

Impact Evaluation of the Primary Health Care Initiative

United Nations Volunteer Doctors in Trinidad and Tobago



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Acronyms

ARs	Annual Report
AWP	Annual Work Plan
CBC	Complete Blood Count
CMOH	Chief Medical Officer of Health
DHV	District Health Visitor
ERHA	Eastern Regional Health Authority
GORTT	Government of the Republic of Trinidad and Tobago
HC	Health Centre
MATT	Medical Association of Trinidad and Tobago
MBTT	Medical Board of Trinidad and Tobago
MoH	Ministry of Health
NCDs	Non-Communicable Diseases
RF	Results Framework
RHAs	Regional Health Authorities
RM	Results Matrix
PAHO	Pan American Health Organization
PCPs	Primary Care Physicians
PHI	Primary Healthcare Initiative
PA	Programme Assistant
PO	Programme Officer
PPRs	Project Progress Reports
QPCC	Queens Park Counselling Centre
RN	Registered Nurse
T&T	Trinidad and Tobago
UNDP	United Nations Development Programme
UNV FU	United Nations Volunteers Field Unit
UNV	United Nations Volunteer Programme
UWI	University of the West Indies

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DR.HELMER HILWIG WITH DR. BENJAMIN UGBE AT THE ARIMA HEALTH FACILITY¹

¹ Permission was granted for all photos taken.

Executive Summary

Project Background: On 6th June, 2014, the United Nations Development Programme (UNDP) signed an agreement with the Ministry of Health (MoH), Government of the Republic of Trinidad and Tobago (GORTT) for implementation of the “Primary Health Care Initiative” project. The objective of the technical assistance project was to assist the GORTT to reduce the shortage of Primary Health Care Physicians in the public health system, particularly in rural areas, through the provision of 30 United Nations Volunteer (UNV) Doctors. In addition, the project was expected to facilitate the expansion of opening hours at rural and specifically underserved health centres. The project was expected to be executed over a period of thirty-six (36) months from June 2014 to June 2017. The total project costs was USD4,259,706 constituting total direct costs of USD4,018,590 and UNDP General Management Services (GMS) fee of USD241,116.

In accordance with UNDP policy, a final evaluation of the project was commissioned in February 2017 to detail the achievements of the project, lessons learnt over the duration of the project and suggestions as to potential future projects.

Methodology: The evaluation utilized primarily qualitative methods. Face to face and telephone interviews were held with key stakeholders including former and current UNV Doctors, UNDP/UNV Programme Officers, Programme Associate and Programme Assistant, key stakeholders across the Health sector including the Ministry of Health’s International Desk, Former Chief Medical Officer, Health Planning personnel, Regional Health Authority (RHA) Staff, Medical Board of T&T, and the Pan American Health Organization (PAHO) combined with extensive document review. Site visits were also conducted to several Health centres and facilities.

Evaluation Findings

Relevance: Overall the PHI project was relevant to Trinidad and Tobago’s national development objectives related to strengthening the effectiveness and efficiency of primary health care delivery. The project was designed to fill the gaps in service delivery in underserved rural communities, by contracting UNV Doctors who would be present in the Health Centres to provide a full 8 hours of service and thus backstop local practitioners. As such, the project was relevant to filling this capacity gap. That said, the project design needed to take into account several structural dysfunctions within the health system that could and did derail project implementation including the weak coordination, communication and collaboration between the MoH and the Regional Health Authorities, expiration of the Panel for the Issue of Special Temporary Licences and the need to revert to the Medical Board of T&T for registration, among others. In addition, a more rigorous design could have addressed many of the issues identified in the mid-term evaluation of the previous UNV Doctors project including, collection of baseline data to enable assessment of project relevance as well as measure effectiveness of the intervention. Any future iteration of the project should be based on a comprehensive assessment of human resources capacity gaps and risks associated with the management of the health system.

Project Results: Despite the range of design and implementation challenges, the project achieved significant results. The insertion of UNV Doctors in the primary health care system facilitated a more patient centric approach, characterized by effective listening and enhanced communication with patients. Feedback from Supervisory staff, colleagues and patients indicated that UNV Doctors were held in high regard and much appreciated. The project also successfully planted the seed of volunteerism, through UNV Doctors involvement in community outreach, provision of support to partner agencies of the MoH, NGOs, and development and implementation of volunteer activities. Regarding the extent to which there was a transfer of knowledge and skills, several UNV Doctors noted learning about the prevalence of NCDs, among other areas. However, they also indicated that system issues such as the requirement to turnover patients in 5 to 15 minutes compromised both their understanding of the 'right way' to treat with patients as well as the standard of care delivered.

Implementation Effectiveness: Overall, the project delivered on its primary output regarding the selection and recruitment of 26 UNV Health Professionals. The evaluation suggested that improved geographical access was evident in rural Health Centres such as Cedros, Moruga and Tabaquite due to the assignment of UNV Doctors. The project was less successful in supporting the establishment of extended opening hours. Further, the lack of data regarding centres with extended opening hours, since the assignment of UNV Doctors, means that a definitive conclusion cannot be made. Challenges related to the overall weak management of the health system contributed to frustration and disappointment of the UNV Doctors regarding the potential for the programme in Trinidad and Tobago. These include perception of local doctors that UNV Doctors intended to 'take' their jobs; necessity for referrals to District Health Facilities due to lack of diagnostic tools/laboratory tests, underutilization of UNV Doctors' skills, lack of clear protocols and guidelines and poor communication within the RHAs and with relevant stakeholders.

Implementation Efficiency: Generally, the project was implemented in keeping with the budget allocation. An implementation schedule was not developed; therefore it was difficult to assess the implementation efficiency of key activities. That said, both the recruitment and placement processes were delayed by issues that the UNDP/UNV administrators had little control over. Based on a comparison of the compensation package with the Cuban Doctors, IUNV Doctors were more cost effective and presented good value for money

Project Administration: Effective administration of the project was compromised by limited adherence to the management arrangements included in the project agreement. These included the difficulty in establishing a Project Board, failure to recruit an external Project Manager, insufficient support from the Ministry of Health's International Cooperation Desk, delayed implementation due to poor coordination with the RHAs regarding allocation of UNV Doctors and medical registration issues caused by the expiration of the Ministry's Special Panel for Temporary Licences, among other issues. In spite of these challenges, cohesiveness of the UNDP/UNV team and their willingness to go the extra mile supported implementation of the project. That said, UNDP/UNV arrangements and administration requires some review and strengthening. UNV Doctors feedback indicated some areas of dissatisfaction with the settling in and management process. Finally, limited adherence to the project's monitoring framework meant that

data/evidence to inform decision making and performance assessment was inadequate. This area also needs to be strengthened.

Recommendations: This evaluation concurs with the recommendations of the mid-term evaluation of the earlier UNV Doctors project and suggests the following additions:

Recommendation 1: A comprehensive assessment of the Primary care health system including the critical gaps in capacity should be the basis of any further UNV intervention.

Recommendation 2: Any future iteration of the UN Volunteer programme, particularly one involving the assignment of Doctors and Nurses must take into account several critical success factors as well as recognize the limitations of interventions in the health system.

Recommendation 3: A more rigorous results matrix should be developed.

Recommendation 4: Need to ensure that key stakeholders, particularly the executing agency and its personnel understand the overall project design, how elements are linked and the required sequence.

Recommendation 5: Proposals such as this need to ensure that complementary interventions are critical to achieving stated programme outcome.

Recommendation 6: Clearly articulated roles and responsibilities need to be documented in any project agreement, with a clear understanding between partner agencies on specific performance standards and expectations.

Recommendation 7: The Ministry of Health needs to conduct a performance assessment of the primary health care system to identify obstacles to improved waiting times and integrated health care, among other things.

Recommendation 8: The UNDP/UNV in collaboration with the Ministry of Health needs to develop indicators related to the organization's mandate including the promotion of volunteerism.

Recommendation 9: Project Governance arrangements must be closely monitored to ensure the adequacy of oversight. The establishment of a Project Board or Steering Committee is vital to more effective project management.

Recommendation 10: The establishment of a UN volunteer as project manager within the MoH may contribute to more effective and efficient project implementation.

Recommendation 11: Monitoring and Evaluation requirements must be adhered to in any future programmes.

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1.0 Introduction

1.1 Background

1.1.1 On 6th June, 2014, the United Nations Development Programme (UNDP) signed an agreement with the Ministry of Health (MoH), Government of the Republic of Trinidad and Tobago (GORTT) for implementation of the “Primary Health Care Initiative” project. The objective of the technical assistance project was to assist the GORTT to reduce the shortage of Primary Health Care Physicians in the public health system, and particularly in rural areas, through the provision of 30 United Nations Volunteer (UNV) Doctors. In addition, the project was expected to facilitate the expansion of opening hours at rural and specifically underserved health centres. The project’s primary objective was to recruit 30 Doctors to work in regional health centres to provide care and support to the citizens of Trinidad and Tobago over a 3-year period.

1.1.2 The project was expected to be executed over a period of thirty six (36) months from June 2014 to June 2017. The total cost of the project was USD 4,259,706 constituting total direct costs of USD 4,018,590 and UNDP General Management Services (GMS) fee of USD 241,116.

1.1.3 In accordance with the programming policies and procedures outlined in the UNDP User Guide, a project evaluation was required upon completion of the project. The evaluation was expected to detail the achievements of the project, lessons learnt over the duration of the project and suggestions as to potential future projects.

1.1.4 In this regard, the UNDP contracted Mrs. Alexa Khan; an Evaluation Consultant on February 7th 2017 to conduct the final evaluation of the project. The objective of the consultancy was to prepare the final evaluation and specifically to determine:

- The extent to which the project enhanced the original situation at the Health Centres throughout the country, the effectiveness of the strategy adopted and the continued relevance of the intervention;
- Inputs on amendments to be made for the duration of the current project;
- The effectiveness and efficiency of the Ministry of Health as it relates to the execution of the program strategies;
- The effectiveness of the relationship between the UNDP/UNV and the International Desk within the Ministry of Health;

- The findings and potential future recommendations to all relevant parties: The Ministry of Health, UNDP and UNV

1.1.5 This report constitutes the Final Report on the Impact Evaluation of the Primary Health Care Initiative.

1.2 Organization of the Report

1.2.1 Following the introduction, the report is organized as follows:

- Section 2 details the evaluation approach and methodology including the key evaluation questions, data collection tools and techniques and limitations encountered;
- Section 3 presents a brief description of the rationale and impetus for implementation of the project. The theory of change underlying the project design and anticipated outcomes of the project are also detailed;
- Section 4 provides the evaluation findings including the issues related to the project's design and relevance, effectiveness and efficiency, project administration and sustainability; and
- Section 5 includes an overview of general conclusions and lessons learned

2.0 Methodology

1.1 Evaluation Approach and Methodology

2.1.1 Considering the limited time available for data collection, the evaluation utilized primarily qualitative methods. Face to face and telephone interviews were held with key stakeholders including former and current UNV Doctors, UNDP Programme Officer, /UNV Programme Associate and Programme Assistant, key stakeholder across the Health sector including the Ministry of Health's International Desk, Health Planning personnel, Regional Health Authority (RHA) Staff, Medical Board of T&T, and the Pan American Health Organization (PAHO) combined with extensive document review. Site visits were also conducted to several Health centres and facilities. Data from each component of the evaluation (interviews and document review) were triangulated to identify themes and issues related to the key evaluation questions.

2.1.2 An **evaluation matrix** (see Appendix II) was developed during the inception phase and agreed to with the UNDP and UNV focal personnel. The evaluation matrix details the evaluation dimensions, the corresponding key questions, indicators and sources of data. The key questions reflected in the evaluation matrix² constituted the foundation for the evaluation and included:

- I. The extent to which given the original situation at the Health Centres throughout the country, the effectiveness of the strategy adopted and the continued relevance of the intervention;
- II. Inputs on amendments to be made for the duration of the current project;
- III. The effectiveness and efficiency of the Ministry of Health as it relates to the execution of the program strategies;
- IV. The effectiveness of the relationship between the UNDP/UNV and the International Desk within the Ministry of Health;
- V. The findings and potential future recommendations to all relevant parties: The Ministry of Health, UNDP and UNV.

2.1.3 Work planning and primary data collection for the evaluation took place from 7th to 24th February 2017.

Document Review

2.1.4 The Evaluation Consultant reviewed a range of documentation including:

- The Project Document
- UNDP/UNV Site visit reports
- Correspondence between UNDP/UNV and Medical Board of Trinidad and Tobago (MBTT), Regional Health Authority (RHA), MoH
- Project Concept Notes related to outreach activities to celebrate International Volunteer Day (IVD) on the 5th of December 2016
- The GORTT's Medium Term Policy Framework 2011-2014

- Mid Term Evaluation Report re Institutional Strengthening and Support to the MoH (2007)
- Performance Appraisals re UNV Doctors

A complete list of documents referenced is detailed at Appendix V.

Interviews

2.1.5 Key stakeholders interviewed included UNDP/UNV staff, International Cooperation Desk (MoH) staff, UNV Doctors (11), Health Sector Human Resource Planning, RHA staff, Ministry of National Security, MBTT. Twelve (12) Repatriated UNV Doctors were contacted via email and asked to complete the focus group protocol; however, only four (4) responses were received.

A complete list is provided in Appendix IV.

Site Visits

2.1.6 Site visits were completed to Hansen's Disease Control Unit, Arima Health Facility, Tabaquite Health Center, Indian Walk Health Centre and Roy Joseph Health Center.

2.2 Limitations

2.2.1 **Adequacy of Documentation:** The documentation required to assess project implementation was insufficient to inform the evaluation. Project Progress Reports were not available and information on UNV performance, particularly their outreach activities was not well documented. The evaluation was limited to using informal feedback from key informants and UNV newsletters.

2.2.2 **Measurability of outcomes:** No data collection strategy was established to track key outcomes identified at the outset of the project including, improved waiting times, expanded service delivery, health centres with extended opening hours and increased availability of primary health care physicians among others. It is noteworthy that the midterm evaluation of the earlier UNV Doctors project recommended the inclusion of these indicators.

2.2.3 **Poor response rate of repatriated staff:** Although the Consultant was able to interface with almost all³ of the UNV Doctors still working in Trinidad and Tobago, the response from repatriated UNV Doctors was low.

2.2.4 **Limited patient feedback information.** Ideally, patient satisfaction surveys would have provided key feedback on the performance on UNV Doctors in the work place; however, such information was not readily accessible. The Consultant received some anecdotal feedback regarding patient perceptions of UNV Doctors from site visit reports (both by UNV Field Unit and the Evaluation Consultant's primary data collection)

³ Two Doctors were out of the country

3.0 Primary Healthcare Initiative: Context and Profile

3.1 Primary Healthcare (PHC) Overview

3.1.1 The Ministry of Health (MoH) provides comprehensive PHC Services through a network of integrated, collaborative and inter-sectoral programmes targeted at improving the quality of life and extending the life of the nation's population. Some PHC strategies include:-

- Health promotion;
- Health education;
- Disease prevention;
- Monitoring of health risks; and
- Risk reduction.

These activities are executed with the assistance of dedicated units such as the Health Education Division, the Public Health Inspectorate, the National Surveillance Unit and other vertical units.

Organization and Management of Primary Health Care Services

3.1.2 Primary Healthcare Services in Trinidad and Tobago are organized in a seamless system of healthcare programs that target specific populations. The management of the PHC system has been shared between the MOH through its vertical programmes and services and the Regional Health Authorities (RHA's), through its community/primary health services. The MOH relies on the network of Health Centres and District Health Facilities strategically located throughout Trinidad and Tobago which is managed by the RHA's, the private sector and the NGO community to provide Public Health Care services. These facilities are constantly upgraded and reformed both at the health technology level and the service provision level to keep pace with the expressed needs of respective communities and best practices in the delivery of PHC services. Currently, there are seven (7) District Health Facilities, two (2) Enhanced Health Centres and seventy-eight (78) Outreach and Health Centres.

3.1.3 Over the years, the range of services offered through PHC Services have improved with the introduction of the tobacco control legislation, risk reduction by screening and tobacco control clinics to prevent smoking. Other services that have assisted in improving PHC include Home Health Care Services where District Health Visitors and Medical Officers visit homes, a "passport" where members of the public are invited to health centres to get their screens done as well, health care personnel visit work sites to screen for blood pressure, HB1c and Cholesterol etc.

3.1.4 The emphasis in the Health Care Policy is prevention. However, along with that strategy is risk reduction which involves the identification of segments of the population that may be at risk and the strategies to deal with the problem e.g., the results of two (2) surveys employed to identify the percentage of overweight children were found to be alarming since the rate had increased. The risk reduction strategy in this case indicated that obesity and a lack of exercise can lead to hypertension and diabetes. As such, schools were targeted in collaboration with the Ministry of Education to promote the right mix of school nutrition and exercise as an intervention before a health problem arises.

3.2 Project Rationale⁴

3.2.1 The health of a nation's population has been globally accepted as a crucial component in the measure of a country's human development, as evidenced by Sustainable Development Goal (SDG) 3, Good Health and Wellbeing. The United Nations Development Programme (UNDP) Human Development Index recognizes health as one of the three determinants in a country's progress towards sustained human development and the provision of primary health care for all by 2015 is one of the key Millennium Development Goals agreed by Governments. Access to quality health care services, coupled with lifestyle choices, impact on the quality of life and life expectancy of individuals. To create and maintain healthy populations, governments must develop programmes to address these elements.

3.2.2 The health sector in Trinidad & Tobago, while probably the best-equipped in the English-speaking Caribbean, suffers from limited opening hours in primary healthcare facilities, particularly in rural health centres. At the time of the development of the project, over 200 vacancies existed for specialist medical professionals, general practitioners, health service managers and technical personnel. Similar situation exists throughout the English-speaking Caribbean and can be attributed in part to the pull factors of larger healthcare markets (e.g. The United States, Great Britain and Saudi Arabia) which attract a significant number of local healthcare professionals abroad. Additionally, there is continuous outflow of young professionals who migrate to pursue post-graduate training abroad. Traditionally, medical professionals have used the public health sector to gain experience in their related fields before moving on to more lucrative career options at home and abroad, with more opting for private practice rather than meeting the needs of the national public health system.

3.2.3 The Public healthcare system has several strengths and has achieved a measure of success in controlling communicable diseases. There remains, however, room to strengthen the quality of healthcare services, including improvements in the rates of maternal and perinatal morbidity and mortality. At the same time, the spread of communicable diseases, such as HIV/AIDS, have created a new range of challenges. In addition, the epidemiological profile of the nation has shifted significantly and is now dominated by chronic degenerative conditions and the predominance of "lifestyle" diseases. The leading causes of death are heart disease, cancer, diabetes, cerebrovascular diseases and injuries.

3.2.4 Healthcare in Trinidad and Tobago is provided by both public and private institutions. Public institutions offer primary, secondary and tertiary level services through a network of nine (9) hospitals and ninety-six (96) primary healthcare facilities plus a variety of special programmes and support services. Primary healthcare facilities are located throughout the two islands and provide the majority of the population coverage for preventative programmes. These programmes include maternal and child health services, chronic disease clinics and health education. Health Centres provide the population with 10% of curative primary care whilst a further 36% is provided

⁴ Based on the project agreement

through hospital accident and emergency departments. Private doctors account for 54% of curative primary care provided to the population.

3.2.5 Recognizing the significant contribution that an effective health system can make to national development, the MoH identified the following key priorities:

- Delivery of efficient and effective healthcare;
- Increased access to healthcare for citizens;
- Development of internationally recognized centres of specialized medicine;
- Reduction/containment of the spread of the HIV/AIDS and NCDs;
- Reduction in the labour shortages within the Health sector

3.2.6 In light of the foregoing, the UNDP proposed to support the GORTT's objective to improve the delivery of primary health care services in Trinidad and Tobago.

3.3 Project Description and Objectives⁵

3.3.1 The project aimed to assist the GORTT to improve the delivery of health care to underserved populations, particularly in rural Health centres. Through the provision of at least thirty (30) trained Doctors recruited through the United Nations Volunteer Programme, the programme's objective was to facilitate extended opening hours at health centres throughout Trinidad and Tobago. In addition, the programme anticipated that due to extended hours at the health centres, self-referrals to Hospitals would be reduced resulting in more optimal use of Hospital resources.

3.3.2 It was anticipated that the majority of UNV Doctors would be placed at underserved Health centres in rural districts, given the reluctance of local doctors to provide services at those centres. The UNV Doctors would be contracted for period of up to one year with the possibility to extend for an additional two years and were expected to be deployed to primary health centres in an effort to complement local health care professionals.

3.3.3 All UNV doctors assigned to Trinidad and Tobago were expected to be trained at schools accredited by the GORTT and were expected to be fluent in English. Additionally, each was expected to receive a certificate of full registration by the Medical Board of Trinidad and Tobago (MBTT) and this process was to be facilitated by the UNV Field Unit.

3.3.4 The project also anticipated that the utilization of UNV Doctors would facilitate the promotion of volunteerism. The UNV approach is characterized by the spirit of solidarity, cultural sensitivity and capacity building. Volunteers are driven by their desire to serve a global society. The UNV Doctors through shared experiences and knowledge/skills aim to foster programmes of

community outreach, promote the volunteer ethic and train counterparts to ensure UNV inputs are sustainable.

3.3.5 UN Volunteers receive a modest living allowance termed a Volunteer Living Allowance (VLA) to cover living expenses. They do not receive a wage. As such, they constitute a cost-effective option for complementing local human resources.

3.4 Project Implementation

3.4.1 The project was expected to be implemented over a three-year period from 2013 to 2015⁶, however due to several delays including the lengthy review/approval process of the Solicitor General's office; actual project implementation commenced on June 6th 2014 and will be completed in December 2017⁷. The Project's management arrangements included a Project Board to provide oversight and monitoring and the MoH as executing agency. The UNDP/UNV was responsible for recruitment of UNV Doctors and the In-Service phase including induction programme, administration of UNV Doctors entitlements/obligations and Monitoring of UN Volunteer performance. A Project Manager was also expected to manage day to day management of the project, provide guidance to the project team, liaise with UNDP, the Project Board, manage project consultants and liaise with Government on financial matters.

3.5 Project Costs

3.5.1 The total costs of the project were US\$4,259, 706.00 comprising US\$4,018,590.00 related to required resources and the UNDP General Management Service Fee of US\$241,116.000. Financing of the project was sourced from funds allocated to the Ministry of Health by the GORTT.

3.6 Monitoring Framework and Evaluation

3.6.1 The project's monitoring was expected to include:

- Quarterly quality assessments monitoring progress toward completion of key results;
- An Issue log to facilitate the tracking and resolution of potential problems;
- Updating of the Risk Log
- Project Progress Reports (PPR) generated and submitted by the Project Manager
- A Project Lessons Learned Log to support ongoing learning and adaptation within the organization
- A Monitoring Schedule Plan updated to track key management activities
- Completion of Annual Review Reports
- Annual Project Review aimed at assessment of the project during the fourth quarter of the year and completion of the Annual Work Plan (AWP) for the following year.

⁶ See project Agreement

⁷ In agreement with the Ministry of Health

4.0 Key Evaluation Findings

4.1 Project relevance and Design

4.1.1 The following paragraphs discuss the overall relevance of the project and its design. These two dimensions of the evaluation have been coupled in one section recognizing that a project's design must be relevant to identified needs. The OECD-DAC Glossary defines relevance as "the extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies." The Glossary also notes that, "...retrospectively, the question of relevance often becomes a question as to whether the objectives of an intervention or its design are still appropriate given changed circumstances."⁸ The project's design therefore must be relevant to both the problem to be addressed and contextual factors. This section of the report examines the design of the project and presents findings on the extent to which the approach taken was relevant to the capacity constraints identified and the GORTT's strategic development goals.

Finding 1: The project was relevant to the GORTT strategic objective of providing safe, quality health services that are patient centered.

4.1.2 The GORTT's Medium Term Policy Framework (MTPF) 2011-2014 revealed that one of the key strategies identified to improve the public health system was the development of an integrated Primary, Secondary and Tertiary Health Care System. Specifically, the MTPF⁹ included the following specific measures:

- Development of a National Health Services Delivery Plan that rationalizes primary, secondary and tertiary health care services across the various Regional Health Authorities;
- Extend opening hours at community health centres;
- Upgrade earmarked community health centres to provide diagnostic facilities, screening programmes and multidisciplinary teams to provide holistic care as a method for reducing reliance on the general hospitals.

4.1.3 The foregoing suggests that the project, as conceptualized was generally consistent with the GORTT's objective regarding the provision of safe quality health services. That is, for example, the project anticipated that through the provision of additional PHPs 1, health centres in underserved areas would benefit from extended opening hours and/or the provision of additional services during the 8.00 am to 4.00 pm period. The potential for the latter was due to the fact that Doctors may not have been assigned to certain rural health centres on a daily basis, for example Blanchisseuse and Cedros

⁸ OECD-DAC Glossary of Evaluation Terms

⁹ Medium Term Policy Framework 2011-2014 dated October 2011, Ministry of Planning and the Economy, pg. 50

Finding 2: Data supporting the extent of human resources shortages in the Health Sector was not included in the project rationale; as such it is difficult to quantify the extent to which there was a 'shortage' of PCPs. Despite this, informal feedback indicated that primary care service delivery was severely compromised, particularly to rural health centres, due to local doctors' reluctance to provide services in these underserved areas.

4.1.4 It is important to note that at the time the PHI project was being developed (2011-2012) there was a shortage of Primary Care Physicians in the health sector¹¹. However, by the time that the project was operationalized, some two years later¹² the shortage of PCPs was less severe. Data from a Joint Select Committee of Parliament (2013) indicated that the main shortages were specialists -inclusive of Registrars and Senior Primary Care Physicians (PCP II) - which accounted for almost 66% of these vacancies. Further, as data included in Exhibit 4.1 below illustrates, there were only six (6) vacancies identified for the PCP I category. It is possible that

Exhibit 4.1 Status of Vacancies for Doctors as at January 31, 2012 was as follows¹⁰:					
Medical Doctors	SWRHA	ERHA	NCRHA	NWRHA	TOT
Consultant /Specialist Medical Officer	32	7	7	3	49
Registrar	65	11	42	13	131
House Officer	41	8	4	50	103
Primary Care Physician I	2	0	2	2	6
Primary Care Physician II	22	10	6		38
Primary Care Physician III	6				6
Medical Officer I	2	3	3		8
Senior Medical Officer	1			1	
Total	171	39	61	71	342

by 2014, there may have been an increased shortage; however, data related to the actual number of vacancies was not identified in the project rationale.

4.1.5 The project design anticipated that the RHAs would assess the areas with the most severe needs and submit a priority list to the MoH so that the allocation of UNV Doctors could be optimized. However, no such document was submitted and the specific Health Centres experiencing shortages were not identified. Informal feedback suggested that T&T Doctors were

generally reluctant to service Health Centres in rural communities such as Cedros, Icacos, Indian Walk, Tabaquite, Blanchisseuse and Guayaguayare, among others. Several key informants noted "...some Doctors have resigned rather than agree to assignments at rural health centres like Cedros¹³". As such, the RHAs were unable to provide services consistent with the needs of the communities or the MoH's strategic objectives related to effective and efficient service provision.

4.1.6 In addition, the project was conceptualized to ensure that primary health care services were provided during standard hours of operation of the local health centres. Historically, local

¹⁰ Joint Select Committee of Parliament " The Administration and Operations of the Ministry of Health With Specific Focus On Primary Health Care" (2013)

¹¹ Interview Feedback from former Chief Medical Officer, however there was no data to support this assertion.

¹² The agreement was signed in July 2014

¹³ Key informant interview

physicians do not provide the stated 8 hours of service, due to demands of their private practice. As a result, Health centres, both in urban and rural areas do not have a PCP for the full 8 hours of operation. It was believed that the UNV Doctors would be able to backstop the local physicians and/or facilitate extended opening hours, for example, they could work from 12pm to 8 pm.

4.1.7 Another issue that needs to be addressed is reconciling the demand and supply for doctors in the public health sector. Available data from the 2013 Joint Select Committee report on the Primary Health Care system revealed the following regarding advertisement of vacancies by each of the RHAs:

- The RHAs have been advertising to fill vacancies that arose due to retirements and separation as a result of migration and abandonment. As such, the Ministry engaged in both local and international advertising to fill vacancies in 2009 and 2010.
- The data revealed one hundred and sixty-three (163) appropriately qualified nationals in medicine, nursing, and allied health professions indicated their interest in filling the vacancies. Some applications received were transferred to the RHAs because of their authority to recruit in a timely manner.
- The total number of responses received by the MoH from local and international advertising efforts to fill vacancies from 2010-2012 was eighteen thousand, nine hundred and twenty-five (18,925).
- The ERHA, for the period 2010-2012 had a total of four thousand seven hundred and forty-three (4,743) persons expressing interest in filling vacancies in response to local and international advertising as shown below
- The NWRHA had two hundred and ninety-seven (297) persons applying in 2010 and three thousand six hundred (3600) persons applying in the year 2011.
- The SWRHA had a total of seven thousand eight hundred and twenty-two (7,822) persons willing to fill vacancies that were advertised during the years 2010, 2011 and 2012.
- Five thousand, one hundred and seventy-eight (5,178) persons expressed interest in filling vacancies at NCRHA in 2010-2012.

4.1.8 The foregoing suggests that there is high interest and available health human resources to satisfy the demand. This includes a significant number of graduates (estimated at 177 to 200 annually) from the School of Medicine each year in addition to returning scholars. The RHA's noted several challenges to employing returning graduates including the following:

RHA	REMARKS
ERHA	<ul style="list-style-type: none"> • The ERHA is able to absorb only those scholars whose area of study is in relation to the services offered by the ERHA. • The employment of returning scholars would be based on the availability of positions and funding at the time of request by the MoH. • In fiscal 2011/2012 the MoH enquired of the ERHA's ability to recruit thirty-nine (39) returning scholars as such, the ERHA offered employment to fifteen (15) of these returning scholars.

SWRHA	In order to employ scholars, further information on the area of study for each scholar, the number of scholars per area of study and the date of completion of study for each scholar is required.
NCRHA	The NCRHA can absorb returning scholars once there are vacancies.

4.1.9 The abovementioned indicates a number of issues including, (a) that there now appears to be an oversupply of Doctors in the system rather than a shortage. Several key stakeholders noted that there were a large number of young Doctors who were unemployed, some for 18 months after graduation and including returning scholars, who the GORTT has a legal obligation to place within 3 months; (b) despite this oversupply, service provision to the rural and some urban centres is still compromised by the local system of Public Sector Doctors simultaneously providing services via private practice. This latter issue is beyond the control of this project and reflects weak performance management of local doctors. That said, effective service delivery is almost impossible unless the public/private practice is addressed.

4.1.10 Any future iteration of the project must be conceptualized to ensure that:

- ✓ the project's design is based on an assessment of the capacity gaps in Primary care, including an assessment of the specific areas experiencing effective service delivery;
- ✓ Ideally metrics related to service delivery should be developed to inform measurement of the baseline situation;
- ✓ Given the limited options for new graduates, the UNDP may consider promoting the UNV programme to graduates,¹⁴ once funding is available. Graduates of the UWI will also be eligible for full registration and the programme would therefore not encounter the challenges experienced related to MBTT registration.
- ✓ Some assessment of social determinants of health at the community level and the strategies required to address the identified issues, including the requisite staff, might also inform a more comprehensive primary health care strategy. Further, the recently approved policy and strategy on NCDs should also inform the identification of critical human resources.

¹⁴It is important to note here that that International UNVs are not able to be posted in their home countries. If local UWI medical school graduates join the international roster, assuming they meet the UNV evaluation criteria, would be posted elsewhere for other assignments. The only way that they could serve as UNVs in Trinidad and Tobago would be as National UNVs, the pro forma costs for which is just over 10,000.00 TTD with the individuals taking home just under 6,000.00 TTD. The extent to which graduates would find this remuneration acceptable would require further exploration.

Finding 3: The Mid-Term evaluation report of the previous iteration of the project could have been utilized to ensure a more robust design. Information from that report indicated key areas of concern including the need for a functional Project Steering Committee, implementation of a more robust results matrix with measurable indicators; need to streamline administrative systems regarding registration of UNV doctors, approval of Work Permits and proper monitoring of staff, among others. The project design attempted to address some of these issues, however there was limited success.

4.1.11 On the 13th June 2003, the UNDP and the GORTT signed an agreement for the UNDP to support Institutional Strengthening of the Ministry of Health, through the provision of UNV Doctors to ameliorate the estimated shortage of 200 Doctors in the public health system. The intended outcomes of the programme were (i) increased equity and efficiency of delivery of public health services, (ii) promotion of the UNV volunteer ethic toward ensuring an adequate supply of health care professionals and services to address public health issues and issues causing a deficit in health care professionals.¹⁵ A mid-term evaluation of the programme was conducted in June-July 2007, and key findings included:

- Limitations to the evaluation due to the dearth of data and information; the absence of evidence related to Project Steering Committee (PSC) meetings, progress reports, budget revisions, Monitoring and Evaluation activities, data collection for measurement of performance indicators;
- The need for stronger project design;
- The evaluation recommended that the MoH and the UNDP should collaborate to establish Project management procedures and ensure they were adhered to with the support of a dedicated Project Coordinator;
- The Policy Unit should play a more substantive role in the management of the project, including facilitating the identification and matching of demand for specialists at the five RHAs with available supply, domestic and international;
- The Project Coordinator should develop a logical framework with key performance indicators and measurement methods;
- Project design should ensure that data and information are integral to project management and should include patient surveys and a pattern of visits. The PSC should be responsible for this;
- Reports should be generated from scheduled activities of the PSC;
- Supervisors should conduct evaluations of the performance of UNV Doctors as stipulated for tabulation and summarization;
- The PSC should ensure that M&E activities are conducted as indicated in the project document;
- The MoH and the UNDP should ensure with partners (Ministries of Foreign Affairs and National Security) that work permit issue and extensions are processed in a timely manner;

4.1.12 The report also includes recommendations regarding UNDP/UNV and MoH management of the project including the need for data collection and analysis to inform overall project management. The Mid-Term Evaluation of the earlier UNDP/UNV programme identified several key issues and made recommendations aimed at strengthening the overall effectiveness of that programme. A final evaluation report was not identified. As such, it is unclear as to whether the MoH or the UNDP/UNV implemented any of the recommendations.

4.1.13 The PHI (2014) included several key elements included in the report's recommendations including the establishment of a Project Board and a Project Manager. However, neither of these was implemented. The UNDP made several attempts¹⁶ to schedule Project Board Meetings; however, attendance by the MoH could not be secured. The Ministry of Health was not in favour of paying for an external project manager but preferred to assign this role to the Director, of the International Desk.

4.1.14 Regarding the Results Framework, indicators and/or data collection strategies to monitor the project's contribution to the key results areas of the GORTT's Mid Term Policy Framework, were not developed. The project's Monitoring Framework reflected the need for quarterly assessments, an Issue Log, a Risk Log, Project Progress Reports, a lessons learned log and a Monitoring Schedule Plan. The Framework also required the preparation of Annual Review Reports and Annual Project Reviews; both activities to be managed by the Project Manager and Project Board. Only a copy of the most recent Risk Log was forwarded for review. There was no evidence of any other reports, with the exception of field visit reports undertaken by the UNV FU.

4.1.15 The foregoing suggests that despite the findings of the mid-term evaluation of the earlier Doctors project and this project's efforts to improve on the design of the PHI, overall implementation and management of key elements was weak. In particular, the performance of the MoH was less than optimal. One of the contributing factors may have been the changes in CMOs over the life of the project, particularly the movement in and out of the Ministry of the CMO who had conceptualised the project. In the absence of this officer, coordination of the project's administration, particularly the communication and collaboration with the RHAs appeared to have collapsed. Another contributing factor may have been the limited capacity of the International Desk of the MoH to manage this project. Any future iteration of the programme will require the recruitment of a coordinator or Project Manager to ensure that project implementation and administration are efficiently conducted.

¹⁶ See email communications from UNDP to MoH dated 9th March 2016, 15th March 2016, 17th March 2016, 12th April, 2016, 13th April 2016, 21st April 2016, A Project Board meeting was chaired by UNDP on March 16 2017 at which the Ministry of Health was represented.

Finding 4: Overall, the project's design elements were insufficient to achieve stated project objectives related to more effective and efficient health services. Several of the underlying assumptions did not hold true and key elements were therefore not considered.

4.1.16 Exhibit 4.1 below illustrates the PHI anticipated Theory of Change (TOC), that is, an articulation of how the programme was intended to operate. The PHI anticipated that the project inputs including coordination and collaboration among the key stakeholder groups would contribute to the completion of key activities related to selection and recruitment, facilitation of licences to practice, work permit exemptions, identification of priority health centres and assignment of UNV Doctors. It was expected that UNV's would be allocated to primary health centres servicing the most underserved populations, specifically in rural areas and would facilitate extended opening hours and the delivery of additional services. The project also expected that a full staff complement would reduce wait times and also reduce self-referrals to the Regional and General Hospitals.

4.1.17 Unfortunately, many of the underlying assumptions on which the project's logic was based, did not hold true. Although the MoH stated its committed to the project, coordination with the RHAs was less than effective. As noted earlier, there was limited evidence¹⁷ to support the extent to which the MoH collaborated with the RHAs to identify underserved health centres, given the delays in assigning UNV Doctors once their medical registration and work exemptions were in order. Further, there were no criteria for the identification and selection of these health centres. This resulted in UN Volunteers being assigned to facilities that would not necessarily be described as high priority including the Arima Health Facility, Queens Park Counseling Centres (POS and San Fernando) Hansen's disease Control Facility, MoH Policy Unit, among others.

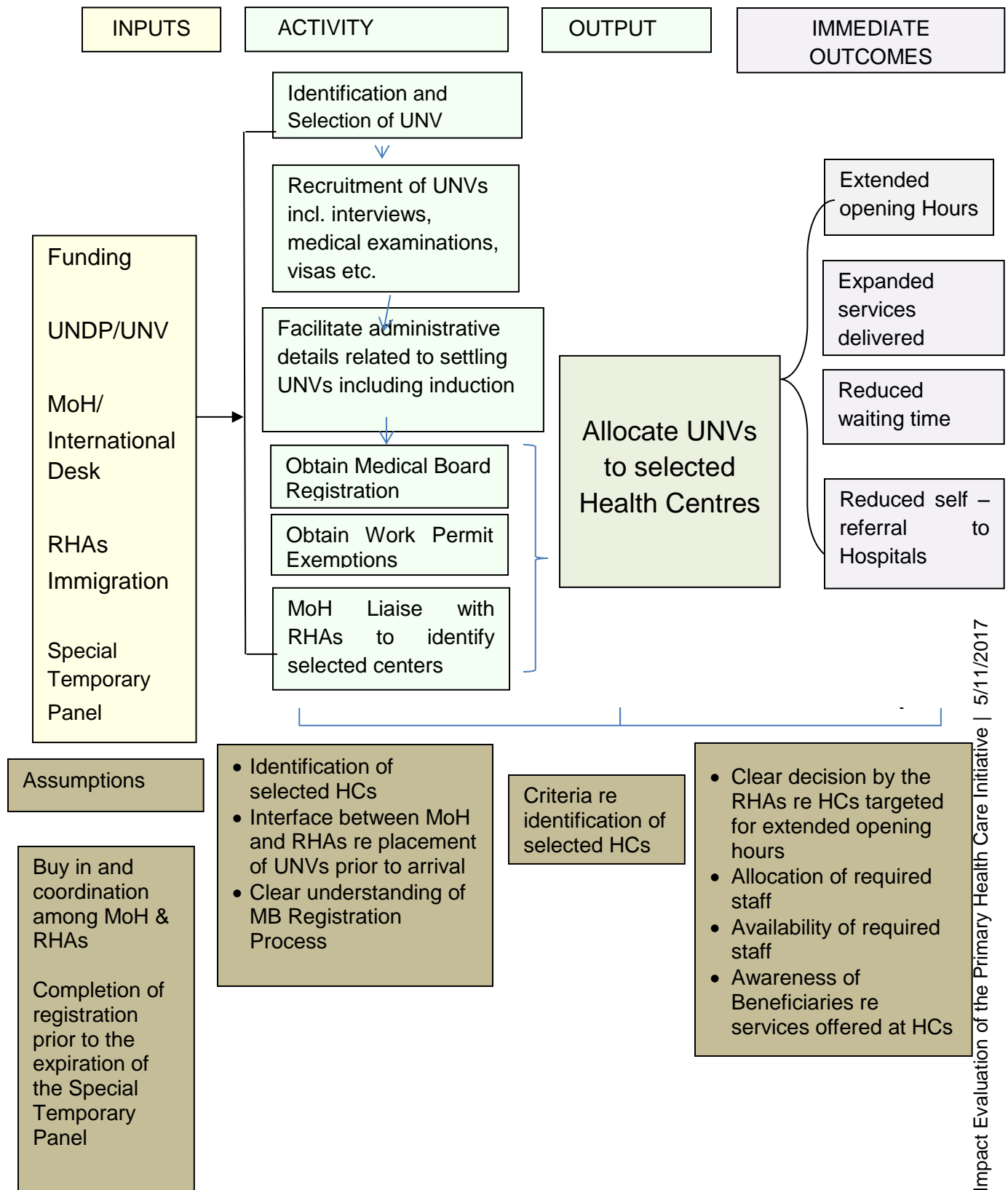
4.1.18 Evidence supporting the extent to which the assignment of UNV Doctors contributed to extended hours of service provision at primary health centres was not available. Further, no information was collected on the reduction in wait times at the centres in question. It is important to note here, that the allocation of UNV Doctors was not sufficient to support extended hours or additional services since related ancillary staff would also have had to be assigned. Further, in some cases, UNV Doctors were left to operate independently when PCP IIs were not assigned.

4.1.19 No information on reduced self-referrals to the Regional and General Hospitals was available. On the contrary, UNV Doctors noted the need to refer patients for services that could have been performed at the health centres if the required diagnostic equipment was available, including basic blood tests and X-rays. The expressed intention¹⁸ to equip targeted health centres with basic diagnostic equipment may have facilitated less referrals and more effective follow up care.

¹⁷ Informal Feedback revealed that the former CMO discussed the identification of underserved health centres with the RHAs however, there was no follow up submission by the RHAs.

¹⁸ See Medium Term Policy Framework 2011-2014 op cit.

Exhibit 4.1 - Primary Health Care Initiative-UNV Logic Model



Finding 5: The project design may have underestimated the need to include an orientation period for UNV Doctors to support their acclimatization to the nuances of the T&T culture, policies, procedures and protocols of the local health system.

4.1.20 One of the key issues that emerged during discussions with key informants as well as UNV Doctors was the need for an orientation period by the Ministry of Health of 1-2 months to acclimatize UNV Doctors to all aspects of the health system in Trinidad including policies, procedures and protocols. In addition, UNV Doctors need to be acclimatized to Trinidad's slang and culture. The UNV facilitates a preliminary session on culture and life in Trinidad and Tobago and the MoH was expected to provide an orientation for UNV Doctors, however, this latter arrangement was not realized. The MoH indicated that due to the arrival of individual Doctors, rather than a group, one-on-one orientation was not possible. This assertion is questionable, given that orientation could have been organized by assigning UNV Doctors to observe the practices, protocols and procedures at any number of health centres while they awaited their approvals to work. The following feedback is illustrative:

“ I requested an orientation about the local regulations, medical malpractice laws and the like but I was told there was none, but that the office will arrange for one, but it was many months later, and wasn't necessary anymore as we were already working and had gotten the hang of it. I took it upon myself, and the other doctors waiting for their papers to visit one of the health centers being served by an IUNV doctor to get an idea of the working situation. I do not know how the earlier IUNV doctors coped without an orientation¹⁹”

4.1.21 Feedback from several key stakeholders also supported the need for some orientation of UNV Doctors as well as other foreign health professionals, prior to them assuming duties at local health facilities. One Senior Doctor noted, that while many of the UNV Doctors would have had experience in dealing with emergency situations in war zones, they would also have been working with basic technology and were therefore less familiar with the equipment at the District Health Facilities, Regional and General Hospitals. An orientation period would also involve training them to use unfamiliar equipment, particularly in Accident and Emergency (A&E) Departments that require quick response times.



DR IVAN RIZANO OKLSWANDI ATTENDS TO A PATIENT AT ARIMA HEALTH FACILITY

Finding 6: Recent data from the Health Sector Planning Division as of 2016, suggests that there are a large number of vacancies for Primary Health Physicians specifically at the South West RHA and District Health visitors across all RHAs. Any future intervention should focus on the DHVs and other ancillary staff, and secondarily Doctors, given the challenges related to the registration of UNV Doctors to date.

4.1.22 Exhibit 4.2 details approved posts and vacancies by Regional Health Authorities based on the data received from the RHAs up to 31st December 2016. Taking into account Acting positions, the largest number of vacancies (without bodies) appears to be for PCP I (39²⁰) and PCP II (26) in the South West RHA. In addition, there appear to be significant vacancies for District Health Visitors across each of the RHAs, particularly North West RHA (32) and Eastern RHA (17).

4.1.23 The oversupply of Doctors suggests that variables other than a 'shortage' may be the cause²¹ of existing vacancies. Further, apart from DHVs, there may be shortages in other support staff. The 10 year Health Sector Manpower Plan -expected to be completed by April 2017- should inform any intervention in the area of human resources to support the performance of the Health system. However, data is only one component. A key informant suggested the need to do a comprehensive study of the social determinants of health as an input to a community based health programme. Such a programme might require the following human resources:

- *Diabetes educators* – many lifestyle changes are needed in managing diabetes that require time spent educating patients which doctors simply do not have
- *Podiatrists* – good foot care is extremely important, especially in diabetes mellitus, to help curb the high number of amputations we face in the nation

²⁰ Subsequent feedback from the SWRHA indicated that 40 Doctors were hired in the First Quarter of 2017. Whether these Doctors were hired to fill these positions needs to be confirmed.

²¹ The Consultant contacted the SWRHA for feedback on the issue of vacancies; however no further information was communicated.

- *Social workers*– many social cases are encountered including cases of abuse and indigence, which medical and nursing staff are unable to deal with, but which impact significantly on health
- *Physiotherapist* – having physiotherapist in the community can aid from the most minor of limb traumas to severe conditions while alleviating the situation in hospitals
- *Fitness instructors* – it is time we invest in sessional instructors so we can show patients by example how to exercise and increase their fitness levels
- *Dieticians* – diet affects a great number of illnesses; we still do not have sufficient of these resource personnel in the system

4.1.24 A community based programme might provide a better context for a UNV intervention and could be developed in partnership with the Pan American Health Organization, the UNDP, the MoH and the RHAs.



DR. SAMWARIT GEBREMARIAM. AT THE ROY JOSEPH HEALTH CENTRE, SAN FERNANDO

Finding 7: The overall project design and its related objectives may have underestimated the implications of structural dysfunctions in the health sector, including the under-performance related to Doctors simultaneously practicing in the public and private sectors.

4.1.25 As discussed at Findings 2 and 4, the performance of interventions such as the PHI are likely to be compromised by structural dysfunctions within the Health system. These include:

- a) The general acceptance, historically, of Doctors practicing in the public and private sector, simultaneously. Doctors, as with all employees are recruited based on terms and conditions that include working an 8 hour work day. However, as there is no legislation or regulations specifically disallowing the practice, many local Doctors also conduct a private practice. This means that they are rarely present for more than 3 to 4 hours at health centres as they must also see patients at their private practice. As such, although they are remunerated for a full (8 hour) workday, the majority of Doctors are not available at the health centres for that period. This issue is a significant contributing variable to ineffective service delivery in the health system. Further, it is essentially a performance management issue. That is, Doctors, at all levels must be held accountable for poor performance, including penalties for absences from the workplace. Unless this problem is addressed, interventions such as the PHI will have limited success;
- b) Another issue is the Ministry of Health's reluctance to cede control to the RHAs for overall management of the Health system. As part of the Health Sector Reform implemented in 1994, the MOH no longer exercised operational responsibilities and was solely responsible for policy making and vertical programmes. The management of health service delivery, including recruitment, was allocated to the Regional Health Authorities. Despite this, the MoH continues to be involved in operational issues. This programme may have been more effective if the overall development and implementation was coordinated between the UNDP and the RHAs. The establishment of a focal point in each RHA to coordinate the programme would have helped to streamline project administration and overall communication.
- c) Registration to practice with the Medical Board of T&T. The Special Temporary Panel was established to address the deterrents established by the Medical Board of T&T to prevent the registration of non-nationals during the industrial relations crisis of 2003. The intent of the PHI was to ensure the registration of all UNV Doctors prior to the expiration of the Special Panel in June 2015. However, due to the delays in project development, recruitment (ostensibly due to the challenges experienced in obtaining local doctors to sit on the interview panels) and financing, the majority of UNV Doctors did not assume duty until late 2014 early 2015 and just half of the doctors were in fact able to be registered under the Special Panel. When the panel's life expired, non-nationals were required to seek registration via the Medical Board of T&T. However, non-nationals must meet the eligibility requirements of the MBTT including, certification by 'traditional schools'²² if Doctors are to be assigned 'full registration' and permission to practice in the Health Centres. This presents a problem for

²² See Appendix 6

the UNV Doctors project, particularly any future iteration of the project. Technically, the MBTT reports to the Minister of Health, therefore some negotiation of the registration process should be possible. The Chief Medical Officer also chairs the MBTT. The extent this issue is resolved will depend on the 'will' of all parties concerned.

- d) Limited diagnostic equipment in health centres; The provision of a higher level of health services at the health centres means that at least basic diagnostic equipment is allocated in addition to the technical staff. The goal of reduced referrals to the General and District Hospitals requires that basic lab tests (blood tests) and x-rays machines are available. Such equipment will support a more effective diagnosis and efficient treatment of the patient. Despite the GORTT's stated strategy to equip health centres to enable diagnoses without referral to specialist and other clinics, only district health facilities have been so equipped. Unless this issue is addressed,
- e) Availability of ancillary staff: The project's design aimed to support extended opening hours. However, unless additional support staff was available, extended hours would not have been possible. This issue needed to be discussed with the RHAs and developed as an implementation objective.
- f) Weak communication/coordination system across primary and secondary levels of health care: One of the Government's stated objectives was to promote an integrated approach to health service delivery to ensure continuity of care from primary to secondary and potentially tertiary care. That said, systems have yet to be implemented to ensure coordinated care across the system. The lack coordination is a clear challenge to effective service delivery.

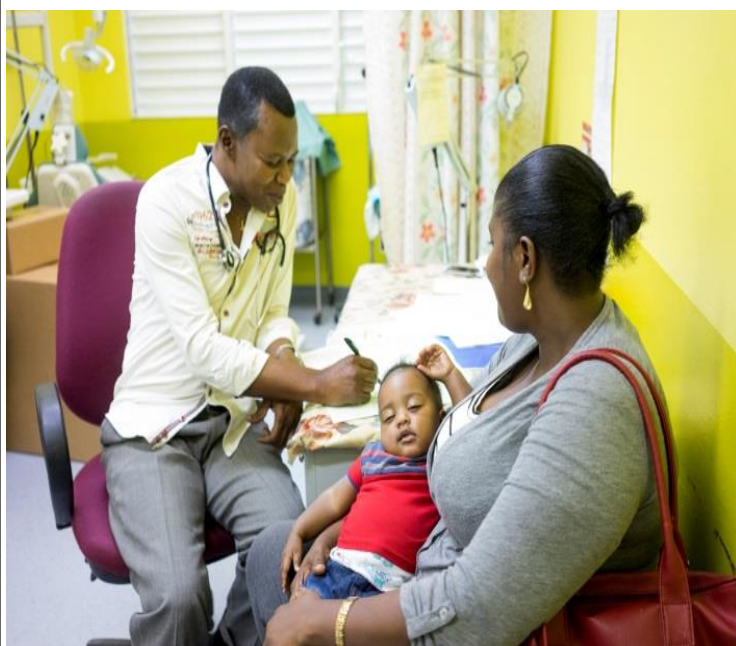
Several of the aforementioned issues are further discussed under the implementation effectiveness and project administration section of the report.

4.2 Project Impact/Results

4.2.1 This refers to the positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended. This involves the main impacts and effects resulting from the activity on the local social, economic, environmental and other development indicators. The examination should be concerned with both intended and unintended results and must also include the positive and negative impact of external factors. When evaluating the impact of a programme or a project, it is useful to consider the following questions:

- What has happened as a result of the programme or project?
- What real difference has the activity made to the beneficiaries?
- How many people have been affected?

Finding 8: The UNV Doctors have made a significant contribution to patient centric care in the primary health system. Informal and formal feedback supports the high regard for the bedside manner and communication skills of UNV Doctors.



4.2.2 A significant result of the PHI was the general consensus that UNV Doctors provided excellent quality care, communicated effectively with patients, spent a great deal of time with patients and carefully explained diagnoses and treatment approaches. In particular, their tremendous work ethic was commented on by every key informant interviewed. Peers and colleagues noted the willingness of UNV Doctors to work in excess of the hours required when patients needed to be seen or paperwork to be completed. This informal feedback is supported by Performance appraisal reports, wherein the majority of UNV Doctors scored above average and outstanding.

DR. BONDEKE ATTENDS TO A PATIENT AT INDIAN WALK HEALTH CENTRE

Comments on appraisal reports included:

“Outstanding worker...an asset to any department”; “ Hard working Team Player, willing to go the extra mile”; “Skillful Doctor with pleasant personality, has adapted well and fits in with the team. I am also pleased with his bedside manner”. Even in cases where the skills of a UNV may have required improvement, the excellent bedside manner was considered to be an important asset. As one Senior Doctor noted, “...you cannot teach good bedside manner”.

4.2.3 UNV Field reports and documents also supported the finding:

“A supervisor at the Arima Health Centre made the following comment after observing 2 of our international UN volunteers after only 2 weeks: “They are polite, pleasant and willing to learn. I am somewhat more impressed with the skills [...and...] with [the] pleasant and humble personality.”

Additionally, the Eastern Regional Health Authority awarded one of the international UN volunteers with a certificate of appreciation which notes: *“I refer to an Expression of Praise and Thanks received from a client at the Guayaguayare Outreach Centre, eloquently expressing their gratitude for the exceptional customer service that was observed whilst at the facility...I am extending a Special thank you for your continued dedication and professionalism, which is applauded. In an attempt to tangibly acknowledge your perseverance and unswerving efforts in ensuring that our clients are consistently provided with the best quality of service, we award you [...] with a Certificate of Appreciation”²³*

4.2.4 UNV Doctors also shared several stories of positive interactions with patients:

“There was this Friday and I had this patient ...she brought her child to the health centre...her son was holding her to walk and she is just 38 and then I said, excuse me Anisha how are you doing, what is the problem with you, this is not usual, why are you walking like that and she said she had this weakness, so I said we need to investigate it...she said she went to hospital and they gave her ‘this’ even with the weakness and I said no come to the clinic let’s see what’s happening....I took a complete history and she said she had been to a chiropractor for her scoliosis and she also suffered a herniated disk...I referred her to the hospital and their tests showed her reflexes were fine so they sent the patient to do an MRI and you know what the patient had? A tumour and it was in the dura. The hospital asked who referred her and told her to go back and thank that Doctor because if she had come later and the tumour had spread nothing could have been done. They were able to resect the entire tumour...the patient came back to me and cried thanking me for saving her life”. (UNV)

4.2.5 UNV Doctors noted that patients often expressed their gratitude for the Doctors treatment and the time they took to explain their diagnoses and treatments.

“Anna, a 23-year-old patient at the Mayaro Health Centre stated the following about our UN Volunteer Doctor Emma Thompson: “She is kind, loving and understanding. If she sees something that is in your file that shouldn’t be there, she goes to check to find out why. She always puts you on the right path.” This was Anna’s second visit with Dr Thompson. She is very approachable. She

takes her time with the patients and explains things to the patients in detail, said Dr Thompson's colleague, Ms. Jackson, the District Nurse.

After visiting Mayaro Health Centre, the next stop was Tabaquite Health Centre with UN Volunteer Doctor Diki Wangyal. A two-time patient, Peter, 59 years old, stated that Dr Wangyal is "loving and explains to me about my visit and what needs to be done. I hope she returns. Ms. Alexander, District Health Visitor at Tabaquite Health Centre noted that she had "no complaints, only compliments" about Dr Wangyal, and that "she has been the only doctor in charge due to the vacations [of the other doctors.] The patients are very happy."²⁴.

4.2.6 Several UNV Doctors noted that patients often requested to see them specifically, regardless of the Health Centre system where patients are assigned to available Doctors rather than a specific Doctor. It is clear that the UNV Doctors have brought a much appreciated level of care and communication to the delivery of health care in Trinidad.

Finding 9: The Un Volunteer Doctors assigned to the Queens Park Counseling Centres at Port of Spain and San Fernando General Hospitals, respectively, facilitated a more human rights based approach (HRBA) to treating with persons diagnosed and living with HIV/AIDS. Doctors assigned to the aforementioned centres, noted the stigma and discrimination displayed by the medical staff and suggested the need for more education and sensitivity training of staff at the centres.

4.2.7 It is widely acknowledged that HIV-related stigma and discrimination in the health-care sector impedes access to services and impairs the quality of health-care delivery for people living with HIV and other key populations. It also undermines efforts to achieve the highest attainable standard of health for everybody.²⁵ As such, stigmatizing and discriminatory practices/behaviour to persons living with HIV and AIDS (PLWHAs) affects access to services through for example, the denial of health care and unjust barriers to service provision, inferior quality of care and a lack of respect, abuse and other forms of mistreatment. Although the project agreement did not specify any outcomes related to improving the service provision to PLWHAs, this outcome would have been implicit in the GORTT's strategic objective related to effective and efficient delivery of quality health care. In this regard, the UNV Doctors have made a significant contribution given their compassion and interest in the wellbeing of PLWHAs. The following testimonials are enlightening:

²⁴ UNV FU Field Mission Report and UNV Newsletter 7th October 2015

²⁵ http://www.unaids.org/en/resources/presscentre/featurestories/2015/november/20151113_healthcare

"...I work in an HIV clinic and it is interesting to note the amount of stigma and discrimination in this country...if you have HIV and test positive, to them that is not a disease of Trinidad, you are supposed to be put in a different country...so you find even the local doctors here don't want to work in the clinic for HIV because they feel they will get contaminated by those patients, but I think it is also based on the stigma attached to the clinic, they don't even want to work there, but for the patients who are infected and affected, they appreciate that service and they need that help. So in specific specialized areas, they are lacking and they probably don't understand how the lack comes about..." (UN Volunteer Doctor)

"In my clinic (QPCC), many patients come from Tobago, not because there are no doctors, but the service is not available...the local doctors don't even want to come and touch these patients, and the people up there feel that is a sickness of those poor guys in Laventille and Morvant, nobody cares...right now there is a backlog of tests for three months all because a very cheap reagent is unavailable...they are not employing enough technicians to read the backlog of tests and it is very disheartening...the stigma and discrimination here is really bad" (UN Volunteer Doctor)

"My supervisor feels like the UNV Doctors are the backbone of the clinic, she says "I don't want to lose you guys, you are the ones who really work here...but the clinic has 7 doctors and instead these doctors wanted to add even more UN doctors...most of them want to coast through the system to become Registrars because they believe that is less work and they don't have to see patients" (UN Volunteer Doctor)

4.2.8 The need to proactively address the level of stigma and discrimination in the health sector should be a priority for the MoH and could potentially be a niche opportunity for the UNV programme in Trinidad and Tobago.

Volunteer in Action: Dr John Kimani

"Ward 2 clinic of San Fernando general hospital in Trinidad and Tobago is hard to find. The clinic is located in an old, dilapidated, Victorian building dating back to the pre-colonial era - a far cry from the 12 story ultra-modern San Fernando Teaching Hospital building next to it. This is the infectious diseases clinic where HIV/AIDS is managed."

"Several stories could be told on everyday events, like the story of a 36 year old Trinidadian lady of Christian background, single, with no children. After being diagnosed HIV positive four years ago, she immigrated to USA escaping from social stigma and isolation. She returned to Trinidad after she fell ill. She came to Ward 2 where we counseled her to the best of our abilities where she was also able to attend the clinic with other patients without any form of disguise. She is now progressing very well and even brought her new partner to the clinic for testing, a testimony to newfound love and determination to live."

"An even more amazing story that caught my attention was a 19 years old girl that acquired HIV prenatally (at the time of birth). Despite all the setbacks she has suffered in life, she is in good health, looking forward to attending college to become a clinical psychologist. And like any other young brilliant ambitious Trinidadian teenage girl, Anil dreams of finding love, settling down and raising a family. Her positive attitude can guarantee all!"

UNV Newsletter

Finding 10: From the perspective of the UNV program, the project has also contributed to planting the seed of volunteerism. The UNV Doctors have made a significant impact on the degree of community outreach activities within their respective communities and support provided to key partner institutions.

4.2.9 The project's results framework does not specifically mention the 'promotion of volunteerism' as an objective of either the project or a measure of project success. However, the project document details the benefits of the UNV approach: "Assignments are characterized by the spirit of solidarity, cultural sensitivity and capacity building embodied in a volunteer ethic...UNV assignments strategically aim to foster programmes of community outreach, promote the volunteer ethic and train counterparts to ensure UNV inputs are sustainable in the long term"²⁶.

4.2.10 Further, the UNV Description of Assignment includes as an expected result: "... a final statement of achievements towards volunteerism for development during the assignment, such as reporting on the number of volunteers mobilized, activities participated in and capacities developed"²⁷". Each of these implies that the UNDP/UNV also assesses the promotion of volunteerism as a key objective of programme effectiveness.

4.2.11 Although little official documentation was available to summarize the outreach interventions that UNV Doctors conducted on a voluntary basis, the UNV Field Office was able to document interventions based on informal feedback from UNV Doctors and formal requests from Ministries. Generally, UNV Doctors were instrumental in conceiving and implementing several programmes over the period. Two significant interventions are noted here:

Sports to Fight Childhood Obesity²⁸: Research done in different areas of Trinidad and Tobago revealed that one in four children are overweight in the county of St George, and one in three in South Trinidad. Since then, the Regional Health Authorities have taken matters in their own hands to help support children and provide them with different avenues to deal with weight management. For instance, the Roy Joseph Health Centre, where international UN Volunteer Dr Samwarit Gebremariam (Eritrea) has been placed since November 2015, saw an increase in the number of obese children in their daily clinical sessions. Because of this, the Health Centre implemented an exercise programme in July 2016 to coincide with the Olympics. This initiative targeted eight primary schools in the San Fernando area of South Trinidad, where the prevalence of the problem is high. Ten to twelve students from each school who were deemed to be obese based on their body mass index (BMI), measured at the start of the initiative, were selected. The Roy Joseph Health Centre received funding from the Ministry of Health to purchase cricket bats and balls for each school participating in the research, and collaborated with the physical activity instructors to ensure that every child in this programme was playing cricket for at least 1 hour and 30 minutes every day. Parents and their children, along with nutritionists, doctors and physical activity instructors have all come on board with this initiative doing their part to promote healthier lifestyles. The project is aimed to run for a 4-month period whereby the BMI will be re-assessed in October and compared to the measurements taken in June to examine the changes. International UN

²⁶ Primary Health Care Initiative Programme Agreement, pg. 6, paragraph 4.

²⁷ UNV Description of Assignment

²⁸ Published on UNV (<https://www.unv.org>)

Volunteer Dr Gebremariam, who is helping to implement this initiative by tracking the children's BMI, stated that *"I believe it is one of the best initiatives taken in the primary health sector because cardiovascular diseases have become the highest rate of death in Trinidad & Tobago, more so than in the US and Canada. With the main leading cause for these illnesses being obesity, if we can fight it since early ages it will show a remarkable reduction"* .

Project to assist in the instructional support and approaches of people with Autism: Autism spectrum disorder (ASD) manifests in early childhood and is characterized by qualitative abnormalities in social interactions, markedly aberrant communication skills, and restricted repetitive behaviors, interests, and activities (RRBs). In Trinidad and Tobago, there are 500 families registered with the Autistic Society of Trinidad and Tobago (ASTT), a non-governmental organization, but extrapolating international data of 1 in 68 children, there would be a few thousand individuals on the autism spectrum. In Trinidad and Tobago, there are limited facilities that cater to the needs of those living with autism spectrum disorder. The Therapeutic and Life Skills Centre, located in Point Fortin, is a centre that offers targeted education and training for those living with autism spectrum disorder. The Centre was established in November 2003 and accepted its first student in January 2004. Since then it has expanded its enrollment to more than 15 students with ages ranging from 3 years to more than 20 years of age. All of the teachers receive training in autistic care through the Autistic Society. Consultation with the head of the school revealed that there were many needs, which included a new building for the school and a bus to aid in the transportation of students. They also needed equipment to enhance the learning environment which includes benches and chairs for the younger students, sensory educational toys and a laminator machine. This project was directed towards individuals with special needs in the community, and provided:

- Provision of tables and benches for children between the ages of 3 and 10 years
- Provision of Sensory educational toys (See Appendix 1)
- Provision of Laminator machine (to aid in the production of learning materials which are made by the staff of the school)
- Mentoring mothers/audience on Autism and volunteerism

Apart from the UNV Doctors, a local Doctor also participated in the project. The intervention was well received by both Parents and Educators.

UNV Doctors also participated in a range of activities in their respective communities including outreach activities at Santa Rosa, Tabaquite and other communities. In addition, the UNV Doctors were commended by civil society organizations and governmental agencies such as the Ministry of National Security based on the ready support provided to these communities.



UN VOLUNTEER DOCTORS PARTICIPATE IN OUTREACH ACTIVITIES



DR. LUIS VEDOR PARTICIPATES IN UN DAY ACTIVITIES



DR MOHAMMED DARWAISH AT TABAQUITE OUTREACH ACTIVITIES

4.2.12 Several other projects were proposed including (i) Support to the Queens Park Counseling Centre scale up STD and HIV information and testing services to key populations and (ii) Promotion of Volunteerism by supporting local health teams and the community through ICT for on-job-training as well as health education and promotion. However, the anticipated support from supervisors and/or colleagues was not readily available.

Finding 11: Mixed views were expressed about the extent to which the project contributed to some transfer of knowledge and skills and learning by the UNV doctors.

4.2.13 On the one hand, several Doctors acknowledged that their overall experience has been good and they have shared their knowledge and skills and learned from their Peers and Senior Doctors. Several UNV Doctors noted that the Trinidad experience was their first as a UNV and they had learned a great deal, especially in the Accident and Emergency (A&E) Department. Further, the prevalence of chronic non-communicable diseases in T&T constituted a good learning opportunity for those UNV Doctors who had not dealt with this prevalence.

“My third assignment (2014) was as a UNV Medical Doctor in Trinidad & Tobago, working as a Primary Health Care provider in the remote Tabaquite Health Centre, catering to the poor rural community. This health centre was a Chronic Disease Clinic for diabetes, hypertension, asthma, and a Mother and Child health care centre. Thanks to these volunteering experiences, I was able to provide satisfactory and quality health care services to the needy, poor and sick, especially women and children in remote areas. Volunteering gave me the strength to accept the things that I could not change in different and difficult environments, and to share my skills with colleagues and unit staff so that we, as a team, could provide better and quality health care services to the less fortunate sections of local communities, hence marching towards fulfilling the SDGs. Through these volunteer assignments I am now thoroughly experienced with diseases like malaria, HIV/AIDS, tuberculosis, diabetes, hypertension, and asthma. Volunteering gave me international exposure, with travels to different countries where I met people from different ethnic and cultural backgrounds.”(UN Volunteer)

4.2.14 On the other hand, several UNV Doctors also noted that they were often placed in situations where they felt their training and knowledge of the ‘right’ procedure, was being compromised. One of the contributing causes to this issue was the requirement to treat patients within 5 to 15 minutes. UNV Doctors were unanimous in their disappointment and disapproval of a system that prioritizes quick turnover of patients over quality care. The following are instructive:

“We see them according to their condition...so if you come earlier you are not a serious case you may wait longer...but here they have this rule that you have to see a patient in 5 to 10 minutes, which I don’t totally agree with...patients when they come you don’t just treat upon their diseases but you need to deal with them holistically and most of these chronic patients they need to be counselled in terms of everything so it is not like rationing ...giving them 2 minutes and sending them...I

was called out by my supervisor and told that I take too long with my patients and it was one of my colleagues who complained that I took too long...and the funny part was that she never even stayed in the afternoons...I was the one who always stayed by myself until four...It does not make sense to me to finish at 12 and go home”(UN Volunteer)

“Look let me tell you, here a patient that came to (health centre name) with a vaginal discharge, she said she felt as if something was dead inside her, she was complaining because she had this offensive discharge...she was in her late 20s and I asked if she was seeing any Gynaecologists and she said she had been seeing doctors for this reason for 7 years...and nobody ever did a PV examination or anything...they were like ‘you have this’...so I let her lie down and I examined her and her cervix was totally irregular on my fingers, so I took her to another room and I used my speculum and light, the whole cervix was gangrenous, it was smelling bad so I immediately referred her to the oncology clinic...so if you don’t give time to your patients...we know how they deal with them...”(UN Volunteer)

“Some patients tell you about the doctors here...they say sometimes before you enter the room they start writing prescriptions...you see here people don’t explain, that is also another issue, I told them of course I need to explain to my patients that ‘this’ is what you are suffering from and this is how we are treating it...do you have any questions...this will not take 5 minutes...where in medical school you will go and see a patient for five minutes...I told them I am not going to do that...I will take my time and see me patients properly”(UN Volunteer)

“If you are not clerking patients properly and not doing examinations, you lose your clinical skills...it is not all about investigations, I told them 90% of the diagnosis is from the history you do...I cannot come and take bad habits...you want to follow your education...we need to be doing things properly!”(UN Volunteer)

4.2.15 The preceding suggests that there are negative practices in the local health system that need to be addressed to ensure the delivery of a high quality of health care. Informal feedback from senior health professionals indicated that the requirement of adhering to the 5-15mins per patient was an effort to reduce waiting time. However, other variables need to be assessed to improve wait times including re-engineering processes and procedures to improve overall efficiency.

Finding 12: A positive unintended outcome has been the growing awareness of patients regarding the type and standard of services they should expect from GPs at the Health centre.

4.2.16 Informal feedback from the UNV Doctors indicated patients were very satisfied with the quality and care of UNV Doctors:

“If we are talking about the impact of UNV Doctors, especially in the periphery, I would say we have made a big impact in terms of quality of care, the time spent with the patient, the physical examination and diagnosis...for example sometimes clients ask “what are you doing, I did not complain about that” but we try to do a general check- up...the client is used to being asked only about his specific complaint” (UN Volunteer)

“During the early weeks of my stay in the village health center, it was very difficult. Most of the patients with chronic conditions (hypertension, diabetes etc.) weren't managed properly, the former doctors in the health center come from other health centers who were obliged to spend a day in Cedros, and because of transport problems in the afternoon, they want to go home before the workday ends. As an example, Mr. A, a hypertensive taking metoprolol once a day was still maintained on metoprolol for many months to years even if the resting blood pressure is high. The previous doctors just write down their prescriptions based on their file, without even seeing the patients. I had to review their histories, examine and modify their medical management. I sometimes have to spend 15 minutes to a half hour per patient during the early months, and many patients waiting were angry at me. They just want their repeat maintenance prescriptions and want to go home as soon as possible. Many complained at the slow pace of work. However, later they became thankful when they see their BP or blood sugar going down. Or when a Specialist sees them (I referred many to specialists, like ophthalmologists for their diabetic retinopathy).”(UN Volunteer)

4.2.17 UNV Doctors noted that because they made every effort to ensure proper patient histories were completed, perform physical examinations and explained both their diagnosis and treatment options, patients now had an expectation of a higher quality of care. *“Now clients know all these things need to be done and they will ask, before they don't know that...sometimes you go to a Doctor's office and his face is so straight, he does not say hello or good morning” (UN Volunteer)*

Finding 13: UNV Doctors have contributed to filling the gap related to Health Centres that did not have daily availability of a General Practitioners and/or the required allocation of Doctors. These included Cedros, Moruga, Tabaquite and Indian Walk, among others.

4.2.18 The project's rationale was predicated on an assumption that the reason for vacancies in the primary health sector was a shortage of primary health physicians. As a result of these vacancies, several health centres, particularly those in the rural areas, did not have the services

Exhibit 4.3 Sample of PCP Attendance At Rural Health Centres in Trinidad and Tobago (February 2017)²⁹

Community Health Centre	PCP Attendance	Comments
Blanchisseuse	Doctor on site on Tuesday (walk in Clinic) and Friday (Chronic Disease)	Any Emergency cases are sent to Mount Hope
Brothers Road, Tabaquite	Mon. to Friday (8-4) and Saturday (9-5) and Sunday (9-2)	
Cedros	Tuesday and Thursday Walk In: Monday and Friday. Clinics	No Doctor on Wednesday
Cumana	Monday, Thursday and Friday	
Grand Rivere	Tuesday (Immunization and Anti natal)and Thursday(everything) Mon-Fri General Practitioner from 4pm-8pm	Consistent with website info. However, website does not give afternoon opening hours
Guapo	Monday and Friday (8-4)	
Guayaguayare	Mon-Fri 8-4 and 4pm-8pm	But generally leaves by 1.00pm The doctor on the later shift remains for the full period
Icacos	Tuesday- Child Health, Ante Natal, Pap Smear, Family Planning, Health Office / Chronic Diseases Clinic, Phlebotomy, Dressings, Public Health Inspector Men's Health Clinic (last Wednesday of each month)	No PCP on Monday, Wednesday, Thursday and Friday.
Las Cuevas	Integrated clinic Monday and Wednesday	No PCP on Tuesday, Thursday and Friday

of a PCP I on a daily basis. Exhibit 4.3 details a small sample of 'rural' Health Centres. Only two (2) of the nine (9) centres identified reflected daily attendance of a PCP, that is, Guapo and Brothers Road Tabaquite.

4.2.19 As noted earlier, one of the issues appears to be the reluctance of local doctors to service these Health centres, rather than a shortage of doctors. One key informant noted, *"We have 10 doctors assigned to Health Centres in St. Patrick and only three are local, the rest are Cuban, Indian and UNV Doctors...we have had Doctors resign when we say we need you to go Cedros for a couple of months"*. The Evaluator did not review any documentary evidence supporting the aforementioned assertion.

4.2.20 One key informant suggested that if the underlying issue was the reluctance of local Doctors to service rural health centres, a financial incentive could be provided to compensate Doctors for the wear and tear on vehicles due to traversing the poor roads and long distances.³⁰ This bears consideration, if in fact the issue is reluctance to service rural centres. In addition, local doctors assigned to the Health

²⁹ The Consultant conducted a telephone survey enquiring as to the days a Doctor is in attendance at the Health Centre,

³⁰ It was estimated that the daily journey to Icacos from San Fernando was 200kms both ways.

centres should abide by the same management protocols of foreigners, including application for leave when absent from work.

Finding 14: The weak communication between the Ministry of Health and the Regional Health Authorities resulted in a limited understanding of the PHI's objectives. In the case of the Eastern Regional Health Authority, the most consistent demand and placement of UNV Doctors was noted, however they were not allocated to health centres as intended.

4.2.21 The lack of coordination between the MoH and RHAs contributed to delays in assigning UNV Doctors to selected centres. The assignment of nine (9) Doctors to the Eastern Regional Health Authority, with the majority providing services at the Arima Health Facility, rather than rural health centres indicated some level of misunderstanding and/or miscommunication about the intent of the programme. When asked why the ERHA was the most responsive to accepting UNV Doctors, the response was that there was always a need for good physicians and the services of UNV Doctors was not financed by the RHA's budget.

"I always thought, through medical school, that UN Doctors were sent to places with poor resources so I was not clear why they were sent here in particular..."(Local Physician)

"What happen is all of a sudden we were sent doctors from Cuba and the UN...we did not know what the rationale was behind it...and we wouldn't refuse Doctors and the RHAs were happy to have them because they were not paying for it" .."(Local Physician)

4.2.22 The foregoing suggests the need to involve a key stakeholder such as the RHA during project development. In fact, as recruitment and management of the health system is the mandate of the RHAs, as noted earlier, a more direct interface with the RHAs may have supported more effective project implementation, including more streamlined administration and monitoring of UNV Doctors.

4.3 Implementation Effectiveness

4.3.1 This is the extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance. Also used as an aggregate measure of (or judgment about) the merit or worth of an activity, i.e. the extent to which an intervention has attained, or is expected to attain, its major relevant objectives efficiently in a sustainable fashion and with a positive institutional development impact. To reiterate, the primary objective of the project was to recruit 30 medical professionals to work in regional health centres to provide care and support to the citizens of Trinidad and Tobago over a 3-year period. This intervention was expected to contribute to (a) efficient and effective health care delivery; (b) increased access to health care services and (c) reduced labour shortages within the health sector.

Finding 15: Overall, the project delivered on its primary output regarding the selection and recruitment of 26 UNV Doctors. The evaluation suggested that improved geographical access was evident in rural Health Centres such as Cedros and Tabaquite due to the assignment of UNV Doctors. However, the extent to which these benefits are sustainable is questionable, given that the SWRHA continues to experience challenges related to allocating health sector personnel to these rural centres.

4.3.2 According to the project document, the primary output of the project was the recruitment of 30 UNV Doctors. The baseline indicator was “pre-selected primary health care facilities identified for weak health care delivery due to shortage of health care professionals”. The anticipated target was “fifteen percent (15%) increase in utilization of primary health care facilities with extended opening hours”. As noted earlier under the Project Design section of the report, no criteria was developed for selection of the targeted Health Centres. Further, no baseline data was collected to measure the increased utilization of PHC facilities with extended opening hours. As such, a definitive conclusion on the effectiveness of the intervention cannot be made. On a positive note, the project successfully selected and recruited twenty six (26) UNV Healthcare Professionals.

4.3.3 The challenge related to allocating staff to rural centres was discussed earlier. As such, one can conclude that the assignment of UNV Doctors to previously underserved rural centres significantly improved access to primary health care services in these centres. On a daily basis, UNV Doctors performed the key functions as follows:

“I worked from 8:00 a.m. to 4:00 p.m. with a break. I had a room to examine the patients with the necessary material, the patients were previously seen by the nurses who completed a file and then we performed a more thorough clinical examination. As a general practitioner, my usual tasks were to perform the examination of the patient, complete the clinical history, request the complementary studies, perform a diagnosis and a treatment, in case it is not within my reach to make the referral of the patient to the appropriate service” (UN Volunteer)

4.3.4 According to the UNV Field Unit assessment, "...each one of our international UN volunteer doctors sees on average approximately 36 patients per day which is approximately 180 patients per week per doctor which in turns translates to 720 patients per month per doctor. In total, through the primary health care initiative, our international UN volunteer doctors have attended to over 190,000 patients in one (1) year."³¹ In fact, this may be an underestimation since the numbers also vary by clinic. UNV Doctors self-report reflected the following: *"Average number of patients seen per day: San Fernando (40) Indian Walk (60), Point Fortin (80). On Chronic disease day there may be 160 patients so 60 to 80 per doctor. The Point Fortin clinic is really big so it is split into two clinics... Tabaquite (40 to 50)* The average number of patients seen by UNV Doctors stationed at the A&E Department may be around 10 to 12, however, a Doctor might spend as much as an hour on a particular case depending on the situation (gunshot wound, heart failure, stroke, severe asthma attacks) Three to five doctors may see an average of 150 patients per shift.

4.3.5 Volunteers also worked beyond the hours of their local counterparts. *"If it is 5 days a week, I don't think that it is being manned by a local doctor five days a week...if it is that they do come every day, they are certainly not there for 8 hours...try to have back stopping through two UNV Doctors at the same centre"*(Key Informant)

In addition, UNV Doctors also provided services to other institutions such as District Health Facilities:

"I had great experience at my assigned post. I am a Paediatrician by training. I was assigned to a district health facility which had a pediatric unit and there was no Paediatrician at the facility. Again, not because the country has a shortage of paediatricians. The reason was that there was no vacancy for a Paediatrician at the health facility but because I was a volunteer they happily accepted me to work at the health facility which according to me needs the presence of Paediatrician. They wanted me to stay on for as long as possible offering my services as paediatrician at the same facility yet there local doctors, some paediatricians who were willing to work at the same health facility" (UN Volunteer)

4.3.6 UNV Doctors generally agreed that if the doctors allocated to work at the Health centres worked for the stipulated 8 hours, the system would be much more effective. Many UNV Doctors noted that they were often hurried out of the centre before 4pm by support staff. This may be attributed to the culture of local Doctors staying a limited number of hours at the centres in order to service their private practice. One key informant noted that the UNV Doctors also fill the gap created when local doctors are not at the health centres for the full 8 hours. The clear downside though, is that a PHP I is required to be supervised by at least a PHP II. Therefore a PHP II must always be there to back stop the PHP I. However, this latter category is also in short supply based on the data submitted by the RHAs.

Finding 16: Despite the objective to ensure expanded opening hours, in successive iterations of the UNV intervention, centres were opened for additional hours only in instances where two doctors may have been assigned. Further, the lack of data regarding

centres with extended opening hours, since the assignment of UNV Doctors, means that a definitive conclusion cannot be made.

4.3.7 No evidence was available to assess the extent to which the project contributed to extended opening hours at targeted health centres. In fact the MoH and/or the RHAs should be able to state whether the health centres that UNV Doctors were allocated to, were able to offer extended opening hours. However, as at this evaluation, the UNV FU stated that they were not aware of any of the centres offering extended opening hours.

Finding 17: Challenges related to the overall weak management of the health system have contributed to frustration and disappointment of the UNV Doctors regarding the potential for the programme in Trinidad and Tobago. At the same time, the ability to work through these challenges was gratifying in a few instances.

4.3.8 Several UNV Doctors noted their complete disappointment with the functioning of the health system in Trinidad. Issues highlighted included:

- **Perception of competitors:** UNV Doctors revealed that they were initially perceived as threats by the peers. This made for a less than cooperative working environment. “We keep saying we are not here to take your jobs, we only want to help”³² On a positive note, the situation improved over time and the majority of UNV Doctors noted that the support of colleagues and peers has facilitated a pleasant and collaborative working environment. In fact, when asked to identify a high point of their experience, many cited the relationships developed with peers and colleagues.
- **Necessity of referrals to DHF or Hospitals for basic lab work:** One of the objectives of the PHI was to reduce the number of self-referrals to A&E Departments and the General Hospitals through the provision of access to the GP services within the community. However, due to the lack of lab equipment to run basic blood tests or X-rays, Doctors are required to refer patients to DHFs, Regional or General Hospitals. The need to refer patients to other facilities often compromised the quality of care provided, given the lengthy delays in obtaining test results, loss of results and the need to make a second request, no follow up information from the referring institution which affected continuity of care.

“...glad that we are trying to help the community, But I feel we can offer more than this...for me sitting in a community health centre is not very rewarding...what we can request for our patients is very limited in terms of labs etc...and most of the time we do not even get the feedback from the patient...we send them and it just disappears...we are the ones who try to communicate with them to find out what happened...if we had the resources at

³² UNV

the health centre we could provide more than what we are doing now....there is no continuity of care” UN Volunteer)

“We are just doing empirical investigations...sometimes when you send for lab results; you are waiting for six weeks, in six weeks sometimes you have to do your treatment without the results” (UN Volunteer)

“When you come here you expect to work on really underprivileged cases ...cannot make definitive diagnosis without some lab tests...sometimes we want to check the cbc, the cell count and for this we have to send the client to the DHF or the hospital...or to the private sector...the private sector is too expensive they cannot afford it...so when we send the patients for these tests they have to wait months...” (UN Volunteer)

“Basic things need to be done to improve the system...lab work need to be done quicker...sometimes they lose the results and then you have to make the requests again...for RFTs the wait time is even longer...I know I can always make a differential diagnosis, but I want to be sure...you have to use a high index of your clinical suspicion...if patient shows improvement in one week then you know your suspicion was correct...but it depends on what diseases you are seeing”(UN Volunteer)

- **Inability to utilize specialist skills, despite volunteering to support needs of the Hospitals:** With the exception of a few cases³³, UNV Doctors indicated that their specialized skills and experience were underutilized.

“We can do minor surgeries but in Trinidad they prefer that you refer the patient....eg. a woman went to the private sector for an episiotomy repair and was told it would cost \$8000.00..she then came to the health centre and I asked the nurse why we couldn’t simply do it here ...we have everything re suture materials and it is a simple procedure...Maybe our exposure to emergency situations makes us more open to performing these procedures, whereas here people are used to functioning in there specialised areas...” (UNV)

Two UN Volunteers revealed that they had sought permission to provide services at the General Hospital in the areas of Obstetrics and Gynaecology and Paediatrics, but did not receive any response. This was supported by feedback from a Senior Doctor who indicated that she had sent correspondence to the International Cooperation Desk about the possibility of assigning a UNV to the Paediatric Clinic, however she received no response. UNV Doctors noted that lacking the ability to practice in their respective areas of specialization weakened their clinical skills and also negatively affected their self-esteem. There was a general consensus that UNV Doctors should be allocated to areas in which their skills can be optimized. It must be noted here that UN Volunteer Doctors were recruited to serve as General Practitioners and were informed both at the stage of

³³ UNVs with HIV/AIDS background assigned to QPCC, UNV with Health Design training to Mount Hope Hospital, UNV with Public Health background assigned to Policy and Planning, etc.

the interview and in the agreement signed with the UNV. As such, the expectation that they could practice in specialist areas was groundless.

- **Perception of dysfunctions in the Health system:** UNV Doctors expressed dismay regarding the apparent limited emphasis of prioritizing patients for care:

“Last year I had this patient with renal problems so he was referred to Mount Hope for an echocardiogram...but Mount Hope said he could not have the echo until 2017 and the patient was so ill...I could not stomach that...I really did not understand that because that was a really urgent case...we need to prioritize patients” (UN Volunteer)

“I had a patient with rheumatoid arthritis and he was given an appointment in 2019...this is a person in pain...and the way they send them to the specialist clinic they just manage them and send them back to the centre...once these patients don’t improve they don’t have follow up care at the specialist clinics...and they come back to you and sometimes there is nothing you can do for them and you can only advise them to go back to the specialist clinic as there condition needs to be managed in that setting...”(UN Volunteer)

- **Lack of protocols and guidelines:** UNV Doctors noted the need for clear protocols and guidelines to treat with emergency and other situations. The need for guidelines regarding the prescribing of drugs and handling emergencies, especially in rural health centres where access to A&E services is limited. One UNV related the experience of an emergency situation in which staff of the health centre did not seem to know what to do. If protocols and guidelines and systems are not in place, they need to be developed and staff should be trained to handle basic emergencies.
- **Poor communication within the health authority and with key stakeholders.** All UNV Doctors suggested the need to improve communication within the RHAs as well as the Ministry of Health and the UNDP. They agreed that knowing the right channels to pursue issues was problematic and there were no clear guidelines regarding their roles and responsibilities or those of the RHAs/MoH. Asked to recommend improvements to the project, it was suggested that a document delineating the duties and obligations as well as privileges and rights between UNV and the host organization would be helpful.

4.3.9 The need for improved communication was echoed by Senior Doctors and other key informants. This experience also points to another issue regarding the rights of UNV Doctors in the health system and the need for support/representation if and when any legal issues arise. At present, there does not appear to be any medico-legal representation for UNV Doctors. As such, they must individually address any issues that may arise. Any further iteration of the programme, especially if it involves medical human resources must include systems to mediate any conflicts or grievances.

4.3.10 Overall, these findings suggest that there are issues that can be addressed cost effectively to improve integrated delivery of quality care as per the MoH's strategic objectives. These include, preparation of protocols and guidelines related to emergency care at Health centres, training of staff in protocols, equipping of health centres with basic diagnostic tools³⁴, and development of a feedback mechanism to Health centres related to patient referrals to Hospitals and to Specialist clinics.

4.4 Implementation Efficiency

4.4.1 A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results. Efficiency measures the outputs -- qualitative and quantitative -- in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted. When evaluating the efficiency of a programme or a project, it is useful to consider the following questions:

- Were activities cost-efficient?
- Were objectives achieved on time?
- Was the programme or project implemented in the most efficient way compared to alternatives?

Finding 18: The project appears to have been implemented in keeping with the budget allocation, based on informal feedback. An implementation schedule was not developed; therefore it is difficult to assess the implementation efficiency of key activities. That said, both the recruitment and placement processes were delayed by issues that the UNV/UNDP administrators had little control over.

4.4.2 The evaluation did not review or assess the project's financial data. Feedback from the UNV FU indicated that the project did not require any additional allocation and to date, all tranches have been received by the UNDP. The absence of an implementation schedule means that a definitive assessment of the extent to which project activities were completed according to specified timelines was not feasible. That said, the project experienced a series of delays due to factors outside of the control of the UNV FU or the UNDP. These are discussed under the project administration section of the report.

Finding 19: Based on a comparison of the compensation package with the Cuban Doctors, IUNV Doctors are more cost effective and present good value for money.

4.4.3 The UNV FU notes that the recruitment of an international UN volunteer Doctor costs the Ministry of Health approximately \$32,500TTD per month whereby it costs approximately \$45,000TTD per month to recruit a Cuban doctor, therefore saving the government approximately \$150,000TTD per doctor per year. In addition to the financial savings, UNDP/UNV organizes all the logistical aspects of a volunteer's placement, including finding appropriate housing, processing of health insurance, allowance payments, etc. The UNDP/UNV requires support from the International Desk of the Ministry of Health regarding issuance of Work Permit Exemptions liaising with the respective health authorities regarding placements of volunteers, provision of relevant paperwork to the MBTT and support related to establishing interview panels.

4.5 Project Administration

Project administration/performance assesses the degree to which a development intervention or a development partner operates according to specific criteria/standards/guidelines or achieves results in accordance with stated goals or plans.

Finding 20: The project management arrangements detailed in the project agreement were not implemented as stated. As discussed under Finding 4, a Project Board was not established and a Project Manager was not contracted. These deficiencies compromised effective and efficient implementation of the project.

4.5.1 According to the project agreement, a Project Board, comprising representatives of both the UNDP and the MoH was responsible for:

- Making decisions on major project changes
- Provide approval to move to different phases of the project
- Recommend to the Minister and Cabinet cessation of activities or injection of additional resources
- Oversee project Implementation on a quarterly basis via report/updates from project Manager
- Scheduling and convening of Project Board meetings on a quarterly basis

4.5.2 As such, the Project Board would have been instrumental in providing oversight of project implementation, as well as facilitate communication, coordination and collaboration among the key stakeholder agencies. Despite several efforts on the part of the UNDP to convene Project Board Meetings³⁵, a meeting has not been convened to date³⁶. The need for a Project Steering Committee was also emphasized in the 2007 Mid Term Evaluation³⁷; however, it appears that it was not perceived to be an important element for effective project management. It is instructive that the proposed agenda items for discussion were and continue to be persistent obstacles to efficient project management including:

- Addressing issues regarding international UN volunteer Doctors attaining registration from the Medical Board of T&T;
- Addressing the delay in placement of landed UNV Doctors and possible placement of recently landed international UN volunteer Doctors to health centres where existing Doctors may require relief;
- Decision by the Ministry regarding the recruitment of radiologists, bio-medical statistician,
- Up-scaling of the Primary Health Care Initiative

³⁵ See email correspondence between UNDP Programme Officer and Director, International Desk dated 9th March, 2016; 11th March, 2016, 15th March, 2016; 17th March, 2016, 12 April 2016, 13th April, 2016

³⁶ That is, prior to the submission of this report.

³⁷ The earlier UNV Programme

4.5.3 Similarly, the failure to contract a Project Manager also impacted project administration. Although the project document does not clearly state which agency was responsible for hiring the Project Manager, the role included the following tasks:

- Manage activities which are required to obtain project outputs;
- Provide direction and guidance to the Project Team/responsible parties;
- Liaise with the Project Board to ensure overall direction and integrity of the project;
- Responsible for Project administration
- Liaise with UNDP
- Prepare Annual Reports
- Management of project consultants
- Liaise with Government on financial matters

4.5.4 In the absence of a Project Manager overall coordination and management was weak. It is also important to note here, that many of the tasks assigned to the Project Manager were vague. A more robust project design would have elaborated on the tasks assigned and included a comprehensive implementation plan guiding project implementation. Further, as noted earlier, the project agreement did not clarify which agency was responsible for recruiting the Project Manager. Key informants have suggested that in any future iteration of this or a similar programme, a national UN volunteer could be procured to manage the programme.

Finding 21: The performance of the MoH was not consistent with stakeholder expectations. Although the project agreement detailed the role of each partner in project implementation, greater specificity of tasks may have contributed to more effective implementation. That said, informal feedback indicated that the tasks to be undertaken by the International Cooperation Desk of the MoH were clearly communicated to staff of the Unit.

4.5.5 Based on the Project Agreement, the MoH was responsible for:

- I. Obtaining and allocating resources for the project in a timely manner;
- II. Certification of annual expenditure reports prepared by UNDP
- III. Participation in Project Board Meetings
- IV. Participation in monitoring and evaluation of the project
- V. Collaborating with UNDP in drafting ToRs
- VI. Take responsibility for administrative arrangements within Government departments to facilitate working arrangements for project personnel

4.5.6 While (I) to (V) appear to be clear, VI may have required some elaboration. Feedback from the UNDP/UNV indicated that their understanding was that the MoH would be responsible for the following:

- Liaise with RHAs to inform them of the project and its purpose and work with the RHAs to identify regional health centers that needed doctors and to place them accordingly;

- Liaise with Ministry of National Security, Immigration Department to provide Work Permit Exemptions and visas as required for all of our doctors and supporting documentation for their dependents;
- Ensuring that the Immigration Department at the airport was aware of the arrival of the doctors to avoid delays and deportation upon arrival;
- When the project was first designed the Ministry of Health was responsible to provide Special Temporary medical licences for the doctors (a parallel system of registration at the time) – once this changed they were to provide all necessary documentation for the doctors to get their registration through MBTT;
- Chair and lead on project board meetings;
- Work with RHAs to conduct evaluation of the doctors;

4.5.7 Feedback from both the MoH and the UNDP, indicated that none of the aforementioned tasks were consistently undertaken by the MoH. As a result, the UNDP assumed responsibility for liaising with partner institutions such as the MBTT, RHAs, Ministry of National Security (Immigration) and the Ministry of Foreign Affairs. Feedback from Senior Doctors indicated complete lack of awareness of the purpose of the project and who they were supposed to liaise with regarding management of the UNV Doctors. This confusion regarding coordination and management negatively impacted overall project administration and contributed delays and serious issues, such as the registration and placement of doctors. The following is instructive:

“Sometimes I wonder if this country needed any Doctors at all...first of all, first experience was bad because I felt we were not welcome at all, especially starting with the immigration at the airport...I arrived here at 11.30 at night and I was detained there until 1.30 in the morning, so many questions about the work permit...the last thing I said is “if you don’t want me I go. I came here to volunteer...if you don’t want me then send me back. I came from India, travelled 42 hours...second thing is like after coming, there is no fixed agenda...at UN office, first three days we have security briefing, we have our ID card issued...but to get the registration and work permit we wait three months...I just waited and wasted time...”(UN Volunteers)

“When I arrived for the first time I had to be sent back to my home country because the immigration at Piarco airport was not aware of my coming. I was very disappointed that there was no one from the office to receive me at the airport. I had to go to Houston en route to my country then that’s when I received an email asking me to go back to Trinidad the following day”.(UN Volunteers)

“I left the UNV T&T in June of last year after a year of service. It was quite poorly organized; sometimes the doctors have to wait months before the T&T authorities allowed the international UN volunteers doctors to work. In my previous post with UNMIT, all the paperwork was done upon my arrival in Dili, and after two days I was on my way to my duty station). I was lucky I waited only for 6 or so weeks in POS. The SIG was released only many weeks after arrival, and only upon my

informing the program manager that we were missing meals (it is expensive in Port of Spain). A huge percentage of the SIG was spent for the accommodation in POS while waiting for our post and papers” (UN Volunteers)

4.5.8 The preceding was supported by the findings of a UNV Feedback session report conducted in October 2015.³⁸ In addition, the issues regarding timely processing of work permits, licences and coordination with the RHAs was identified in the Project Risk Log. These appear to be recurrent issues that have not been resolved, partially due to the lack of a Project Board and seeming lack of urgency by the key stakeholders. That said, any future initiative needs to streamline processes, procedures and systems for more efficient and effective project implementation. The issue of the work permit exemptions appears to be a function of the workload at the Immigration Office, based on feedback from that office. Such an assertion partially explains why the 3 month leave of the assigned Immigration Officer, resulted in a 3 month delay in processing the work permit exemptions. Feedback from the department indicated that the replacement officer was unable to handle the work load. However, since work permits can be obtained prior to entry into T&T, the process should allow for the same regarding work permit exemptions. This is an issue that needs to be resolved to ensure that any UNV Doctors arriving in T&T can proceed to work within two to three days of arrival.

Finding 22: Reversion to the Medical Board of Trinidad and Tobago (MBTT) for granting of licences to practice has constrained project implementation since the expiration of the “Panel for the issue of Special Temporary Licences” in July 2015. This was an oversight that could have been mitigated if it was noted at project conception, through either an extension of the Panel’s life or discussion with the MBTT. The MBTT requirements for issuing Temporary Licences are clearly detailed on their website, and Temporary licences do not grant permission to practice in Primary HealthCare Centres.

4.5.9 At commencement of the project, the medical registration of UNV Doctors was processed by the Ministry of Health’s Panel for the Issue of Temporary Licences, established by Act No. 7 of 2009. The Panel was instituted “to issue special temporary licences in cases of a shortage of persons available to practice medicine in the public health sector, for the recognition of diplomas granted by certain institutions and for matters related thereto”.³⁹ The Panel’s was empowered for six (6) years from the time of Assent to the Amendment, which was July, 2009. Therefore, the Panel’s life expired in July 2015. The MBTT was the only legally constituted body to grant medical licences from that time. It is important to note here that the MBTT registration guidelines are clearly detailed on its website www.mbt.org and states that Medical Practitioners with Temporary Registration may pursue employment in one of the following health institutions in Trinidad and Tobago.

- Eric Williams Medical Sciences Complex, Mt. Hope
- Mt. Hope Maternity Hospital
- St. Ann’s Hospital, St. Anns

³⁸ “UNV Feedback Session Report, Whitney David (October 2015)

³⁹ Republic of Trinidad And Tobago Act No. 7 of 2009

- Port-of-Spain General Hospital, Port-of-Spain
- San Fernando General Hospital, San Fernando
- Tobago Regional Hospital, Scarborough, Tobago
- Point Fortin Area Hospital, Point Fortin
- St. James Medical Complex, St. James
- Caura Hospital
- Sangre Grande County Hospital, Sangre Grande
- Caribbean Epidemiological Centre (C.A.R.E.C.)
- Queen's Park Counselling Center
- All District Health Facilities

4.5.10 These institutions are included on the Registration Certificates as well. Only Doctors with Full Registration licences can practice in all medical facilities. Full registration means that they must have graduated from the list of Traditional Medical Schools as detailed at Appendix 6. This information is also included on the website. As a result of the foregoing, UNV Doctors have recently been recalled from practicing in the Health Centres. It is not clear when and how this oversight came to light. Feedback from the UNDP/UNV indicated that both the MoH and the MBTT were aware of the rationale for licensing Doctors under the PHI programme, specifically for them to work in the primary health care system. As such, it is unclear how this situation has only recently (February 2017) come to light.

4.5.11 The SWRHA, which forwarded the relevant correspondence to the UNV FU, appears to have been alerted by the MBTT. Feedback from Senior Doctors at the SWRHA indicated that they had never seen licences of the UNV Doctors, so they were unaware of the registration issue. It is also not clear to what extent the Human Resources Department of the RHAs were involved in the management of UNV Doctors. Based on this situation, UNV's must now be recalled from the Health Centres and reassigned to the facilities listed above. This issue may have affected thirteen (13) of the Doctors (See Appendix VII) who were contracted after July 2015. However, seven (7) of these were assigned to institutions on the list; therefore only six (6) would have been operating in contravention of the MBTT regulations.

4.5.12 Informal feedback indicated that the expiration date of the Special Panel was an oversight, as the project anticipated registering all UNV Doctors prior to the July 2015. In retrospect, the recruitment and selection process should have utilized the list of traditional schools as a criterion for selection of UNV Doctors to be assigned to Health Centres. However, this advice would have had to be given by the Chief Medical Officer, MoH, whose responsibility it was to ensure that all criteria were defined and finalized.

Finding 23: The project's implementation was also delayed by the lengthy review process of the Solicitor General's Department, the delay in receipt of the first tranche of funds from the GORTT and absence of a system for allocation of UNV Doctors to priority health centres.

4.5.13 Informal feedback indicated that the project start was delayed by one and a half years due to the lengthy review process undertaken by the Office of the Solicitor General. The Solicitor

General's department is responsible for advising on the legal aspects of Trinidad and Tobago's international relations including relations with international organizations. As such, the project agreement would have had to be vetted by the Department.

4.5.14 In addition, the project's implementation was hindered by the late receipt of the first tranche of funds. Review of correspondence between the UNDP and the MoH revealed the initial request for first tranche of funds was submitted by letter dated 6th June 2014, subject line, "Cost sharing for Project #00090710-Primary Health Care Initiative Project. A follow up correspondence dated 21 October, 2014, subject line "Outstanding Cost Sharing Payment for Project #00090710-Primary Health Care Initiative Project and Request for IUNV Doctor Assignments" enquired about the status of the outstanding initial cost sharing payment. Further, the correspondence noted how many International UN Volunteer Doctors were already selected (10) and the fact that two (2) had arrived. As such, the project was operating in deficit. Both UNV Doctors had not been assigned by the MoH and had been employed (and paid) in the project since September 2014. As a result of the late receipt of payments, the UNDP/UNV was forced to make alternative arrangements to meet commitments. The first tranche was received six (6) months after project signing.

4.5.15 Finally, the anticipated readiness of the MoH and the RHAs to allocate staff to health centres did not occur as planned. The project anticipated that the MoH in collaboration with the RHAs, would have identified the primary healthcare centres lacking PCP I prior to the arrival of UNV Doctors. Such early planning would have facilitated the identification of accommodation close to the workplace for UNV Doctors and commencement of work. In practice, the UNV FU had to contact each RHA directly to verify staffing needs. This lack of preparatory work contributed to further delays in project implementation.

Finding 24: Cohesiveness of UNDP/UNV team and the willingness of UNDP/UNV staff to go the extra mile supported implementation of the project.

4.5.16 Informal feedback indicated that the cohesiveness of the UNDP/UNV FU team contributed to facilitating implementation of key elements of the project. The small team of four (4) persons made significant efforts to follow up administrative arrangements that according to the project document should have been undertaken by the MoH. These included the need to liaise with state institutions and partners to ensure that:

- Doctor's medical registration with the MBTT was completed,
- Coordination with the RHAs to ensure the assignment of UNV's in a timely manner;
- Facilitation of the approval of work permit exemptions through the provision of paperwork to the MoH and follow up communication to jump start the process
- Monitoring and reporting on the performance of UN Volunteers

The intervention of the UNV FU ensured that delays outside of their control were minimized as much as feasible.

Finding 25: UNDP/UNV arrangements and administration requires some review and strengthening. UNV Doctors feedback indicated dissatisfaction with the settling in and management process.

4.5.17 The majority of UNV Doctors indicated that the relationship with the UNDP/UNV FU staff was good; staff was approachable and generally tried to address concerns as they arose. That said, the UNV Doctors noted several areas requiring improvement including:

- The assignment of a UNV FU staff member to meet UNV Doctors on arrival at the airport to clarify any issues that may arise with Immigration;
- Contracting of a driver or taxi service to transport UNV Doctors on arrival in Trinidad;
- Preparation of permits and licences prior to their arrival to facilitate the start of work;
- Provision of options for accommodations at reasonable costs;
- Improved support to obtain medical registration, particularly compensation for unplanned internal travel;
- Establishment of an orientation period at the health facility to which they will be posted;
- Formal communication to the RHAs regarding their assumption of duties and their field of practice;
- Allocation of Doctors according to their areas of specialization to ensure optimization of Doctors skills;
- The assignment of an officer capable of assisting with personal issues including health and related issues.

Key informants also noted the need for the UNDP/UNV to provide support to UNV Doctors regarding identification of proper accommodation and bureaucratic details regarding school entrance for dependents, among other things. Informal feedback from the UNV FU indicated that they continue to make an effort to provide the necessary support to UN Volunteers, including available resources such as the UNDSS approved counselors.

Finding 26: Despite the efforts of the UNDP/UNV FU to assume responsibilities for managing all aspects of the programme, the lack of clearly articulated responsibilities for each partner agency meant that several issues fell through the cracks.

4.5.18 Key informants noted that despite the best efforts of all involved, the programme needed to streamline reporting and management responsibilities. It is important to note here that the management of UNV Doctors was somewhat dual track. That is, the UNDP/ UNV FU was responsible for almost all of the HR responsibilities of UNV Doctors from contracting to payment to performance monitoring. The RHA's were responsible for day to day supervision. However, there remain gaps in the management of the programme. These include:

- **The need to coordinate casual and vacation leave of UNV Doctors:** Supervisors noted that at the beginning of each year, an effort was made to plan vacation leave to ensure that staff were available to deliver services as seamlessly as possible. However, since the RHA's HR did not seem to have a role regarding approval of vacation leave for UNV

Doctors, supervisors were often unaware of the vacation plans of staff. They would be informed by the UNV when they were proceeding on leave.

- **Flexibility re allocation of UNV Doctors:** Supervisors noted challenges regarding the re-assignment of UNV Doctors in instances where they required staff to fill in for absent colleagues. UNV Doctors informed them that they could not work at another centre since they were assigned to a specific centre.
- **Notice of meetings:** The need for better communication with the UNDP/UNV FU was noted, particularly regarding advance notice of UNV Doctors need to attend meetings in Port of Spain. Though the situation has improved through the communication of emails, supervisors noted the need for a more formal communication system rather than emails.
- **Performance appraisal:** The Supervisors of UNV Doctors complete appraisal reports on the performance of Doctors. Since the RHAs do not need them for promotion or other HR processes, they are forwarded to the MOH International Desk. However, since the International Cooperation Desk does not have any responsibility for managing UNV Doctors, the reports are placed in a file. The UNV FU requests copies of the performance appraisals from UNV Doctors and these copies are placed in their respective files. The purpose of the performance appraisals completed to date is to support any extension of the UN Volunteer as well as a basis for any other assignments.
- While it provides some documentary assessment of the performance of UNV Doctors, the assessments do not appear to be comprehensive. Further, the performance appraisals formats are different for each of the RHAs, therefore there is no consistency in measurement. Finally, the performance appraisals do not reflect some of the key performance metrics included in the Volunteers Agreement including:
 - a) Plan and undertake technical training workshops
 - b) UNV Doctors will be expected to respond to emergency calls even after working hours
 - c) UNV Doctors are sometimes asked to speak on “healthy living and lifestyles” at community events, religious institutions and gatherings
 - d) Participate in voluntary activities as well as initiate same
 - e) Assist with the UNV Buddy Programme
 - f) Promote or advise local groups in the use of online volunteering

None of these tasks are assessed by the RHA’s performance appraisals. There is a clear need for the UNDP/UNV FU to develop an appraisal format that reflects on the performance expectations of UNV Doctors or other personnel.

Finding 27: There was limited adherence to the project’s monitoring framework. As such, critical information was not fed back into the project to support decision making.

As indicated at paragraph 3.6, the project’s monitoring and evaluation arrangements included:

- Quarterly quality assessments monitoring progress toward completion of key results;
- An Issue log to facilitate the tracking and resolution of potential problems;
- Updating of the Risk Log

- Project Progress Reports (PPR) generated and submitted by the Project Manager
- A Project Lessons Learned Log to support ongoing learning and adaptation within the organization
- A Monitoring Schedule Plan updated to track key management activities
- Completion of Annual Review Reports
- Annual Project Review aimed at assessment of the project during the fourth quarter of the year and completion of the Annual Work Plan (AWP) for the following year

The only monitoring report available for review was the Risk Log. However, it was not clear how issues identified in the risk log were ameliorated. That is, although countermeasures were included to address identified project risks such as delays in extension of visas and work permit exemptions and non-strategic placement of UNV Doctors, it is not clear how the counter measures were implemented. No PPRs, quarterly or annual assessments were completed and neither was a monitoring schedule. Close monitoring and early identification of issues is critical to ensuring effective project implementation and must be strengthened in any future proposed programmes.

5.0 Conclusion

The Primary Health Care Initiative-UNV Doctors was implemented to support the allocation of Primary Care Physicians to underserved communities in Trinidad. The project anticipated that the UNV Doctors would contribute to improving the quality of health care delivery by reducing wait times, facilitating extended opening hours, expanding services delivered and reducing self-referrals to the General Hospitals and/or District Health Facilities.

Overall, it is undeniable that the UNV Doctors brought an improved level of care and communication to the local health system. The patient-centric approach that gave primacy to listening to patient's concerns, explaining diagnoses and options for treatment as well as the follow up treatment were all identified as valuable attributes that local doctors should aspire to. Further, the proactive nature of UNV Doctors including identifying and treating ailments that patients may not have realized they had, ensured a high quality of health care. In addition, the participation in community outreach, particularly in rural communities that were previously underserved, meant a wider coverage of health services and focus on preventative care. Finally, in the case of UNV Doctors who live within their communities, easy accessibility in the case of emergencies also constituted significant value added.

The extent to which the intervention was the most effective strategy or can even be deemed to be sustainable is questionable. It was certainly insightful that UNV Doctors and local Doctors, as well as the MBTT, agreed that the problem in Trinidad was not a shortage of Doctors. This was clear from the numbers of graduates who applied for positions and were still unemployed, the number of returning scholars that could not be placed and the number of international applicants for jobs. The data from the Health Sector HR Planning Division suggested that there were other areas with more critical shortages. The issue that the project was developed to address appears to have been the reluctance of PCP1s to provide services at rural centres, and the limited number of hours that local doctors function within the health centres. This issue can be dealt with through a range of options including incentivizing Doctors to work at the rural health centres and improving the performance management of Doctors by the RHAs. However, given the entrenched culture of public/private practice and the hesitancy of the RHAs to address the issue, improvements are not anticipated in the short to medium term.

The UNV programme clearly constitutes good value for money, given the comparative costs of Health Sector personnel from Cuba and local personnel. The programme can potentially contribute to improvements in the health and other sectors, assuming a more rigorous evidence based project design, detailed implementation process and clear administration arrangements as well as continuous monitoring. This evaluation supports the conclusions and recommendations detailed in the 2007 Mid Term Evaluation. A short list of additional recommendations is included in the following section of the report.

6.0 Recommendations

Project Design

Recommendation 1: A comprehensive assessment of the Primary care health system including the critical gaps in capacity should be the basis of any further UNV intervention.

Finding 2 detailed the lack of data supporting the assertion that there was a shortage of doctors in Trinidad and Tobago. The issue of human resources capacity constraints should be based on a comprehensive assessment of capacity gaps at all levels of the health system. Further, such an assessment should indicate the factors that contribute to the capacity gaps, that is, if the Tertiary systems is producing x number of graduates annually and there are vacancies in the Health Centres, why are these vacancies not being filled. Further, can the system absorb the numbers of graduates being produced? Such an assessment also needs to take into account the HR needs related to new facilities and policy interventions. For example, the National Policy on NCDs and its related Strategy are likely to require community based interventions aimed at prevention of lifestyle related diseases. The need for health educators is therefore expected. The demand for District Health Visitors will also increase, as well as the personnel mentioned at paragraph 4.2.21 of this report. It is anticipated that the 10 year Health Sector Manpower Plan will be completed by April 2017 and will inform any further interventions.

Recommendation 2: Any future iteration of the UN Volunteer programme, particularly one involving the assignment of Doctors and Nurses must take into account several critical success factors as well as recognize the limitations of interventions in the health system.

Findings 2, 4 and 7 reflected the project's theory of change; that is, the expectations of project implementation and performance. The evaluation noted several assumptions did not hold true during implementation. In this regard, any future iteration needs to take account of the following:

- a) The need to involve registration or regulatory agencies during project development. Specifically, the Medical Board and the Nursing council. This will facilitate discussion of issues that may hinder implementation including licensing non-nationals to practice in the primary health system. If the issue is related to the supervision of non-nationals, a Senior Medical Professional could be assigned to perform this function.
- b) The selection and recruitment process should include at a minimum, criteria related to the MBTT guidelines for full registration status;
- c) Criteria for the identification of health centres that urgently require the support of primary health professionals.
- d) The provision of diagnostic equipment in health centres as stated in the GORTT policy statements;
- e) Involvement of the RHAs at the project development stage and the identification of focal points to support project administration and performance monitoring;

Recommendation 3: A more rigorous results matrix should be developed.

Results frameworks need to be clearly articulated, including the definition of measurable outcome indicators including relevant indicators, baselines data and targets as well as a clear data collection, analysis and reporting plan. In addition, projects need to incorporate from the design phase systems- including personnel - for data collection and reporting at the output and outcome level. One of the major limitations of this project evaluation was the lack of measurable outcomes, but also the poor documentation related to monitoring and reviewing project performance. Finally, project such as this one, need to identify indicators and targets that are most closely aligned with the intervention logic and can be realistically achieved. For example, enhanced patient satisfaction, additional services provided and availability of a Primary Care Physician providing services during an 8 hour work day are likely to be measurable indicators of project effectiveness.

Recommendation 4: Need to ensure that key stakeholders, particularly the executing agency and its personnel understand the overall project design, how elements are linked and the required sequence.

Findings 17, 18 and 19 reflected a limited understanding of the project's intent and proposed operationalization. Ensuring that all stakeholders understand the project rationale, objective, change theory and implementation mechanism is generally one of the objectives of the project launch workshop. However, revisiting the projects theory of change, that is, how the project outputs are expected to translate into intended outcomes and the sequence necessary for this to happen effectively, is critical throughout the project's life cycle. In particular, when project implementation personnel are recruited after the project, sessions should be held with new staff to ensure that all key personnel are on the same page and have the same understanding of the project design and implementation

Recommendation 5: Proposals such as this need to ensure that complementary interventions are critical to achieving stated programme outcome.

Finding 4 indicated the extent to which the project intervention, that is, the recruitment of 26 UNV health professionals was insufficient to achieve stated outcomes related to reduced waiting times, extended opening hours, expanded service delivery and reduced self-referrals. The project design for interventions such as this one must recognize that the intervention, by itself, is unlikely to achieve intermediate outcomes as indicated by the results framework. Outcomes most closely related to the intervention should therefore be selected.

Recommendation 6: Clearly articulated roles and responsibilities need to be documented in any project agreement, including expectations of performance.

Findings 17, 18 and 19 also indicated the need for clearly stated roles and responsibilities of all partner agencies. While the project document articulated the general role that each partner may have had in the project, many of the elements should have been elaborated. In particular, the performance expectations for partners outside of the UNDP/UNV should be detailed. Clearly articulated MoUs between the UNDP and partner agencies may need to be implemented to support effective commitment to project implementation. Systems for accountability of project partners are critical to successful project implementation.

Project Effectiveness

Recommendation 7: The Ministry of Health needs to conduct a performance assessment of the primary health care system to identify obstacles to improved waiting times and integrated health care, among other things.

The evaluation findings generally determined that reduced waiting time required more than the addition of Doctors. Factors related to the appointment system, allocation of files, the number of patients for specific clinics, adequacy of support staff (RNs, Nursing Assistants) etc. all affect waiting time. The need to triage patients depending on the severity of ailments also affects waiting time. In the case of the latter, the importance of triage should be explained to patients in the context of managing expectations regarding treatment. The identification of outcomes such as those included in the project agreement, suggests the need to understand all of the underlying issues that impact delivery of quality health care so that the most appropriate interventions are selected. An intervention to address re-engineering of processes at the various health facilities may support improved effectiveness and efficiency. The extent to which current processes, guidelines and protocols are consistent with globally accepted good practices should be assessed.

Recommendation: 8: The UNDP/UNV needs to develop indicators related to the organization's mandate including the promotion of volunteerism.

The UNV Volunteer Agreement clearly articulates the importance of promoting the 'volunteer ethic'. However, the extent to which this objective has been achieved has been hindered by the lack of indicators and reporting systems regarding volunteer activities. This area needs to be strengthened in any future iteration of the programme.

Project Administration

Recommendation 9: Project Governance arrangements must be closely monitored to ensure the adequacy of oversight. The establishment of a Project Board or Steering Committee is vital to more effective project management

The need for a functioning Project Board is critical, to provide oversight and support the mitigation of any issues that arise during project implementation. In the case of this intervention, such a Board should have included representatives from the respective RHAs as well as representative of the UNV Doctors so that each of the key stakeholders would be apprised of any emerging issues.

Recommendation 10: The establishment of a National UN volunteer as project manager within the MoH may contribute to more effective and efficient project implementation

Findings 23 and 24 detailed some of the gaps that occurred in administration, despite the efforts of the UNDP/UNV FU. The recruitment of a UNV Project Manager who could work as the focal point within the MoH but also liaise closely with the UNV FU would ensure that all stakeholders have a clear liaison on project issues. A Project Manager may also be the most effective mechanism to ensure improved communication and coordination during project implementation.

Recommendation 11: Monitoring and Evaluation requirements must be adhered to in any future programmes.

Finding 24 indicates the deficiencies in documenting and monitoring the project's performance. Evaluation depends on performance data/documentary evidence of all aspects of a project in order to support findings and conclusions. Even where a project may have contributed to key objectives, without any supporting information, evaluation of the intervention is challenging. This is therefore another area that requires the allocation of dedicated resources to ensure that data is collected systematically.

Appendices

Appendix 1 Terms of Reference

CONSULTANT FOR THE EVALUATION OF THE PRIMARY HEALTHCARE INITIATIVE PROJECT IN TRINIDAD AND TOBAGO

Location:	Trinidad and Tobago
Type of Contract:	Individual Contract
Post Level:	International Consultant
Languages Required:	English
Expected Duration of Assignment:	January-February 2017 (7 weeks)

1. Background

The health of a nation's population has been globally accepted as a crucial component in the measure of a country's human development, as evidenced by Sustainable Development Goal (SDG) 3, Good Health and Wellbeing. The United Nations Development Programme (UNDP) Human Development Index recognizes health as one of the three determinants in a country's progress towards sustained human development and the provision of primary health care for all by 2015 is one of the key Millennium Development Goals agreed by Governments. Access to quality health care services, coupled with lifestyle choices, impact on the quality of life and life expectancy of individuals. In order to create and maintain healthy populations, governments must develop programmes to address these elements.

The health sector in Trinidad & Tobago, while probably the best-equipped in the English speaking Caribbean, suffers from limited opening hours in primary healthcare facilities, particularly in rural health centers. At the time of the development of the project, over 200 vacancies existed for specialist medical professionals, general practitioners, health service managers and technical personnel. Similar situation exists throughout the English-speaking Caribbean and can be attributed in part to the pull factors of larger healthcare markets (eg. The United States, Great Britain and Saudi Arabia) which attract a significant number of local healthcare professionals abroad. Additionally, there is continuous outflow of young professionals who migrate to pursue post-graduate training abroad. Traditionally, medical professionals have used the public health sector to gain experience in their related fields before moving on to more lucrative career options at home and abroad, with more opting for private practice rather than meeting the needs of the national public health system.

The Public healthcare system has a number of strengths and has achieved a measure of success in controlling communicable diseases. There still remains, however, room to strengthen the quality of healthcare services, including improvements in the rates of maternal and perinatal morbidity and mortality. At the same time, the spread of communicable diseases, such as HIV/AIDS, have created a new range of challenges. In addition, the epidemiological profile of the nation has shifted significantly and is now dominated by chronic degenerative conditions and the predominance of "lifestyle" diseases. The leading causes of death are heart disease, cancer, diabetes, cerebrovascular diseases and injuries.

Healthcare in Trinidad and Tobago is derived by both public and private institutions. Public institutions offer primary, secondary and tertiary level services through a network of nine (9) hospitals and ninety-six (96) primary healthcare facilities plus a variety of special programmes and support services. Primary healthcare facilities are located throughout the two islands and provide the majority of the population coverage for preventative programmes. These programmes include maternal and child health services, chronic disease clinics and health education. Health Centers provide the population with 10% of curative primary care whilst a further 36% is provided through hospital accident and emergency departments. Private doctors account for 54% of curative primary care provided to the population.

2. Objective

The objective of this consultancy is to conduct an impact evaluation of the Primary Healthcare initiative project in Trinidad & Tobago. The consultant would be expected to develop a report that outlines the findings and potential future recommendations to all relevant stakeholders, specifically, the Ministry of Health, UNDP and UNV. The report will then be made available to the general public.

UNDP is seeking a consultant with extensive expertise and experience in the Monitoring and Evaluation of projects, and specifically on conducting impact evaluations.

The consultant would be expected to review documentation from the Ministry of Health, UNDP and UNV and consult with:

- ☐ Ministry of Health
- ☐ Various Regional Health Authorities where UN Volunteers are based;
- ☐ Medical Board of Trinidad & Tobago;
- ☐ Staff within the regional Health Authorities (especially non UNV doctors, head nurses, etc.);
- ☐ UN Volunteer doctors themselves;
- ☐ Members of the UNV Field Unit;
- ☐ The UNDP Country Office for Trinidad and Tobago; and
- ☐ Other relevant stakeholders;

As well as report on:

- ☐ The extent to which given the original situation at the Health Centres throughout the country, the effectiveness of the strategy adopted and the continued relevance of the intervention;
- ☐ Inputs on amendments to be made for the duration of the current project;
- ☐ The effectiveness and efficiency of the Ministry of Health as it relates to the execution of the program strategies;
- ☐ The effectiveness of the relationship between the UNDP/UNV and the International Desk within the Ministry of Health;
- ☐ The findings and potential future recommendations to all relevant parties: The Ministry of Health, UNDP and UNV.

3. Responsibilities of the consultant

Guided by the UNDP Project Document, the Consultant will be responsible for designing an evaluation tool, an evaluation report template as well as develop a framework for stakeholder consultations. They will also be expected to collect, distill and analyze quantitative and qualitative data and information gathered to evaluate the primary healthcare initiative as well as to complete the evaluation report, which should also include recommendations for future initiatives where possible.

Recommended Outputs/Elements of Project Document

i. The methodology for conducting the impact evaluation, inclusive of:

- ☐ The impact evaluation report template;
- ☐ Appropriate impact indicators;

ii. An impact evaluation report on the Primary Health Care Initiative project inclusive of recommendations for possible future initiatives

4. Deliverables

a) A draft methodology evaluation report template and appropriate impact indicators as well as a work plan to be submitted within 1 week of signing of contract. This will be submitted to the project board for review and feedback. (5% payment)

b) A final/approved methodology evaluation report template and appropriate impact indicators as well as work plan to be submitted within 1 week after receiving feedback on the draft. (15% payment)

- c) A comprehensive draft Impact Evaluation Report to be submitted within 5 weeks following submission of draft evaluation tool/template and work plan to the project board for consideration. The draft impact evaluation report should include the objectives of the project; the findings of the evaluations conducted and recommendations on possible future initiatives. (50% payment)
- d) Final Impact Evaluation Report to be submitted to the project board within 1 week following receipt of feedback on draft report. The final evaluation report should include the objectives of the project; the findings of the evaluations conducted and recommendations on possible future initiatives (30% payment)

5. Competencies, Expertise and Qualifications

The expert is expected to possess the following:

- a) At least 5 years' previous experience in working on development issues in the Caribbean. Have extensive (7+ years) working experience in international development and with a focus on health;
 - b) A Master's degree in monitoring and evaluation, project management or related field;
 - c) Demonstrated ability to prepare analytical reports, and undertake technical research;
 - d) Excellent communication skills and fluent in English (comprehension, written, and spoken);
 - e) Capacity to work in a multi-cultural, multi-stakeholder environment, and ability to create team-based participatory work;
 - f) Excellent computer skills including application of MS Windows, MS Office etc.
 - g) Knowledge of the health sector in Trinidad & Tobago would be considered a strong asset.
- Furthermore:
- h) Demonstrate high moral integrity by modeling the UN's values and ethical standards, sound political judgment as well as diplomacy, impartiality and discretion and proven capacity of initiative, discretion and leadership;
 - i) Promote the vision, mission and strategy of UNDP and UNV;
 - j) Displays cultural, gender, religious, race, nationality and age sensitivity.

6. Time Frame

The work should commence on the 7th of January 2017 and should be completed with the submission of the final evaluation by the 24th of February 2017.

7. Reporting Requirements

The consultant will report directly to the Programme Officer for Poverty and Governance, UNDP Trinidad and Tobago Country Office as well as the Programme Officer, UNV Caribbean Regional Sub-Hub. He/she is expected to meet as necessary with UNDP TT personnel and government personnel as required.

All project outputs inclusive of the final project impact evaluation document shall be submitted to the UNDP TT Country Office for review by the project board. Once reviewed and approved by the project board, all outputs become the property of UNDP to be utilized as deemed necessary.

UNDP is committed to achieving workforce diversity in terms of gender, nationality and culture. Individuals from minority groups, indigenous groups and persons with disabilities are equally encouraged to apply. All applications will be treated with the strictest confidence.

Appendix 2 Evaluation Matrix

Issue	Key Questions	Indicators	Source of Data	Methods of Data Collection
Project Results	<p>To what extent has the project contributed to or is likely to contribute to:</p> <ul style="list-style-type: none"> Efficient health care delivery Effective Health care delivery Improved access to health care services by citizens Reduced labour shortages within the health sector 	<p>Average wait time</p> <p>Type and number of services provided</p> <p>Geographical distance to Health Centre</p> <p>Opening Hours</p> <p>Distribution of Health workers by region, primary health care facility, specialization</p> <p>Annual No. Graduates from EWMS</p>	<p>MoH reports</p> <p>Focal Point representatives</p> <p>PHC Facility Administrative records</p> <p>Health Facility Assessment</p> <p>Reports</p> <p>Administrative records from individual training institutions.</p> <p>Medical Board of T&T</p>	<p>Desk review</p> <p>interviews</p>
Project Relevance	<ul style="list-style-type: none"> What issues/analysis informed the design of the PHI? Were obstacles/challenges to project implementation clearly identified during the project planning stage? If so, were mitigating strategies identified? If not, why not? Was the proposed approach relevant given the development objectives of The MoH and changes in the environment including political, economic and institutional? Was the proposed approach sufficient to achieve the anticipated objectives? If not, what mitigating strategies were developed, if any? 	<p>Studies and reports informing the project design</p> <p>Project risk analysis</p> <p>Alignment of project with MoH Development objectives</p> <p>Review of the project theory of change</p>	<p>Project Manager</p> <p>Project documents</p> <p>Country Focal Point</p> <p>Key informants</p> <p>Partner Agencies</p>	<p>Desk review</p> <p>Interviews</p> <p>E-survey</p>

	<ul style="list-style-type: none"> To what extent has the project met or is expected to meet the needs and expectations of key stakeholders? 	Proportion of stakeholders indicating project met expectations		
Implementation Effectiveness	<ul style="list-style-type: none"> To what extent did the project achieve intended outputs, including: <ul style="list-style-type: none"> Recruitment and placement of 30 UNV Doctors To what extent have project components been implemented in accordance with the project documents? How have project outputs contributed or are likely to contribute to their relevant objectives? Is this supported by evidence? Has the project resulted in the achievement of any unintended outcomes? Positive or negative? Have key stakeholders been effectively targeted? 	<p>Evidence of recruitment and placement at priority Health Centres</p> <p>Alignment of project components with project planned activities outlined in RM</p> <p>Contribution analysis of outputs to objectives</p> <p>Selection criteria for priority Community Centres</p>	<p>Project Coordinator</p> <p>Project Reports</p> <p>Project Beneficiaries</p> <p>Project Documents/Proposal</p> <p>MoH selection criteria</p>	Desk review Interviews
Implementation Efficiency	<ul style="list-style-type: none"> To what extent have project outputs been implemented on time and within budget? Were UNV Doctors recruited according to UNDP/UNV guidelines Did the PM comply with reporting requirements over the project's lifetime? What factors related to the project's governance structure facilitated or 	<p>Comparison of project performance targets based on implementation schedule</p> <p>Evidence of UNV selection and recruitment process</p> <p>Evidence of reporting schedule</p>	<p>Project Manager</p> <p>Project Reports</p>	Desk review Interviews

Project Administration	<p>hampered implementation of the project?</p> <ul style="list-style-type: none"> • What factors related to key partners (the UNDP, UNV, MoH) facilitated or hindered project implementation? • What variables external to the project context facilitated or hampered the project? 		<p>Project Partners</p> <p>Project reports</p>	
Sustainability	<ul style="list-style-type: none"> • To what extent are project outcomes likely to be sustained? • Have complementary systems, processes and procedures been established to support improved delivery of primary health services in priority communities? 	Evidence of systems aimed at sustained health care capacity	<p>Key informants</p> <p>Project Manager</p> <p>Project proposal and reports</p>	Desk review interviews
Lessons and Recommendations	<ul style="list-style-type: none"> • What have been key lessons learned in terms of Systems and procedures necessary to facilitate efficient administration; • Knowledge built and innovative approaches developed; • What would be some of the key recommendations for similar interventions in the future? 		<p>Key Informants</p> <p>UNV Doctors</p> <p>Partner agencies</p>	Interviews Focus Group

Appendix 3 Documents reviewed

Mid Term Evaluation Report: Institutional Strengthening and Support to the Ministry of Health (July 2007)

Medium Term Policy Framework 2011-2014 dated October 2011, Ministry of Planning and the Economy

Primary Health Care Initiative: Project Risk Log

Performance Appraisal Reports for sample of UNV Doctors

Project Agreement: Primary Health Care Initiative (July 2014)

Republic of Trinidad And Tobago Act No. 7 of 2009

UN Volunteer Agreement

UNV FU Back to Office Report

UNV Newsletter 7th October 2015

UN Volunteers: Feedback Session Report (Whitney David) October, 2015

Value of a UN Volunteer Doctor, (Article)

Email Correspondence between MoH and UNDP

Written Correspondence between the MoH and the UNDP

Appendix 4 List of People Interviewed

Contact Name	Designation	Date of Interview
Ministry of Health Staff		
David Constant	Director International Desk	16 th February, 2017
David Williams	International Desk	16 th February, 2017
Terrence Deyalsingh	Minister of Health	No Feedback
Richard Madray	Permanent Secretary	No Feedback
Karen Sealy	Technical Advisor	No Feedback
Dr. Misir	Former Chief Medical Officer	4 th April, 201
Jennifer Andall	Health HR Planning and Development	22 nd February, 2017
Medical Board of Trinidad & Tobago	Kavita MaCoon	23 rd February
UNDP/UNV		
Isele Robinson Cooper	Programme Officer	15 th February 2017
Nicole Dagher	UNV Programme Officer	15 th February 2017
Lyndon Wright	Programme Associate	13 th February 2017
Rene Berryman-Sheppard	UNV Programme Assistant	13 th February 2017
Richard Blewitt	UNDP Resident Representative	10 th February 2017
PAHO/WHO		
Dr Edwin Bolastig	Senior Health Advisor	13 th February 2017
Ministry of National Security (Immigration)		
Mr. Balliram Maharaj	Schedule Officer (Work Permits)	21 st February 2017
Regional Health Authorities		
UNV Doctors currently on the ground		
Samwarit Gebremariam	Roy Joseph Health Centre	15 th February, 2017
Stephanie Awa Mendy Sylva	Point Fortin Health Centre	15 th February, 2017
Mabaundebunde Bondeke	Indian Walk Health Centre	15 th February, 2017
Daniel Ghebriwet	Tabaquite Health Centre	15 th February, 2017
John Mburu Kimani	QPCC San Fernando	15 th February, 2017

Arsenia Moran	Hansens's Disease Unit	16th February, 2017
Diki Wangyal	Arima Health Facility (previously at Tabaquite)	16th February, 2017
Benjamin Ugbe	Arima Health Facility (A&E)	16th February, 2017
Andrew Mugeniy	QPCC&C Port of Spain	16th February, 2017
Ivan Rizano Iswandi	Arima Health Facility	16th February, 2017
Albert Onderah	Arima Health Facility (A&E)	16th February, 2017
David Owino Musa	MRF - Port of Spain	Out of Country
Majid Batambuze	Moruga Health Centre	Out of Country
UNV Doctors colleagues/Supervisors		
Dr. Aruna Kumari - QPCC&C POS	Dr Mugeniyi's Supervisor	No Feedback
Dr Helmer Hilwig - Arima (A&E	Dr Ben Ugbe and Albert Onderah's Supervisor	20 th February
Lydia Benoit, Head Nurse	Tabaquite	20 th February, 2017
Nurse Francis	Indian Walk	23 rd February 2017
Dr. Mohammed	Roy Joseph Health Center	23 rd February 2017
Dr. Ramghulem	Indian Walk	23 rd February 2017
Dr. Claudia Thomas Nathaniel	?	23 rd February 2017
Dr. Parasaram	Cedros	23 rd February 2017
Sharon Rogers, Social Worker	Hansen's Disease Control Unit	20 th February 2017

Previous UN Volunteers - repatriated		
Israel Robero Dasuza	Cedros Health Centre (one month)	No Feedback
Sandra Corbett	MOH - Head Office Policy Advisor	No Feedback
Pablo Huppi	Arima Health Facility	Written Submission
Kamusisi Chinuyindo	Chaguanas Health Centre	Written submission
Flavio Cardone	Arima Health Facility	Written submission
Ariel Zabat	Cedros Health Centre	Written submission
Chakra Rai	Arima Health Facility	No Feedback
Ngongo Bob Bushiri	Arima Health Facility/QPCC&C Port of Spain	No Feedback
Emma Thompson	Mayaro / Guayaguayare Health Centre	No Feedback
Luis Vedor	Ministry of Health (health officer - currently employed by MoH)	No Feedback
Moahmmad Darwaish	Tabaquite Health Centre	No Feedback

Appendix 5 Interview Protocols

Interview Guide with UNDP/UNV/MoH Administration Staff

Project Background and Relevance

- ✓ What was your role in the project and how long have you been involved?
- ✓ What was the rationale for the project?
- ✓ What problems or challenges was the project attempting to address? Did this analysis emerge from any needs assessment? Are these issues still relevant?
- ✓ What were the general objectives of the project?
- ✓ Describe, from your perspective, how the project components were expected to contribute to the project objectives?

Effectiveness

- ✓ To what extent has the project's output –recruitment and selection of 30 UNV doctors– contributed to improving effective and efficient delivery of primary health care; improving access to health care services; reducing labour shortages within the health sector?
- ✓ Would you say that the results have mostly been at the output level? What about at the outcome level?
- ✓ What factors supported or limited the project in achieving the anticipated outcomes?
- ✓ Have project outputs been achieved within budget and schedule?
- ✓ Was the project cost effective, in light of the cost to output on the project components?

Project Administration

- ✓ Describe your role in the management of the project?
- ✓ What factors supported your management of this project?
- ✓ What challenges did you experience in managing this project? Were these challenges identified in the risk analysis of the project? If, not, why not?
- ✓ Did you experience any management issues in the following areas:
 - Arrangements related to recruiting UNV doctors?
 - Establishment and management of the Project Board?
 - Process re placing of UNV doctors?
 - Registration with the Medical Board?
 - Monitoring the performance of UNV Doctors?
 - Administration of UNV emoluments?
 - Coordination/Communication between Partner agencies?
- ✓ How did you monitor project implementation? For example, was a reporting schedule established at project inception? Were reports submitted as scheduled?
- ✓ Were any mitigating strategies implemented to address challenges experienced? If not, why not?

Project Sustainability

- ✓ Have processes and systems been established that will sustain project outcomes?
- ✓ How can project outcomes be sustained in the medium term?

Project Results

- ✓ From your knowledge, has the project met the needs and expectations of key stakeholders across government?
- ✓ How has it contributed to stated outcomes identified in the proposal? Is there supporting evidence for each of the outcome indicators?

Recommendations/Lessons Learned

- ✓ What have been key lessons learned in terms of:
- ✓ Systems and procedures necessary to facilitate efficient project administration of similar projects;
- ✓ Knowledge built and innovative approaches developed
- ✓ What would be some of the key recommendations for future projects in this area?

Conclusions

Is there any other information that you would like to share?

Thank you for your collaboration

Interview Guide with Key Informants (Supervisors, MoH, RHAs)

Project Relevance

- ✓ How long have you been involved in the UNV programme?
- ✓ From your perspective, what issues were being addressed by the project?
- ✓ From your general knowledge, how relevant is the UNV initiative to the issues identified?
- ✓ Are there other capacity gaps that the UNV programme can support? Is there any supporting evidence for this? Surveys, studies etc.

Effectiveness

The specific objective of the Programme was to recruit 30 medical professionals to work in regional health centres to provide care and support to the citizens of Trinidad and Tobago over a 3-year period. As a result, it was expected that more efficient and effective primary health care would be delivered to targeted communities, rural communities would benefit from improved access to primary health care and labour shortages would be reduced over the project period.

- ✓ From your perspective how effective was the project in achieving its stated objectives?
- ✓ Can you identify some specific results? For example, provider patient interaction? Patient satisfaction? Expansion of services offered? Reduced wait times? Improved management of Health centres? Transfer of knowledge and skills to local personnel?
- ✓ Would you say that the results have mostly been at the output level? What about at the outcome level?
- ✓ What factors supported or limited the project in achieving the anticipated outcomes?

Recommendations

- ✓ How could the UNV programme be more effective? Is the programme targeting the most critical capacity gaps in the Public Health System?
- ✓ How can the programme best support the Public Health System?

Thank you for your collaboration

Focus Group Guide with UNV Doctors

UNV Experience

- How long have you been involved in the UNV programme?
- Why did you become a UNV? What motivated you?
- Can you describe your experience in previous postings? (Probe what worked well, what could have been improved? What would the ideal experience look like?)

UNV Experience in Trinidad and Tobago

- What were your expectations of being a UNV in Trinidad and Tobago?
- Describe your experience to date including overall administration of the programme? What worked well? What would have been the ideal experience?
- Describe your experience at your assigned posting?
- What do you do on a daily basis?
- How many clients do you see on average?
- What services do you provide?
- What works well at the health centres?

Peak Experience: In your work here, you have probably some high points and low points. Think about a time that stands out to you as a high point- a time when you felt most involved, most effective, most engaged. It might have been recently or some time ago.

- What was going on?
- Who were the significant people involved?
- What were the most important factors that helped to make it a high-point experience? (e.g., leadership, qualities, rewards, structure, relationships, skills, etc.)

Values

- What aspect of your work do you value most?
- Describe one outstanding or successful achievement or contribution of which you are particularly proud.
- ✚ What unique skills or qualities did you draw on to achieve this result?
- ✚ What organizational factors helped you to create or support your achievement?

Recommendations

- If you could make any changes to the programme, what would be your top three priorities?

Appendix 6 Listing of Traditional Medical Schools

COUNTRY/STATE/AREA	MEDICAL SCHOOL/LICENSING BODY	QUALIFICATIONS
AUSTRALIA	All qualifications obtained in Australia and registrable with the Australian Medical Council.	M.B.,B.S. B.M.,B.S.
BAHRAIN	Royal College of Surgeons in Ireland - Medical University of Bahrain (RCSI Bahrain).	M.B.,B.Ch.,BAO LRCP(I),LRCS(I)
BANGLADESH	Dhaka Medical College. Conditions as for India, but approved by the Bangladesh Medical Council.	M.B.,B.S.
CANADA	All qualifications obtained in Canada and approved by the Medical Council of Canada.	M.D. M.D.,C.M.
EGYPT	The Universities of Ain Shams, Al Azhar, Alexandria, Cairo and Mansura.	M.B.,Ch.B.
GHANA	The University of Ghana	M.B.,B.S.
GREAT BRITAIN	All qualifications obtained in Great Britain and recognized by the General Medical Council of Great Britain.	M.B.,B.S.M.B.,Ch.B.L.R.C.P M.R.C.S L.M.S.S.A.
GRENADA	St. George's University School of Medicine	M.D.
GUYANA*	The University of Guyana	M.B.,B.S.
HONG KONG	The University of Hong Kong	M.B.,B.S.
INDIA	All schools approved by the India Medical Council. Conditions: They must be non-private institutions, be affiliated to a University and the medium of instructions must be in the English Language.	M.B.,B.S.
KENYA	The University of Kenya	M.B.,B.S.
MALAYSIA	The University of Malaya (K.L.), Penang Medical College (PMC)	M.B.,B.S. M.B.,B.Ch.,BAO LRCP(I),LRCS(I)
NEW ZEALAND	Universities of Ackland and Otago	M.B.,Ch.B.
NIGERIA	The Universities of Benin, Ibadan, Lagos and Nigeria.	M.B.,B.S.
PAKISTAN	Conditions as for India but approved by the Pakistan Medical Council.	M.B.,B.S.
PHILIPPINES	Universities of Philippines and Santo Tomas	M.D.
REPUBLIC OF IRELAND	All qualifications obtained in EIRE and registrable with the Irish Medical Council	M.B.,B.Ch.,BAO LRCP(I),LRCS(I) LM (RCP,SI)
SINGAPORE	The National University of Singapore	M.B.,B.S.
SOUTH AFRICA	The Universities of Cape Town, Natal, Orange Free State, Pretoria, Stellenbosch and Witwatersrand.	M.B.,Ch.B. M.B.,B.Ch. B.M.
SRI LANKA	Universities of Sri Lanka, Colombo and Peradeniya.	M.B.,B.S.
UNITED STATES OF AMERICA	All qualifications obtained in the U.S.A. and approved by the Association of America Colleges.	M.D.
WEST INDIES	The University of the West Indies	M.B.,B.S.
ZAMBIA	The University of Zambia.	M.B.,B.S.
*As per Regular Monthly Meeting 595 on 11th June 2014, Council agreed to register graduates qualifying from 2009 to 2015 without further examinations.		

Appendix 7 UNV Doctors In Trinidad and Tobago (current)

	Last Name	First Name	Contract Start Date	Contract End Date	Location	Specialization	Exposure
1	Batambuze	Majid	19-Dec-14	18-Dec-17	Moruga	General Practitioner	HIV/AIDS
2	Bondeke	Mabaundebunde	7-Jul-16	6-Jul-17	Tabaquite Health Centre	General Practitioner	Infectious diseases HIV/AIDS
3	Gebremariam	Samwarit	17-Sep-16	16-Sep-17	Roy Joseph Health Centre	General Practitioner	
4	Ghebriwet	Daniel	21-Nov-16	20-Nov-17	Tabaquite Health Centre	General Practitioner	HIV & TB, OBGYN
5	Iswandi	Ivan Rizano	15-Mar-16	14-Mar-17	Arima Health Facility	General Practitioner	
6	Kimani	John Mburu	4-Nov-14	3-Nov-17	QPCC San Fernando	General Practitioner	HIV/AIDS
7	Mendy Sylva	Stephanie Awa	6-Jul-15	31-Dec-17	Point Fortin Health Centre	General Practitioner	OBGYN
8	Moran	Arsenia	29-Sep-14	28-Sep-17	Hansen's Disease Unit, Cocorite	General Practitioner	Public Health
9	Mugenyi	Andrew	15-Feb-16	14-Feb-17	QPCC POS	- General Practitioner	HIV/AIDS
10	Musa	David Ownio	2-Sep-14	1-Sep-17	QPCC POS	- HIV&AIDS Counseling & psychology	
11	Onderah	Albert	11-Nov-16	10-Nov-17	Arima Health Facility	General Practitioner	
12	Ugbe	Benjamin	12-Dec-15	11-Dec-16	Arima Health Facility	General Practitioner	HIV/AIDS/emergency
13	Wangyal	Diki	2-Nov-16	1-Nov-17	Arima Health Facility	General Practitioner	OBGYN

Repatriated UNV Doctors								
	Last Name	First Name	Contract Start Date	Contract End Date	Location		Specialization	Exposure
1	Corbett	Sandra			Ministry Health Office	of Head	Public Health	
2	Cardone	Flavio	12-Sep-15	11-Sep-16	Arima Facility	Health	General Practioner	
3	Chinyundo	Kamusisi	11-Sep-15	10-Sep-16	Chaguanas Health Centre		Paediatrics	
4	Rai	Chakra	10-Sep-15	9-Sep-16	Arima Facility	Health	Paediatrics	
5	Darwaish	Mohammed	30-May-15	29-May-16	Tabaquite Centre	Health	General Practioner	HIV/AIDS/emergency
6	Vedor	Luis	18-Jan-15	17-Jan-16	Mt. Hope		Masters in Health Design, Master in Sustainable Architecture in Technology Innovation for the Environment	
7	Da Sousa	Israel Ribeiro	10-Nov-14	9-Nov-15	Cedros		General Practioner	HIV/AIDS
8	Zabat	Ariel	24-Jun-15	23-Jun-16	Cedros		General Practioner	
9	Bushiri	Ngongo Bob	18-Oct-15	17-Oct-16	Arima Facility	Health	General Practioner	HIV/AIDS
10	Huppi	Pablo	13-Apr-15	12-Apr-16	Arima Facility	Health		
11	Thompson	Emma	28-Oct-14	31-Dec-16	Mayaro/Guayaguayare Centre	Heath	General Practioner	