Albertina Sisulu Executive Leadership Program In Health (ASELPH) Final Evaluation Report

26 September 2016

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Albertina Sisulu
Executive Leadership
Programme in Health
Excellence, Innovation, Transformation

This report was prepared for the Albertina Sisulu Executive Leadership Programme in Health.

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September 2016

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List of acronyms

AP	The Atlantic Philanthropies
ASELPH	Albertina Sisulu Executive Leadership Programme for Health
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHC	Community Health Centre
CPD	Continuing Professional Development
DCST	District Clinical Specialist Team
DDG	Deputy Director General
DHIS	District Health Information System
DHS	District Health System
DM	District Manager
DMT	District Management Team
DOH	Department of Health
EC	Eastern Cape
GIBS	The Gordon Institute of Business Science
HOD	Head of Department
HPRS	Health Patient Registration System
HSPH	Harvard School of Public Health
HW	Health and Welfare
IDP	Integrated Development Plan
KMS	Knowledge Management System
KZN	KwaZulu-Natal
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MEC	Member of the Executive Council
MOA	Memorandum of Agreement
MPH	Masters in Public Health
MPhil	Masters in Philosophy
MSC	Most Significant Change
MTR	Mid-Term Review
NDOH	National Department of Health
NGO	Non-Governmental Organisation
NHI	National Health Insurance

NHLS	National Health Laboratory Services
PGD	Post-Graduate Diploma
PHC	Primary Health Care
QA	Quality Assurance
SA	South Africa
SADC	South African Development Community
SAP	South Africa Partners
SC	Steering Committee
SETA	Skills Education Training Authority
SMT	Strategic Management Team
SOP	Standard Operating Procedure
SWOT	Strengths, Weaknesses, Opportunities, Threats
USAID	United States Agency for International Development
UFH	University of Fort Hare
UP	University of Pretoria

EXECUTIVE SUMMARY

The Albertina Sisulu Executive Leadership Programme for Health (ASELPH) is a collaboration between the National Department of Health (NDOH), the University of Pretoria (UP), the University of Fort Hare (UFH), the Harvard School of Public Health (HSPH), and South Africa Partners (SAP). The initiative is funded jointly by The Atlantic Philanthropies (AP), Elma Philanthropies and the United States Agency for International Development (USAID). The programme was designed to address critical gaps in executive health management training at all levels based on the results of an investigation into health management training capacity conducted in 2011. It was envisioned as a flagship program capable of setting the standard for executive level health management training in SA. The goal of ASELPH is to strengthen the NDOH's ability to meet its health transformation challenges, particularly at the district level. The six program objectives and key activities to achieve these include:

- Establish and maintain a critical mass of knowledge, skills, competencies and leadership among current and emerging District Health leaders. Key activities include establishment of the ASELPH Executive Fellows Programme; Postgraduate Diploma and Masters Programmes and E-learning.
- Improve policy implementation strategies through a collective understanding of the political and organizational context and the crosscutting issues that underpin decision-making and implementation. Key activities include conducting policy seminars and roundtable discussions and incorporating pertinent issues that arise into teaching and learning.
- Promote and maintain high quality service delivery standards at the district and community level. Key activity is applied research.
- Build an executive leadership pipeline through increased executive leadership training capacity among South African faculty and educational institutions that includes increased capacity in curriculum development and distance learning technology and techniques. Key activities include course development, preparation and teaching, faculty capacity development, case study development, and teaching.
- Effectively and efficiently manage the ASELPH Programme through good governance, funder accountability, partnership maintenance and communication. Key activities include convening partnership meetings, Steering Committee (SC) meetings, establishing a memorandum of agreement (MOA), maintaining funder relations, monitoring and evaluation (M&E), financial and narrative reporting and development of a communication plan.
- Contribute to ASELPH sustainability beyond initial funding period. Activities include development of a stakeholder network, coordinating alumni relations, quality assurance of the academic programme and developing a knowledge management system.

The first phase of the program covers the period 2012-2016. In April 2016 the Public Health Agency was commissioned to conduct an independent summative end of project evaluation with a focus on both accountability and learning. The overarching and sub-evaluation questions were:

- How, and to what extent, has ASELPH contributed to service delivery improvements in SA?
    - Is ASELPH *effective*[1] as an executive leadership development programme?
    - Is ASELPH delivering a product that is *uniquely valuable in terms of method and content*?
    - Has ASELPH *built SA faculty capacity*?
    - Has ASELPH built a framework/mechanism/*system to deliver emerging leaders*?
    - Is ASELPH *sustainable* and providing *value for money*[2]?

We employed a mixed methods approach that included a desktop review of program documents as well as interviews with stakeholders and beneficiaries directly and indirectly associated with ASELPH.

[1] Effectiveness based on the competencies ASELPH sought to develop in Fellows
[2] Value for money defined as "The optimal use of resources to achieve intended outcomes" (DFID)

Secondary data collection involved a data trawl reviewing relevant program and related documentation to extract existing evidence and data from monitoring reports. Primary data collection focused on collection of qualitative data using a semi-structured interview technique with the assistance of an interview guide. This included individual and group interviews as well as observation site visits. Site visits included interviews with the Fellow, their manager, peers and subordinates to validate findings in order to provide feedback from a 360^0 perspective.

The evaluation focused on four main groups/areas: course participants (Fellows), academic partners (Faculty), project management and support (Steering Committee, SA Partners, Academic Partners, DOH) and process issues (Steering Committee, SA Partners, Academic Partners, DOH, Funders). The aim was to tell the story of ASELPH's performance from a number of perspectives and using multiple lines of evidence.

The evaluation used a whole-systems approach to allow us to look for changes in leadership capability (behavior) displayed by/affecting individuals, organizations (or the team with which the individual works) and the broader system or environment in which the individual functions, that has resulted in, or has the potential to generate, improved service delivery and ultimately positively affect health outcomes. Data were analyzed according to the outcomes in the pathways of change towards achieving the six program objectives. These preliminary findings were presented to a group of 20 ASELPH stakeholders that included representatives from the three academic institutions, SAP, NDOH, SC, funders and Fellows. Participants then provided feedback on the findings and worked in small groups to give inputs as to the extent of ASELPH's contribution to health systems strengthening (and/or its potential to do this) and to provide recommendations for the program going forward.

The table below lists the five strengths and weaknesses/challenges that respondents cited most commonly. A detailed description of the findings against each program is provided in the body of the report.

THINGS THAT WORKED WELL	THINGS THAT DID NOT WORK SO WELL
• The Harvard brand, peer learning and teaching methodology contribute to making ASELPH unique in the executive health leadership development space. • Relevance of the course content to what is current and topical in the SA health system and context, in part because of involvement of the NDOH. • Empowerment of the Fellows and capacitation of faculty: in the case of Fellows, enabling them to contribute more effectively to health systems strengthening; and in the case of Faculty, to develop modules and case studies and teach them using a new pedagogy. • The unique partnership, which brings together the strengths of three universities with very different histories, NDOH and an NGO. • ASELPH already leaves a legacy of a PGD at UP and MPH at UFH; UFH now has Faculty of Health Sciences and a Health Institute.	• Delays and inefficiencies in some university administrative issues, which are outside the ASELPH program, but impact on the quality of the affected Fellows' experience. • No formal competency framework for faculty was developed. • Ongoing evaluation of Fellows was not complemented by good 360^0 feedback and assessment. • Underutilization of SAP's strengths. • Incomplete documentation of processes and activities e.g. no policy papers, inadequate analysis of monitoring data to facilitate timely action and documentation of evidence to demonstrate the ongoing learning.

LESSONS LEARNED

These represent the most commonly expressed views by the various respondent groups and are drawn mainly from responses to the interview questions 'what worked well?'; 'what did not work so well?'; and 'what are key lessons?'

1. *ASELPH is exceptional in the health leadership development space in terms of the teaching and learning approach* - all respondent groups described the pedagogy employed in the ASELPH Fellows program in glowing terms. Outstanding features include the manner in which it promotes peer learning, the ease of applicability of the tools and methods used during the contact sessions, and the focus on executive leadership rather than a generic public health approach that includes leadership training.
2. *An academic strategy to drive a development program* - ASELPH was conceptualized as a development program that uses a unique academic training approach as the vehicle to contribute to improved health service delivery and ultimately improved population health outcomes. The focus during this first phase has been on establishing and monitoring progress against the academic program and self-reported changes against the leadership competency framework. It has proved difficult to measure changes in the workplace related to Fellows' participation in ASELPH, which some have argued is outside the remit and control of the universities.
3. *Partnership with NDOH allows ASELPH to fulfill its 'responsiveness mandate'* – a particular strength of ASELPH's partnership model is the integral involvement of the NDOH as a partner and chair of the SC. This direct oversight and guidance makes it easier for the program to fulfill its mandate for being responsive to the department's policy imperatives and implementation priorities and therefore extremely relevant for Fellows.
4. *Partnership means collective ownership and responsibility* – the ASELPH academic partners were deliberately chosen for their respective strengths and also from an equity perspective, to strengthen a historically disadvantaged university. UFH has fewer resources in terms of staff and infrastructure and this has affected the quality of the ASELPH experience on the part of the Fellows. Whilst there is a pressure to deliver, in some instances there was an impression of a 'separate' ASELPH at each of the SA universities and the historically disadvantaged institution remained at a disadvantage. This 'disconnect' became more apparent as Harvard stepped back from a hands-on role. To paraphrase in the words of a respondent; "…should remember that any program is also as weak as its weakest link.'
5. *Careful selection of candidate Fellows enhances the quality of the learning experience* – the ASELPH selection criteria and process works well and creates diversity in the group in terms of representation from hospitals, health programs, support systems such and human resources (HR) and finance as well as a mix of policy makers and implementers. This enhances the Fellows' understanding of the whole public health system and clarifies their role in it.
6. *Support from senior provincial managers is important to enable Fellows to make workplace changes* – this has to be continued, and strengthened where necessary, as it is important in supporting the work for every Fellow and in developing a critical mass to ensure that Fellows can apply what they have learnt from participating in ASELPH**.**
7. *Need to measure faculty development* – whilst SA faculty report increased competence and confidence, as is the case with Fellows, there is need to define a faculty competency framework against which to measure faculty development over time as a result of exposure to ASELPH.
8. *Local research outputs would strengthen case studies* – information gleaned from the applied research conducted by Fellows could be used to develop new case studies and inform course material to ensure that this remains up to date.

ASSESSMENT

The assessment section also draws from respondent responses as well as those from the stakeholder feedback and consultative workshop.

How, and to what extent, has ASELPH contributed to service delivery improvements in SA?
ASELPH's implementation timespan has been too short to measure contribution to service delivery improvements in SA. The workplace site visits demonstrated that Fellows are implementing initiatives that are already working and have the potential to improve health services. To date ASELPH has inducted 178 Fellows of which 52 have graduated. This represents a small proportion of the health managers in the country. However, Fellows report passing on their learning (theory and

practice) to colleagues in the workplace, which does create a ripple effect and thereby extend ASELPH's coverage.

Is ASELPH effective[3] as an executive leadership development programme?
The serial self-assessments done by the Fellows in each cohort demonstrate improvements in the 14 leadership competencies. It is difficult to verify these self-reported improvements because of the paucity of information in the routine 360⁰feedback report system. The observation and assessments conducted at four purposively selected workplaces confirm changes in leadership behavior and implementation of workplace initiatives that have the potential to improve services and positively influence health outcomes. Documentation of what Fellows are doing in the workplace would provide useful material to integrate into teaching material as well as for dissemination to showcase the program. There is very limited evidence of the effectiveness of mentoring and slow implementation of e-learning has somewhat impeded the effectiveness of that aspect of the academic program.

Is ASELPH delivering a product that is uniquely valuable in terms of method and content?
According to unanimous feedback from fellows and faculty ASELPH is unique in terms of method and content – the peer learning, case study methodology, incorporation of topical content taught by guest lecturers from the department, depth and breadth of knowledge brought by Harvard faculty and the opportunity to engage with how other countries have dealt with health problems are all valued aspects of the program, as are the models of analysis and problem solving that can be applied in the workplace. ASELPH's methodology and content have been transformative in exposing people to and opening up a different way of learning and what they took from that learning. Fellows were clear that 'ASELPH should not become less of a leadership and more of a public health program.'

Has ASELPH built SA faculty capacity?
SA faculty have undergone capacity building activities in case study development and teaching and applied research and report more competence. They are capable of running high-level courses that are evaluated by students. A baseline assessment and documentation of pre- and post levels of competence would have provided stronger evidence.

Has ASELPH built a framework/mechanism/system to deliver emerging leaders?
ASELPH has developed a system to select, train and support (mentor) Fellows in the workplace. The first two components in this system function well and the third requires strengthening of the mentoring and better documentation of process and outcomes. These deficiencies probably affect emerging leaders more than those who currently hold executive leadership positions.

Is ASELPH sustainable and providing value for money[4]?
The program has the potential to be sustainable in the long term depending on continued funding (H&W SETA funding is a positive development), continued involvement of Harvard and attention to the aspects of the program that are not working so well. While institutionalization of the program into the universities contributes to sustainability, some respondents cautioned that 'mainstreaming will make them (the PGD and MPH) just another university program and lose what is ASELPH'. All respondents felt that ASELPH provides value for money. There could have been more efficient use of Harvard time in the first year and efficiency was lost in the dependence on paper and use of conference venues, however, the latter was outside the program's control.

RECOMMENDATIONS

In formulating these recommendations we have focused upon strategic issues in the belief that consideration is already being given to the operational matters.

[3] Effectiveness based on the competencies ASELPH sought to develop in Fellows
[4] Value for money defined as "The optimal use of resources to achieve intended outcomes" (DFID)

1. We strongly recommend that the program and the ASELPH partnership be continued. Since the academic program has been established, a review of the partnership model should be considered in order to establish a best fit for the next phase of the program. For example, it may be timely to establish an independent body to house ASELPH, which would also provide an opportunity to review the governance and establish a framework to monitor and support partnership as an integral component of this unique model.
2. Attention should be given to ensuring that ASELPH adopts an equity approach within the program itself. This would mean establishing and/or strengthening the systems at UFH and UP and providing assistance and support as required for the effectiveness of the program and to maintain the integrity of ASELPH as 'whole' rather than the sum of disparate parts.
3. ASELPH should enhance its potential to contribute to the SA policy space by continuing to arrange policy seminars and round tables on topical issues. These could possibly be decentralized to provincial level and should be written up as policy briefs. Consideration should be given to registering these for continuing professional development (CPD) points and providing these as podcasts to increase coverage.
4. ASELPH should continue to further nurture and grow its relationship with the DOH at both national and provincial levels. There should be interactions and report backs at national and provincial levels to showcase program achievements and continue to garner support. Fellows and Alumni should play an active part in these.
5. It is important to find a way that the unique dimension that Harvard brought to the classroom is maintained. In addition to its QA role Harvard should still play a teaching role (even if it is reduced) as Fellows valued the interaction with HSPH faculty very highly.
6. ASELPH should develop a more systematic/formalized approach to faculty development.
7. Blended learning needs to be implemented evenly across the entire program, and in order to achieve a good balance between peer learning and Fellows not leaving their workplace.
8. The potential of the mentoring component of the program should be developed and formalized for both Fellows and Faculty.
9. Strengthen knowledge management (KM) and specifically monitoring of Fellows' activities outside of the classroom. This should include revisions based on the 360^0 assessment pilots as well as documenting the ASELPH story and sharing the lessons learnt. Consideration should also be given to a follow up evaluation of Fellows once they have graduated (at 3 years and 5 years for example) to monitor their progress and contribution to the public health system.
10. Formalize the Alumni Association to ensure continued interaction between past and current Fellows
11. ASELPH should make a concerted effort to mobilize the additional resources necessary to support consolidation of the program as well as adaptation and strengthening of some components because of its potential to make a significant contribution to strengthening the health system, and ultimately improving health outcomes.

CONCLUSION

ASELPH has established itself in the health executive leadership development space. It provides an offering that is unique in method and content. The program is making a contribution to health system strengthening in SA and has the potential to impact significantly going forward, particularly if attention is given to the e-learning and post-classroom support components. Institutionalization of the PGD and MPH at UP and UFH plays a significant role in program sustainability. ASELPH should definitely continue and strong efforts should be made to mobilize resources to support the next phase of the program.

1 INTRODUCTION

The Albertina Sisulu Executive Leadership Programme for Health (ASELPH) is a collaboration between the South African National Department of Health (NDOH); three, equal status partner academic institutions – the University of Pretoria (UP), the University of Fort Hare (UFH) and the Harvard School of Public Health (HSPH); and South Africa Partners (SAP), a nongovernmental organization (NGO) that builds mutually beneficial partnerships between the United States of America (USA) and South Africa (SA). ASELPH was envisioned as a flagship programme capable of setting the standard for executive level health management training in SA. The initiative is funded jointly by The Atlantic Philanthropies (AP), Elma Philanthropies and the United States Agency for International Development (USAID).

The programme was designed to address critical gaps in executive health management training at all levels based on the results of an investigation into health management training capacity conducted in 2011. The research identified a specific gap in training at the executive leadership level, covering policy and strategy development and also operations and coordination. ASELPH used a combination of strategies to strengthen the following three key components of health transformation in SA:

- Targeted training of health managers responsible for the various levels of services related to the NHI;
- The management capability of current and emerging district health related leadership within the public health system responsible for the reengineering of the Primary Health Care (PHC) system; and
- Advancing sustainable relevant educational and training capacity for health executives responsible for management of large public health programmes such as HIV/AIDS and TB

The initial funding period covered the first four years of the programme from 2012-2016. A midterm review (MTR) was conducted in 2014. The emphasis of this formative assessment was on process, using a systems approach to extract lessons from aspects of the programme and translate these into recommendations to strengthen the programme in its latter two years. In April 2016 the Public Health Agency was commissioned to conduct an independent summative end of project evaluation with a focus on both accountability and learning. The following two key objectives were thus formulated to guide the evaluation:

a) To demonstrate the extent of the effectiveness and impact of ASELPH in improving the provision of health services at an organizational or district level
b) To generate key lessons and insights regarding the characteristics that under- pin effectiveness of the program and explain why particular parts have or have not worked well.

2 PROGRAMME DESCRIPTION

The goal of ASELPH is to strengthen the NDOH's ability to meet its health transformation challenges, particularly at the district level. The programme specifically aims to strengthen three components of health transformation in South Africa:

1. *Service Delivery Improvements* – targeting the management and leadership capability of current and emerging leadership at hospital, district, provincial and national levels. ASELPH selects leaders who are committed and values driven and provides a unique educational package that blends the health sector focus with top-end executive leadership and management capabilities.

2. *Meeting Key Policy Operational Goals* – through the selection and training of executive level managers responsible for implementing key policy issues such as the National Health Insurance initiative and the Reengineering of Primary Health Care; including collaborative meetings with the National Department of Health that refine implementation plans associated with these policy issues. The programme encourages leaders to think innovatively and creatively as they implement the NHI.

3. *Excellence in Executive Level Training* – a longer term effort to build critical capacity at UFH and UP to establish and deliver executive leadership courses in health that will address the country's immediate need for an effective pipeline for the training of senior health managers capable of successfully addressing current challenges at all levels of service delivery within the country. ASELPH aims to create specialized expertise in managing large public health programmes by providing insights and techniques for devising and implementing streamlined systems, effective resource allocation, and developing a workforce.

The educational institutions apply adult or engaged learning pedagogical strategies in interacting with course participants. These include experiential methods like case teaching and techniques such as e-learning which increase the level of interaction and peer learning exchange. Interventions include exposure of cohorts of senior managers to policy and implementation roundtables and executive leadership courses addressing generic skills, cutting edge challenges related to implementation of the three streams of PHC reengineering, and specific topics identified in consultation with the NDOH e.g. NHI, PHC reengineering. SAP is responsible for the programme management of ASELPH.

The six programme objectives and corresponding key activities are listed below. It is important to note that although these are listed as discrete activities linked to a particular objective, all the programme activities are interlinked and contribute to the various objectives. For example, whilst the development of case studies is specifically listed under objective 4, case study development may also significantly influence objectives 1, 2 and 3 and likewise e-learning is positioned under objective 1 but contributes to objectives 2-4 as well. The greatest emphasis, in terms of level of effort and the proportion of budget expended, was placed on objectives 1 and 4 – establishing the ASELPH Fellows programme and developing the capacity of SA faculty to provide executive leadership training.

Objective 1: Establish and maintain a critical mass of knowledge, skills, competencies and leadership among current and emerging District Health leaders. Key activities include establishment of the ASELPH Executive Fellows Programme; Postgraduate Diploma and Masters Programmes and E-learning.

Objective 2: Improve policy implementation strategies through a collective understanding of the political and organizational context and the crosscutting issues that underpin decision-making and implementation. Key activities include conducting policy seminars and roundtable discussions.

Objective 3: Promote and maintain high quality service delivery standards at the district and community level. Key activity is applied research.

Objective 4: Build an executive leadership pipeline through increased executive leadership training capacity among South African faculty and educational institutions that includes increased capacity in curriculum development and distance learning technology and techniques. Key activities include course development, preparation and teaching, faculty capacity development, case study development, and teaching.

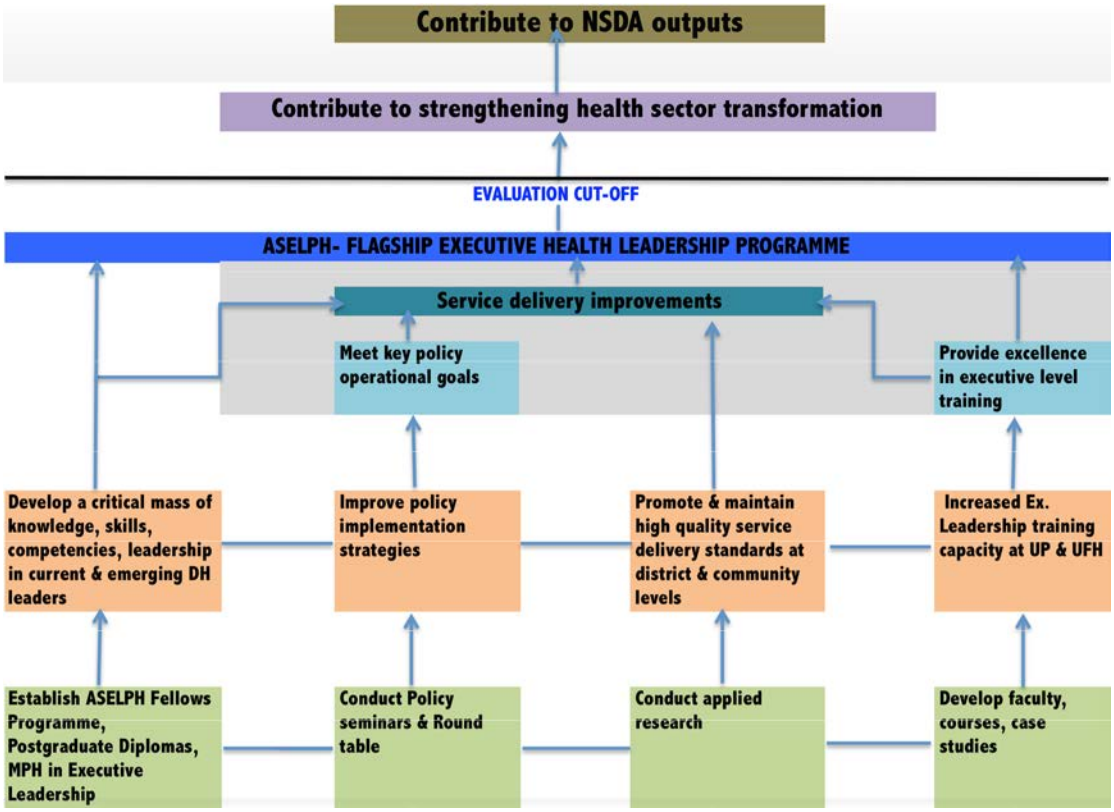
Objective 5: Effectively and efficiently manage the ASELPH Programme through good governance, funder accountability, partnership maintenance and communication. Key activities include convening partnership meetings, Steering Committee (SC) meetings, establishing a memorandum of agreement

(MOA), maintaining funder relations, monitoring and evaluation (M&E), financial and narrative reporting and development of a communication plan.

Objective 6: Contribute to ASELPH sustainability beyond initial funding period. Activities include development of a stakeholder network, coordinating alumni relations, quality assurance of the academic programme and developing a knowledge management system.

The interdependency of the activities (green blocks) related to the four objectives (orange blocks) linked to health systems strengthening are illustrated in the theory of change diagram below. The evaluation focused on the outcomes in the grey-shaded area of Figure 1.

Figure 1: ASELPH theory of change



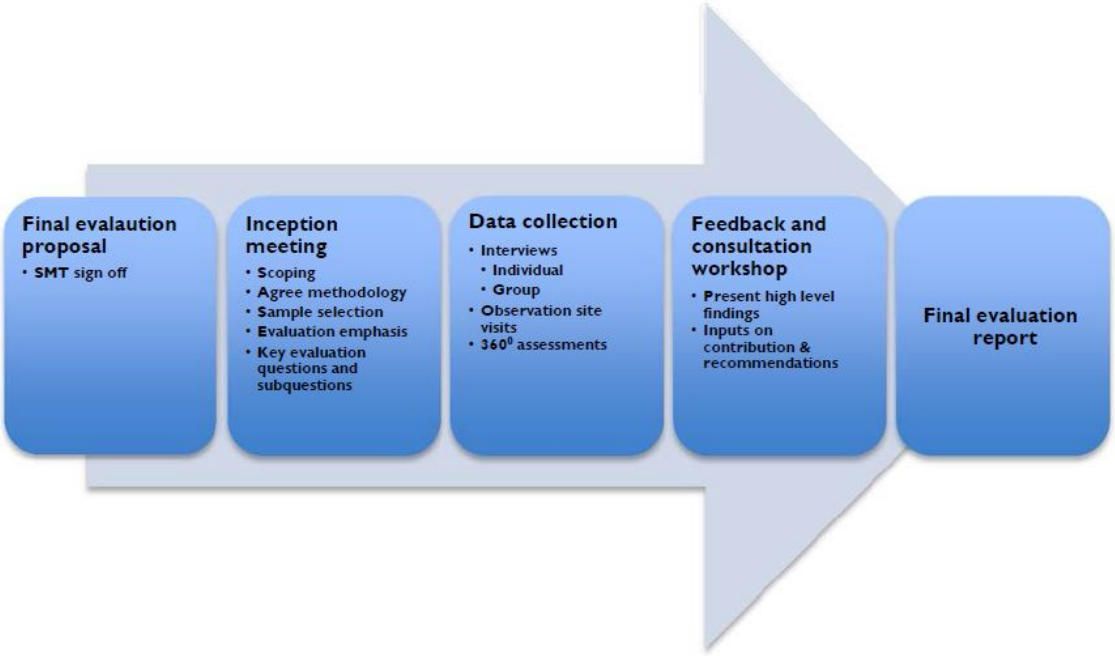
2.1 Programme governance

ASELPH is structured as an equal partnership between five parties/partners – the National Department of Health (NDOH) and four implementing partners (UP, UFH, HSPH and SAP). A Steering Committee (SC) provides oversight of progress and strategic planning to ensure alignment with government priorities. The SC is comprised of representatives from the national and provincial DOH, health experts, the three partner universities (UP, UFH and HSPH), the funders, and the Sisulu family. The NDOH chairs the SC.

3 EVALUATION APPROACH

We used a consultative and participatory approach to conducting the evaluation. Consultation workshops were held at the inception of the project with representatives from the universities and SAP, and then a broader consultation of ASELPH stakeholders after the preliminary data analysis, bringing the whole system together in a room. The important steps in the evaluation process are mapped out in Figure 2 below.

Figure 2: Process for the final evaluation



3.1 Inception and scoping

After signoff of the final evaluation proposal we held two inception workshops[5] with the ASELPH implementation partners to agree on the scope of and focus areas for the evaluation, to clarify the programme logic, identify existing data and lists of potential key informants, deliberate on what evaluation activities were feasible to conduct within the allocated resources, as well as to prioritise the evaluation questions.

The workshops decided on the following:

- The evaluation would focus on the programme's high-level outcomes – service delivery improvements, meeting key operational goals and providing excellence in executive level education, which collectively would contribute to making ASELPH a flagship programme.
- It was agreed that an evaluation focus on Objectives 1, 4 and 5 was appropriate.
- The overarching or key evaluation question was:
    - How, and to what extent, has ASELPH contributed to service delivery improvements in SA?
- Sub-evaluation questions were agreed as:
    - Is ASELPH *effective*[6] as an executive leadership development programme?
    - Is ASELPH delivering a product that is *uniquely valuable in terms of method and content*?
    - Has ASELPH *built SA faculty capacity*?
    - Has ASELPH built a framework/mechanism/*system to deliver emerging leaders*?
    - Is ASELPH *sustainable* and providing *value for money*[7]?

[5] Separate inception workshops were conducted with the ASELPH teams from UP and UFH
[6] Effectiveness based on the competencies ASELPH sought to develop in Fellows
[7] Value for money defined as "The optimal use of resources to achieve intended outcomes" (DFID)

3.2 Methodology

We employed a mixed methods approach that included a desktop review of programme documents as well as interviews with stakeholders and beneficiaries directly and indirectly associated with ASELPH.

Secondary data collection involved a data trawl reviewing relevant programme and related documentation to extract existing evidence and data from monitoring reports. These included, but were not limited to:

- Project documents such as approved work plans, policies, procedures, job descriptions, partnership agreements, quarterly and annual reports, budget and expenditure reports etc.
- List and definition of Competencies that ASELPH seeks to develop for Fellows and Faculty; the monitoring framework/plan for assessing/measuring these; and periodic reports, including 360 feedback reports.
- Individual Course evaluation reports from students.
- Student assessment results and progress reports, as well as evidence of implementation of student projects and how these have strengthened systems and/or improved health outcomes.
- Evidence of capacitation of Faculty e.g. courses and workshops attended and the outputs from these.
- Case studies used for courses as well as case studies and materials developed by SA Faculty.
- E-learning (capacity upgrades), videoconference seminars – sharing and access – minutes of e-learning meetings.

Primary data collection focused on collection of qualitative data using a semi-structured interview technique with the assistance of an interview guide. This included individual and group interviews as well as observation site visits. The aim was to tell the story of ASELPH's performance from a number of perspectives and using multiple lines of evidence. The evaluation focused on four main groups/areas:

- The course participants (Fellows)
- The academic partners (Faculty)
- Project management and support (Steering Committee, SA Partners, Academic Partners, DoH)
- Process issues (Steering Committee, SA Partners, Academic Partners, DoH, Funders)

Sites for the observation visits were selected for their ability to demonstrate positive change (illustrate a success story) or to provide a useful lesson (show why things did not work). Site visits included interviews with the Fellow, their manager, peers and subordinates to validate findings in order to provide feedback from a 360^0 perspective.

The evaluation used a whole-systems approach to allow us to look for changes in leadership capability (behaviour) displayed by/affecting individuals, organisations (or the team with which the individual works) and the broader system or environment in which the individual functions. We looked for expected changes/actions (or not), as a result of the programme, incremental changes over time as well as fundamental shifts and unanticipated changes.[8] Table 1 below sets out the types of evaluation questions according to the four focus areas identified. An adapted Most Significant Change (MSC) technique was used as a way of capturing stories of change, both expected and unexpected, amongst Fellows that has resulted in, or has the potential to generate, improved service delivery and ultimately positively affect health outcomes.

[8] Drawn from EvauLEAD methodology

Table 1: List of evaluation questions per evaluation focus area

EVALUATION FOCUS AREA	KEY EVALUATION QUESTIONS	IN WHO'S OPINION? WHO DO WE ASK?
Fellows	i. Has the programme contributed to changes in knowledge? ii. Has the programme contributed to changes in leadership capability? Have iii. new/improved leadership behaviours resulted in improvements in the health services/system? iv. What is the most significant change and/unanticipated consequence of the programme? v. What changes would you make (about the programme) to make it more effective?	- Course participants - Colleagues (peers), managers & subordinates of course participants (ii and iii)
Faculty	i. Are the programme content and teaching methods effective/unique? ii. Has the research and teaching capacity of faculty increased? Is the iii. programme attracting the intended participants? vi. What is the most significant change and/unanticipated consequence of the programme? vii. What changes would you make (about the programme) to make it more effective?	- Academic partners - Course participants - Steering Committee/Department of Health - Academics at other universities??? (i, ii and iii)
Project management/support	i. Is ASELPH established as a leadership development programme in the health sector? ii. Is the programme sustainable? Have iii. funds been effectively utilized? iv. What is the most significant change and/unanticipated consequence of the programme? v. What changes would you make (about the programme) to make it more effective?	- SA Partners - Academic partners - DOH
Process issues	i. Has the project Steering Committee been effectively utilized? ii. Have the course participant selection criteria been effective Has iii. the ASELPH partnership been effective? iv. Have the universities attracted and retained appropriate level staff? Have v. managers been retained in the public sector? viii. What is the most significant change and/unanticipated consequence of the programme? vi. What changes would you make (about the programme) to make it more effective?	- SA Partners - Academic partners - Department of Health (v) - Funders

3.3 Data analysis and integration

Data were analysed according to the outcomes in the pathways of change towards achieving the six programme objectives (Figure 1). These preliminary findings were presented to a group of 20 ASELPH stakeholders that included representatives from the three academic institutions, SAP, NDOH, SC, funders and Fellows. Participants then provided feedback on the findings and worked in small groups to give inputs as to the extent of ASELPH's contribution to health systems strengthening (and/or its potential to do this) and to provide recommendations for the programme going forward.

3.4 Limitations

Since this evaluation was intended as an outcomes assessment focused on workplace changes, the time ASELPH Fellows have had to implement initiatives (maximum 18 months) is too limited a

duration within which to observe significant organizational level change and especially better health outcomes. Our evaluation thus uses five vignettes to illustrate examples of workplace changes that Fellows have implemented, which if taken to scale by some or all Fellows could contribute significantly to systems strengthening and health outcome improvements.

Due to time and resource constraints, we undertook purposive sampling for the individual interviews with Fellows (class captains of each of the cohorts at UP and UFH) and the observation site visits. An open invitation was extended to Fellows to attend group interviews during our district visits (approximately 55 Fellows were interviewed in total) and these yielded a wealth of anecdotal evidence of similar workplace initiatives that Fellows have undertaken.

4 FINDINGS

The response to our requests for interviews for the ASELPH final evaluation was extremely heartening. As evaluators we would be remiss not to mention the efforts made by Fellows, their managers and colleagues to attend and actively participate during our interview sessions and site visits. Many Fellows and their colleagues traveled long distances to give 'testimonies' of either what ASELPH had done for them as individuals (in the case of Fellows) or in support of their managers who were Fellows. Staff members waited long hours and even stayed after facility closing time to show us the evidence of improvements made at their facilities under their managers' leadership and guidance.

Table 2: Number and type of interview respondents

Interviewee type	Number of interviewees invited	Number of persons interviewed
Fellows & Colleagues (360^0)	Open	68
Core faculty	5	5
Emerging faculty	5	4
Other academics	3	2
SAP	4	4
Funders	3	3
NDOH & SC	4	3
Mentors	4	1
TOTAL		**90**

In the findings section of the report we provide a narrative summary focusing on key themes emerging from the interviews we conducted with representatives of the ASELPH program staff, Steering Committee, funders, Fellows, professional colleagues of Fellows - managers, subordinates and peers – as well as observations during our workplace site visits. During all these interactions we attempted to discern changes at individual, team and organizational (system) levels that could be linked to participation in ASELPH and to understand the respondent's view as to why they made that link.

We have also attempted to tell the story of ASELPH through the voice of Fellows, as the primary beneficiaries of the program, by providing five vignettes (presented at the end of the report) that describe behavioural changes in themselves as individuals and leaders and workplace initiatives that they have instituted as a result of, or that have been influenced by learnings from ASELPH. These represent Fellows 'working with what they have' to bring about improvements and innovations in various settings including a regional hospital, a rural district team, a national program, a provincial budgeting system, and a rural hospital and clinic.

At the end of this section we provide a table summarizing the information from the program document review. We report against all six objectives even though the greatest level of effort in implementing ASELPH and in conducting the evaluation was expended on objectives 1 and 4. Many of the activities listed under a particular objective relate to and influence others. Therefore, in presenting the achievements and challenges key themes have been drawn from across our findings.

4.1 Objective 1: Establish and maintain a critical mass of knowledge, skills, competencies and leadership among current and emerging district health leaders

Three main activities were carried out under this objective: (1) Establishing of the ASELPH Executive Fellows Programme, which involved recruiting cohorts of Fellows as well as maintaining contact between contact sessions via e-learning and mentorship to examine issues; (2) Establishing public health Postgraduate Diploma (PGD) and Masters programmes (MPH) at UP and UFH; and (3) E-learning.

4.1.1 ASELPH Fellows Program:

The ASELPH Fellows Programme has been established in the form of a PGD at UP and a MPH at UFH. To date a total of 178 candidates have enrolled on the Executive Fellows programme – 57 in the first cohort of diploma students at UP and 50 in the first cohort of Masters students at UFH making a total ASELPH first cohort of 107 Fellows. Of these, 52 (48 in April 2015 and 4 in September 2015) graduated with a PGD from UP, a completion rate of 92,8%, and 49 UFH Masters students completed their first year of studies. In 2015 a total of 68 Fellows enlisted in the second cohort – 42 at UP and 26 at UFH. The enrolment figure of 178 Fellows exceeds the enrolment target of 100 Fellows listed in the 2015 high-level work plan.

Fellows were unanimous in their responses that participation in ASELPH has had a significant influence on their personal behavior as leaders. Frequently used descriptors were 'empowered', 'built confidence', 'we now see ourselves as leaders' and 'not afraid'. They reported acquiring the relevant skills to enable them to carry out team building, undertake strategic planning, utilise a systems approach to problem solving, to delegate, to manage upwards, and feeling capacitated enough to share their learning with their colleagues. This was borne out by colleagues. Peers and subordinates observed shifts in leadership style from 'undefined' to 'appreciative, empowering, participative, or consultative', 'proper stakeholder involvement' and 'giving direction' or 'allowing space' when appropriate so that individuals could make decisions and teams functioned more effectively and were 'no longer functioning in silos'. They also valued integration of the support functions such as HR and Finance with health programme functions. Managers described how Fellows invited input, were 'open' to advice, provided timely reports of good quality, made good presentations at quarterly reviews and had essentially been transformed from being 'complainers' to 'providing solutions'.

> *"ASELPH has elevated me from being a dot in a sentence to being a phrase that will one day make the world a better place" (Fellow)*

Respondents attributed this growth in leadership behavior partly to the theory they had learnt, but overwhelmingly to the *teaching methodology*. Whilst there was some criticism of there not being enough SA examples there was acknowledgement that the international case studies were relevant, and solutions arrived at from the class discussions were applicable in the local context. All Fellows were highly appreciative of the *teaching and learning tools* that were given, and reported being able to apply these in the workplace immediately after the contact session. They were able to provide anecdotes linked to learnings in the case studies and of applying 'meta-leadership', 'walk in the woods', 'going down to the basement' and 'change management steps' to addressing challenges encountered in the workplace. These, coupled with the outstanding caliber of the *core ASELPH*

teaching staff, created a winning combination that set ASELPH apart according to Fellows that have attended other leadership courses. Fellows also valued being part of a 'health' leadership course. The 'Harvard Brand' was frequently cited as significant both as a draw card and as a marker of excellence.

Another contributing success factor that Fellows cited was the *peer learning* provided by discussions that evolved during the module contact sessions. This provided a sense of comfort to know 'you are not alone' and that other managers face similar challenges. Class discussions also afforded opportunities to explore practical examples of what has worked or not, and the opportunity to contribute to building on these solutions actually generated a sense of excitement. Fellows have formed *informal networks* via WhatsApp to communicate with and support each other. In KZN Fellows from the first cohort provide support to their colleagues in the second cohort. Fellows also credited the *rigorous selection* process for the high caliber of students that generate class discussions of such quality, the *diversity* within the cohorts that enriches these with depth and perspective and deeply appreciated the exposure to a 'new' teaching and learning process that allows for each person to feel heard and their views respected. The use of *guest lecturers from the NDoH* provided current information and background as to policy decisions and facilitated discussion about challenges Fellows experience in their day-to-day work.

A number of Fellows had been promoted during or after participating in ASELPH and feel that skills gained on this course contributed to these promotions. For example in KZN:

> *"One of the group members has moved from a small hospital to become CEO in a regional hospital. We have one who has been interviewed for the post of District Manager, another has moved from being a manager in a CHC to be the manager of a hospital in the south coast of KZN" (Fellow).*

> *"UFH has performed an excellent job in the implementation of the programme and the results are reflected on District staff" (Participant, Policy Seminar feedback)*

Fellows completed baseline, six-month and end-of-course self-assessments for each of the fourteen ASELPH competencies[9]. A review of the quantitative scores as well as qualitative data shows a progressive development of Competency from baseline, through to completion of the ASELPH programme.

> *"The programme made me a thinker, to question WHY things happen, be innovative, and scientific in my approach. It brought the concept of an integrated approach home and the understanding of the South African Health System." (Fellow)*

> *"Through ASELPH I gained sound understanding of the evolving South African health care system and I am equipped with the skills and competencies necessary to make decisions based on sound evidence that responds to the health care service needs." (Fellow)*

> *"I have become a better person in terms of understanding the South African Health System and have been able to identify my role in the District Health Services. The program has strengthened my belief that DHS is the engine of the South African Health System and failure to resource it properly will result in the collapse of health services in the country. It has created a different network of people for me to interact with whom I would not have known." (Fellow)*

However, monitoring the capacitation of Fellows outside of the self-assessments proved challenging. The response rate for the workplace 360⁰-feedback assessments, designed as a means to

[9] ASELPH Leadership and Management Competencies are based on those used in the District Management Study conducted by Health Systems Trust published in 2009.

corroborate the self-assessments, was very low. The final assessment of competencies included piloting a 360^0 online assessment.

Qualitative feedback indicates a perception that KZN Fellows receive a great deal of support from senior DOH managers whereas this is less so in the EC. Interviews with Fellows yielded similar information.

4.1.2 E-learning:

Development of e-learning systems and implementation of e-learning has progressed at different rates at the two SA universities. UFH appointed a part time person to support e-learning. ASELPH provided the IT infrastructure for the videoconferencing facility at UFH as well as the end user training. Five faculty members were capacitated through consultations. One ASELPH module is available electronically.

UP appointed an e-learning instructional designer, on a part time basis, to work with ASELPH faculty in developing a blended learning approach. An E-learning Manual was developed and seven faculty members were capacitated through conferences, workshops or training. The system is utilized to disseminate module information and presentations, guided pre-reading, submission of assignments, discussion boards, surveys, tests, blogs, assignment marking, and group announcements. Nine of eleven modules are available electronically and free Wi-Fi is available on campus allowing a paperless environment. The evaluators observed a demonstration of the system.

UFH and UP jointly hosted a workshop of e-learning for faculty members.

4.1.3 Videoconferences:

Monitoring reports are available for 7 videoconferences with input from a total of 149 participants. Responses indicate an increase in knowledge, a willingness to participate in similar conferences in future, and a request for greater participation of officials from the DoH national and provincial levels, but also to include the departments of social development and education. Respondents found this a useful way of linking with other centres although the sound was inaudible at times. The discussion slides used during one videoconference, 'Advancing Nutrition for Better Maternal and Child Health in the first 1000 days' have been uploaded onto the ASELPH website.

4.1.4 Mentorship:

UP conducted a workshop with mentors of the first cohort. More than 60 people have volunteered to be ASELPH mentors and 41% of 1st cohort Fellows continue to receive support from mentors who include senior officials from the national and provincial departments of health. While some Fellows found their interactions with their mentor to be beneficial, they felt there was a need for greater clarification of the purpose and objectives of the mentoring.

This view was supported by a mentor.[10] She was approached and briefed by the mentee, received a letter of confirmation from ASELPH, but no training and the mentoring relationship was 'unstructured and not formalized'. She did however develop a good rapport with her mentee, has attempted to be responsive to her needs and is confident that the mentee turns to her for support.

According to the 2015 Annual Report the program has implemented strategies to strengthen the mentorship component based on lessons learned with the first cohort.

The following areas for improvement, suggested by interviewees, do not apply uniformly across the program: turnaround time for feedback on assignments and assessments; some guest lecturers were

[10] We secured an interview with one of the four 'active' mentors we were referred to and received no responses from repeated requests for interviews with the other three potential respondents.

ill prepared and knew less than the Fellows; too much paper and poor quality of handouts (illegible); the sequencing of some of the core modules; some of the elective modules should be core and vice versa; unbalanced weighting of topics e.g. too much emphasis on marketing; tablets are too small to be useful for reading documents; problems with registration and student numbers so unable to access e-learning platforms and libraries; defining the mentoring process more clearly; and the need for more SA case studies.

4.2 Objective 2: Improve policy implementation strategies through a collective understanding of the political and organizational context and the crosscutting issues that underpin decision making and implementation

According to the high-level work plan, policy seminars and round tables were undertaken in pursuit of this objective. Issues identified during these seminars were to be incorporated into ASELPH course offerings and case studies to advance participants' management skills and their ability to lead on activities related to NHI and PHC reengineering. However, the entire course engaged with this objective as faculty linked all learning and reflection to the South African context through the experience of the Fellows, their own knowledge and understanding of the SA health system, and the inputs of guest lecturers.

A total of six seminars addressing key policy issues of importance to South Africa were held between 2012 and 2016. These were addressed by local and international speakers covering topics including a number of aspects in preparation for the NHI, health systems strengthening, decision making in district management, and ASELPH's future directions and contribution to health reform. According to the annual reports a total in excess of 500 people were reached.

Some people are of the view that the NHI related policy seminars provided a unique opportunity for scholarly discussion with regard to contentious issues, and furthermore that the discussions influenced the White Paper.

The number of evaluation feedback forms submitted at each of the sessions varied from 17 to 74 and report a significant increase in knowledge after the seminars. Proceedings of two policy seminars were written up and have been uploaded onto the website. No policy papers or briefs were developed.

4.3 Objective 3: Promote and maintain high quality service delivery standards at the district and community levels

Applied research was the main thrust under this objective. Planned activities included conducting research in seven NHI pilot districts (WBOT rapid assessment), fundraising for research projects in two districts, and holding applied research workshops for faculty and research assistants. However, the key to achieving this objective was through the Fellows applying what they had learnt in the leadership of their districts and health programmes.

ASELPH conducted the WBOT rapid assessment and presented the report to the NDoH. The recommendations will be considered in drawing up the WBOT policy.

Harvard conducted three applied research workshops aimed primarily at SA faculty. Four research proposals have been developed and were approved by the Ethics Committee. The research areas include: a study to determine the health care needs of communities and the effectiveness of the education for community health workers in addressing the needs in Vhembe District; a facility survey to assess facility management, patient satisfaction, and perceived quality of care; a comparative

analysis of public hospital costs in SA; and a baseline survey on the perspectives and perceptions of households regarding PHC services which will serve as a platform for NHI in Vhembe District.

Fellows have selected research topics related to their work. They report that ASELPH has assisted them to develop analytical and research skills such as proposal writing, literature review, policy analysis, the ability to critically review journal articles as opposed to 'reading them like a story', and the ability to extract the implications of research findings for practice and application in the workplace. One Fellow developed a poster presentation, in collaboration with the development support partner in the district (The Aurum Institute) and the provincial managers, which was accepted at the July 2016 International AIDS Conference held in Durban.

4.4 Objective 4: Build an executive leadership pipeline through increased executive leadership training capacity among South African faculty and educational institutions that includes increased capacity in curriculum development and distance learning technology and techniques

The four main activities underpinning this objective were: course development, preparation and teaching, faculty development, and development of case studies. There was consensus amongst the other ASELPH partners that the key value of the Harvard team was their grasp of training executive leaders and that Faculty and Fellows had benefited greatly from this exposure.

4.4.1 Harvard course attendance:

27 ASELPH faculty, including core and emerging lecturers as well as guest lecturers, attended courses on HRH, Decentralization, and Quality Improvement at Harvard. Some faculty felt that they would have benefited from reflective discussions with Harvard faculty to unpack the rationale for the content and methodology instead of simply being students. Faculty have been designated as module coordinators and are responsible for adapting the HSPH course modules for SA on their return, as well as teaching on the course.

4.4.2 Case study development:

Faculty attended case study development workshops at Harvard and the UP Business School (GIBS - The Gordon Institute of Business Science). SA faculty have developed a total of 17 case studies and are awaiting feedback from Harvard. The case study on decentralization is of a high enough standard to be used at Harvard.

4.4.3 ASELPH Module Preparation and Teaching:

A number of modules were initially developed with support from Harvard, and SA faculty taught alongside Harvard lecturers. Local universities are now able to plan and teach on their own. SA faculty report that they felt really supported by Harvard when they started to teach. SA faculty received informal feedback from Harvard at the end of every day during the modules they were teaching; students also provided feedback. No formal list of competencies was developed for faculty in the way it was for students, although all faculty have developed personal development plans.

Core faculty members report that the whole team has grown in its grasp of how to develop executive leaders, as opposed to administrative managers, and all have advanced their capabilities for doing this. Faculty capacity development has occurred through a combination of activities including exposure to Harvard faculty in the classroom; trips to attend Harvard courses; the opportunity to expand their area of expertise (each faculty member is allocated a module to develop and coordinate according to their interests); e-learning support and feedback from students.

In 2015, ASELPH core and emerging faculty lead in the delivery of 90% of the courses developed jointly with Harvard. ASELPH SA faculty include 21 senior lecturers, 12 junior or emerging lecturers of whom four are ASELPH alumni and three are joint appointments with the DOH. Harvard now plays a coaching role. All SA faculty describe the relationship with Harvard as one of mutual learning and respect.

Areas for improvement include development of a structured competency framework for faculty development; staff turnover due to short contracts; and difficulty appointing dedicated staff due to universities freezing posts.

4.5 Objective 5: Effectively and efficiently manage the ASELPH program through good governance, funder accountability, partnership maintenance and communication

SAP carries the primary responsibility for the activities supporting this objective. The program has a memorandum of agreement (MOA) in place. ASELPH has established well functioning program management structures. The strategic and operational management teams meet regularly.

The Steering Committee (SC), chaired by the NDOH provides oversight of progress and strategic planning to ensure alignment with government priorities. A criticism of the SC governance framework is that it has only a decision making structure, but no accountability structure. There is a move to revise the MOA to incorporate governance issues related to ASELPH as a whole.

ASELPH has established a constructive relationship with the three program funders who have been extremely accommodating by adopting a common reporting framework for the project instead of adhering to each funder's requirements. The ASELPH partners agree that SAP has done a sterling job of narrative reporting as well as managing the funds and financial reporting. SAP also provided capacity building for the financial support staff at the two SA universities. However some respondents were of the opinion that SAP's strengths were under-utilized as they performed primarily a secretariat function. This does not detract from the uniqueness of the ASELPH partnership model and the lessons it could offer.

ASELPH has developed a communication plan that deals in the main with branding.

The program developed a monitoring and evaluation (M&E) framework and established a routine monitoring system. Participant feedback is collected after each course offering and inputs incorporated into revised modules. Routine monitoring was conducted against the high level activity plan and was a standing item on the SMT agenda.

4.6 Objective 6: Contribute to ASELPH sustainability beyond the initial funding period

The academic programs have been established and institutionalized at UP and UFH. The UP PGD articulates with the MPH and two first cohort UP ASELPH Fellows are enrolled on the current MPH programme. There are plans for establishing a UP Masters in Philosophy (MPhil) program. UP has secured funding from the Health and Welfare Skills Training Education Authority (HW SETA).

UFH has established a Health Institute, which will provide short courses mainly to the EC DOH. ASELPH modules will comprise most of these.

ASELPH has developed a sustainability plan. A stakeholder list of 65 people has been compiled. These represent private sector, academia, civil society and NDoH selected for their ability to network and engage with their sector on behalf of ASELPH.

There has been limited progress in terms of other planned activities under this objective such as: development of an ASELPH Alumni Association, establishing an ASELPH Quality Assurance (QA) Team, and developing a Knowledge Management System (KMS) that documents the history of the program, lessons and challenges.

Table 3: Results table from program document review

ACTIVITIES	EXPECTED RESULTS – 4 YEAR OUTCOMES	PROGRESS	GAPS/CHALLENGES	ASSESSMENT
Objective 1: Establish and maintain a critical mass of knowledge, skills, competencies and leadership among current and emerging district health leaders				
• Establishment of the ASELPH Executive Fellows Programme • UP PGD in Health Management Services • UP MPH in Executive Leadership • UFH MPH in Executive Leadership • Establishment of UFH PGD in Executive Leadership	• ASELPH Executive Programme established and sustainable at UP and UFH • Curriculum and programme design capable of training competent and skilled cadre of managers who will provide core leadership and management at all levels of the SA health care system – clear articulation between PGD and MPH; 15 Fellows enrolled for MPH • Increased leadership and management training capacity at UP & UFH – 100% of Harvard courses adapted to SA context and SA faculty co-teach course offerings • Increased capabilities among executive managers in the SA health system to address priority health needs (95% of Fellows in UP report increased knowledge, skills and enhanced competencies in executive leadership – 90% Fellows enrolled in 2nd year at UFH; 40 Fellows inducted in MPH in 2015	• ASELPH programme established at UP and UFH • Curriculum design approved by university senate committee • 178 (target 150) Fellows enrolled • Articulation between UP PGD and MPH • 2 Fellows enrolled for UP MPH • 100% of Harvard courses adapted and co-taught by SA faculty • Competency framework developed - Fellows report increased skills & competencies • 49 Fellows (98%) enrolled in 2nd year UFH MPH (target 90%)	• 2 (target 15) Fellows enrolled for UP MPH • 26 (target 40) Fellows inducted in UFH MPH 2nd cohort	**Achieved** 
• E-learning	• UP and UFH will increase e-learning capacity that will broadly benefit their institutions • E-learning framework adopted and implemented	• Video conferencing facilities installed at UFH • Videoconference links to health stakeholder sites • 1 UFH module and 9 of 11 UP modules available on e-learning platform	• No E-learning framework	**Partially achieved** 
Objective 2: Improve policy implementation strategies through a collective understanding of the political and organizational context and the cross cutting issues that underpin decision making and implementation				
• Conduct policy seminars addressing key policy issues of importance in South Africa • Identify issues during the policy seminar and incorporate into courses being offered and case studies being produced	• Greater knowledge and understanding of NHI and PHC reengineering by senior health leadership, frontline management and key stakeholders • Expanded national discourse on select policy issues within the NHI and reengineering of PHC that are the topic of further research and deepened debate • Increased use of ideas, discussions and deliberations from policy seminars to benefit ASELPH teaching and learning	• Overall Seminar participants report greater knowledge and understanding in all post seminar evaluations • Policy seminars have reached approximately 500 stakeholders, mainly from DOH • Faculty report incorporation of discussions and deliberations into all aspects of teaching and learning	• 4 (target 6) seminars conducted • Uncertain of district/site coverage • No policy briefing papers produced • *Feedback comment regarding lack of involvement of senior EC officials "ECDOH executive managers including all district mangers and regional hospitals CEO not in attendance yet they have influence on Fellows attending programme"*	**Partially achieved** 

ACTIVITIES	EXPECTED RESULTS – 4 YEAR OUTCOMES	PROGRESS	GAPS/CHALLENGES	ASSESSMENT
Objective 3: Promote and maintain high quality service delivery standards at the district and community level				
• Applied research	• Greater research evidence that can inform improvements in the DHS – 4 research projects implemented in Vhembe and OR Tambo districts; WBOT findings documented & presented to NDOH • Increased research capacity of faculty – 8 faculty capacitated in research skills	• WBOT research findings will be considered in policy formulation • 4 research proposal developed & passed through Ethics Committee • 15 persons attended Harvard-run research seminars	• District research projects in Vhembe and OR Tambo not yet implemented	**Partially achieved** 
Objective 4: Build an executive leadership pipeline through increased executive leadership training capacity among SA faculty and educational institutions that includes increased capacity in curriculum development and distance learning technology & techniques				
Course development, preparation & offering • Identify & develop courses • Intensive capacity development for SA faculty at HSPH covering selected areas such as HRH, Decentralization & Quality of health care	• Adaptation of HSPH courses for UP and UFH offerings – 80% of courses are led by SA faculty	• 90% of courses led by SA faculty • 27 people attended HSPH courses at Harvard • SA faculty have adapted Harvard courses for local context		**Achieved** 
Faculty development • Mentoring of faculty • Implement teaching & training workshops • Training on key pedagogical approaches & teaching methods (i.e. case method teaching) • Workshops for faculty on integration of e-learning	• Enhanced capacity of SA faculty that are skilled and competent in teaching and research and are able to sustain the program – All SA faculty who undergo intensive HSPH capacity development contribute to development of a relevant SA course; 8 junior faculty report sufficiently capacitated in case development, case teaching and other pedagogical approaches	• All SA faculty who attend Harvard courses contribute to development of relevant SA courses • Faculty have personal development plans • 21 senior and 12 junior ASELPH lecturers listed	• Faculty report increased capacity in teaching and research. No faculty competency framework – difficult to assess competence • Turnover of staff	**Achieved/partially achieved** 
Objective 5: Effectively and efficiently manage the ASELPH programme through good governance, funder accountability, partnership maintenance and communication				
• Partnership meetings • Steering Committee • Memorandum of Agreement • Funder relations • Reporting • Monitoring and evaluation	• Smooth operations among the partners and a well functioning ASELPH partnership • An informed and engaged SC that provides oversight of progress and strategic planning for future years • A reviewed MOA that is relevant, provides oversight and clarity in ASELPH partnership • A constructive working relationship between ASELPH funders to ensure clear communication and implementation of financial agreements • A routine narrative and financial reporting system that underpins the ASELPH activities and deliverables • A robust M&E system that ensures ongoing learning and	• Regular partnership meetings held • SC engaged and provides oversight & strategic direction • MOA in place • Constructive working relationship with funders • Routine narrative and financial reporting system established • Routine M&E system established	• SAP's strengths not optimally utilized • MOA to be reviewed to address governance issues • Insufficient analysis of monitoring	**Achieved** 

ACTIVITIES	EXPECTED RESULTS – 4 YEAR OUTCOMES	PROGRESS	GAPS/CHALLENGES	ASSESSMENT
• Communication Plan	improvements of ASELPH • Key lessons and outcomes to improve on the implementation of the project – Report on 360^0 assessment; ASELPH Impact Framework/Protocol for M&E • ASELPH Communications Plan, tools and resources are utilized within the programme; Keeping stakeholders and ASELPH target audience and beneficiaries updated about the programme activities	• E-blasts and newsletters disseminated	data and documentation of evidence to show the ongoing learning • Poor 360^0 response rate • No ASELPH Impact Framework/Protocol for M&E	
Objective 6: Contribute to ASELPH sustainability beyond the initial funding period				
• Stakeholder network • Alumni relations • Academic quality assurance • Knowledge management	• Increased understanding and support for ASELPH among key stakeholders • Establish & maintain a network of 50 key contacts for the ASELPH program. Representatives from private sector, academia, civil society & DOH selected for their ability to network & engage with their sector on behalf of ASELPH • Conduct consultation & communication with stakeholders	• Sustainability plan developed • Stakeholder list of 65 • E-blasts and newsletters disseminated	• Alumnus Association not yet constituted • Academic QA team not yet established • Knowledge management system not yet established	**Partially achieved** 

4.7 Things that worked well

In this section we list the five strengths most commonly cited by respondents.

- The Harvard brand, peer learning and teaching methodology contribute to making ASELPH unique in the executive health leadership development space.
- Relevance of the course content to what is current and topical in the SA health system and context, in part because of involvement of the NDoH.
- Empowerment of the Fellows and capacitation of faculty: in the case of Fellows. enabling them to contribute more effectively to health systems strengthening; and in the case of Faculty, to develop modules and case studies and teach them using a new pedagogy.
- The unique partnership, which brings together the strengths of three universities with very different histories, NDOH and an NGO.
- ASELPH already leaves a legacy of a PGD at UP and MPH at UFH; UFH now has Faculty of Health Sciences and Health Institute.

4.8 Things that did not work so well

In this section we list the five challenges most commonly cited by respondents.

- Delays and inefficiencies in some university administrative issues, which are outside the ASELPH program, but impact on the quality of the affected Fellows' experience.
- No formal competency framework for faculty was developed.
- Ongoing evaluation of Fellows was not complemented by good 360^0 feedback and assessment.
- Underutilization of SAP's strengths.
- Incomplete documentation of processes and activities e.g. no policy papers, inadequate analysis of monitoring data to facilitate timely action and documentation of evidence to demonstrate the ongoing learning.

4.9 Challenges outside of ASELPH's control

In keeping with ASELPH's mandate of 'responsiveness to government priorities' the program made a significant shift in direction during the start up year when offerings of individual and certificate courses were stopped in favor of the institution of PGD (UP) and MPH (UFH) courses with executive leadership tracks. This effectively delayed program implementation by almost 12 months.

During the first half of the program, contact sessions were held at conference venues because of space constraints at the universities. Fellows complained that these were sometimes uncomfortable and did not have facilities conducive to learning. This has since been resolved as the UP building upgrades have been completed and UFH has purchased a suitable new building. ASELPH did not provide for these infrastructure upgrades.

4.10 SWOT analysis

Table 4 provides a summary of ASELPH's strengths and weaknesses as well as potential opportunities and threats that the program faces. This SWOT analysis includes potential areas for recommendations and improvement of the program.

Table 4: Analysis of strengths, weaknesses, opportunities and threats

STRENGTHS	WEAKNESSES
• Peer learning • Teaching methodology • Student selection • Excellence of Harvard staff • Some faculty have acquired competence in blended learning approaches • PGD and MPH established • DoH commissioned ASELPH to conduct WBOT research • SA faculty are teaching the courses • SA case studies have been developed • SA faculty and Fellows have internalized a new approach to teaching and learning • Competency framework to monitor leadership development in Fellows • Adapted HSPH courses to the SA environment • Collegiality developed between UP and UFH • SAP effective program management • Steering Committee chaired by DoH • Single format for narrative and financial reporting • School of Health Sciences and Health Institute established at UFH • Good relationship with funders • Maintaining an effective partnership between 3 universities, an NGO and DoH • Have sustainability plan • Have funding from H&W SETA • Faculty capacitated in methodology - sustainability	• PGD versus MPH qualification[11] • Quality of some guest lecturers • Balance of content of modules • Sequencing of modules • Options of electives versus core modules • Dependence on paper • Blended learning approach not applied universally • Alumni Association not yet formalized • Incomplete documentation of processes and activities • Faculty competencies were not developed • 360^0 assessment process not yet functioning optimally • Mentoring program
OPPORTUNITIES	**THREATS**
• Offering individual modules as short courses • Extend coverage of videoconferencing • Maintaining links between Fellows to embed the ASELPH approach • Clarify the mentoring relationship and its role within ASELPH • Fellows conduct research in their workplaces • Develop guest lecturers in the ASELPH approach to teaching and learning • Write up the process of working in a partnership with 5 very different organizations • Resolve governance issues in the Steering Committee • Target particular categories of executive leaders e.g. NDOH provincial, district teams • Focus on new policy initiatives – provincial workshops to deconstruct new policies • Adapt the ASELPH structure to optimize partner strengths • Share the ASELPH methodology with other universities	• MPH course not registered in time for students to graduate[12] • Perception that the quality of the courses would deteriorate with more limited Harvard participation in future • Funding • Lack of support from senior provincial DOH mangers • Partnerships collapse • Competing university priorities on Faculty • Competition between universities

[11] Students perceive courses (PGD and MPH) and level of effort to be the same.
[12] Fellows express great concern that the MPH course has not yet been registered and fear that they might not be able to graduate. UFH is taking steps to address this as a matter of urgency.

5 LESSONS LEARNED

In this section we summarize the key learnings from ASELPH's first four years of existence. These represent the most commonly expressed views by the various respondent groups and are drawn mainly from responses to the interview questions 'what worked well?'; 'what did not work so well?'; and 'what are key lessons?'

1. *ASELPH is exceptional in the health leadership development space in terms of the teaching and learning approach* - all respondent groups described the pedagogy employed in the ASELPH Fellows program in glowing terms. Outstanding features include the manner in which it promotes peer learning, the ease of applicability of the tools and methods used during the contact sessions, and the focus on executive leadership rather than a generic public health approach that includes leadership training.
2. *An academic strategy to drive a development program* - ASELPH was conceptualized as a development program that uses a unique academic training approach as the vehicle to contribute to improved health service delivery and ultimately improved population health outcomes. The focus during this first phase has been on establishing and monitoring progress against the academic program and self-reported changes against the leadership competency framework. It has proved difficult to measure changes in the workplace related to Fellows' participation in ASELPH, which some have argued is outside the remit and control of the universities.
3. *Partnership with NDOH allows ASELPH to fulfill its 'responsiveness mandate' – a particular strength of ASELPH's partnership model is the integral involvement of the NDOH as a partner and chair of the SC. This direct oversight and guidance makes it easier for the program to fulfill its mandate for being responsive to the department's policy imperatives and implementation priorities and therefore extremely relevant for Fellows.*
4. *Partnership means collective ownership and responsibility – the ASELPH academic partners were deliberately chosen for their respective strengths and also from an equity perspective, to strengthen a historically disadvantaged university. UFH has fewer resources in terms of staff and infrastructure and this has affected the quality of the ASELPH experience on the part of the Fellows. Whilst there is a pressure to deliver, in some instances there was an impression of a 'separate' ASELPH at each of the SA universities and the historically disadvantaged institution remained at a disadvantage. This 'disconnect' became more apparent as Harvard stepped back from a hands-on role. To paraphrase in the words of a respondent; "…should remember that any program is also as weak as its weakest link.'*
5. *Careful selection of candidate Fellows enhances the quality of the learning experience – the ASELPH selection criteria and process works well and creates diversity in the group in terms of representation from hospitals, health programs, support systems such and human resources (HR) and finance as well as a mix of policy makers and implementers. This enhances the Fellows' understanding of the whole public health system and clarifies their role in it.*
6. *Support from senior provincial managers is important to enable Fellows to make workplace changes – this has to be continued, and strengthened where necessary, as it is important in supporting the work for every Fellow and in developing a critical mass to ensure that Fellows can apply what they have learnt from participating in ASELPH.*
7. *Need to measure faculty development – whilst SA faculty report increased competence and confidence, as is the case with Fellows, there is need to define a faculty competency framework against which to measure faculty development over time as a result of exposure to ASELPH.*
8. *Local research outputs would strengthen case studies – information gleaned from the applied research conducted by Fellows could be used to develop new case studies and inform course material to ensure that this remains up to date.*

6 ASSESSMENT

The assessment section also draws from respondent responses as well as those from the stakeholder feedback and consultative workshop.

6.1 How, and to what extent, has ASELPH contributed to service delivery improvements in SA?

ASELPH's implementation timespan has been too short to measure contribution to service delivery improvements in SA. The workplace site visits demonstrated that Fellows are implementing initiatives that have the potential to improve health services. To date ASELPH has inducted 178 Fellows of which 52 have graduated. This represents a small proportion of the health managers in the country. However, Fellows report passing on their learning (theory and practice) to colleagues in the workplace, which does create a ripple effect and thereby extend ASELPH's coverage.

Respondents were of one voice that ASELPH has made some contribution and has the potential to have significant impact if the program continues to train more Fellows and provide support in the workplace. The relative current and potential future contribution to health service improvements of each of the ASELPH key activities illustrated in Figure 3 below considers stakeholder inputs from the consultative workshop.

- Applied research – as yet the WBOTs study and 4 new research proposals have yielded no outcomes. However, there is potential for applied research to make a significant contribution to strengthening the health system, particularly if Fellows implement operational research in their workplaces and relevant findings were incorporated into courses, developed into case studies, and informed health policy.
- Attendance at Harvard courses by SA faculty – has contributed to developing the capacity of SA faculty and adaptation of HSPH courses for the SA context. This activity will continue to contribute. However, since a corps of ASELPH faculty has been developed at UP and UFH it might be more effective for Harvard to interact with the 33 SA faculty locally than for individual staff members to travel to HSPH.
- Develop SA case studies – the 17 local case studies have not yet made a contribution to HSS as they have not yet been used for teaching (currently being reviewed by Harvard), but this local material has the potential to contribute in future.
- Fellows program – the 1st and 2nd cohorts have made some contribution to improving health services by implementing workplace changes. By training more Fellows in future ASELP has the potential to develop a critical mass of competent leaders and contribute significantly.
- Mentoring – this component of the program was initiated but not formalized. As an ad hoc activity it has been meaningful to some Fellows but made an insignificant contribution to HSS to date. This activity has potential to contribute if strengthened.
- Module preparation and teaching – has contributed and has the potential to maintain this contribution.
- Policy implementation – has contributed by equipping Fellows for the SA health context. This has potential to be significant in future if SA case studies and research findings are incorporated into teaching and learning as well as for advocacy and to inform policy and effective decision-making.

Figure 3: Current and potential contribution of ASELPH activities to health service improvements in SA

ASELPH'S CURRENT CONTRIBUTION	ASELPH's POTENTIAL FUTURE CONTRIBUTION			
	Insignificant	Some	Contributed	Significant
Insignificant			- Develop SA case studies - Mentoring	- Applied research
Some		- Attend Harvard courses		- Fellows Program - Policy Implementation
Contributed			- Module preparation and teaching	
Significant				

6.2 Is ASELPH *effective*[13] as an executive leadership development programme?

The serial self-assessments done by the Fellows in each cohort demonstrate improvements in the 14 leadership competencies. It is difficult to verify these self-reported improvements because of the paucity of information in the routine 360⁰feedback report system. The observation and assessments conducted at four purposively selected workplaces confirm changes in leadership behavior and implementation of workplace initiatives that have the potential to improve services and positively influence health outcomes. Documentation of what Fellows are doing in the workplace would provide useful material to integrate into teaching material as well as for dissemination to showcase the program.

There is very limited evidence of the effectiveness of mentoring and slow implementation of e-learning has somewhat impeded the effectiveness of that aspect of the academic program.

6.3 Is ASELPH delivering a product that is *uniquely valuable in terms of method and content*?

According to unanimous feedback from fellows and faculty ASELPH is unique in terms of method and content – the peer learning, case study methodology, incorporation of topical content taught by guest lecturers from the department, depth and breadth of knowledge brought by Harvard faculty and the opportunity to engage with how other countries have dealt with health problems are all valued aspects of the program, as are the models of analysis and problem solving that can be applied in the workplace. ASELPH's methodology and content have been transformative in exposing people to and opening up a different way of learning and what they took from that learning.

Fellows were clear that 'ASELPH should not become less of a leadership and more of a public health program.'

6.4 Has ASELPH *built SA faculty capacity*?

SA faculty have undergone capacity building activities in case study development and teaching and applied research and report more competence. A baseline assessment and documentation of pre- and post levels of competence would have provided stronger evidence.

6.5 Has ASELPH built a framework/mechanism/*system to deliver emerging leaders*?

ASELPH has developed a system to select, train and support (mentor) Fellows in the workplace. The first two components in this system function well and the third requires strengthening of the mentoring and better documentation of process and outcomes. These deficiencies probably affect emerging leaders more than those who currently hold executive leadership positions.

6.6 Is ASELPH *sustainable* and providing *value for money*[14]?

The program has the potential to be sustainable in the long term depending on continued funding (H&W SETA funding is a positive development), continued involvement of Harvard and attention to

[13] Effectiveness based on the competencies ASELPH sought to develop in Fellows
[14] Value for money defined as "The optimal use of resources to achieve intended outcomes" (DFID)

the aspects of the program that are not working so well. While institutionalization of the program into the universities contributes to sustainability, some respondents cautioned that 'mainstreaming will make them (the PGD and MPH) just another university program and lose what is ASELPH'.

All respondents felt that ASELPH provides value for money. There could have been more efficient use of Harvard time in the first year and efficiency was lost in the dependence on paper and use of conference venues, however, the latter was outside the program's control.

7 RECOMMENDATIONS

In formulating these recommendations we have focused upon strategic issues in the belief that consideration is already being given to the operational matters.

1. We strongly recommend that the program and the ASELPH partnership be continued. Since the academic program has been established, a review of the partnership model should be considered in order to establish a best fit for the next phase of the program. For example, it may be timely to establish an independent body to house ASELPH, which would also provide an opportunity to review the governance and establish a framework to monitor and support partnership as an integral component of this unique model.

2. Attention should be given to ensuring that ASELPH adopts an equity approach within the program itself. This would mean establishing and/or strengthening the systems at UFH and UP and providing assistance and support as required for the effectiveness of the program and to maintain the integrity of ASELPH as a 'whole' rather than the sum of disparate parts.

3. ASELPH should enhance its potential to contribute to the SA policy space by continuing to arrange policy seminars and round tables on topical issues. These could possibly be decentralized to provincial level and should be written up as policy briefs. Consideration should be given to registering these for continuing professional development (CPD) points and providing these as podcasts to increase coverage.

4. ASELPH should continue to further nurture and grow its relationship with the DOH at both national and provincial levels. There should be interactions and report backs at national and provincial levels to showcase program achievements and continue to garner support. Fellows and Alumni should play an active part in these.

5. It is important to find a way that the unique dimension that Harvard brought to the classroom is maintained. In addition to its QA role Harvard should still play a teaching role (even if it is reduced) as Fellows valued the interaction with HSPH faculty very highly.

6. ASELPH should develop a more systematic/formalized approach to faculty development.

7. Blended learning needs to be implemented evenly across the entire program, and in order to achieve a good balance between peer learning and Fellows not leaving their workplace.

8. The potential of the mentoring component of the program should be developed and formalized for both Fellows and Faculty.

9. Strengthen knowledge management (KM) and specifically monitoring of Fellows' activities outside of the classroom. This should include revisions based on the 360^0 assessment pilots as well as documenting the ASELPH story and sharing the lessons learnt. Consideration

should also be given to a follow up evaluation of Fellows once they have graduated (at 3 years and 5 years for example) to monitor their progress and contribution to the public health system.

10. Formalize the Alumni Association to ensure continued interaction between past and current Fellows

11. ASELPH should make a concerted effort to mobilize the additional resources necessary to support consolidation of the program as well as adaptation and strengthening of some components because of its potential to make a significant contribution to strengthening the health system and ultimately improving health outcomes.

8 CONCLUSION

ASELPH has established itself in the health executive leadership development space. It provides an offering that is unique in method and content.

ASELPH is making a contribution to health system strengthening in SA and has the potential to impact significantly going forward, particularly if attention is given to the e-learning and post-classroom support components.

Institutionalization of the PGD and MPH at UP and UFH plays a significant role in program sustainability. ASELPH should definitely continue and strong efforts should be made to mobilize resources to support the next phase of the program.

Vignette 1: Regional Hospital

Dr S Tshabalala, CEO, Prince Mshiyeni Memorial Hospital.

In May 2015, while still a Fellow on ASELPH, I was appointed as the CEO of Prince Mshiyeni Memorial Hospital, a Regional facility that is the largest hospital in KZN.

Personal Empowerment The ASELPH programme changes attitudes. It helped me grow from being a medical practitioner to become a manager, taught me how to be firm when necessary, and to adopt a problem solving approach. It helped me gain confidence and understand how to use the power of my position in a constructive way: to respect every employee, to consult widely, and encourage participation at all levels. I realised the value in keeping an 'open door'; I began to understand the significance of how the work environment and context influences performance.

Focus on Community Outreach The ASELPH modules on '*Decentralisation*', and on '*NHI and Primary Health*' helped me to understand that historically the trajectory of health care has generally been towards centralisation of care in hospitals and clinics, rather than reaching out to communities to serve them. I realised that health services need to be de-centralised, and place their most important stakeholder, the patient, at their centre. Reaching out to communities can reduce expenditure for health services and patients, especially if illnesses and complications are prevented. My focus on community outreach is also influenced by '*Operation Sukuma Sakhe*', a provincial initiative encouraging all government departments to provide holistic services to the community, with a view to empowering communities to become self sufficient and less dependent upon government services.

Our community outreach takes a number of forms, within the hospital and in the broader community. We are guided by the health calendar, and utilise a multidisciplinary team. With regard to Mental Health, for example, we spend time with the families of hospital patients to help them understand and accept the individual, and we visit schools in the neighbourhood to give talks about mental health. Another example is helping the community understand potential employment opportunities; at the request of a local NGO we have given talks about job opportunities in the health system. Within the hospital we are trying to establish a 'Women's Forum' (a Men's forum already exists).

Clinics are the entry point to the health system and I am keen to encourage our clinics to strengthen their health education and prevention activities. To this end I have met with chairpersons of clinic committees to raise issues around community outreach and prevention. I am also endeavouring to strengthen our Hospital Board, which is the go between for the community and us. I encourage the Board to share our successes with the community, and to urge community members to actively participate in the health sector. This strategy paid off recently when members of the Board played an active role in helping me resolve a strike by Community Health Workers.

Building our relationship with the community is not something that can be achieved overnight and I know that the benefits of this work will only be fully realised over a period of time.

Adopting a Systems Approach It was as a Fellow that I began to appreciate the interconnectedness of every part of the hospital and its clientele. My participation in ASELPH has enabled me introduce, or revive, a number of initiatives that I believe will strengthen the hospital as a whole system. One of these has been the revival of the clinical governance committee which had never been used as a tool to improve hospital management in an integrated fashion.

Strategic planning I brought together a task team to develop our strategic plan. The planning group included the DMT, all heads of department, community leaders and organised labour. We are in the process of implementing the plan, which is aligned to the Provincial plan. The implementation will take the form of annual plans which will be monitored frequently and evaluated quarterly.

Policy committee Most of our policies were outdated so I revived the policy committee. The actual revision of policies has been undertaken by junior managers, who submit the revised policies to Exco for review and finalisation. Many other committees are being revived, like the complaints committee.

Clinic supervision Prince Mshiyeni has 16 clinics, which fall under it. I have already created monitoring teams to assist in supporting and transforming these clinics, and am working with the DMT to resolve some anomalies with regard to clinic supervision.

Quality assurance and infection control In the absence of a quality control manager, I have appointed a quality assurance team comprising representatives from infection control, waste facility, the assistant nurse manager, maintenance and the systems department. I liaise with them every week, and our infection control reports now prioritise high risk areas including the nursery and milk kitchen. We have had no recent outbreak of infection.

Management by walkabout Everyday I start my day by walking around the hospital, and once a quarter I get senior managers to do a full round of the hospital with me. This has taught us to learn from the lower level staff and rhymes well with the upwards delegation I learnt from ASELPH.

Vignette 2: Provincial Budgeting System

Mr. Montwedi Botsane, Director, Budget Management, Gauteng Provincial Department of Health.

I have worked for the Gauteng Provincial Department of Health within the Chief Financial Officer Branch, Budget and Revenue Management Chief Directorate since May 2006. In May 2015, after graduating as an ASELPH Fellow, I was appointed as Director, Budget Management. For most of the first year I was in the post I reported directly to the Chief Financial Officer, as the Chief Director Budget and Revenue Management post was vacant.

Personal Empowerment ASELPH enhances each and every Fellow; I also benefitted a lot. In the past, even though I was in a management and leadership post, I used to take an operational approach. Since I have been an ASELPH Fellow, I have been more effective. I am now able to prioritise and manage time, as well as handle multiple projects and deadlines effectively. The ASELPH approach is on solving challenges, and this made me grow. It helped strengthen my ability to be strategic and make meaningful contributions towards improving South Africa's Health Systems, and Gauteng's in particular. My focus is on finding solutions and being persuasive as per ASELPH lessons.

Focus on the Budget Process One of the strategic goals for the National Department of Health, outlined in their '*Strategic Plan 2014/5 to 2018/19*' is to improve financial management by improving capacity. Some of the challenges of financial management are highlighted by the Minister in his '*2016/17 Budget Vote*' speech. Gauteng Department of Health has experienced its own challenges over the years. For example there was a period when we were receiving negative publicity with regard to suppliers not being paid and this had an adverse impact on service delivery. Recently we have been faced with a sharp, and unplanned increase, in litigation costs.

Good governance lies at the heart of effective service delivery. With regard to the department's finance status, a well-functioning budget committee is essential for good governance. Budget committees should advise and put in place control measures for the finances of the department, ensure that the budget allocation is informed by the priorities of the department and is equitable and fair, monitor cash flow and expenditure, and keep spending within budget. When I was appointed as the Director, Budget Management, my priority was to strengthen governance as the Department had never had a budget committee.

Using the skills I had acquired from ASELPH I began by persuading the Chief Financial Officer of the need for the committee, and getting buy-in from other senior management with regard to necessity for the committee. Once this was achieved, I was responsible for identifying who the members of the committee should be, for developing the roles and responsibilities of these members, and for defining exactly what the committee should do (what is its purpose, how can it help us understand the impact of policies as they relate to the budget, and ensure that service delivery is not compromised, and how can it help avoid cash shortages). The ASELPH lesson of always probing and asking 'why' as possible solutions are identified, and of examining what reasoning underpins the answer to every question, was absolutely critical for me in being able to shape the role of the committee. Other initiatives included the setting up of the departmental cash flow committee, which is now functioning well and providing much needed support and advice. Just one example is the role they play is when there is a cash shortage, deciding which creditors should be prioritised so that service delivery is not compromised.

Adopting a Systems Approach ASELPH helped me understand the health *system.* As a finance person, I was studying with health practitioners and this assisted me to grasp the way in which finance and service delivery are intertwined. I have tried to use that understanding to strengthen interaction within my department, as well as between my department and other departments, including the provincial treasury. I see building understanding and relationships as absolutely vital to achieving this. Some of the initiatives I have put in place to strengthen the system include:

Integration of functions Integration of finance officials at Central Office. In the past, programmes had their own finance officers who were based in the programme, responsible to the programme manager, even though the CFO had an oversight role for all financial matters. Now, while remaining dedicated to their particular programme, they are all integrated within the Budget and Revenue Chief Directorate. This facilitates integration, financial reporting and monitoring, appropriate supervision, and assessment.

Planning I now do operational planning in a consultative manner. I involve staff as widely as possible, and try to help them to understand the process. I have tried to institutionalise a budget process before crafting the budget. This process includes organising budget bi-laterals between the Central Office (Chief Financial Officer Branch) and Hospitals or Districts, giving each institution the opportunity to prepare and present their budget bid to head office and, wherever possible to Gauteng Treasury. The Chief Directorate Budget and Revenue Management then consolidates the budgets and presents them to Gauteng and National Treasuries.

Monitoring Timelines for resource allocation are not always aligned, for example a new national policy will impact upon how we allocate resources, and this may need to be done mid-year. The Budget Committee is very helpful here as it can advise on how we reallocate resources without compromising other services. I have also put in place processes for monitoring facilities on their budgets and expenditure performance, meeting with facilities and giving feedback on corrective measures to be undertaken.

Personnel Development After participating in ASELPH I initiated the practice of taking junior staff to attend meetings with me. I believe that this exposure assists staff development and involvement, and I try to ensure that I discuss what happened at the meeting with staff in order to build their understanding and knowledge.

Vignette 3: District

ASELPH Fellows, OR Tambo District, Eastern Cape
OR Tambo is a large rural district with poor health outcomes. UFH undertook a situational analysis of the NHI pilot District, and it was as a result of this that 11 staff (one of whom subsequently was appointed as the DM) from the OR Tambo management team joined the ASELPH programme.

Personal Empowerment As a group we have grown in confidence as managers, *"ASELPH has taught us to be afraid of no-one"*. We feel empowered and able to empower people around us. We are able to think strategically. Our planning skills have improved, and we are able to align the budget with plans, and identify gaps that need filling. We now understand many things, including the reason for implementing the NHI that used to be unclear to us. As a result of ASELPH we feel we are different people, that we have insight, and we are eager to showcase our achievements. We have been equipped to deal with staff problems that we would have referred to head office in the past and we have also changed how we relate with labour unions. We are acquiring the ability to manage human resources better now we realise that everything costs.

Focus on Patient Registration HPRS is a fundamental building block of the NHI. An analysis of OR Tambo DHIS reports revealed weaknesses in our DHIS processes, including inadequate involvement of managers at district, sub-district, and facility level, in data verification, lack of training of key staff, limited availability of basic materials, and inadequate attention paid to data collection.
As ASELPH Fellows we had become familiar with Kotter's 'Eight Steps to Change Management' and the 'Walk in the Woods' 4-step process to problem solving. Using these tools to analyse the information challenges we faced we were able to develop strategies to overcome the problem and identify an intervention, 'Patient Registration in Mbekweni CHC' (the facility that had been identified by NDoH to pilot the e-health strategy). We utilised the strategies we had developed in the process of problem analysis to assist us implement our chosen intervention.
As a result of the intervention the HPRS has been implemented and is working well (18,654 patients have been registered). Daily data capturing is done at facility level, utilising new, rationalised PHC tick registers. Utilising available resources, for example the clinic had two permanently employed Data Capturers who we involved to assist with patient registration, (a strategy which Province approved of) and they are working well with the clinic clerks. The clinic also had three working computers with good internet connectivity. A data verification team has been established, policies and SOP's for data management have been developed, and staff orientation has been done.
Stage 2 of the implementation involves the roll out to all facilities in the District using the model piloted in Mbekweni clinic. OR Tambo is now recognised as a leader in the Province for HPRS and has been assisting other Districts in the Province, eg Alfred Nzo.

Adopting a Systems Approach Thanks to our participation in ASELPH we are able to work well together to identify systemic challenges, and put in place interventions to overcome those challenges.

Building the DMT Our effectiveness as a team is augmented by the DM who has developed a participatory leadership style, promoted teamwork, demonstrated her trust in us and given us space to make decisions. For example, when she is not around we feel confident about making decisions. This has helped us to work well together, and we no longer work in silos. We keep abreast with what is happening in each of the health programmes as well as in the support programmes. This approach contributes positively to planning. We have also put in place teams to support sub-districts and individual facilities. The DM has encouraged a sharing of resources to enable all sub districts to reach the same level.

NHI We feel that we can now support the NHI effectively. Working with the DDG responsible for NHI, we have already contracted 45 GPs to work in clinics, and this is already helping to reduce pressure on hospitals. We have been able to de-centralise responsibility for tasks, with separate managers taking responsibility for various components of the NHI.

IDP We have strengthened our relations with the Municipality and participate much more appropriately in the IDP process as we now understand why we need to interact with the municipality and do joint planning.

Strengthening Programmes MCH was identified as a priority by the DM. Once she had appointed an ASELPH fellow who she felt had potential to lead MCH at District level, we began to see improvements, for example immunisation coverage under 1 year rates rose from 58.7% in 2013/14 to 88% in 2015/16.

Community Engagement We decided to run community dialogues to market our services. We feel this has had a very positive impact and that community users now have a better understanding of what services we offer. When the School Health Team identified a school with high teenage pregnancy rates we were able to provide an outreach team that worked at the school with local NGOs.

Vignette 4: Rural Hospital and Clinic

Ms Linah Maepa. District Executive Manager, Sekhukhune District, Limpopo Department of Health
I have worked for the Limpopo Department of Health since September 1996. I was appointed as the Sekhukhune District Executive Manager at the beginning of June 2010.

Personal Empowerment Since ASELPH I have developed my leadership style; I try to be optimistic, appreciative, supportive and consultative. I am more participative, and endeavour to engage managers in the district. I do my best to empower my colleagues, for example I rotate chairing meetings in order to develop staff. I delegate authority to co-workers while maintaining responsibility and accountability for our health care. There is now more follow through in terms of decisions that have been made to make sure that things happen and I try to ensure clear target setting. Whereas we used to work in parallel structures, I have tried to build teamwork. I engage with people who have expertise in doing the work and I am identifying future leaders. Through ASELPH, I learnt new concepts, as well as how to take action using those concepts. For example, I had heard of 'emotional intelligence', 'cultural diversity' and 'transformational leadership' many times in the past, but before ASELPH I had never understood them, or how they could help me appreciate relationships at work. This was also true for 'primary healthcare management' and 'systems thinking'. Whilst in the past I have acquired knowledge in these fields, now I know how to use them practically. I feel that I am now able to manage the complex issues that arise within a District Health system. I have always wanted to understand research, and now after what I learnt through ASELPH, I feel so empowered I believe I could even teach research!

Focus on Jane Furse Hospital Jane Furse had the highest number of maternal deaths both in the District and in the Province. Over time some initiatives had been put in place but had not been successful in ameliorating the problem. Once I began studying with ASELPH, I asked myself the question as to why, what was the cause of the problem: was it leadership, was it the culture of the department? I identified the initial task as being to build a very strong team spirit in the DMT so that they would be interested to identify the cause of the problem, and to find solutions.
Together with the Province, a specialist and the DMT we visited the hospital, where we found a lack of leadership. The first thing we did was to appoint a CEO from among the senior managers. The CEO brought together a hospital management team, which was at the centre of solving the problem. They went through the diagnostic tree, asked themselves the '5 whys'[15] and came up with a strategy. This included deploying the District Clinical Specialist Team to the hospital on full time basis. The DCST found many areas of challenges including that the hospital was not using data to inform its care, protocols were not being followed, sessional doctors were not always on site, no training was provided, and no drills were performed.
Many of these problems have now been ameliorated: protocols were printed and put up on the walls of every delivery room; emergency drills are practised every week; we have created a call room in the hospital so that a doctor sleeps on site and the operational manager undertakes a daily analysis of problems which has led to the immediate detection of problem labours. We have established a very strong maternal response Unit that has a frequent and robust engagement with a variety of stakeholders including social development. As a result of our interventions there has been a definite fall in maternal mortality in Jane Furse, and we are implementing these strategies in other hospitals.

Adopting a Systems Approach ASELPH helped me understand the significance of using a systems approach and I bring this thinking to all my work.
Jane Furse was serving two municipalities (one of which has no hospital), and referral clinics were not following standard procedures. With the MEC and HOD we brought all stakeholders together in the municipality where there is no hospital. Some critical issues were identified and we managed to get high-level support for an intervention plan. Some deliveries now take place in clinics, and we have clustered clinics both to improve 24 hour facilities as well as to try to ensure they use the health centre in the Municipality where there is no hospital. This has resulted in some relief for Jane Furse. We also identified some key indicators like early booking and appropriate use of the referral system, and organised a community summit to encourage our mothers to work with us.
We have collaborated with other sectors, including Municipalities, to find joint solutions to problems. For example, we used the need for tarring roads to clinics as a project to encourage inter-departmental collaboration. We now share our plans with Municipalities, enabling them to include our needs in their planning. In the future we aim to influence Province as a whole.

HIV and AIDS and 90/90/90 Sekhukhune presented a paper at the July 2016 AIDS Conference in Durban. We have taken a multisectoral approach to managing HIV. We ran a successful AIDS campaign in the rural areas of our District, I organised a seminar to motivate multisectoral stakeholders and clinicians, convened a Round Table with the MEC and HOD to look at early warning signs of drug resistance, and ensure that I sit in on the review for every programme. Most districts in the country were at 30% for viral load suppression, through 'Operation Hlasela' and 'Operation Find All Patients', Sekhukhune has achieved 81% viral load suppression. Our initiative has informed the NHLS interventions.

Ideal Clinic Initiative By the end of 2015/16, Sekhukhune was the leading District with regard to Ideal Clinics in Limpopo, with Elandskraal, Motetema and Magalies Clinics having achieved Platinum status. Ikageng and Mphanama Clinics and Nchabeleng Health Centre achieved Gold status.

[15] A technique for problem analysis taught by ASELPH

Vignette 5: National Programme

Dr. Patrick Moonasar, Chief Director, Malaria Programme, NDOH

Personal Empowerment Since becoming an ASELPH Fellow I have gained in confidence, and feel able to contribute to discussions at a strategic level. The ASELPH programme taught us the theory of how to lead people and teams, and how to inspire teams so that they will deliver. Like everyone, I would like things to go the way I want them to, but I now try harder to be flexible. I have learnt to choose which battles to take on and which not to fight, an important skill because we work in the SADC region, and multilaterally, so we need to be able to make small compromises while not losing the bigger picture. I have also acquired the skill to share our vision and national goal with other organisations in South Africa in such a way as to get more buy in and encourage them to align themselves with the national strategy.
Since becoming an ASELPH Fellow I have been appointed by the Department to two senior committees: the adjudication committee for the evaluation of tender recommendations, and the Board for the National Health Laboratory Service. ASELPH helped me be better equipped to contribute positively. I am able to understand the nuts and bolts of how the organisations work, and am utilising the costing and accounting skills I acquired.

Cell phone reporting of newly diagnosed cases of Malaria Knowing about new cases of malaria in good time is essential as part of our goal of eliminating malaria in South Africa by 2018. To help us get notification as quickly as possible we have initiated a project that informs us of newly diagnosed cases within 24 hours of diagnosis. The project involves cell phone technology that enables nurses in remote rural areas to use their cell phones free of charge to report diagnosed cases of malaria. It includes multiple partners including the National Institute for Communicable Diseases, the Medical Research Council, and the Clinton Health Access Initiative; government would not have been able to implement the project on our own. The paper system can take four or five days, so we needed to convince nurses to use their own cell phones (the Department pays the cost of the reverse billing). Now we are getting the information in 24 hours, helping us prevent epidemics. Our goal in 2015 was to have five districts as part of the project, and we succeeded in achieving that. In 2016 we are targeting nine districts and by the end of July we have already brought seven districts into the project.

Adopting a Systems Approach In 2012, the government adopted the policy of aiming to eliminate Malaria in the country by 2018. In 2014, as the person in charge of this programme I realised that the goal was not gaining much momentum. ASELPH helped me to appreciate the differing strengths and weaknesses of the team I was working with, and the comparative advantages of the individuals in the team. In order to maximise the strengths of the team, I reorganised our department's organogram and how the work was allocated in order to try to match individuals' functions and responsibilities with their particular skills. Inevitably I encountered some resistance as people inevitably get caught up in the ways of working that they are used to. However, using techniques I learnt as an ASELPH Fellow such as coaching skills, I believe I managed to convince staff, and succeeded in changing the departmental structure. This freed up some of my time and has allowed me to play more of a strategic, rather than an operational role. Part of this role includes staying in touch with staff and providing coaching and mentoring as necessary.

9 List of documents consulted

ASELPH Annual Reports 2012, 2013, 2014, 2015

ASELPH Funders Reports – Quarterly & Semiannual Narrative and Financial Reports, 2012-2015

ASELPH High level work-plans 2014, 2015

ASELPH Sustainability Framework

Minutes - SMT, Operational Team, Steering Committee, Funders Meetings (various)

Attendance registers (various)

ASELPH Communication Guide, 2013

Course evaluations (various)

ASELPH Q&As (various)

Interviews with Fellows and Faculty (various)

Fellows' baseline and 6-month assessment reports

360-degree assessments

Policy seminar evaluations (various)

Round table evaluations (various)

Videoconference evaluations (various)

E-learning progress reports (various)

Mentoring reports (various)

WBOT Research Report

List of case studies

Decentralization case study

Case study summary presentation (two)

ASELPH competency framework

Faculty and guest lecturer list

List of faculty attending Harvard and other courses

Research proposals (four)

ASELPH midterm review report

10 List of interviewees

NAME	POSITION	ORGANISATION	RELATIONSHIP TO ASELPH
Dr Aung	Senior Medical Manager	Prince Mshiyeni Hospital, KZN	Colleague
Tabisa Bata	Programme Manager, ASELPH	SAP	ASELPH Programme Manager
L N Blean	Professional Nurse	Mthatha Gateway	Colleague
N Bokleni	Deputy Director	O R Tambo District, Eastern Cape	Fellow
U N Bomela	Deputy Director	Human Resources, O R Tambo District	Fellow
Tom Bossert	Senior Lecturer	Department of Global Health and Population, HSPH	Faculty
Montwedi Botsane	Director, Budget Management	Gauteng Department of Health	Fellow
Martina Bouey	Deputy Director	SAP	ASELPH Finance Manager
Eric Buch	Dean	Faculty of Health Sciences, UP	SMT
Dr. Bukasa	Acting CEO, St Rita's	Sekhukhune District, Limpopo	Colleague
Manganye Bumani	Operational Manager	Vhembe District, Limpopo	Fellow
Mr Buthelezi	Finance Manager	Prince Mshiyeni Hospital	Colleague
Terence Carter	DDG	NDoH	Chair, ASELPH Steering Committee
S J Digomo	Deputy Director	HR, Sekhukhune District, Limpopo	Colleague
T E Kauculi	Area Manager	Holy Cross	Colleague
Lucy Gilson	Professor	School of Public Health and Family Medicine, UCT	Academic - Other
N J Gqirana		Libode Clinic, Eastern Cape	Colleague
Rodney Harris	Pharmacist	Eastern Cape	Fellow
Stephen Hendricks	Professor	Faculty of Health Sciences, UP	ASELPH Programme Manager
Jeanette Hunter	DDG	NDoH	NDOH & Member, ASELPH Steering Committee
N M Jack	DCST	O R Tambo District, Eastern Cape	Fellow
Marian Jacobs	Steering Committee Member	ASELPH	Member, ASELPH Steering Committee
Tanya Jacobs	M and E Consultant	SAP	ASELPH M and E Consultant
Mrs Khanyile		Charles Johnson Memorial Hospital, KZN	Fellow
Makhosazama Khunene	CEO	Gauteng Department of Health	Fellow
Eva Kobola	Chief Director	HAST, Limpopo Province	Colleague
Raj Latchminarain	Systems Manager	Prince Mshiyeni Hospital	Colleague
Khosi Lupondo	Operational Manager	Holy Cross Hospital, Eastern Cape	Colleague
S E C Mabaso		Uthungulu District, KwaZulu-Natal	Fellow
Vusi Madi	HIV and AIDS Programme	Gauteng Department of Health	Colleague
Zola Madikizela	Programme Manager	The Atlantic Philanthropies	Funder
Lucky Madikane	CEO, District Hospital	Free State Department of Health	Fellow
Linah Maepa	District Chief Director	Sekhukhune District, Limpopo	Fellow

Anne Magege	Senior Programme Manager, Health	The ELMA Philanthropies	Funder
George Mahlangu	CFO	Gauteng Department of Health	Colleague
M A Mahloele	CEO	Sekhukhune District, Limpopo	Colleague
D G Malakalaka	Acting Director	HRM and D, Sekhukhune District, Limpopo	Colleague
Sibongile Mandondo	District Clinical Specialist	O R Tambo District, Eastern Cape	Fellow
Jimmy Mapumya	CEO	Gauteng Department of Health	Fellow
Jane Matsaba	Deputy District Director	Gauteng Department of Health	Fellow
L L Maqubela	Deputy Director	Information, O R Tambo District	Fellow
M V Maserumuhe	Acting Director	PHC, Sekhukhune District, Limpopo	Colleague
M M Mashishi	CEO	Sekhukhune District, Limpopo	Colleague
M L Maunye	Acting sub district Manager	Sekhukhune District, Limpopo	Colleague
N D Mayekiso	Sub District Manager	O R Tambo District, Eastern Cape	Fellow
G N Mazeka	CEO	Holy Cross Hospital, Eatsern Cape	Colleague
Miss Mhlongo	Nursing Manager	Prince Mshiyeni Hospital	Colleague
Ntokozo Mkhize	District Director	Ugu District Health Services, KwaZulu-Natal	Fellow
C NN Mkhwanazi	CEO	Lower Umfolozi War Memorial Regional Hospital, KZN	Fellow
Siphiwe Mndaweni	DDG	KZN Department of Health	Colleague
Jabulile Mngomezulu	CEO, Regional Hospital	Free State Department of Health	Fellow
T Mnyamana	Deputy Director	MNCWH, O R Tambo	Fellow
Anne Molala	DCST	Sekhukhune District, Limpopo	Colleague
John Molokwane	Director	Strategic Planning and Policy Coordination, Limpopo	Colleague
Patric Moonasar	Chief Director	NDoH	Fellow
L J Morokong	Ass Manager	Sekhukhune District, Limpopo	Colleague
M D Moyana	Deputy Director	HRH and CD, Sekhukhune District, Limpopo	Colleague
D J Mpaketsane	Deputy Director	Quality Assurance, Sekhukhune District, Limpopo	Colleague
P Mtheleli	SM	Finance, O R Tambo	Fellow
Sindizama Mthembu	Principal	KZN College of Nursing	Mentor
Dr. Muamba	Acting CEO	Sekhukhune District, Limpopo	Colleague
Professor Ronnie Ncwadi	Professor	UFH	Faculty
Mbulaheni Nemuthandani	Public Health Specialist	Community Health, Limpopo Department of Health	Colleague
J N Ngatyelwa			Colleague
Garfield Ndlovu	Director	Hospital Services Finance and Grants, Eastern Cape	Fellow
Mmabatho Ndwandwe			Fellow
Ms Ngcobo	HR Manager	Prince Mshiyeni Hospital	Colleague
Mrs Ntshanga	District Manager	O R Tambo District, Eastern Cape	Fellow
M S Ralefe	Director	Sekhukhune District, Limpopo	Colleague
L J Rashokeng	CEO	Groblersdal Hospital	Colleague
Laetitia Rispel	Head of School	School of Public Health, WITS	
Rudzani	Gauteng Treasury	Gauteng Department of Health	Colleague

Rasivhetshele			
Beatrice Sandi	Deputy Director	Regional and Tertiary Hospitals Directorate,	Fellow
Marchado Sarda	DCST	Sekhukhune District, Limpopo	Colleague
Derek Sedlacek	Health Development Officer	USAID	Funder
Dan Seekoe	Professor	UFH	Faculty
Pinky Seekoe	Professor	Faculty of Health Sciences, UFH	ASELPH Programme Manager
Gugu Shabangu	Deputy District Manager	KwaZulu-Natal Department of Health	Fellow
Prudence Sikakane	Deputy Director	Gauteng Department of Health	Fellow
T D Siyanghapi	Deputy Director	O R Tambo District, Eastern Cape	Fellow
Gaileen Steele	Infection Control Manager	Prince Mshiyeni Hospital	Colleague
Prof Thakhathi	Professor	UFH	Faculty
Leena Thomas	Faculty	UP	Faculty
Mary Tiseo	Executive Director	SAP	SMT
Ms Thlakane	Acting DDG	Corporate Services, Limpopo Department of Health	Colleague
Mvuyo Tom	Vice Chancellor	UFH	SMT
Leigh Tovell Trollope			Fellow
Sandile Tshabalala	CEO	Prince Mshiyeni Hospital, KwaZulu-Natal	Fellow
Sophy VanderBerg-Cloete	Faculty	UP	Faculty
S V Vilakazi		Zululand District, KwaZulu-Natal	Fellow
Nontlantla Zamxaxa	Provincial Manager for District Health Services	Eastern Cape Department of Health	Fellow