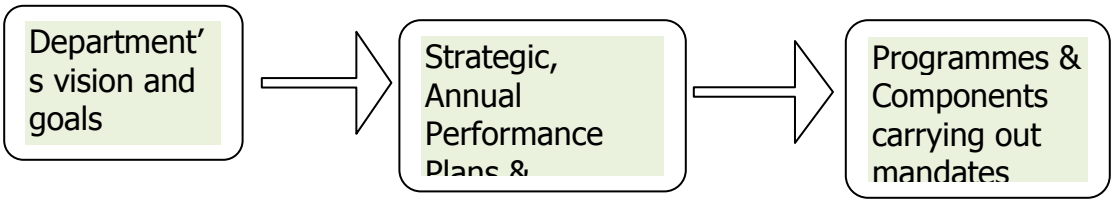
With regard to this study it is important to note that the Department of Health functions within certain perimeters. For instance, there are Department’s vision, goals and objectives. Within these are the Strategic and Annual Performance Plans that include both National and Provincial prescripts. Units within the Department have Programmes and Components which carry out these mandates. They have their performance measures in place to monitor progress towards reaching their objectives. The relevant Component in the respective Unit compiles the Departmental Annual Report for a particular Financial Year which provides data on performance of each Programme or

Component. This forms the baseline for the development of the performance measurement processes (indicators, targets, frameworks and so forth).

It is crucial to note that these elements are guided by an array of legislation, policies and frameworks. In Figure 6.1, these are represented by the structures on the left of the diagram with arrows that show how each category leads to the next and how the upper categories are based on the one below them.

6.6.3.2 Level 2: Prescripts and mandates of the Department

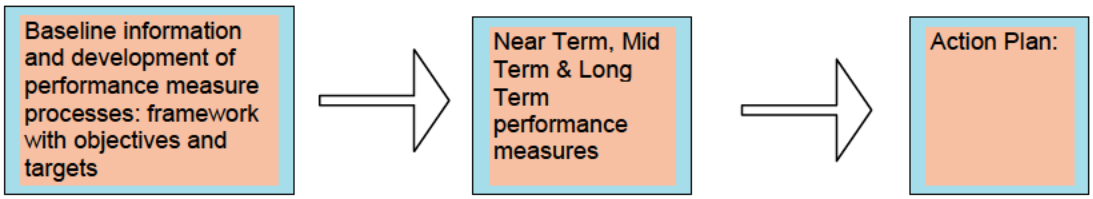
Figure 6.1.1: Prescripts and mandates of the Department



This diagram was extracted from the main figure on the levels of the proposed evaluation process. It illustrates that in order to use this model the Department's vision, goals and objectives including the Strategic Plan and the Annual Performance Plan must be taken into consideration. These are the basic prescripts and mandates that guide and within which the Department – Programmes and Components operate. Taking the cultural environment mentioned in Level 1 above and these prescripts as the platform on which to base the proposed model, will ensure a good kick-start.

6.6.3.3 Level 3: The process of performance measurement

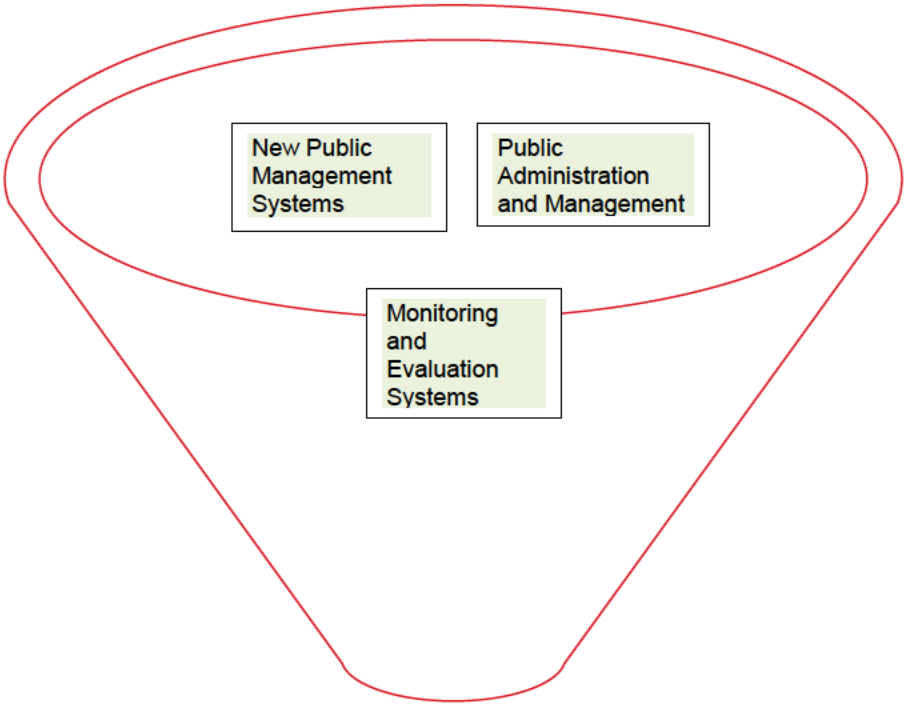
Figure 6.1.2: Process of performance measurements



In order to be able to monitor performance baseline information is required. This feeds into the performance management system of the Programmes and Components so that a framework with objectives and targets and indicator system is developed. The baseline information also feeds into the near term, mid-term and long term performance measurements. There must be an action plan that spells out the necessary steps to take before the process of evaluation is embarked on. The Action Plan is developed also to lay down the terms of reference which the team will follow in its execution of the evaluation process **(www.msu.ed~outreach/mvaa).**

Furthermore, the Action Plan should include the objectives (of the exercise), roles and responsibilities of the team and timeframes. The Team should identify the goals and strategies. The plan on how information will be collected and analysed should be designed. This may include factors like who will assist or collaborate as partners and they should have a clear and consistent understanding of the project vision, goals and objectives. They should also know what strategies they plan to implement in order to reach the objectives; which other relevant partners are responsible for specific tasks and when they should be completed; what resources will be needed and how they will be acquired; how the partnership activities or and projects will be evaluated.

6.6.3.4 Level 4: Factors of the evaluation process



This level is at the heart of the diagram in a funnel shaped figure that incorporates the administration, management and performance measurement of the Department. For instance, the study used the theories (a detailed discussion was provided in Chapter Three) as briefly mentioned below:

Public Administration and Management

Public Management is an extension or a subsystem of Public Administration. Public Administration and Management constitute activities and functions with interrelated processes which, when successfully executed, enable public service employees to achieve required service delivery to the people (Du Toit et al. (2002: 12). These functions operate in the work environment where there are public needs that must be met. Both Public Administration and Public Management operate in conjunction with good governance (Du Toit et al. 2002: 80). This, in particular, refers to the open-system

approach of public administration and management where the environment influences the functions of PA and PM in which they occur (Du Toit et al. 2002:27).

The New Public Management Theoretical Framework

The New Public Management (NPM) approach according to Cameron (2008: 3) refers to a range of different streams of Public Management ideas that seek to bring change in management systems by moving away from a more bureaucratic administrative style of the public sector, towards more individualistic, less rigid and flatter hierarchies. This includes among other factors the creation of the Senior Management System (SMS) category; the use of the contract system for heads of departments; the creation of a more flexible human resources system; and the introduction of Performance Management and attempts to improve service delivery" (Cameron 2008: 3-5).

Monitoring

Performance Management System (PMS) is an intervention to put a stop to poor performance in public service institutions (Malefane 2010: 1). This further denotes that the PMS is about realizing the relationships between individuals, teams and departments in their performance in order to achieve government targets in general and departmental targets in particular.

Evaluation

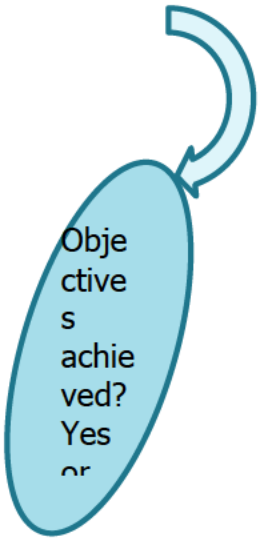
Is the systematic analysis of evidence to assess issues such as relevance, performance (effectiveness and efficiency), value for money, impact, sustainability and the recommended ways forward of a programme. (The Presidency, Department of Performance Monitoring and Evaluation. 2011: iv).

6.6.3.5 Level 5: Decision whether the objectives were met or not

The purpose and the objectives of conducting the evaluation of the M&E system would have been clearly stated at the beginning. After placing the above-mentioned theories in the picture, Level 5 enables the evaluators to refer back to the objectives of the evaluation process and of the M&E Framework and decide whether or not the objectives were achieved.

The draft national guiding principles and standards for M&E of policies and programmes (Republic of South Africa 2006:29) prescribes that when analysing data irrespective of the data collection methods used, the starting point is the evaluation goals, that is, the reason the evaluation was undertaken in the first place. This helps in organising the data and directs the focus to the analysis and the results obtained (Republic of South Africa 2006:40). The results distinguish whether the results were met or not.

Figure 6.1.4: Decision whether objectives were met or not

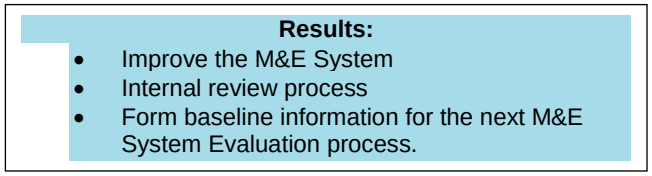


Once the decision in Figure 6.1.4 above is made, Level Six below is followed.

6.6.3.6 Level 6: Taking action on the results

Steps that may be taken are listed in the figure 6.1.5 below:

Figure 6.1.5: Taking action on the results



As shown in the above figure, Level 6 is about the utilisation of the outcomes of the evaluation exercise. For instance, if the objectives were reached a decision to continue with the System are made and areas where strengthening is required according to the recommendations of the evaluation are applied. If the objectives were not reached, the findings of the study may have identified challenges and barriers as well as interventions or remedial actions to apply. These are applied in order to improve the System. The results also inform the internal review processes and can provide the baseline information for the subsequent evaluation processes of the M&E System.

6.8 Suggestions for future research

The current study investigated the effectiveness of the DOH M&E System and efficiency of the management to successfully implement and use the M&E system as a management tool. The study identified several issues which other researchers may use to further investigate this field. In the discussion, there are some of the issues which other researchers may be interested to investigate.

It is recommended that studies be conducted to establish the readiness of the entire organisation (Readiness assessment) to implement any intervention. This is

recommended particularly in the implementation of the M&E systems as it is still a new concept and practice in Government. If such a study is conducted before any intervention, acceptance and 'buy-in' of the proposed intervention may be elicited, therefore, saving finance and other material sources.

In investigating the opinions and attitudes of the staff, particularly those at Management positions, towards the implementation of the M&E system in the Department, the staff in other categories were omitted from the study. For instance, the staff collecting data at grassroots level were not part of the study. It is recommended that a exploratory study be conducted to establish the plight at Primary Health Care (PHC) level given the enormous workload, staff shortage and scarce skills.

Benchmarking in other provinces and at national should be undertaken in order to learn from the best practices. This may include opinions of the M&E Committee or Team in the DPME on the best way to establish a successful M&E system.

The problem statement hinted on the concerns of the citizen on unsatisfactory service delivery that culminate in public actions or strikes. Elsewhere in this thesis, governance was defined as participation, transparency, inclusion and accountability. These terms are also the tenets of the M&E system. The M&E system of the government does not focus on the experiences of the citizens of the government services and use of such evidence to improve performance (The Department of Performance Monitoring and Evaluation 2013: iii). It is suggested that the future research investigate the voice of the populace on service delivery and recommend how this evidence could be used to improve performance and service delivery.

It came as a concern that the Department displays conflict of interest, whereby certain decisions were made from a political standpoint without considering the needs of and the effects on the citizenry. Further research conducted in this area could be of value to good governance in a democratically governed country.

6.7 Conclusion

Based on data and accompanying narratives, the chapter elucidated the results in terms of developing a theoretical model on which the evaluation of the DOH M&E System was based.

Though the proposed model is recommended for use as one of the ways to understand the connection between the Department and the parameters within which it operates and how the M&E System could be evaluated for efficiency and effectiveness, the way forward is to test the model and conduct a baseline study focusing on mainstreaming of the M&E System to all the spheres; and adherence to the new framework - as opposed to the reporting system processes and procedures. As Chilimo (2009:368) rightfully states, the proposed evaluation model cannot demonstrate the relationship between the M&E system and its efficiency; or its effectiveness using quantitative designs. The model is based on a qualitative approach. To order to establish quantifiable variables that will possibly enhance the current status of the model and further develop it, more research may be conducted.

The conclusions of the study were taken from the research findings. An attempt to link the conclusions with the larger issues of the mainstreaming of the M&E system; the implementation at all levels of the Department; and the effect to such conclusions were drawn according to the order in which the research objectives were stated in Chapter One.

The above discussions show that the mainstreaming of the M&E system is complex; and that the components of a department (at all levels) need to join forces for the successful mainstreaming. This exposition accounts for the Provincial situation in general, where it is not all Departments in the Province which have implemented the M&E system. Because of this study, certain problems can now be prevented even before the crafting of the M&E system Framework in any Department; and during the review of the Departmental M&E system. This could not have been the case if it were not because of this study.

REFERENCES

Asibey A.O. 2007. *Managing for Results: World Bank Perspective Public Service Monitoring and Evaluation Learning Network*. National Treasury, Pretoria. The World Bank.

Barbour R.S. and Litzinger T. 1999. *Developing Focus Group Research: Politics, Theory and Practice.* Sage Publications. London and Thousand Oaks.

Booyens S.W. 2002. *Introduction to Health Service Management.* Cape Town. Juta and Company Ltd.

Boston J., Martin J., Pallot J. and Walsh P. 1996. *Public Management: The New Zealand Model*. Oxford University Press. United Kingdom.

Cameron R. 2008. *New Public Management Reforms in the South African Public Service:* 1999-2008. Department of Political Studies University of Cape Town.

Chen H. T. 1990. *Theory Driven Evaluations.* SAGE Publications. USA.

Chief Directorate Office of the Premier 2004-2009. *KwaZulu-Natal Provincial Government Five-Year Report.* KwaZulu-Natal Office of the Premier. Pietermaritzburg.

Chief Directorate 2010. *Monitoring and Evaluation in the Office of the Premier (OTP).*KwaZulu-Natal Office of the Premier. Pietermaritzburg.

Chilimo W. L. 2009. *Information and Communication Technologies and sustainable Livelihoods: A Case of selected Rural Areas of Tanzania*. The University of KwaZulu-Natal Library. Pietermaritzburg.

Claiborne, N., Vandenburgh, H., Krause, T. M. & Leung, P. 2002. *Measuring quality of life changes in individuals with chronic low back conditions: A back education program Evaluation and Program Planning*, *25*(1), 61-70.

Collins, P. 2000 *Applying Public Administration in Development. Guide posts to the future*. London. John Wiley & Sons Ltd.

Constitution of the Republic of South Africa 1996. Cape Town.

Creswell J.W. 2008. *Qualitative Enquiry and Research Design: Choosing Among 5 Approaches. Second Edition.* Thousand Oaks. SAGE.

Curry L.E., Nembhard I.M., Bradley E.H. 2009. *Qualitative and Mixed Methods Provide Unique Contributions to Outcomes Research: Circulation 119:1442 – 1452.*

Daily News Newspaper 2010. *Doctors place greed before need.* Daily News 27 August /2010.

Daily News Newspaper 2010. *Senior Durban doctors warn Department over* Occupation-Specific Dispensation *payments.* Daily News 13 January 2010.

Department of Health 2007*. Part 1 Situational Analysis: Monitoring and Evaluation Strategy for the KwaZulu-Natal Department of Health Version 4.* KZN DOH Pietermaritzburg.

Department of Public Service Administration (2007). Pretoria. Department of Public Service Administration.

Department of Public Service Administration 2005. *Planning for the Public Service.* Pretoria.

Department of Public Service Administration 2008. *Human Resource Development Strategic Framework.* Pretoria. Department of Health Head Office.

Du Toit D.F.P. and Van Der Waldt G. 1999. *The Grass Roots.* Kenwyn. S.A. Juta and Company Ltd.

Du Toit P, Knipe A, Van Niekerk D, Van Der Waldt, G. and Doyle M. 2002*. Excellence in Governance Service*. Johannesburg. Heinemann Publishers.

Duignan P. 2009. *Introduction to Outcomes Theory Knowledge Base Article No. 218. pages 1-3*.

Engela R. and Ajam, T. 2010. *Evaluation Capacity Development. Implementing a Government-wide Monitoring and Evaluation System in South Africa*. ECD Working Paper Series No.21. Independent Evaluation Group World Bank. Washington DC.

Ewalt J. 2001. Theories of Governance and New Public Management: Links to Understanding Welfare Policy Implementation. Department of Government Eastern Kentucky University. Newark.

Guldenhuys J.S.H. and Knipe A. 2002. *The Organisation of Government. An Introduction. Pretoria.* Van Schaik Publishers.

Heads of Departments Public Service Commission 2008. Pretoria.

Hood C. 1991. Public Administration Volume 9, Issue 1, Pages 3 – 19 March 1001.

Hood C. 1991. *A Public Administration for all seasons. Public Administration* 69 (1). 3-19.

Hughes O. E. 2003. *Public Management and Administration. An Introduction.* 3rd edition*.* New York: MacMillan.

Human Resource Development Strategic Framework Vision 2015. version 3 Final Draft. Pretoria. DOH Head Office.

Ile I.U., C. Allen-Ile, C. Eresia-Eke 2012*. Monitoring and Evaluation of Policies, Programmes and Projects*. Van Schaik Publishers. Pretoria.

Ilanga Newspaper 2010. S*ixoshwe nenqwaba isikhulu sesibhedlela.* Ilanga 11 January 2010;

Ilanga Newspaper 2010*. Iziguli zilala ezinqoleni*. Ilanga 28 January 2010

Information Notice on the Executive Board Discussion. Series: Country Report No. 05/346. International Monetary Fund Publication Services. Washington DC.

Keasney K. and Wright, M. 1997. *Corporate Governance Responsibilities, Risks and Remuneration.* England. John Wiley & Sons Ltd.

Kerlinger F. N. 1970. Foundation of Behavioural Research. Fort Worth. Harcourt.

Kettie M. 2002. *"The Transformation of Governance: Public Administration for the 20th Century.* The Johns Hopkins University Press.

King Committee on Corporate Governance 2002. *King Report on Corporate Governance for South Africa: Executive Summary*. Parklands, South Africa.

Körppen D., Mkhize N. and Schell-Faucon S. 2008. *Evaluation Report: Peace Building Programme of Sinani – KwaZulu-Natal Programme for Survivors of Violence, South Africa.* Berlin: Berghoh Peace support.

Kumar N. and Sanga N. 2011. *Performance Monitoring and Evaluation System (PMES. Commonwealth Association for Public Administration and Management. India.*

Löffler E. and Bvaird T. 2003. *Public Management and Governance Second Edition*. Routledge. New York.

Malefane S.R. 2010. *Is it Really Performance that is Measured? A Reflection of the South African Government Performance of Public Management and Development.* Pretoria : University of South Africa.

McClellard S. B. 1994. *Training Needs Assessment Data-gathering Method: Part 3, Focus Groups. Journal of European Industrial training 18 (3): 29-32.*

Mckay K. 2007. *How to Build Monitoring and Evaluation Systems to Support Better Government.* The World Bank. Washington, D.C.

McNabb D. 2002. *Research Methods in Public Administration and non-profit Management: quantitative and qualitative approaches*. M. E. Sharpe, Inc. New York.

Mdluli K.N. 2006 *Developing a Research Policy Model for the South African Local Government Health Sector: A case study at EThekwini Municipality.* Durban. University of KwaZulu-Natal.

The Mercury 2010. *The (KZN) Department 10 Point Plan Priorities is just a rhetoric – an increasing ineffective initiative to hide the consequences of the profound incompetence of the management of the KZN DOH. The* Mercury 18 January 2010.

The Mercury 2010. *Nurses embark on go-slow.* The Mercury 19 January 2010

The Mercury 2010. *Situation unacceptable: hospitals run short of medicines.* The Mercury 12 January 2010;

Mitchell B. and Harrison J. 1991. *Public Administration a Case Study Approach.* London. Pitman Publishing.

Mngomezulu T.M. 2009. *Sexual Practices of Married Women in Rural KwaZulu-Natal: Implications to Women's Vulnerability to HIV/AIDS Epidemic.* Durban. University of KwaZulu-Natal.

Mo Ibrahin Foundation 2012. *Ibrahim index of African Governance Data Report.* Scanplus London, England. www.moibrahimfoundation.org.za accessed 18/07/2013.

Munshi S. and Abraham B.P. 2004. *Good governance, Democratic Societies and Globalisation.* Sage Publications. New Delhi.

National Treasury 2010. *The National Treasury Framework for Managing Performance Information.* National Treasury. *Pretoria.*

Neuman L. 2006. *Digital Ethnography an Examination of the Use of the New Technologies for Social Research.* Senyo Jamal Prince.Toronto: Pearson.

Osborne S.P. 2010. The new Public Governance?: Emerging Perspective on the Theory of Practice of Public Governance. Routledge. New York.

Peterson R.A. 2002. *Constructing Effective Questionnaire*. Thousand Oaks, CA. Sage.

Politt C. and Bouckaert G. 2011. *Public Management Reform: A comparative Analysis - New Public Management, Governance and the Neo-Weberian State*. Oxford University Press. New York.

Provincial Growth and Development Strategy Framework Committee Report 2011. KwaZulu-Natal Province. Pietermaritzburg.

Public Service Commission 2008. *Basic Concepts in Monitoring and Evaluation. Pretoria.*

Ramafoko H. Editor, 2012*. News Official Magazine of the Public Service Commission.* February/March 2012 issue. Pretoria.

Raphael D. 2003 *Health Promotion International.* Oxford University Press, Oxford.

Republic of South Africa 2006. *Draft National Guiding Principles and Standards for Monitoring and Evaluation of Public Policies and Programmes in South Africa*. Government Printer, Pretoria.

Risit R. C. and Kusek J.Z. 2006*. A Handbook for Development Practitioners. Ten Steps to a Results-based Monitoring and Evaluation System.* The International Bank for Reconstruction and Development/The World Bank. Washington DC. New York.

Roberts A. R. and Yeager K. R. 2004. *Evidence-Based Manual: Research and Outcome Health and Human Services. Practice Resources for Social Work*. Oxford University. New York Press.

Rossouw D. 2012. *The social and Ethics Committee Handbook. The Ethics Institute of South Africa*. www.ethicssa.org accessed 30/04/2013.

Sahadeo R. 2012. *Monitoring and evaluation at the Provincial Level with Particular Reference to the Department of Health. Unpublished MPA Assignment. University of KwaZulu-Natal, Westville. Durban.*

SASQAF 2007. *South African Statistical Assessment Framework Policy.* Pretoria.

South Africa *2005. Article IV Consultation—Staff Report; Staff Statement; and Public*

South African Demographic and Health Survey (SADHS) 2003: Life Expectancy. http//www.mrc.ac.za accessed 27.04.2013.

Stout S., Evans A., Nassim J. and Ranney L. 1997. *Evaluating Health Projects Lessons from the Literature. World Bank Discussion Paper No. 356.*

Strydom H., Fouchè C.B. and Delport C.S.L. 2002*. Research at Grassroots for the Sciences and human Service Professions 2nd edition*. Van Schaik Publishers. Pretoria.

Swanepoel B.J., Erasmus B.J., Van Wyk M.W., Schenk H.W. 1998*. South African Human Resource Management Theory and Practice*. Juta and Company Ltd. Zebra Publications. Cape Town.

Terre Blanche M., Durrheim K. and Painter D. *Research in Africa. Applied Methods for the Social Sciences. 2nd Edition*. University of Cape Town Press. Cape Town.

The International Monetary Fund South Africa 2005. *Staff Report for the 2005 Article iv Consultation.* Pretoria.

The Netherlands Ministry of Finance 2000. *Performance Management in Practice: A Comparative Study of Executive Agencies*. Oxford University Press.

The Department of Public Service Administration 2007. *Employee Performance Management and Development System (EPMDS).* Pretoria. Head Office.

The Presidency 2005*. Governance and Administration Chief Directorate. Proposal and Implementation Plan for a Government Wide Monitoring and Evaluation System.* Pretoria. DOH Head Office.

The Presidency 2007. *Policy Framework for the Government-Wide Monitoring and Evaluation System*. Pretoria. DOH Head Office.

The Presidency 2010. *Monitoring and Evaluation.* Government Printer. Pretoria.

The Presidency 2013. *A Framework for Strengthening Citizen – government Partnerships for Monitoring Frontline Service Delivery.* Government Printer. Pretoria.

The Presidency Department of Performance Monitoring and Evaluation. 2011. *Evaluation Framework policy.* Pretoria.

The Presidency Department of Performance Monitoring and Evaluation. 2012. *Evaluation Framework policy.* Pretoria.

The Presidency, RSA 2009. *Policy framework for the Government-wide Monitoring and Evaluation.* Pretoria. DOH Head Office.

The Witness Newspaper 2009. *Judge rules in favour of HIV infected woman.* The Witness 27 January 2009.

The Witness Newspaper 2009. *Food poisoning in a certain hospital.* The Witness 28 January 01 2009.

Thornhill C. (Editor) 2006. *South African Association for Public Administration and Management. Journal of Public Administration.* Volume 41 number 3.1.

United Nations (UNAIDS) 2007. *Good governance*. Geneva, Switzerland.

United Nations (UNAIDS) 2008. The *Joint United Nations Programme on HIV/AIDS, 2008. Report on the Global HIV/AIDS Epidemic 2008*. Geneva, Switzerland.

United Nations Population Fund Division for Oversight Services 2004. Tool Number 2. Defining Evaluation. *Programme Manager's Planning Monitoring and Evaluation.* Daily News Building. New York.

United Nations, 2005. *Unlocking the Human Potential for Public Sector Performance.* World Public Sector Report. 2005. Department of Social and Economic Affairs. New York. University of KwaZulu-Natal.

Van Niekerk D., Van der Walt G. and Jonker A. 2001. *Governance, Politics and Policy in South Africa.* Oxford University Press. New York.

Van Rensburg H. C. J. 2004. *Health and Health Care in South Africa.* Van Schaik Publishers. Pretoria.

Venter A. and Van der Waldt G. 2007. *Municipal Management:* Serving the People. Juta and Company Ltd. Cape Town.

Venter A. and Landsberg C. 2011. *Government and Politics in South Africa. 4th edition.* Van Schaik Publishers. Pretoria.

Welman C., Kruger F. and Mitchelle B. 2005. *Research Methodology 3rd edition.* Oxford University Press Southern Africa. Cape Town.

Willams R. S. 2002. *Managing Employee Performance, Design and Implementation in Organisations.* London Thomson Learning. England. T.J. International Padstow Cornwall.

Zwarenstein M. 1994. *The Structure of South Africa's Health Service.* www.ncbi.nlm.nih.gov/pubmed/12345506.

Unpublished sources

Chief Directorate: *The Presidency Draft 5 National Evaluation Policy Framework*. 2005. Pretoria.

DFID HIV and Multi-sectoral Support Programme & DOH 2007. *Part 1 - Situational Analysis. Monitoring and Evaluation Strategy for the KwaZulu-Natal Department of Health.* Version 4. Pietermaritzburg. DOH Head Office.

Dlomo S. 2009. *The Member of the Executive Committee Budget Speech.* KwaZulu-Natal Department of Health. Pietermaritzburg.

Government Gazette 13.07.1990.

Government Notice R1012 of July 2003.

Human Resource Planning Strategic Framework Version 3 Final Draft, 20 October 2008. Pietermaritzburg. DOH Head.

KwaZulu-Natal Department of Health 2008/2009. The Provincial Quarterly Report Quarter 2 2008/2009. Pietermaritzburg. DOH Head Office.

KwaZulu-Natal Department of Health 2009/2010. The Provincial Quarterly Reports 2009/2010. Pietermaritzburg. DOH Head Office.

KwaZulu-Natal Department of Health 2010. The Monitoring and Evaluation Framework. Pietermaritzburg. DOH Head Office.

KwaZulu-Natal Provincial Department of Health Strategic Plan (2005/2006 – 2009/2010) Pietermaritzburg. DOH Head Office.

The Presidency Report 2009. *KwaZulu-Natal Provincial Department of Health Member of the Executive Council's Budget Speech (2009/10).* Pietermaritzburg. DOH Head Office.

The Department of Health *Workplace Good Governance and Ethics* 2009. KwaZulu-Natal. Pietermaritzburg

KwaZulu-Natal Provincial Department of Health Mid-term Report 2009. Pietermaritzburg. DOH Head Office.

KwaZulu-Natal Provincial Department of Health Annual Report 2007/2008. Pietermaritzburg. DOH Head Office.

KwaZulu-Natal Provincial Department of Health Annual Report 2008/2009. Pietermaritzburg. DOH Head Office.

The Department of Health Annual Performance Plan 2008/2009 2010/2011. Pietermaritzburg. DOH Head Office.

The Department of Health Annual Performance Plan 2009/2010 – 2011/2012. Pietermaritzburg. DOH Head Office.

The Department of Health Annual Performance Plan 2010/2011 – 2012/2013. Pietermaritzburg. DOH Head Office.

The Department of Health Annual Performance Plan 2011/2012 – 2013/2014 Pietermaritzburg. DOH Head Office.

The Department of Health Annual Performance Plan 2013/2014 – 2015/2016 Pietermaritzburg. DOH Head Office.

Province of KwaZulu-Natal Monitoring and Evaluation Strategy Part 1 (Chief Directorate: Monitoring and Evaluation. KwaZulu-Natal. Pietermaritzburg.

Websites

Department of Performance Monitoring 2008. *The Role of Premier's Offices in Government-Wide Monitoring and Evaluation: A Good Practice Guide.* Department of Performance Monitoring. Pretoria. http://www.thepresidency.gov.za – accessed on 27/03/2013

Introduction to outcomes Theory - Outcomes Theory base. 2011. Las Vegas Nevada. United States. http://www.outcomestheory.org - accessed on 11/09/2013

Public Service Commission – *National Treasury report 2005/2006.* Department of National Treasury. Pretoria. http://www.treasury.gov.za – accessed on 27/03/2013

Points of Distinction: A Guidebook for Planning and Evaluating Quality Outreach. 1996. Michigan State University Board of Trustees. http://www.msu.ed~outreach/mvaa - accessed on 01/03/2013

Provincial Government. *Information on Government in South Africa.* http://www.southafrica.info/about/government/gov.htm) - accessed on 5/12/2012

IGR – Interrelations. *Intergovernmental relations Framework Act No. 13 of 2005.* s. COGTA. http://www.cogta.gov.za – accessed on 02/10/2013

Day C. and Gray A. 2010. Health and related indicators. *The University of KwaZulu-Natal.* Durban. http://www.hst.org.za/uploads/files/chap16_08.pdf accessed on 05/03/2013

Mollet J. 2008. *Guidelines for Good Practice in the Conduct of Clinical Trials in Human Participants South Africa Working Draft.* http://www.doh.gov.za - accessed on 04/05/2013

Public Governance Indicators: A Literature Review. 2007. New York. http://info.worldbank.org/governance/wgi/index.asp - accessed 07/12/2011

APPENDIX 1

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Research Office (Govan Mbeki Centre)
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 3587
Fax No: +27 31 260 4609
Ximbap@ukzn.ac.za

26 October 2011

Mrs T M Mngomezulu (202523698)
School of Public Administration and Management

Dear Mrs Mngomezulu

PROTOCOL REFERENCE NUMBER: HSS/1061/011D
PROJECT TITLE: Monitoring and Evaluation systems in Public Governance: A Case Study of the KwaZulu-Natal Department of Health

EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

[redacted]

.....

Humanities & Social Sciences Research Ethics Committee

cc Supervisor – Professor P Reddy
cc Mrs C Haddon

APPENDIX 2

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : **HRKM105/11**
Enquiries : **Mrs G Khumalo**
Telephone : 033 – 3953189

12 December 2011

Dear Mrs T Mngomezulu

Subject: Approval of a Research Proposal

1. The research proposal titled **'The Monitoring and Evaluation System in Public Governance: A case study of the KwaZulu-Natal Department of Health'** was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at **Umkhanyakude, Amajuba, Ugu, Umzinyathi, Uthukela, Umgungundlovu, Uthungulu & Zululand districts**. The study may commence at ***Ilembe, eThekwini and Sisonke*** districts once the relevant district managers have given you support for the study.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

[redacted] **Committee**
Health

Date: 13/12/2011

APPENDIX 3

To Whom It May Concern:

PERMISSION TO CONDUCT RESEARCH AS PART OF THE DOCTORAL DEGREE IN PUBLIC ADMINISTRATION (DPA)

Name: Thembeka Mary-Pia Mngomezulu

Student No: 202523698

Dissertation Topic: "The Monitoring and Evaluation System in the Public Governance: A case Study of the KwaZulu-Natal Department of Health"

It is a requirement of our Public Administration Doctoral Degree that all students undertake a practical research project, in their final year of study.

Typically this project will be a "practical problem solving" exercise, and necessitate data gathering by questionnaires or interviews.

Your assistance in permitting access to your organization for purposes of this research is most appreciated. Please be assured that all information gained from the research will be treated with the utmost circumspection. Further, should you wish the result from the thesis "to be embargoed" for an agreed period of time, this can be arranged. Confidentiality and anonymity will be strictly adhered to by the student.

If permission is granted the UKZN require this to be in writing on a letterhead and signed by the relevant authority.

Many thanks for your assistance in this regard.

Yours sincerely
Mrs. T. Mngomezulu

APPENDIX 4

UNIVERSITY OF KWAZULU-NATAL

SCHOOL OF PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT
DOCTORAL DEGREE IN PUBLIC ADMINISTRATION RESEARCH PROJECT

RESEARCHER: THEMBEKA MARY-PIA MNGOMEZULU
CELL NUMBER: 071 549 9278
SUPERVISOR: PRFOFESSOR P.S. REDDY
OFFICE TELEPHONE NUMBER: 0312607578
RESEARCH OFFICE: MS P XIMBA 031-2603587

Title of Survey

The purpose of this survey is to solicit information from the Department of Health KwaZulu-Natal Head Office regarding the evaluation of the Monitoring and Evaluation of the Department of Health. The information and ratings you provide us will go a long way in helping us identify relevant aspects in the evaluation of the M&E System and developing a Model for evaluation of the M&E Systems. The questionnaire should only take 10-15 minutes to complete. In this questionnaire, you are asked to indicate what is true for you, so there are no “right” or “wrong” answers to any question. Work as rapidly as you can. If you wish to make a comment please write it directly on the booklet itself. Make sure not to skip any questions.

Thank you for participating!

APPENDIX 5

Informed Consent Letter Template – Focus Group Discussion

UNIVERSITY OF KWAZULU-NATAL
SCHOOL

SCHOOL OF PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT

Dear Respondent,

Doctoral degree in Public Administration Research Project
Researcher: Thembeka Mary-Pia Mngomezulu (Cell number: 0715499278)
Supervisor: Professor P.S. Reddy (Office Telephone number: 0312607578)
Research Office: Ms P Ximba 031-2603587

I, am **(THEMBEKA MARY-PIA MNGOMEZULU)** a Doctoral Degree in Public Administration student, in the School of Public Administration and Development Management at the University of KwaZulu- Natal. You are invited to participate in a research project entitled ***"The Monitoring and Evaluation System in Public Governance: A Case Study of the KwaZulu-Natal Department of Health"***

The aim of this study is to critically review how the existing M&E System has developed; how well it is performing; the extent to which the M&E information is being used to improve the Departmental performance towards reaching the goals and objectives of the Department; and the extent to which good governance has been achieved.

Through your participation, I hope to understand the:

- Capacity of the Senior Management to effectively and efficiently manage the Department of Health;
- Compliance of the DOH to the basic tenets of good governance;
- Compliance of the DOH to the tenets of the existing GWM&E System;
- Extent to which the M&E information is used in management; and
- Current M&E challenges that the Department is faced with and how they can be addressed.

The results of the focus group discussion are intended to develop the researcher's research capacity and contribute to the body of scientific knowledge on performance management and good governance in the public sector in order to benefit other departments within the government and the citizens of the KZN Province through improved quality of health care service.

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this survey. Confidentiality and anonymity of records identifying you as a participant will be maintained by the SCHOOL OF PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT, UKZN. However, as this is a participation in a focus group, please be aware that I cannot assure that other group members will retain confidentiality.

If you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me or my supervisor at the numbers listed above.

The focus group discussion should take you about 45 to an hour to complete. I hope you will take the time to complete the focus group discussion.

Sincerely

Investigator's signature_____ Date_____

(This page is to be retained by participant)

UNIVERSITY OF KWAZULU-NATAL
SCHOOL OF PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT

Doctoral degree in Public Administration Research Project
Researcher: Thembeka Mary-Pia Mngomezulu (Cell number: 0715499278)
Supervisor: Professor P.S. Reddy (Office Telephone number: 0312607578)
Research Office: Ms P Ximba 031-2603587

CONSENT

I……(full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT DATE

……

(This page is to be retained by researcher)

APPENDIX 6

SCHOOL OF PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT

Dear Respondent,

Doctoral degree in Public Administration Research Project
Researcher: Thembeka Mary-Pia Mngomezulu (Cell number: 0715499278)
Supervisor: Professor P.S. Reddy (Office Telephone number: 0312607578)
Research Office: Ms P Ximba 031-2603587

I am **(THEMBEKA MARY-PIA MNGOMEZULU)** a Doctoral Degree in Public Administration student, at the School of Public Administration and Development Management of the University of KwaZulu- Natal. You are invited to participate in a research project entitled ***"The Monitoring and Evaluation in Public Governance: A Case Study of the KwaZulu-Natal Department of Health"***

The aim of this study is to critically review how the existing M&E System has developed; how well it is performing; the extent to which the M&E information is being used to improve the Departmental performance towards reaching the goals and objectives of the Department; and the extent to which good governance has been achieved.

Through your participation, I hope to examine the:

- Capacity of the Senior Management to effectively and efficiently manage the Department of Health;
- Compliance of the DOH to the basic tenets of good governance;
- Compliance of the DOH to the tenets of the existing GWM&E System;
- Extent to which the M&E information is used in management; and
- Current M&E challenges that the Department is faced with and how they can be addressed.

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this survey. Confidentiality and anonymity of records identifying you as a participant will be maintained by the SCHOOL OF PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT, UKZN.

If you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me or my supervisor at the numbers listed above.

The survey should take you about 8 to 15 minutes to complete. I hope you will take the time to complete this survey.

Sincerely

Investigator's signature_____ Date_____

SCHOOL OF PUBLIC ADMINISTRATION AND DEVELOPMENT MANAGEMENT

Doctoral degree in Public Administration Research Project
Researcher: Thembeka Mary-Pia Mngomezulu (Cell number: 0715499278)
Supervisor: Professor P.S. Reddy (Office Telephone number: 0312607578)
Research Office: Ms P Ximba 031-2603587

CONSENT

I……(full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT DATE

……

APPENDIX 7

THE INTERVIEW GUIDE

1. Capacity of the Senior Management to effectively and efficiently manage the Department of Health;

Would you say the Programme Managers understand/know M&E?

2. The extent to which the M&E information is used in management;

How is the M&E information used in the programme and the department?

3. The current M&E challenges that the Department is faced with and how they can be addressed.

What are the current M&E challenges?

How can the M&E challenges be addressed?

4. Model for evaluation of the M&E System/Framework

What is it that was done wrongly by the M&E System that you wish not to be repeated?

How best can the M&E System be introduced in the Department?

APPENDIX 8

THE QUESTIONNAIRE FOR THE SENIOR MANAGEMENT SERVICES STAFF

Dear Respondent,

Thank you for taking part in the study. Please mark your answers with an X where necessary and please fill in the requested information.

Governance arrangement	
Description of (public) governance	
To your knowledge what policies exist on accountability transparency and inclusion	
What activities are there to ensure that each of the mentioned is practiced and give an example of each?	1=Accountability: 2=Transparency: 3=Inclusion:

Compliance with the M&E Framework	
Have you seen the Departmental M&E Framework?	1=No 2=Yes 3=Can't remember
Where can one access the Departmental M&E Framework?	1=Annual Performance Plan 2=Strategic Plan 3=Reporting Template 4=Intranet 5=Other - state
Give major parts of the M&E Framework you think are crucial in your work	
Briefly describe parts of the M&E System you feel apply to your M&E work	
Describe the M&E reporting system using data flow, responsible personnel, reporting template and timeliness	

Senior Management commitment to implementation of the M&E Framework

Describe your role in the implementation of the M&E Framework?	
How much is your involvement in the implementation of the M&E Framework? (scale)	0=None 1=minimal 2=Great
Do you have an Implementation Plan of the M&E Framework for your Program? (Yes/no)	0=None 1=Yes
If yes would you show the researcher?	0=No 1=Yes
If no, what is the reason for not having one?	0=unnecessary 1=was not aware I should 2=Unskilled
Comment/input on the implementation of the Departmental Framework/System	

M&E System as a management tool	
Do you consider the M&E System a management tool? (Yes/no)	0=Don't know 1=No 2=Yes
If yes where does it help in management?	
If no, why not?	
Does the M&E System help you in the management of your Component/programme? Explain	

Capacity of Senior Management	
From the list select words that are associated with Monitoring	1=system, 2=continuous, 3=tool for managing, 4=progress, 5=baseline, 6=targets, 7=impact, 8=framework,
Mention at least 3 tenets/principles of the Government Wide M&E System	
Explain how they are applied in the department?	
From the list select words that are associated with Evaluation	1=Baseline, 2=outcomes, 3=impact, 4=continuous, 5=progress, 6=once off, 7=monthly, 8=long term

Provide a list of uses for the M&E System	
What is your role in the implementation of the Departmental M&E System?	
Have you ever been trained on M&E?	Formal training: 0=No 1=Yes (state duration) Informal training 0=No 2=Yes (Explain how)

From a list of indicators that you monitor select one indicator in each type:

Indicator	Type	Purpose for monitoring it	Desired outcome
	Input		
	Output		
	Outcome		
	Impact		

Provide mandates for monitoring your indicators? (what obliges you to monitor your core indicators)	
How do you ensure data quality in your Component/programme data? (Mention systems in place)	

Reporting System	
How do you do reporting for your programme? And why?	
Do you have Programme Information Team? What is its role?	

Evaluation of the M&E System

What is your evaluation of the Departmental M&E System?						
	1	2	3	4	5	
Introduction	Very poor	not so poor	good	Not so good	Very good	
Reporting System	Very poor	not so poor	good	Not so good	Very good	
Implementation	Very poor	not so poor	good	Not so good	Very good	
Monitoring of	Very poor	not so	good	Not so	Very good	

implementation		poor		good		
Use of M&E System	Useless	useful	Don't know	Not sure	No comment	
Enlist all elements you want added in the revised M&E Framework						

Thank you for participating in the survey.

APPENDIX 9

THE QUESTIONNAIRE FOR THE EXTERNAL STAKEHOLDERS (Modified)

Dear Respondent,

Thank you for taking part in the study. Please mark your answers with an X where necessary and please fill in the requested information.

Governance arrangement	
In broad terms, what is your understanding of effectiveness of a Department?	
When do we say the Departmental M&E System is effective and efficient (Or How can a Department show efficiency and effectiveness regarding the implementation of the M&E System)	
Which M&E knowledge and skills should the Senior Management have to efficiently and effectively manage their programmes.	
Why is it important for the Senior Management to know the principles of governance? And why? a) Mention a few of the basic principles of Public Administration and how they contribute to good governance/service delivery b) Which ones are practiced in your component, workplace	

Compliance with the M&E Framework	
What should a manager do to show compliance with the M&E System of their department? a) Do you know the Departmental M&E Framework b) What are some of the components of the Framework you remember? c) How do you comply with the M&E System of the Department?	
What incentives does the HOD use to encourage compliance? What incentives should be used to encourage workers to comply to M&E System requirements?	
How could the managers make use of the Departmental M&E Framework?	
What determines that the managers are utilizing the framework?	

Senior Management commitment to implementation of the M&E Framework	
Describe the role of the SMS Managers in the implementation of the M&E Framework?	

Capacity of Senior Management	
What M&E capacity capacity should the managers have in order to execute their work?	
How (on what) should the Departmental M&E Champion capacitate the SMS Managers?	
To what extent should the M&E System of a Department be based on the Government-Wide M&E System	
How much should the Managers know about the tenets of the GWM&E System	
What are mandates that prescribe the use of an M&E System in a Department	
Who should ensure data quality of a programme: a Departmental M&E Champion or a Programme M&E Official or a Programme Manager?	
Reporting System	
How should data flow from the Health Facilities to the Head Office?	

Evaluation of the M&E System	
How should the M&E System be evaluated in the work place? And how often?	
How would you drive the process forward (steps to follow)	
What Evaluation Models can be suggested for the evaluation of the M&E System?	

M&E information use	
Why is the M&E System important in a Department?	
How does the M&E System help in managing a programme?	
How can the information derived from the M&E System be used in a Programme?	
What important sections should be included in the Departmental M&E Framework?	
What important issues should the M&E System include?	

Thank you for taking time to complete the questionnaire.

End of the Questionnaire

APPENDIX 10

PRIMARY OBJECTIVES OF THE STUDY ARE TO:

1. Critically examine the M&E governance arrangements nationally and provincially and within the DOH;
2. Examine to what extent the M&E was complied with;
3. Establish the level of commitment of the senior management towards the implementation of the M&E Framework in the Department and used as a management tool (in planning and decision-making);
4. Evaluate the M&E capacity of senior management in the DOH;
5. Explore challenges and remedial actions towards improved utilization of the M&E information policies and their implementation; and
6. Determine factors to consider in evaluation of the M&E system in the Department.

Key questions to be answered

1. Is the DOH being effectively and efficiently managed?;
2. Is the Department complying with the basic tenets of the GWM&E System and good governance?;
3. What benefits were accrued from the Departmental M&E System?;
4. What M&E challenges are currently being faced by the Department and how should they be addressed?; and
5. What are the essential elements of an Evaluation Framework for an M&E System for the Department?

APPENDIX 11

THE QUESTIONNAIRE FOR THE SENIOR MANAGEMENT SERVICES STAFF

Date: *24 April 2012*

Duration: *2 hours*

Dear Respondent,

(Manager: - The Unit is not mentioned for confidentiality)

Thank you for taking part in the study. Please mark your answers with an X where necessary and please fill in the requested information.

Governance arrangement	
Description of (public) governance	*Participation – there is public oversight: there is a need to inform the people and give them feedback. There is a need to share information with people. It is difficult and we need paradigm shift. Not fully function we make decisions on behalf of the public; there must be a loop that goes back to them.*
To your knowledge what policies exist on accountability transparency and inclusion	*I don't know any policy but there is an Act on information but we do not implement policies. Reports should be public matter so that the public has access – outside public has no access. I have not seen any policy on that – all of us are responsible for this. Information and reports should be published and circulated. It is not available with people with means but ordinary citizens do not have access.*
What activities are there to ensure that each of the mentioned is practiced and give an example of each?	1=Accountability: *This is just on paper – no one has ever been held accountable. For instance if there is no delivery then no one does it. There's no coach to do it; there is none in this Department. Yes the HOD is accountable but if the HOD has senior management for accountability who are not accountable it is difficult for her. There is no general understanding – management do not have adequate understanding of accountability* 2=Transparency: *There is no transparency whatever is decided stays with MANCO. It does not go back to the universities, NGOs and relevant communities. Patients never receive these reports. If clinic Committees are functional they should be informed and take those out to the communities. It is our responsibility. This is core function of a manager and it links to accountability the manager should ensure that distribution is done otherwise the mandate stops at MMS management level when the manager does nothing beyond that. Management should have a vision beyond operational sphere to enable MMS to disseminate e.g. quarterly Reports which cannot. The manager should have a vision and objective and MMS operationalise it. Inability of managers to manage leads to lack of governance and therefore PMs have not into the M&E System. It is*

	very said; new leadership is needed that would take people forward but we are stuck. This makes people lose their vision also at lower levels. This is a problem of management at all levels. Managers are expected to provide leadership and direction at all levels. They should know what to do to take things further. It they are stuck as a manager you should provide solution. Systems and processes in place and links at all levels. "there are grey areas" *I am a planner and not responsible to monitor; it is for the M&E Component to monitor. We are just doing it for the next cycle of planning e.g. we monitor DHER reviews so that it goes to the APP and the next cycle. M&E does not have a clue of the link to the budget i.e. service delivery link with expenditure and the effect it has on service. We see what system of DHER should function (Team: data management, PERSAL,, M&E Planning e.g. using a matrix of the problem at all spheres to identify the source of the problem. The matrix helps strengthening solve problems or issues identified – i.e. monitoring systems for operational purpose.* *DHER is for resolving budget issues at districts etc. All done on behalf of M&E i.e. M&E responsibility to provide detailed feedback in order to make them open up with their issues – linking DHP with DHER. It is also for capacity building so as to integrate their data so that they come up with tools.* 3=Inclusion:

Compliance with the M&E Framework	
Have you seen the Departmental M&E Framework?	1=No 2=*Yes* 3=Can't remember
Where can one access the Departmental M&E Framework?	1=Annual Performance Plan 2=Strategic Plan 3=Reporting Template 4=Intranet 5=Other – state *Don't know*
What are the major aspects of the M&E Framework you think are crucial in your work	*Everything is crucial.*
Briefly describe parts of the M&E System you feel apply to your M&E work	*As above*

Describe the M&E reporting system using data flow, responsible personnel, reporting template and timeliness	*There is the DQPR, Head Office M&E – from facilities to districts to M&E at Province people do as they please – they do not follow the reporting system but ask data directly from the districts and facilities. At Head Office there is Data Management and DHIS. In Districts there are M&E Managers and M&E Planning. At facility CEOs but they do not interrogate their data.*

Senior Management commitment to implementation of the M&E Framework	
Describe your role in the implementation of the M&E Framework?	*Though not formalized but everything is for the implementation of the M&E system, all is done based on M&E Framework – Operational Plan, DHP, DHER etc.*
How much is your involvement in the implementation of the M&E Framework? (scale)	0=None 1=minimal 2=*Great*
Do you have an Implementation Plan of the M&E Framework for your Program? (Yes/no)	0=*None* 1=Yes
If yes would you show the researcher?	0=*No* 1=Yes
If no, what is the reason for not having one? *Because is the M&E mandate to do it. It is like we are doing it (implementation plan) through these documents.*	0=*Unnecessary* 1=Was not aware I should 2=Unskilled
Comment/input on the implementation of the Departmental Framework/System	*Nothing as I have never heard it being referred to in any districts. They just see their daily work as routine work no M&E framework implementation. They detach themselves from M&E as theirs and not ours. There is no link. What is crucial is to know that they are familiar with content and comply – not with finer details.* *Problems identified are not related to M&E for advice we have a 'don't care' attitude to what wrong is there. Giving wrong message tot districts.*

M&E System as a management tool

Do you consider the M&E System a management tool? (Yes/no)	0=Don't know 1=No 2=*Yes*
If yes where does it help in management?	*Everywhere: - as it is just compliance but they just make good graphs on the walls but never make sense of it; no integration of data at their analysis. Even if they see it as a management tool that do they do about it after implementing they do not see change – no outcomes. Therefore M&E is not used to change their situation; they have never been trained. They should be taught the basic skills therefore they cannot be held accountable; they should have in-depth of how is M&E a management tool.*
If no, why not?	N/A
Does the M&E System help you in the management of your Component/programme? Explain	*No. M&E does not help me in anyway – poor data and narrative but do my own analysis. I expect an analytic report from M&E which I don't get. Lacking is: Plan on how to report with minimum criteria to comply with what is expected in their report/critical analysis – what is the norm and to what extent is deviation (outliers/inliers) – an SOP e.g. on reviews what is expected – overview of what is happening at a Provincial level. Everybody involved; benchmark best Practices from other districts (mentioning the District Manager of Sisonke).*

Capacity of Senior Management	
From the list select words that are associated with Monitoring. *All*	*1=system,* *2=continuous,* *3=tool for managing,* *4=progress,* *5=baseline,* *6=targets,* *7=impact,* *8=framework,*
Mention at least 3 tenets/principles of the Government Wide M&E System	*Sustainability, inclusion, accountability, transparency, indicators.*
Explain how they are applied in the department?	
From the list select words that are	*1=Baseline,* *2=outcomes,*

associated with Evaluation. *Depending on what project or system is being evaluated.*	*3=impact,* *4=continuous,* *5=progress,* *6=once off,* *7=monthly,* 8=long term *"this is used in research; rather mid-term"*
Provide a list of uses for the M&E System	*There is nothing one can do without monitoring even in private life.*
What is your role in the implementation of the Departmental M&E System?	*Refer to the above discussion.*
Have you ever been trained on M&E?	Formal training: 0=No *1=Yes (state duration: a year*) Informal training 0=No 2=Yes (Explain how)

From a list of indicators that you monitor select one indicator in each type:

Indicator	Type	Purpose for monitoring it	Desired outcome
	Input	*(The respondent is responsible for developing (together with all programmes) the indicators in the Strategic and Annual Performance Plans. Therefore, this section can be left unfilled).*	
	Output		
	Outcome		
	Impact		

Provide mandates for monitoring your indicators? (what obliges you to monitor your core indicators)	*Planning depends on it – form pillars of planning; National Health Act; treasury regulations.*
How do you ensure data quality in your Component/programme data? (Mention systems in place)	*Constant verification and contacting relevant components: M&E and Data Management; districts. We also investigate the data issues e.g. in DHER etc. with linked indicators that impact on others. Follow up on month to month reporting. Interrogating with people who are sources of data even the Local municipalities and their Clinics. Data is then corrected and*

	feedback to the source.
Reporting System	*(The respondent is responsible for developing (together with all programmes) the indicators in the Strategic and Annual Performance Plans).*
How do you do reporting for your programme? And why?	
Do you have Programme Information Team? What is its role?	

Evaluation of the M&E System

What is your evaluation of the Departmental M&E System?

	1	2	3	4	5	Comment
Introduction	Very poor	not so poor	good	*Not so good*	Very good	*It is not everyone who follows the reporting lines/data flow but things happening outside the data flow. This due to lack of accountability. There must be a circular stating strongly*
Reporting System	Very poor	not so poor	good	*Not so good*	Very good	
Implementation	Very poor	not so poor	good	*Not so good*	Very good	
Monitoring of implementation	Very poor	not so poor	good	*Not so good*	Very good	
Use of M&E System	Useless	useful	Don't know	*Not sure*	No comment	

List all elements you want added in the revised M&E Framework

1. *Lessons learnt be accommodated in the new M&E System. There should be no distancing between M&E System and the Framework implementation. They do not see it as a guideline of what they routinely do. They should apply principles. Training on these is needed; more of mentoring;*
2. *Review can do mentoring – whole process will be understood by all e.g. tools from data collection and all – collation, analysis, reporting so that these people know.*
3. *Identify people who are good at district and facilities and this will mentor and ensure sustainability, i.e. to have a pool "as foot soldiers" i.e. at delivery level. These will also keep me updated information and these may even be placed in the M&E Framework and be acknowledged.*
4. *Review in District are empty – and M&E should teach them to look at trends interpret them and be trained on what review is and how it should be done.*
5. *To develop training plan on what to teach on how should reviews are done. Do it with the UNIT including Data Management, research and planning Component with M&E leading the process and getting support from other Provinces – benchmark for best practices.*
6. *Health Information Teams (HIT) are not trained and so they fail and cannot do reviews that will get down the assumptions. Even those HIT that have been there are regressing some are no longer there.*
7. *They should be doing reviews **with outcomes.***
8. *Training by M&E has never been done; no feedback loop between M&E and Data*

Management. (Different data submitted at different levels e.g. differs as it goes up). Information feedback should go back to the source. People lose interest as they do not get feedback. Therefore feedback loop needed between M&E and data Management.

9. *Feedback should include reviews that involve other facilities so as to have a mirror picture against*
10. *Therefore M&E management feedback-loop.*
11. *Sisonke did that kind of review t now even its reporting is getting down – are we failing them?*
12. *Tedious and long procedures that are not responded to.*

End of interview

APPENDIX 12

UMKHANYAKUDE DISTRICT

Date: 28 February 2012
Venue: UMkhanyakude District Office
Participants (10): M&E Manager, Planning Manager, QUALITY ASSURANCE AND CONTROL Coordinator, Fleet Manager, TB/Communicable Diseases Control Coordinator, Finance Manager, Clinical and Programme Manager, District Health information officer (DIO), HIV and AIDS Coordinator and Health promotions and Oral Health Coordinator
Duration of the Focus Group Discussion: 1 hour 30 minutes.

Legend: "Q" refers to question from the interviewer; A refers to answers from respondents.
QUESTION: Would you say the Programme Managers understand/know M&E?
(They all agreed that they know M&E).
A: The challenge is in a particular programme to monitor my programme; do I have capacity to develop tools to assist me in my programme.
A: There is an overall understanding of M&E but the specifics of M&E are lacking; training is needed. Programmes have targets but the setting of systems is lacking. The confusion arises when a particular performance suddenly shoots from say 15% to 85% then you do not understand what has happened. For example, the PAP smear tend to shoot up suddenly. This could be due to the lack of understanding of definitions which are not properly communicated to us.
A: For MCWH we are also not doing well – early booking because of data elements that are not well aligned into the system.
A: Even if tools are there we do not have a clue of how they are developed.
A: The DHIS definitions are also a challenge. We can say there is basic understanding of M&E because managers from the facilities are supporting the system.
A: I agree with the others that there is knowledge but a gap exist between knowledge and practice. We do not know how we can improve the situation though we can see that there are problems - this is really a gap.
Q: How is the M&E information used in the Programmes and the Department?
A: In planning – it provides baseline and makes planning of targets easy and also directs planning according to baselines for resources both financially and human. It also makes one looks evaluate as to what helped towards the success of the programme.
A: Resource allocation, setting of targets and goals at a Programme Management level. At Operational level they do not use M&E information. Decentralisation of resources is done at that level.

A: One of the challenges is lack of buy-in at facility level. As a district, we do not have power over facilities as they have own management. We just provide guidance and advice but we cannot force them to comply.

A: Yes advice given at district level is accepted but there is no synergy between the district and the facility level such that some problems arising at a facility level cannot be addressed. This is due to the fact that M&E was not cascaded to the facility level. The approach was a focus to the districts excluding facilities. There is no buy-in we need to expand it further.

A: Buy-in from all managers will take time i.e. for all managers at all levels. Managers at facility level work in silos they should work together so that any problem that arises is tackled by all.

Q: I understand that you conduct monthly reviews for all the facilities quarterly. What happens during reviews?

A: During reviews when presentation of their data is done people become defensive. They do not want to accept feedback given to them and own their mistakes. I think the District Manager and the CEO should engage the Programme Managers; they should rectify this so that there is accountability of personnel at facilities no one accounts for their programmes as they work in silos.

A: The M&E Component should prescribe where support visits are required based on poor performance trends are made so that training strategies are developed.

Q: Though challenges have been mentioned; what are the additional current M&E challenges?

A: Lack of capacity for M&E and supervision; intensify capacity on M&E and improve supervision and management skills.

A: People know their jobs but there is lack of basic supervision in the workplace; on-going training.

A: No common M&E for all; all stakeholders equally exposed to M&E.

A: Performance management not done (EPMDS); one-on-one supervision.

A: Lack of on-going training and regular in-service training; Performance management monitoring aligned to the individual performance.

A: Attitudes and lack of commitment; training conducted when there are new changes.

A: Close scrutiny done to ensure that people really qualify for what they are employed for.

A: Information does not reach lower levels; cascade information to the lowest level by people who attend trainings/workshops.

A: There is no link between the levels of the Department i.e. between province and district and between district and facilities; needs enforcement of a working relationship between all levels.

Q: How best can the M&E System be introduced in the Department this time around to avoid previous errors?

A: When facilities do not function well at a district level we cover for them as they concentrate on only one section of reporting i.e. providing data they do not provide narrative to explain the causes of deviations and what remedial actions they will implement; we cover for them.

A: We feedback to them but very limited response is elicited District Management Teams reports presenting; there is no commitment so that buy-in remains a challenge.

A: Data quality is compromised because of unrealistic timeframes. There is no time to go back and verify data also because of staff shortage**.**

A: There is need to engage with people at the lower level. By the way, who is supposed to provide remedial actions?

A: *(Respondent)* The facilities.

A: Were they made aware of this role?

Q: Can I ask this: have you seen the Departmental M&E Framework?

(*Only one from the group admitted and the M&E Manager. The rest of the group had not seen it – the Framework was developed in 2008! They were reminded about this and that it is in the Intranet)*

A: I am not sure if they were trained on the Framework by the Managers at District level.

A: Programme Managers should encourage them to engage in their roles.

A: At Hospital level it is only the FIOs who is normally exposed to trainings. The FIO do not meet with the Programme Managers.

Q: I understand that there are HIT where all meet?

A: The HIT is still lacking; they need skills and the person driving it is not capacitated.

Q: Can we now be specific and say what is needed to be done when introducing the reviewed M&E System?

A: Roles are not known by the M&E Managers at facilities; they do not have direction; there is overlap in terms of functionality.

A: There is fixation in terms of moving from the old to the new practices; the job description of the M&E Manager is not clear.

A: All should be called for the introduction of the M&E System.

A: M&E has always been there but for the new system a vigorous introduction is recommended.

A: There is no integration of issues; no proper directive of how programmes are integrated .

A: At a Provincial level there should have been an operational plan of how M&E was to be implemented.

Q: Are you aware that the M&E Framework has an Implementation Plan? *(There was surprise in their faces they did not know this)*.

Q: Can we really discuss about the M&E Framework?

A: The Framework has never been read or understood.

A: I suggest that training on M&E should start afresh – the whole M&E concept.

A: Rigorous involvement in order to get the buy-in; sort of road shows.

A: Provision of support to districts and facilities; i.e. cascading information to lower levels.

A: Strengthening supervision practices and 'craft' M&E in supervision skills training; link accountability to Programme Managers during their training.

A: Alignment of the job description with M&E.

A: Expectations/roles of an M&E personnel emphasized and guidelines given.

A: Intensify M&E training to the already existing and also work on their attitudes.

A: Placement of the right people in the right positions and then strengthen supervision.

A: Strengthen supervision at all levels!!! *(This was said with an emphasis).*

A: Districts encourage facilities to invite them so that both sit down during quarterly report writing and write it together so that they can improve on report writing.

A: The DHIS should be strengthened so that data elements talk to definitions and vice versa. Changes made to the DHIS should be communicated to the Managers who provide supervision.

A: Attitude change should be worked on.

A: Obviously M&E has caused tension so that working relations have soured.

Q: How can that be addressed?

A: By making people understand M&E, its role, the policy/framework and capacitate them on M&E. You know the approach goes a long way in addressing attitudes.

A: Even in the Province there are same attitudes (surprisingly). The HAST Programme is an example its staff has an attitude.

(Conclusion was made and the focus group discussion was ended).

APPENDIX 13

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

UMGUNGUNDLOVU HEALTH DISTRICT OFFICE
OFFICE OF THE DISTRICT MANAGER
Private Bag X9124, Pietermaritzburg, 3200
Brasfort House, 262 Langalibalele Street,
Pietermaritzburg, 3201
Tel.: 033-8971000,
Fax: 033-897 1078
Email.: thule.kunene@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mrs. N.M. Zuma - Mkhonza

Ref No: 15/16
Date: 24 November 2011

TO: MS THEMBEKA MNGOMEZULU

RE: PERMISSION TO CONDUCT A RESEARCH IN EVALUATION OF DEPARTMENTAL M & E SYSTEM

Your correspondence regarding the permission to conduct the ***Evaluation of Departmental M & E System***

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research in ***Evaluation of Departmental M & E System***

PLEASE NOTE THE FOLLOWING

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thank you

MRS N.M. ZUMA - MKHONZA
DISTRICT MANAGER
UMGUNGUNDLOVU HEALTH DISTRICT

APPENDIX 14

Department:
Health
PROVINCE OF KWAZULU-NATAL

Umkhanyakude Health District Office
Dr C H Vaughan Williams
Medical Manager, Senior
Private Bag X 026, Jozini 3969
Tel: 035 5721327, Fax: 035 5721251
Cell. 072 584 3472
Email:hervey.williams@kznhealth.gov.za

Reference :
Enquiries : Dr CH Vaughan Williams
Telephone : 035-5721327 Ext 114

17 November 2011

Dear Ms Mngomezulu,

Re: Dissertation Topic: "The Monitoring and Evaluation System in the Public Governance: A case Study of the KwaZulu-Natal Department of Health"

Permission is given by Umkhanyakude Health District Office to conduct the above research in Umkhanyakude District .

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

[redacted]

THE DISTRICT MANAGER
17 NOV 2011
Umkhanyakude Health District
Private Bag X026
Jozini 3969

APPENDIX 15

Department:
Health
PROVINCE OF KWAZULU-NATAL

Umkhanyakude Health District Office
Dr C H Vaughan Williams
Medical Manager, Senior
Private Bag X 026, Jozini 3969
Tel: 035 5721327, Fax: 035 5721251
Cell. 072 584 3472
Email:hervey.williams@kznhealth.gov.za

Reference :
Enquiries : Dr CH Vaughan Williams.
Telephone : 035-5721327 Ext 114

17 November 2011:

Dear Ms Mngomezulu,

Re: Dissertation Topic: "The Monitoring and Evaluation System in the Public Governance: A case Study of the KwaZulu-Natal Department of Health"

Permission is given by Umkhanyakude Health District Office to conduct the above research in Umkhanyakude District.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

THE DISTRICT MANAGER
17 NOV 2011
Umkhanyakude Health District
Private Bag X026
Jozini 3969

[redacted]

APPENDIX 16

APPENDIX 16

HEALTH
KwaZulu-Natal

UGU DISTRICT OFFICE
41 Bissett Street, Port Shepstone, 4240
Private Bag X735, Port Shepstone, 4240
Tel.: 039 6883000, Fax.: 039 6826296
Email.:veeran.chetty@kznhealth.gov.za
http://www.kznhealth.gov.za/ugu.htm

Reference : Research
Enquiries : Mr V. Chetty
Telephone : 039-6883000
25 November 2011

Mrs T Mngomezulu
c/o DOH

by e-mail

Re: Letter of support for research in Ugu District: **"The Monitoring and Evaluation System in Public Governance: A Case Study of the KwaZulu-Natal Department of Health"**

- I refer to your e-mails and attachments(6 and 11 November 2011) requesting support for the above research
- I apologise for delay in responding. The difficulty has been the unusual way the request has been submitted to us: absence of a full protocol to consider all aspects and the fact that University Letterhead usedresearch to request PERMISSION in your personal capacity as student and ANNOUNCEMENT being signed –off as the employee of the Department . I believe it should have been in your personal capacity as student. Also that the request is that we sign and scan the LETTER FROM UKZN ,which in fact is a letter from you on a letterhead of UKZN
- Nevertheless, I have perused the ETHICAL APPLICATION and support for the project is given subject to DOH approval.
- Once approval is obtained, please liaise with the manager : District M&E in implementing the project
- A signed copy of this letter can be obtained from my secretary.
- All the best with your project

Yours faithfully

Mr Veeran Chetty

APPENDIX 17

APPENDIX 17

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

UMZINYATHI HEALTH DISTRICT OFFICE
Postal Address: Private Bag x 2052 Dundee 3000
Physical Address: 34 Wilson street Dundee 3000
Tel: 034-2999 100 Fax: 034- 212 4800
charlotte.vanross@kznhealth.gov.za
www.kznhealth.gov.za

OFFICE OF THE DISTRICT MANAGER

TO	:	MRS. T. MNGOMEZULU DEPUTY MANAGER: MONITORING AND EVALUATION
FROM	:	MR. J. MNDEBELE DISTRICT MANAGER
DATE	:	29TH NOVEMBER 2011
RE	:	PERMISSION TO CONDUCT RESEARCH AS PART OF THE DOCTORAL DEGREE IN PUBLIC ADMINISTRATION (DPA)

Umzinyathi Health District Office supports your request to undertake the dissertation topic:" The Monitoring and Evaluation System in the Public Governance: A case study of the Kwazulu –Natal Department of Health."

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District / our facilities will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the district office.

Thank

[redacted]

APPENDIX 18

APPENDIX 18

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

UTHUKELA DISTRICT
60A Midblock, Corner Alexander Street,
Ladysmith
P/Bag X9958, Ladysmith, 3370
Tel: 036 6312202
Fax: 036 6310530
E-mail: thandeka.zulu@kznhealth.gov.za
www.kznhealth.gov.za

25 November 2011

Mrs T Mngomezulu
Deputy Manager
Monitoring & Evaluation

RE: PERMISSION TO CONDUCT RESEARCH AS PART OF THE DOCTORAL DEGREE IN PUBLIC ADMINISTRATION (DPA)

Please be informed that I have acknowledged your request for conducting research as part of the doctoral degree in Public Administration.

Please note the following:

1. Your letter dated on 06 November 2011refers.
2. Uthukela District must ensure adherence to all the policies, produces, protocols and guidelines of the Department of Health with regards to this research.
3. Your research will only commence once this office has received confirmation of the approval by HOD from the provincial Health Research Committee in the KZN Department of Health.
4. However the Management takes note of the intended research.
5. I trust that you will find all to be in order.

[redacted]

APPENDIX 19

APPENDIX 19

HEALTH
KwaZulu-Natal

[redacted]
No2 Lead Avenue, Cor Chrome & Leopard Avenue, [redacted]
Private Bag X [redacted], [redacted]
Tel: 033 [redacted], Fax: [redacted]
Email: [redacted]
[redacted]

OFFICE OF THE DISTRICT MANAGER

Enquiries: MM ZUNGU

TO	:	Ms Thembeka Mngomezulu
Email	:	Thembeka.mngomezulu@kznhealth.gov.za
FROM	:	DISTRICT MANAGER
DATE	:	17 November 2011
SUBJECT	:	Permission to Conduct Research at Uthungulu District: Evaluation of Departmental M&E System

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research on "Evaluation of Departmental M&E System".

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thanking you

[redacted]

NB: KINDLY RETURN ALL DOCUMENTATION WHEN REPLYING!!

APPENDIX 20

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

ZULULAND HEALTH DISTRICT OFFICE,
KING DINIZULU HIGHWAY
ADMIN. BUILDING
Tel.: (035) 874 2453
Fax. : (035) 874 2411
Email: daphne.memela@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries : Mrs. DT Memela
Telephone : (035) 874 2303

02 December 2011

Mrs T Mngomezulu
DEPUTY MANAGER
Monitoring & Evaluation

PERMISSION TO CONDUCT RESEARCH AS PART OF THE DOCTORAL DEGREE IN PUBLIC ADMINISTRATION (DPA)

Dear Mrs Mngomezulu,

Your emailed dated 06 November 2011 have reference.

Zululand District hereby supports the research to be conducted provided that the Head Office has approved.

[redacted]
DISTRICT MANAGER
ZULULAND HEALTH DISTRICT

APPENDIX 21

UNIVERSITY OF KWAZULU-NATAL

September 1, 2011

To Whom It May Concern:

PERMISSION TO CONDUCT RESEARCH AS PART OF THE DOCTORAL DEGREE IN PUBLIC ADMINISTRATION (DPA)

Name: Thembeka Mary-Pia Mngomezulu

Student No: 202523698

Dissertation Topic: "The Monitoring and Evaluation System in the Public Governance: A case Study of the KwaZulu-Natal Department of Health"

It is a requirement of our Public Administration Doctoral Degree that all students undertake a practical research project, in their final year of study.

Typically this project will be a "practical problem solving" exercise, and necessitate data gathering by questionnaires or interviews.

Your assistance in permitting access to your organization for purposes of this research is most appreciated. Please be assured that all information gained from the research will be treated with the utmost circumspection. Further, should you wish the result from the thesis "to be embargoed" for an agreed period of time, this can be arranged. Confidentiality and anonymity will be strictly adhered to by the student.

If permission is granted the UKZN require this to be in writing on a letterhead and signed by the relevant authority.

Many thanks for your assistance in this regard.

Yours sincerely
Mrs. T. Mngomezulu

Supported subject to ethics committee approval.
Will permit the officials of Monitoring & Evaluation unit to be subjected to interviews.

[redacted]

General Manager
Mrs R. Mavuso
Office of the Premier