LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT

UNDP
South Africa

UNDP SUPPORT TO THE HEALTH SECTOR IN LIMPOPO

Health Professionals Volunteerism and Capacity Development

Outcome Evaluation: Part One

December 2011

by

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ACKNOWLEDGEMENTS

This report is a result of many people's dedication and contributions, thus I wish to express my sincere thanks and gratitude to the UNDP Country Office for its effort to make sure that all aspects of the evaluation process proceed smoothly and provide me with all logistical assistance, and the required sub-programme related information.

I am indebted to the Programme Management Unit in Polokwane for devoting its time to schedule and inform all service delivery points (hospitals), provide Global Positioning System (GPS) coordinates of the health facilities, and supply with the necessary information regarding UNV profiles.

I finally wish to thank all respondents and organisers. Hospital management (CEO and clinical managers) were instrumental to organise interview sessions despite their busy schedules and responsibilities for attending patients. Members of the steering Committee (from Provincial department of Health), UNVs, and co-workers (doctors and nurses) took time to provide their thoughtful answers to the evaluation questions. Without the warm and enthusiastic participation of all respondents the evaluation effort wouldn't have come to fruition.

ABBREVIATIONS

ACLS	Advanced cardiac life support
BLS	Basic life support
CBOs	Community-based organisations
CEO	Chief executive Officer
CHCs	Community health centres
CTO	Compensatory time-off
DIRCO	Department of International Relations and Cooperation
EMS	Emergency Medical Services
ENT	Ear, nose and throat
FBOs	Faith-based organisations
FNB	First National Bank
GDP	Gross domestic product
GPS	Global positioning system
HIV/AIDS	Human immunodeficiency virus/ Acquired immune deficiency syndrome
HPCSA	Health Professionals Council of South Africa
HSBC	Hong Kong and Shanghai Banking Corporation
ID	Identity document
IYV+10	Tenth anniversary of the International Year of Volunteers
KASA	knowledge, attitude, skills, and aspirations
MDGs	Millennium development goals
NGOs	Non-governmental organisations

OPDs	Out-patient departments
OSD	Occupational Specific Dispensation
PDoH	Provincial Department of Health
PHC	Primary healthcare
PMU	Programme Management Unit
PSD	Programme Support Document
SANC	South African Nursing Council
TB	Tuberculosis
ToR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
UNVs	United Nations Volunteers
USD	United States Dollar
VLA	Volunteer living allowance

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EXECUTIVE SUMMARY

This is an evaluation report of UNDP's support to the Health Sector in Limpopo, South Africa. The Third Phase of the '*Health Professionals Volunteerism and Capacity Development Sub-programme'* covers a period of four years (December 2007 – December 2011). The purpose of this evaluation is to determine the outcomes of the four years of UNDP's contribution to service delivery through a support programme to the health sector in Limpopo Province in relation to the stated objectives and outcomes including the effectiveness, relevance and sustainability of the sub-programme. This executive summary gives a brief synopsis of the overall findings of the evaluation by highlighting achievements, challenges, lessons learned, and recommendations.

1. Key evaluation findings

The evaluation assessed the aspects of performance of the sub-programme against its stated objectives and expected outcomes. The findings are the result of analysis of the perspectives of four main groups of respondents: the United Nations Volunteers (UNVs), hospital management, and health personnel (doctors and nurses), working with the UNVs, UNDP, PMU and the Limpopo Provincial Department of Health.

1.1. Brief demography of the UNV doctors and specialist services rendered

During the reporting period a total of 41 UNV doctors were deployed in 14 hospitals (two tertiary, five regional, and seven district) in the province of Limpopo, South Africa. The highest number of UNVs, i.e. 71% (29 out of 41) were appointed and deployed during Phase III, while 29% (12 out of 41) during the previous Phases.

The majority of the UNVs were Filipinos (11), followed by Russians (8), Indians (5), Ukrainians (4), Pakistanis (2), and Myanmar (2). Each one of the remaining is from Bangladesh, Canada, Netherlands, Egypt, Nigeria, Sierra Leon, Sudan, Tanzania, and Uganda.

Most of these were specialists of family medicine, general surgery, and anaesthesia followed by obstetrics and gynaecology, and internal medicine as illustrated below in Table. The rest had specialisations in paediatrics, cardiology, and ophthalmology, dermatology, endoscopy, neurology, orthopaedic surgery, and general practitioner.

Table 1. Summary of the UNVs profile currently under the sub-programme (end of December, 2012)

Gender	
Female	12
Male	29
Nationality distribution	
Bangladeshi	1
Canadian	1
Dutch	1
Egyptian	1
Filipino	11
Indian	5
Myanmar	2
Nigerian	1
Pakistani	2
Russian	8
Sierra Leonean	1
Sudanese	1
Tanzanian	1
Ugandan	1
Ukrainian	4
Total	**41**

Distribution of specialisation	
Anaesthesia	7
Cardiology	2
Dermatology	1
Endoscopy	1
Family Medicine	7
General Surgery	7
Internal Medicine	4
Neurology	1
Obstetrics and Gynaecology	4
Ophthalmology	2
Orthopaedic Surgery	1
Paediatrics	3
General Practitioner	1
Total	**41**

Distribution in health facilities	
Dilokong	1
Elim	3
Lebowakgomo	2
Letaba *(Regional)*	4
Mecklenburg	2
Mokopane *(Regional)*	3
Philadelphia *(Regional)*	1
Polokwane & Mankweng *(Tertiary)*	9
Sekororo	3
Siloam	1
St Ritas *(Regional)*	4
Tshilidzini *(Regional)*	7
Zebediela	1
Total	**41**

1.1. Achievement of sub-programme objectives

1.1.1. Appointment and deployment of health professionals

The recruitment, selection, and deployment of UNVs fluctuated over the years; but after a steady decline from 2006 to 2009, the sub-programme showed a dramatic increase in 2011, though it could not compensate for the backlogs of 2010 (see Figure 1). This improvement was not only in quantitative terms but also had qualitative aspects where the sub-programme was able to appoint UNVs of a high calibre fit to deliver the required health services. Most of the UNVs have earned wide-spread admiration for their skills and work ethic from the health staff, including hospital management.

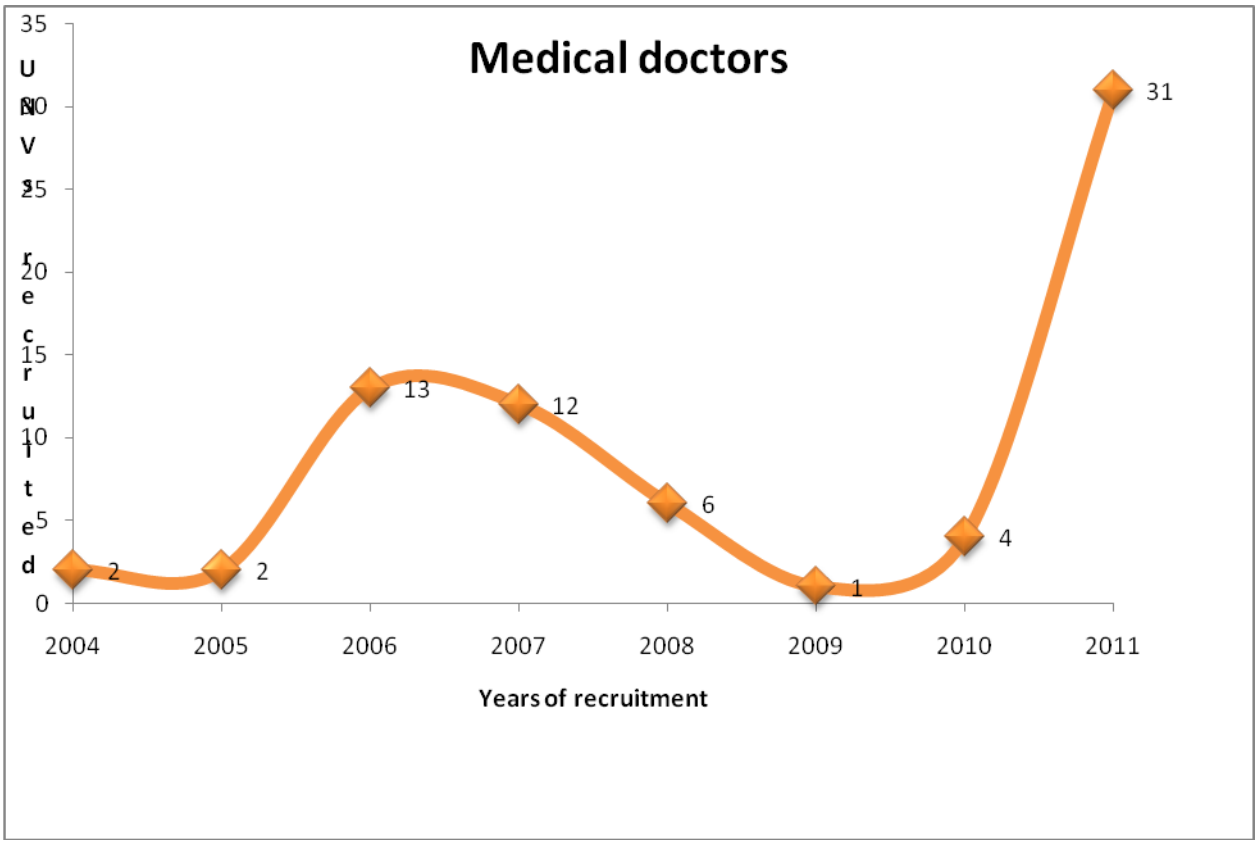

Figure 1. UNVs appointed over the years (2004-2011).

However, the shortcomings of the sub-programme in appointment of UNVs overshadowed its successes. The sub-programme could not appoint UNVs according to its plan and was far behind its overall specified annual targets. Since its inception, the sub-programme only appointed and deployed 38% of the cumulative planned number of doctors, and none of the clinical engineers, pharmacists, and specialist nurses. In fact, during the first year of Phase III, only 7% of the target was met. In terms of appointment performance Phase II (December 2004- December 2007) did well as 34 out of the projected 40 (i.e. 85%) could be imported and deployed in hospitals.

Since 2006, the PMU has coordinated and served as a secretariat for all UNV interviews together with the respective clinicians assigned by the Department of Health. However, the selection process experienced challenges as there were incidents when some UNVs were screened without the participation of the clinicians. Furthermore, the evaluation found that some of the UNVs were even not interviewed at all. The probabilities of missed opportunities to select the best candidates can be high if the important step of interviewing is not designed properly.

.However, it is widely acknowledged that in general, foreign doctors have different levels of qualifications and experience to that of the local doctors, which may result in UNV doctors confined to general medicine at the initial stages of the assignment. However, according to hospital reports, this has not necessarily led to unsatisfactory performance by qualified UNV doctors, hence the number of doctors who have resigned due to this is insignificant.

There were also suboptimal usages of skills because of misallocation of UNVs which could be linked to the point that the selection and deployment processes need some improvement. Some of the UNVs had been appointed and deployed to different areas of their specialisation, resulting in underutilisation of their skills.

Furthermore, as a result of the unstructured and insufficient induction procedures there were UNVs that experienced discomfort in the sudden unfamiliar cultural environment. This was believed to have contributed slow adjustment to the work environment in some instances. There were also instances of arguments between local doctors and UNVs about medical procedures that could have been ironed out through proper induction procedures.

1.1.2. Providing care and support to UNVs

Most of the hospitals had provided the UNVs with relatively appropriate housing, transport, and security and made an effort to include them in their skills development plans and management processes. However, more could be done as there were some complaints of deterioration of support to upgrade skills, insufficient funding, and inefficiency in administration.

The other challenge was lack of proper guidelines on how to manage UNVs in hospitals. Almost all hospitals did not make references to the two vital documents, *UNDP Support to the Health Sector in Limpopo: Phase III Programme Document* and *Conditions of Service for International UNV Volunteers*. This left hospitals without a full understanding of the objectives of the sub-programme and a leverage to manage emerging UNV issues. It is worthy to note that one of the consequences of this shortcoming was the ambiguity of the implementation of the 'Compensatory Time-Off (CTO)' for extra hours worked by UNVs was differently managed by different hospitals. The use of CTO was differently managed by different hospitals. The use of compensatory time-off for extra hours worked was practised uniformly by hospitals. Some

hospitals did not accumulate extra hours worked and allowed compensatory time-off monthly; others did not put UNVs on duty call because they were not sure of how to manage the extra hours. However, other hospitals accumulated the extra hours worked and allowed UNVs to take compensatory time-off for as long as three months (including one month for annual leave). However, removing some UNVs from duty calls, and giving others prolonged leaves had negative impact on the already strained health service delivery system. The applications of these non-standardised and inefficient approaches of handling UNVs issues boils down to the need for strengthening the PMU's monitoring capacity to ensure the possession and enhance adherence to the vital documents for proper guidance.

Moreover, there were serious administrative issues that were affecting the optimal performance of UNVs and decisions on whether or not to continue volunteering. The inefficiency to have Health Professionals Council of South Africa (HPCSA) registration, work permits, and, UNV Identity document (ID) cards were appalling to the extent that they were putting the sustainability of the sub-programme at risk. There were also areas that required attention on the issue of Volunteer living allowance (VLA transfer). All UNVs were concerned about the money lost in exchange rate from United States Dollar (USD) to local currency (Rand) and back to USD.

The vacancy of a UNV Programme Officer that could oversee the programme's performance created work pressure at the UNDP Country Office. It had been difficult to handle the workload by one person and this situation contributed to the delays in the UNV administrative processes.

Generally, the care and support given to UNVs had not been sufficient enough to keep them satisfied and this had negative consequences in their decisions for their contract renewal, and willingness to be ambassadors of volunteerism.

1.1.3. Transfer of knowledge and skills through a mentorship programme

The sub-programme created an environment of efficient knowledge and skills transfer by bringing together a pool of diverse skills from many countries. Irrespective of whether health workers took advantage of it or not, the sub-programme had become a dynamic interface between locals and UNVs to share experiences and was a shortcut to reach and access multiple sources of knowledge.

In some hospitals where interns had been deployed, the skills transfer was more structured and the UNVs role was strategic and well appreciated. There were also some other pockets of excellence of skills transfer in other hospitals, and if the UNVs were to leave, the dynamics of skills transfer would be at stake. Some UNVs had improvised and introduced new, simpler ways of doing things that did not involve complicated machines – with good results. Especially in the area of anaesthesia and surgery, the extent of skills transfer was notable. Furthermore, because of UNVs, there were provisions of new services in district hospitals where these treatments had been possible only in regional hospitals.

However, one of the biggest challenges of the sub-programme in the dimension of skills transfer was that it had fallen short of developing a mentoring programme and consequently, in all hospitals the knowledge and skills transfer was not structured and not systematically done, i.e. no mentor- protégé relationship had been established. That was why the sub-programme did not have a visible influence on the mode of transfer of skills.

There were also some challenges including a lack of motivation to learn, and continuous reshuffling of staff, that affected learning in some hospitals. Many of the doctors were of the opinion that a lack of appreciation to some of the UNVs skills had also impacted on the enthusiasm to learn. The workload was cited as a barrier to skills transfer, as doctors had been overwhelmed by day-to-day work and did not have time for training. UNVs had been taken as additional workforces and most of their roles were limited to service delivery and efforts to systematically transfer skills were minimal. The unstructured skills transfer deprived the sub-programme of the optimal utilisation of UNV knowledge and skills, defeating one of its main objectives.

1.1.4. Promotion of volunteerism culture for local professionals

The sub-programme had a serious weakness as the campaign for volunteerism was numb and nothing had been done at all. After all, there was no manual for volunteerism that hospitals could use as a guideline and reference to promote volunteerism. The absence of this document meant denying the sub-programme a strategic tool towards the achievement of its outcomes.

The campaign for volunteerism was given a very low profile in all hospitals. UNVs were not even well introduced as volunteers, let alone to promote volunteerism. Paradoxically, in some of the hospitals staff was unaware of the presence of UNVs in the hospital until the time of this interview. Hence, the sub-programme did not create any sense of volunteerism as no effort had been made to introduce this concept. Even the hospitals that had introduced the UNVs as volunteers did not explain what volunteerism was all about and how it could be related to the context of the health profession.

As part of the campaign for volunteerism, organising UNV events could have far-reaching impacts. However, the budget that had been made available from UNV Headquarter (Bonn) for the purposes of UNV events, was not even used. The PMU did not come up with plans to celebrate the 10th anniversary of the International Year of Volunteers (IYV+10) despite high expectation from the volunteering doctors.

1.1.5. Retention strategy for health professionals

Having a clear retention strategy is a *sine qua non* for keeping local doctors permanently, and UNVs beyond their one year contracts. This would involve focusing on preventing as well as addressing issues of dissatisfaction and implementing effective skills development programmes. However, the Provincial Department of Health (PDoH), and hospitals did not have comprehensive retention strategies, either for locals or UNVs. Consequently, there were insufficient requests for contract renewal by UNVs and high outflow of local doctors from district hospitals.

1.2. Achievement of sub-programme outcomes

1.2.1. Improved health care service delivery

Though it had required a critical mass of input and activities to bring about a visible change in knowledge, attitude, skills, and aspirations (KASA), and behaviour, there were some indications of attitudinal change in commitment, and devotion to work by local staff that could reasonably be attributed to the sub-programme. No one could deny that the UNVs had been instilling in the local health workers an attitude of work ethic, a greater sense of duty and responsibility for patients.

On the service delivery side, due to the deployment of UNVs, the doctor-patient ratio was generally agreed to have improved to a certain extent. Hence, the patient waiting time had been substantially reduced, and resulted in a lower death rate and less community complaints.

The doctors and management agreed that one of the main causes of maternal death had been a lack of skills in anaesthesia. To highlight the challenge of skills in anaesthesia, it is often said that *'Inappropriate use of anaesthesia kills more people than taxi drivers in South Africa.'* Though it had been difficult to get statistical evidence to validate this assertion, it clearly dramatised the seriousness of the consequences of the dire skill shortage in anaesthesia in the country. Anaesthesia related death was significantly reduced because of the intervention of the sub-programme; specifically reduction of maternal mortality was significant. Moreover, in terms of Millennium development goals (MDGs) the UNVs were directly or indirectly involved by alleviating child mortality and treating HIV/AIDS patients.

On the flip side, the low profile given to volunteerism, and lack of appreciation thereof, had a negative effect on the enthusiasm to learn from UNVs. For UNVs to be exemplary of work ethic and therefore impact on the attitude, aspiration, and behaviour, their volunteerism should have been formally acknowledged and treated accordingly. Though UNVs could have great impact to bring about changes in KASA and behaviour, the hospitals did not take advantage of their skills to the fullest extent.

1.2.2. Improved culture of local volunteerism for better health service delivery

The PMU, PDoH, and the hospitals did not have a volunteerism programme that focussed on the local health workers and had not yet established any formal partnership with the private sector and civil society in the province or in the country. Given that there had not been complete induction, acknowledgement, and campaign for volunteerism, the appreciation of volunteerism by local health workers in the hospitals was almost nonexistent. In this regard the outcome of an improved culture of volunteerism has not been achieved.

1.2.3. Improved retention rate of health professionals

The sub-programme was successful in retaining some of the UNVs for at least over a year. However, the limited rate of retention could not be fully attributable to the sub-programme's operations, as UNVs had different motives to volunteer and continue volunteering.

The retention of medical doctors (locals and UNVs), mainly in district and regional hospitals, had been a continuous challenge in the province, to the extent that it was difficult to run internship programmes in hospitals. Hospitals were suffering from acute shortages of medical doctors and one of the big challenges was that community services and interns had not been continuing working after completion of their duties. This was despite the financial and non-financial incentives available to them to work in rural health facilities.

Similarly, the environment was not also conducive for retention of UNVs. This was, apart from individual choices, to a large extent due to the administrative inefficiencies in the sub-programme. Of those who had been appointed and deployed, 38% already left the sub-programme; almost half of the UNVs who were repatriated had not renewed contract for a second year; and those who decided to volunteer up to the maximum permissible years (six years) were only three.

The overall retention rate of UNVs was very low, which could be attributed, to a certain degree, to weaknesses in the selection and appointment processes, the absence of a retention strategy, low acknowledgment and appreciation of volunteerism, and dissatisfaction in the care and support given to them. This high turnover of UNVs costed the sub-programme substantial amount of resources (cost of selection and appointment is higher than retention). In contrast to the previous Phases, there were higher rates of resignation and termination of UNVs who were appointed in Phase III. These could be associated to insufficient care and support given to UNVs while in duty. The non-financial aspect of the opportunity cost of low retention rate of UNVs could be also high, i.e. the experiences they had got in the hospitals was a big loss to the province, as the sub-programme had to replace them with new ones who had to start afresh and struggle to acclimatise.

1.3. Conclusions, lessons learned, and recommendations

1.3.1. Conclusions

- **Relevance of the intervention:** In the context of acute shortages of medical professionals and the trend of reluctance by interns and community service workers to continue working in district hospitals, the sub-programme will remain to be extremely relevant for some time to come. Despite the poor standards of health in rural communities, local health practitioners were always under-represented.
- **Achievement of objectives and progress towards outcomes:** The sub-programme was successful in improving service delivery and contributed to the efficiency and reduction of the death rate in a province where the health care system had been at a relatively lower level. There was also a moderate achievement in the two-way skills transfer where local health workers and UNVs had gained knowledge and skills from the dynamics of the pool of diverse specialists.

  However, most of the objectives were not met as the sub-programme had been far from reaching its recruitment target in terms of quantity and quality of health professionals. The campaign of volunteerism to enhance commitment of local health professionals, mentorship for a structured and efficient skills transfer, and the retention strategy programme were never implemented.

- **Performance of partners:** the UNDP through its PMU and Country Office made efforts to screen and import international health service volunteers. The Department of Health in Limpopo was also more or less effective in the placement of the UNV doctors. However, there were some challenges:
  - The facilitation for licensing, permits, and VLAs (by the United Nations Development Program (UNDP), Department of International Relations and Cooperation (DIRCO), HPCSA) was not efficient enough to induce satisfactory performance by the UNVs.
  - There had been frequent turnover of Project Steering Committee (PSC) membership, and the PSC meetings were not conducted regularly. These affected the performance of the sub-programme where the PMU had been left without strategic guidance for its operations.

- **Sustainability of results:** The sustainability of the results that were achieved (improved service delivery), was compromised by the absence of campaign for volunteerism, retention strategy for local doctors, and systematic and efficient skills transfer. Hence, given its mode of operations the sub-programme's results could not be qualified as fully sustainable because there had not been guarantee for the sustainability of the momentum achieved.

1.3.2. Lessons learned

1.3.2.1. Recruitment, selection, and deployment of UNV health professionals

- **Overestimation of targets leads to lack of focus.** Given the stringent criteria from the South African Department of Health, and the scarcity of clinical engineers, pharmacists, and specialist nurses in the international job market the targets had been set were unrealistic and require revision. Setting targets out of context result in underachievement.
- **Abandoning proper selection procedures results in the selection and appointment of unsuitable doctors and suboptimal use of resources.** Interviewing UNVs by administrative personnel instead of by relevant clinical staff may result in the selection of less qualified and/or less relevant specialists at the expense of better and/or relevant doctors. There were few UNVs that had been appointed and/deployed outside their areas of specialisation, and contracts of others terminated because of limitations in the selection process.

  The induction process was desirable for both the UNVs and local staff. The incomplete or absence of proper induction procedures in hospitals resulted in discomfort, culture shock, maladjustment to clinical procedures, and sub-optimal performance among some UNVs.

1.3.2.2. Care and support to UNVs

- **Lack of reference to sub-programme's supporting documents seriously limits the care and support given to UNVs.** Not referring to relevant sub-programme documents to administer UNVs negatively affected the quality of response by hospital management to the detriment of UNVs' performance.

The unreasonably long time that had been taken to renew licences and permits affected UNVs performance and contributed to the dissatisfaction with the sub-programme. This adds to the reluctance to continue volunteering that may result in the shrinkage of the pool of potential applicants as it could portray a bad image of South Africa.

1.3.2.3. Transfer of knowledge and skills

- The UNV sub-programme was an efficient platform for the mutual exchange of knowledge and skills through a dynamic interaction of diverse skills from many countries. However, without a structured mentoring strategy, organised in a mentor–protégé relationship, the skills transfer will not be efficient and it will be difficult for the sub-programme to move from mere gap filling to capacity development.

1.3.2.4. Promotion of volunteerism culture for local professionals

- The commitment of UNVs was a showcase of tolerance, and a demonstration of the possibility of working in unfavourable conditions for the betterment of health, irrespective of ethnicity. The UNVs had shown the feasibility of volunteerism in practice by committing themselves to serve communities and share knowledge which indicated the possibility of having local volunteers to improve the health care system.
- Partnership is essential for volunteerism. Chances were slim for the province to successfully promote volunteerism without partnering with the private sector and civil society.

1.3.2.5. Health care service delivery

- The UNV sub-programme had been an efficient stopgap measure of responding to unmet health care needs and saved lives in Limpopo. However, the efforts to attract foreign volunteers as required was not successful, meaning that reliance on external volunteerism will not be the best option to address the backlogs of health service delivery.
- The UNV sub-programme was a shortcut to bring changes in people's attitudes and behaviours. UNVs inculcated the attitude of work ethic, more sense of duty and

responsibility for patients into the local health workers that no one who came into contact with them could deny.

- Ownership and shared vision for the sub-programme can enhance the sub-programme's ability to progress towards its outcomes. Staff awareness of the sub-programme and its objectives is the basis for developing the sense ownership, but this was lacking and the sub-programme could not be said it functioned optimally. The hospitals viewed UNVs only as workhorses and not as instruments of capacity building that had to leave a sustainable legacy of skills and spirit of volunteerism.

1.3.2.6. Monitoring and evaluation

- The absence of a functional M&E framework had denied the sub-programme the ability to track and take immediate corrective actions for UNV issues as they emerged. This has the potential of adversely affecting service delivery because of dissatisfaction; and this can undermine the recruiting capacity of the PMU because unsatisfied UNVs are more likely to badmouth to potential applicants.

1.3.3. Recommendations

- The sub-programme must follow rigorous candidate selection procedures which is a more efficient way for using available resources than dealing with the consequences of poor selection that may result in the resignation and termination of contracts. This can best be done by interviewing candidates by a panel of respective clinical staff.
- Induction should be a mandatory step of the deployment process, in order to help UNVs adjust to the country's health care system and disease patterns of the province, to help the Provincial Department of Health ensure that UNVs meet and match the required standards, and to assist co-workers to have a clear understanding of expected UNVs' role and how UNVs fit into the system.

- The sub-programme has to revise recruitment targets that can be achievable given the country's regulations and availability of health professionals in the job market.
- Make reference to sub-programme documents:—The '*UNDP Support to the Health Sector in Limpopo: Phase III Programme Document*,' and *'Conditions of Service for International*

UNV Volunteers' are the two vital documents that hospitals must depend on for their understanding of the project objectives and outcomes, and administering the UNVs.

- Explore for best practices across the UNV system. The PMU has to explore how other countries are dealing with UNV issues, and try to benchmark and consider some best practices.
- Consider increasing incentives by paying for extra hours worked through negotiating with the UNV Headquarter and the South African Department of Health. This can save many lives by allowing full utilisation of available skills rather than letting UNV remain idle outside the normal working hours.
- Speed up HPCSA registration and temporary residence permits by improving coordinating mechanisms with responsible parties (including UNDP New York, DIRCO, and HPCSA).
- There should be informal and formal recognition and appreciation of volunteerism in hospitals on a daily and occasional basis.
- The sub-programme should assist and ensure the development of a mentorship strategy to systematically transfer skills from UNVs to locals and vice versa.
- Volunteerism should start within health facilities. It is vital for the UNVs themselves to be vehicles of the campaign and hospitals must create an environment where they can play active roles for volunteerism. The sub-programme should have orientation on Volunteer Management Theory that empowers hospital management on how to work with volunteers.
- Build partnership for volunteerism and develop strategies to work with the private sector and civil society where health professionals can come to the public hospitals for assistance and capacity building. It is impossible to promote volunteerism in silos.
- Develop and implement a retention strategy as it is a sine qua non for keeping local doctors for longer duration, and UNVs beyond their one year contracts.
- A robust monitoring and evaluation framework should be designed within the sub-programme to ensure if the appropriate inputs and activities (appointment of the right skills, conduct of appropriate induction, provision of care and support, acknowledgement and appreciation for volunteerism), and outputs (performance, achievement of objectives) are in place. As part of the M&E framework the PMU has to request quarterly UNV reports from hospitals in order to keep track of up-to-date

information, motivate UNVs, and enhance management's sense of ownership and connectedness with the sub-programme.

Section 1: INTRODUCTION

This is an evaluation report of the Third Phase of the '*UNDP's support to the Health Sector in Limpopo (South Africa): Health Professionals Volunteerism and Capacity Development Sub-Programme'* that covers a period of four years (December 2007-December 2011). The purpose of this evaluation is to determine the outcomes of the four years of UNDP's contribution to service delivery through a support programme to the health sector in Limpopo Province in relation to the stated objectives and outcomes including the effectiveness, relevance and sustainability of the sub-programme.

The report is classified into five sections and is structured as follows:

Section 1: ***INTRODUCTION***, following the Executive Summary, this section deals with the background and context of the healthcare system of South Africa and the province of Limpopo focusing on the socio-economic and epidemiological profiles, access to health service delivery and human resources.

Section 2: ***DESCRIPTION*** *of the* ***EVALUATION***, gives the summary of the sub-programme and addresses mainly methodological issues to be followed in this evaluation and covers evaluation objectives, scope, and deliverables of the sub-programme.

Section 3: ***KEY EVALUATION FINDINGS*** *and* ***ANALYSIS***, is the heart of the report and is devoted to the findings of the field visits. Following every attitudinal survey results, there are sub-sections that focus on discussions with the respondents that were conducted for purposes of triangulation; these discussions are organised as: '*Weaknesses*' and '*Strengths*'.

Section 4: ***CONCLUSIONS***, provides overall assessment of the relevance of the intervention, achievement of objectives and progress towards outcomes, and performance of partners.

Section 5: ***LESSONS LEARNED*** *and* ***RECOMMENDATIONS***, has essential lessons and recommendations that can be useful for the sub-programme improvement and similar other interventions by UNDP and other Development Agencies, and the government of South Africa. .

ANNEXES: the Terms of Reference (ToR), questionnaires and list of interviewees are included in this section.

1.1. Background and context

1.1.1. Overview of South African healthcare services

South Africa is ranked as an upper-middle-income economy by the World Bank and is regarded as one of the economic powerhouses of Africa. Its Department of Health aims to transform the public health system to reduce inequalities in the health system, improve quality of care and public facilities, boost human resources and step up the fight against HIV and AIDS, tuberculosis (TB) and other communicable diseases as well as lifestyle and other causes of ill-health and mortality.

Pertinent sections of the Constitution of the Republic of South Africa (Act 108 of 1996) provide for the rights of access to healthcare services, including reproductive health and emergency medical treatment. The National Health Act 61 of 2003 also provides for a transformed national health system for the entire Republic.

Since the advent of democracy, three distinct periods in the restructuring of the healthcare system can be identified: from 1994 to 1999, characterised by post-apartheid reconstruction; 1999 to 2004, largely defined by a changing disease profile and an attendant decline in life expectancy; and from 2004 onwards, which has seen an increase in the scaling up of primary healthcare programmes.

The South African Department of Health Special Programmes and Health Entities Management Programme supports the delivery of health services in provinces including primary healthcare, hospitals, emergency medical services and occupational health. The restructuring of the public health sector in post-apartheid era has achieved substantial improvements in terms of access, rationalisation of health management and more equitable health expenditure is about 8.6% of gross domestic product (GDP). Access to primary healthcare services, as measured by headcounts, reflects a consistent upward trend and immunisation coverage figures indicate a progressive increase in the number and percentage of children fully immunised.

However, the gains have been eroded by a greatly increased burden of disease related to HIV/AIDS, generally weak health systems management and low staff morale. The result is poor health outcomes relative to total health expenditure. Some countries that spend less of their GDP on health have better health outcomes. South Africa's poor showing has been attributed to the rapid escalation of HIV/AIDS and tuberculosis together with a weak primary healthcare (PHC) system.

Data[1] indicates that the under-five mortality, infant mortality and maternal mortality in South Africa are high and increasing. The under-five mortality rate has risen from 59(1998) to 104(2007) per 1000 live births, whereas the 2015 MDG target is 20. The infant mortality rate has remained virtually static at 54(2001) to 53(2007) per 1000 live births, which is equally far from the 2015 MDG target of 18. In the more rural part of the country the infant mortality rate is as high as 80 per 1000 live births. Notable is the maternal mortality ratio which has risen from 369 (2001) to 625 (2007) per 100,000 live births, almost doubling and almost 20 times higher than the 2015 MDG target of 38. There has also been a rapid increase in infectious diseases, with tuberculosis becoming the leading registered cause of death, and the proportion of the deaths due to infectious and parasitic causes has increased from 13.1 per cent to 25.5 per cent from 1997 to 2006.

Other health system challenges include inadequate access, coverage and quality of services; limited governance and management capacity; and limited human resources.

1.1.1.1. Human resources

The extensive and changing burden of disease in South Africa has several implications for human resource development and planning: Health professional training and development must provide for a wide spectrum of conditions.

There were 162,630 health professionals registered with the Health Professions Council of South Africa (HPCSA) in a number of professional categories in June 2011. In addition there were

[1] National Department of Health of South Africa. 2011. Human resources for health South Africa: HRH Strategy for the Health Sector: 2012/13 – 2016/17

231,086 nurses registered with the South African Nursing Council (SANC) in 2010. In 2010 the Pharmacy Council had 12,813 pharmacists and 9,071 pharmacist assistants registered.

South Africa has a shortage of doctors (see also Tables 1 & 2) and other health professionals, but not necessarily a shortage of nurses. It does depend however on competence and type of skills the nurses have and the management of health needs in relation to outcomes. South Africa would need 60,000 more doctors to have the same doctor to population ratio as Brazil.

The supply of health professionals in South Africa is not being actively managed. According to the South African National Department of Health a review of the supply of health professionals in South Africa indicates the following:

- There was a stagnant to negative growth in public sector clinical posts for 10 years from 1997 – 2006;
- Sufficient planning and budgeting for clinical posts in the public sector is not undertaken;
- The numbers of health professionals in the public sector have started to grow slowly since 2002;
- There is high attrition from the key health professions;
- There is insufficient retention of Community Service professionals with about 23.1% indicating they are likely to leave the country due primarily to working conditions in the public sector;
- There is a lack of retention of health professional graduates in the public health sector due to various 'push' factors and limited public sector posts;
- There is a maldistribution of health professionals between rural and urban areas, and the public and private sectors, and this pattern has not changed in the past 15 years;
- There are high numbers of 'vacancies' in the public sector although this data is not reliable and it would be impossible to fund the 'unfilled' posts;
- South Africa compares poorly with its peers in relation to health professionals per 10,000 and health outcomes; and
- Foreign recruitment is not managed efficiently and effectively.

The total number (public and private), as well as the distribution per 10,000 population for the 27 key professions for all provinces, are shown in Table 2 and Figure 2. There is large variance between the provinces, for example, the ratio of Human Resource for Health per 10,000 population of 33.06 in the North West is less than half of the ratios in Gauteng, and the Western Cape. The Eastern Cape has just over half the density of health professionals per 10,000 compared to that of Gauteng and the Western Cape.

Table 2. Public & private health professionals per 10,000 population per province, 2010.

Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	North-West	Northern Cape	Western Cape	Total
44.83	52.01	69.21	58.83	48.83	45.24	33.06	55.53	74.08	481.62
9%	11%	14%	12%	10%	9%	7%	12%	15%	100%

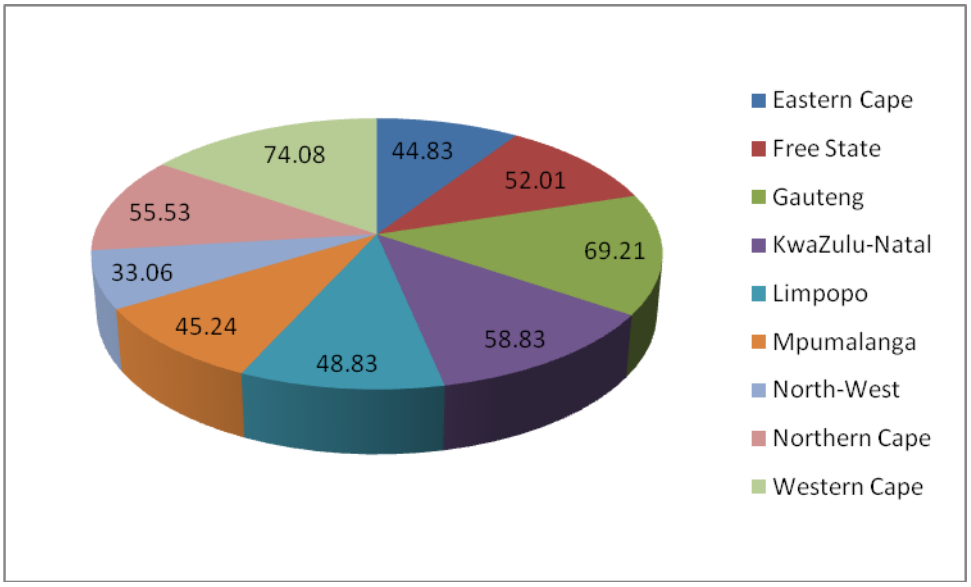

Figure 2. Public & private health professionals per 10,000 population per province, 2010.

Table 3. Percentage increase in selected public sector health professionals, absolute & per population, 2002-2010.

Occupational classification	Absolute numbers				Per 10, 000 uninsured population			
	2002	2010	% increase	Average annual increase	2002	2010	% increase	Average annual increase
Medical Practitioners	7291	11664	60.0%	6.1%	1.89	2.85	50.6%	5.3%
Medical specialists	3585	4513	25.9%	3.0%	0.93	1.10	18.5%	2.3%

Occupational classification	Absolute numbers				Per 10, 000 uninsured population			
	2002	2010	% increase	Average annual increase	2002	2010	% increase	Average annual increase
Professional Nurses	40786	55309	35.6%	3.9%	10.57	13.49	27.6%	3.1%
Dental practitioners	527	828	57.1%	6.3%	0.14	0.20	47.9%	5.5%
Pharmacists	1234	3285	166.2%	13.8%	0.32	0.80	150.6%	13.0%

Source: Source: National Treasury / Persal

A notable trend in human resources for Health in South Africa is the migration of South African trained health professionals abroad. A lack of employment opportunities and an unfavourable working environment in the public sector, results in health professionals pursuing careers outside of South Africa. For the average annual increase of health professionals see Table 3.

A range of issues affect the attrition rate of health professionals from South Africa, which is conservatively estimated at an annual rate of 25%. In additional there is 6% attrition rate due to retirement, death and change in profession. The attrition of Community Service professionals leads to a notable loss of trained professionals to the health system. A survey of medical Community Service professionals in 2009 reported that 17% did not report for Community Service, and a further 6.1% reported that they would emigrate after completing Community Service.

Factors affecting attrition and migration are: lack of posts in the public sector, HIV &AIDS, working conditions, workload in the public sector, workplace security, relationship with management in the public sector, morale in the workplace, risk of contracting TB, personal safety, etc. Lifestyle and income were not the most significant factors.

To make up for the shortages the National Department of Health recruits health professionals from other countries. The current policy of the Department is to limit recruitment of foreign doctors to a maximum of 6% of the medical workforce and only to use country-to-country agreements. There are currently 3,004 foreign doctors in South Africa (approximately 10% of the medical workforce).

1.1.1.2. Access to health professionals in rural areas

In South Africa 43.6% of the population live in the rural areas. However, they are only served by 12% of the doctors and 19% of nurses. Of the 1200 medical students graduating in the country annually, only about 35 end up working in rural areas in the longer term.

Lack of health professionals in rural areas is affected by funding, historical deficiencies in infrastructure, fear of safety, lack of opportunities for schooling for children, lack of work opportunities for spouses of health workers, poor social infrastructure and a lack of strategies to recognise and compensate for these negative factors.

1.1.2. Overview of Limpopo health and socio-economic profile

Limpopo is South Africa's northernmost province which shares borders with Mozambique, Zimbabwe and Botswana, making it the ideal entrance to Africa. The southern border of the province neighbours on Gauteng, Mpumalanga and North West. Named after the great Limpopo River, Limpopo is rich in wildlife with spectacular scenery and a wealth of historical and cultural treasures. The provinces position makes it a perfect stopover between Gauteng and the northern areas of the province and between the country's North-Western areas and the world-renowned Kruger National Park.

There are five municipal districts and 25 subdivisions of local municipalities in Limpopo. These municipalities are focused on growing local economies and providing infrastructure and government services to all citizens in the province.

1.1.2.1. The Limpopo Province Demographic Profile

The Province covers an area of 125 701.86 sq km, which represents 10.2% of the area of South Africa. The geographic location of the Province is seen as an opportunity to promote trade in manufactured goods within the Southern Africa Development Community (SADC) and the rest of Africa. The capital city of the Province, Polokwane, has a potential to develop into the logistical centre for the region.

Mid-year 2005 population estimates[2] for Limpopo was 5 554 657, which represents about 10.98% of the entire population of the country. This makes Limpopo the fourth most populated province in the country after Gauteng, KwaZulu-Natal, and Eastern Cape respectively. The total population comprises 54.6% female and 45.4% male.

The population of Limpopo is youthful with 35.7% (2, 5 million) being children under the age of 15 years. Close to six out of ten people (59.6% or 3.1million) are economically active (15 – 64 years) while elderly people are in the minority making up 4.7% of the province's population.

1.1.2.2. Estimated Population by District

From a district perspective, Limpopo consists of five districts as indicated in Table 4. The province's population is unevenly distributed among the districts, with 47.4% of the population concentrated in Vhembe and Capricorn Districts. The 2009 population estimates highlight migration as a key demographic process in the explanation of the current population distribution in Limpopo. When it comes to gender structure, districts generally emulate the provincial picture – females outnumbering males - with the exception of Waterberg District where males slightly outnumber the females (50.4 %).

Table 4. Estimated population for Limpopo by district and gender, 2009[3]

District	Male	Female	Total population estimate	Percentage share of the provincial population
Capricorn	595 369	645 199	1 240 569	23.73
Vhembe	582 122	655 203	1 237 324	23.67
Waterberg	299 798	295 193	594 991	11.38
Mopani	510 695	555 629	1 066 324	20.40
Sekhukhune	507 116	580 876	1 087 992	20.81
Total	**2 495 100**	**2 732 100**	**5 227 200**	**100.0**

[2] Statistics South Africa. 2011. Mid-year population estimates. http://www.statssa.gov.za/publications/P0302/P03022011.pdf
[3] Department of Health (Limpopo). 2011. 2011/12-2013/14 Annual Performance Plan Vote 7: Health.

1.1.2.3. Socio-economic Profile of the Limpopo Province

Limpopo is a typical developing area, with many rural people practising subsistence farming. Community, social and personal services; agriculture, forestry and hunting; and the wholesale and retail trade are the largest economic sectors among the employed aged 15-65 years The rate of unemployment in Limpopo province was estimated at 22.6% during the second quarter of 2010. This portrays Limpopo province as one of the provinces in the country with lowest unemployment rate following Western Cape (21.8%) and KwaZulu-Natal (20.8%). Available information shows that one in three people (33.4%) aged 20 and older has had no formal education. Such a scenario of having 80% of the population based in rural areas with high illiteracy levels and unemployment fuels the risk of HIV infection.

It is this environment in the Province that creates the need for a multisectoral Provincial response with game changers to effectively manage the scourge of HIV as well as TB. For distribution of health facilities in the province see Figure 3.

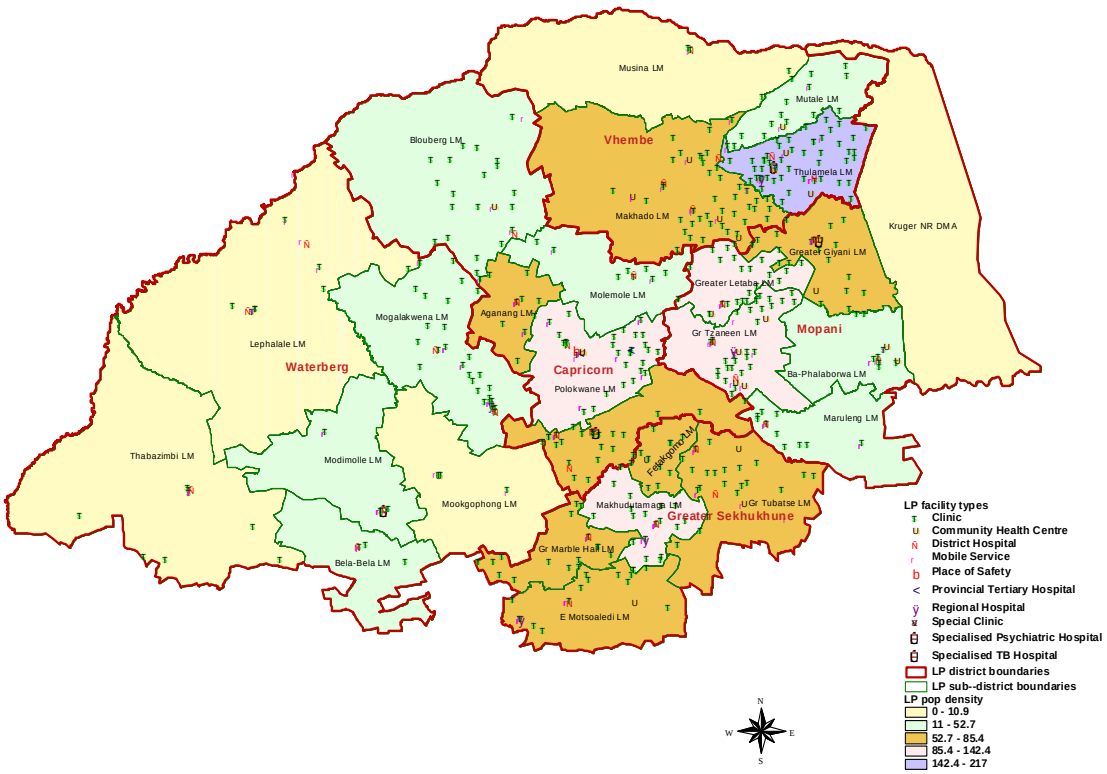

Figure 3. Location of Limpopo Health Facilities

1.1.2.4. Epidemiological profile/burden of diseases

There were a few outbreaks of communicable diseases and severe emerging infectious diseases, particularly severe acute watery diarrhoea's (cholera) and more recently H1N1 influenza[4]. Limpopo reported a total of 4 634 cholera cases with 30 laboratory confirmed deaths (case fatality rate of 0.65%) from 15th November 2008 to 01 June 2009. The majority of the cases were females which accounted for 51% (2 667) whilst children less than five years of age accounted for 14.2% (652).

Human rabies is the most fatal disease in Limpopo as it has a case fatality of 100%. The incidence of confirmed human rabies in Limpopo has decreased from 22 in 2006, to two in 2007, two in 2008, and one in 2009. A total of 7122 animal bites were reported from health facilities in Limpopo for the financial year 2008/2009.

Although malaria cases have showed a gradual decline over the past 10 years, the malaria case fatality rate remains above the National Target of 0.5 %. Seasonal malaria increases are also experienced during the malaria season, with upsurges experienced during the 2010/2011 financial year.

The prevalence of HIV varies considerably at provincial level with KwaZulu-Natal registering the highest prevalence of 39.5% in 2009 and Western Cape is the lowest hit province with prevalence of 16.9%. Limpopo has been the third lowest province since 1990 and currently with the prevalence of 21.4% (the 2009 national prevalence rate is 29.4%).

The prevalence of HIV in Limpopo varies among the districts which is not a unique feature for this particular province. The prevalence varies not only between districts but also within districts over time. Generally HIV prevalence is higher in Waterberg and Mopani districts than in the remaining three districts, with Vhembe district registering the lowest prevalence since 1990. HIV/AIDS was the leading cause of premature mortality and accounted for a third of the total years of life lost, 40% for females and 28% for males.

[4] Department of Health (Limpopo): 2011/12-2013/14 Annual Performance Plan. Vote 7: Health.

Key challenges identified by the Provincial Department of Health include:

- Shortage of health professionals;
- Reaching equity target for people with disabilities;
- Poor quality of care – e.g. long queues, low Emergency Medical Services (EMS) response times, bad staff attitude, inadequate infection control, cleanliness, safety of staff and patients;
- Infant and maternal mortality remain a challenge;
- Increased burden of diseases such as non communicable diseases (cancer, hypertension etc.) which pose a threat to the health status of the people;
- Inadequate pharmaceutical supplies (inability of contracted suppliers to deliver);
- Inappropriate referral system;
- Inadequate and inappropriate health infrastructure;
- Incomplete Health Information System.

1.1.2.5. Limpopo provincial health services delivery model

The mission of the Limpopo Provincial Department of Health is to provide accessible, comprehensive, integrated, sustainable and affordable health services. The Department focuses mainly on the following priorities to further improve health services in the province as outlined in the Social Cluster Programme of Action and the Negotiated Service Delivery Agreement of the Health Sector which focuses on the following four strategic outcomes:

- Increasing Life Expectancy
- Decreasing Maternal and Child mortality
- Combating HIV and AIDS and decreasing the burden of diseases from Tuberculosis
- Strengthening Health System Effectiveness

The Primary health care approach was adopted by the Province as a strategy to reach all communities in the Province through Community Health Centres, fixed clinics, and Mobile services. Primary health care facilities in the Province increased from 316 in 1994 to 416 in 2008

and those providing 24 hour service increased from 164 in 1994 to 321 in 2008. All these facilities are implementing the Primary Health Care Package (see Table 5).

Table 5. Hospital services packages.

Regional hospitals (specialist services)	District hospitals (section/area)
Anaesthetics	Out-Patients Department (OPD)
Diagnostic Radiology	Casualty
General Medicine Services	Theatre/Anaesthetic
General Surgery Services	Radiography
Mental Health Services (Psychiatry & Psychology)	Laboratory (NHLS)
Obstetrics & Gynaecology Service	Medicine
Ophthalmology Specialist Service	Obstetrics
Orthopaedic Service	Paediatrics
Paediatrics Service	Psychiatry
Rehabilitation Centre	Surgery
	Gynaecology

1.1.2.6. Distribution of Health Services in Limpopo

The health services are provided through two Tertiary hospitals in Polokwane (Pietersburg) and Mankweng; five Regional hospitals; 30 District hospitals; 24 Community Health Centres (CHCs); 440 Fixed Clinics; and 4473 Non Fixed Clinics as detailed in Table 6. The network of health institutions is managed from the provincial Department of Health in Polokwane.

Table 6. District health service facilities by health district 2009/10.

Health district	Facility type	No.	Population (non-insured)	Per capita utilisation
Waterberg District	Non fixed clinics	1337	670 646	2.1
	Fixed Clinics	57		
	CHCs	1		
	District hospitals	7		
Sekhukhune	Non fixed clinics	402	1 041 457	2.3

Health district	Facility type	No.	Population (non-insured)	Per capita utilisation
District	Fixed Clinics	84		
	CHCs	3		
	District hospitals	5		
Capricorn District	Non fixed clinics	307	1 247 760	3.1
	Fixed Clinics	94		
	CHCs	4		
	District hospitals	6		
Vhembe District	Non fixed clinics	1033	1 295 079	3.5
	Fixed Clinics	112		
	CHCs	8		
	District hospitals	6		
Mopani District	Non fixed clinics	1 394	1 147 961	3.0
	Fixed Clinics	93		
	CHCs	8		
	District hospitals	6		

1.1.2.7. The State of Medical Human Resources in Limpopo

The Department successfully implemented the Occupational Specific Dispensation (OSD) for medical doctors, dentists, pharmacists, and EMS personnel, in the 2009/10 financial year. Two hundred and fifty new bursaries were awarded to health professionals and 16 to medical students studying in Cuba. However, the Department still experience a challenge of shortage of health personnel as shown in Table 7.

Table 7. Public health personnel in 2009/10[5].

Categories	Number employed	Number per 100,000 people	Vacancy rate
Medical officers	923	18	64.6%
Medical specialists	83	2	79.4 %
Dentists	92	2	67.5%
Professional nurses	7144	136	48.4%
Enrolled Nurses	2782	53	51.2%
Enrolled Nursing Auxiliaries	4516	86	35.7%
Student nurses	770	15	-
Pharmacists	266	5	52.4%
Physiotherapists	108	2	67.4%
Occupational therapists	88	2	72.8%
Radiographers	115	2	68.8%
Emergency medical staff	1456	28	51%
Dieticians/ Nutritionists	131	3	60.9%
Community Care-Givers (even though not part of the PDoH staff establishment)	131	3	-
Total	**18775**	**-**	**-**

Source: Department of Health (Limpopo): 2011/12-2013/14 Annual Performance Plan. Vote 7: Health.

[5] This table comprises of provincial health personnel. Populations are those of resident people; Interns and community service health professionals have been included.

Section 2: DESCRIPTION of the EVALUATION

2.1. UNV Sub-programme summary

This sub-programme, Health Professionals Volunteerism and Capacity Development, is one component of the UNV/UNDP Programme of assistance to the Government of South Africa to improve health care service delivery in Limpopo Province(ATLAS Award ID: UNDP Support to the Health Sector in Limpopo, Award ID: project 00075206). The other three components (sub-programmes) of the Programme are: Health Planning Support, Knowledge Management and Leadership Development, and MDGs, Monitoring and Evaluation System.

This sub-programme is the Third Phase (2009 -2014) of the UNDP Support to the Health Sector in Limpopo which is an extension of Phase I and Phase II, the objective of which is to provide assistance to the Government of South Africa to improve its health care services in Limpopo Province. The resource allocation for this sub-programme is 30,667,000 USD (excluding overhead and administrative costs).

UNDP support to the health sector will provide needed scarce health professionals (120 medical doctors, 12 clinical engineers, 40 pharmacists, and 20 UNV Specialist Nurses) as a strategy to attend to personnel shortage in the short term, and also transfer skill and a spirit of volunteerism to local health professionals.

This was pursued under the following key objectives of the sub-programme as stated in the Programme Support Document (PSD):

a) Recruitment and deployment of health professionals
b) Providing care and support to UNVs
c) A successfully implemented mentorship programme
d) A successful volunteerism programme to enhance commitment of local health professionals to serve in disadvantaged areas as a result of an increased appreciation of volunteerism
e) A successfully institutionalized retention strategy for local doctors and health personnel

The expected outcomes of the sub-programme are:

a) Improved healthcare service delivery in Limpopo Province
b) Increased culture of volunteerism
c) Improved retention rate of health professionals

2.1.1. The Volunteerism dimension

According to the UN there are three key defining characteristics of volunteering[6].

Firstly, the activity should not be undertaken primarily for financial reward, although the reimbursement of expenses and some token payment may be allowed.

Secondly, the activity should be undertaken voluntarily, according to an individual's own free-will. The decision to volunteer may be influenced by peer pressure, personal values or cultural or social obligations but the individual must be able to *choose* whether or not to act[7].

Thirdly, the activity should be of benefit to someone other than the volunteer, or to society at large, although it is recognised that volunteering brings significant benefit to the volunteer as well. Within this broad conceptual framework it is possible to identify at least four different types of volunteer activity: mutual aid or self-help; philanthropy, service to others; participation or civic engagement; and advocacy or campaigning. Each of these types occurs in all parts of the world.

This concept of volunteerism is not alien to the South African context as it is closely related to the values of *Ubuntu*. Based on the above views of volunteerism and the spirit of *Ubuntu* the UNDP facilitates the development and institutionalisation of the local volunteerism programme which is aimed at recruiting and encouraging local professionals to volunteer their skills and time toward health service delivery in Limpopo. Currently the health sector is characterized by a low culture of volunteerism amongst health professionals and requires a systematic intervention.

[6] United Nations Volunteers Report, prepared for the UN General Assembly Special Session on Social Development, Geneva, February 2001
[7] United Nations Volunteers (UNVs). 2011. State of the World's volunteerism Report: Universal Values for Global Well-being.

Although there is a very limited extent of volunteerism amongst local health professionals, the government still believes that the spirit of volunteerism is a fundamental component of active citizenship, which is a vehicle for individuals to engage in society. In order to build strong information sharing networks it is important that people who believe in the greater goals work together in order to achieve the greater outcomes. The recruited international volunteer health professionals will be utilized to encourage local volunteerism especially in the provincial health sector. The envisaged result of this engagement is the increased culture and appreciation of volunteerism, which would ultimately increase the number of local health professional volunteers in the province[8].

2.1.2. Target beneficiaries

The programme document identifies the primary target beneficiaries as the people of Limpopo, who will benefit from improved quality and access to health services. Other institutional beneficiaries include the Department of Health, health facilities and higher learning institutions through transfer of skills and knowledge exchange programmes.

Health professionals and management (viz. nurses, doctors, senior managers and hospital management teams) will benefit from on-the-job training, mentoring and professionals' exchange programmes. It will also have wider long-term impact in the country by inculcating the spirit of volunteerism in the health profession.

2.1.3. Sub-programme justification: Phase III

Phase III is an extension of Phase and II of the sub-programme—UNDP Support to the Health Sector in Limpopo—the objective of which is UNV/UNDP assistance to the Government of South Africa to improve health care service delivery in Limpopo Province. Whilst the Phase I and II of the project have shown considerable outcomes, the implementation of the programme Phase III, would not only address shortages of health professionals through recruitment but would go a long way in sustaining achievements through its integrated and interactive approach towards the improvement of the quality of life of Limpopo citizens.

[8] UNDP Support to the Health Sector in Limpopo Programme (00039493): Phase III Programme Document

Like most poor and largely rural provinces in South Africa, the health service delivery in Limpopo has been affected negatively by a continued deficit of health professionals as a result of the brain drain. As a result, Limpopo Province has chronic shortages of health professionals in all specialties, as well as a low culture of volunteerism, especially in the health sector. Most health professionals prefer to work outside the province and in the private sector in particular. The current ratio of doctors to patients is 4:100,000 in Limpopo. The shortage of human capacity, and doctors in particular, as well as the need for capacity development of clinical skills (for example, clinical engineers, pharmacists and specialized nursing, amongst others), severely impedes on health service delivery in the province.

This intervention is in line with the country's Medium-Term Strategic Framework that seeks to improve the nation's health profile and skills base and ensures universal access to basic services. Improving access to health services and achieving better clinical and patient outcomes from the public health system is a central goal of South African government's health care services. In the short term this sub-programme will therefore contribute to the alleviation of the scarcity of skills, especially in rural areas of Limpopo.

2.1.4. Sub-programme management arrangements

As indicated above this sub-programme is a component of the Programme of 'UNDP Support to the Health Sector in Limpopo' and is managed by a program manager from the office of the Programme Management Unit (PMU) in Polokwane. All the teams (Programme Manger, Sub-programme Officers, and Programme Coordinator and Administrator) working towards the goals of the programme will be located in the current office of the Programme Management Unit, coordinated by the Programme Manager (see Figure 4). This will greatly enhance coordination, communication and common planning. However, no sub-programme officer was allocated so far and it has been managed directly by the Program Manager.

The Provincial Department of Health of Limpopo is responsible for political leadership and strategy focus of the programme including the placement of UNV medical professionals within health facilities in the province.

The programme will be implemented by the UNDP within the delegated National Execution modality, in line with the UNDP Programming for Results management User Guide. The UNDP Programme Official would serve the role of Programme Assurance by supporting the board and carrying out objective and independent oversight and monitoring of the programme. He would ensure that appropriate programme management milestones and managed and completed.

The Programme Board will be established to provide leadership and guidance as well as policy advice and input regarding the overall implementation and running of the programme. The board comprising of focal persons from the Provincial Department of Health of Limpopo, UNDP, and the Programme Manager (Ex officio) would meet regularly to review the implementation of the programme to discuss key strategic matters related to progress and implementation of the programme.

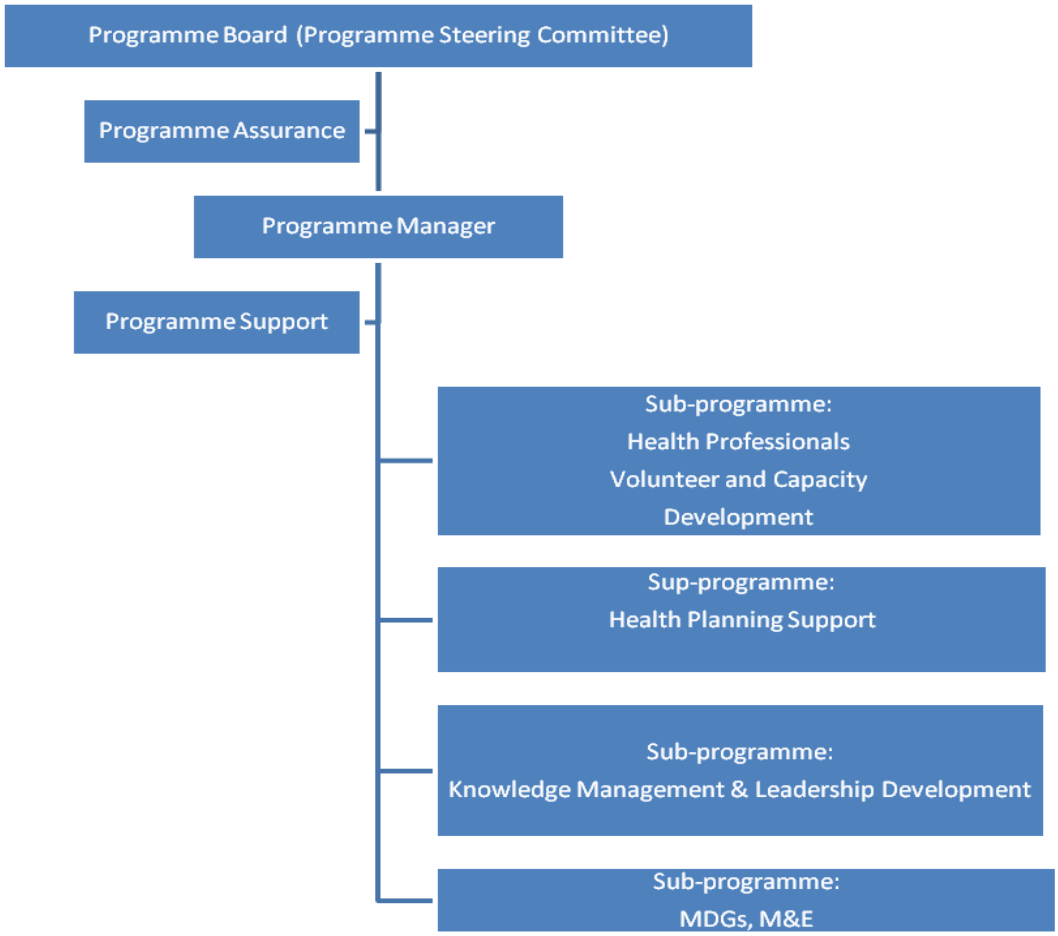

Figure 4. Programme Management Arrangements.

2.1.5. Sustainability and Risks

- The biggest envisaged risk of the sub-programme is unclear commitment for continuous funding from Government and UNDP/UNV.
- The absence of effective Monitoring and Evaluation could result in the inability to identify emerging issues, slow/inadequate responses, limited generation and sharing of knowledge/lessons.
- Lack in effective administrative support and Programme co-ordination to UNVs could also lead to dissatisfaction amongst UNVs and/or diminished interest of future UNVs recruits.

These risks indicate that the sub-programme may have negligible effect on volunteerism and the brain drain of health professionals in the Limpopo Province. At best the sub-programme can only be a temporary solution of skill shortages to save lives in the deprived rural areas.

2.1.6. Purpose of the Evaluation

The purpose of this outcome evaluation is to determine the contribution of the UNV sub-programme to the health service of Limpopo and draw lessons in view of improving implementation for the remaining period of Phase III. The results of the evaluation will be used by all stakeholders to review the sub-programme's role in the achievement of the stated objectives.

2.1.7. Evaluation scope and objectives

The scope of the evaluation is to address all the issues regarding the relevance, efficiency, effectiveness, or sustainability of the sub-programme's intervention in the health service of province of Limpopo.

The main objectives of the outcome evaluation as detailed in the ToR include:

- to analyse and evaluate the effectiveness of the results that the sub-programme has been able to achieve against the objectives as stated in the programme document;
- to assess the effectiveness of the work and processes undertaken in the sub-programme as well as the performance of all the partners involved in the project implementation;

- to assess whether the sub-programme is the appropriate solution to the identified problem(s);
- to determine the sub-programme relevance, and sustainability of results and benefits
- to provide feedback and recommendations for subsequent decision making and necessary steps that need to be taken by the national stakeholders in order to ensure sustainability of the sub-programme outcomes/results;
- to reflect on how efficient the use of available resources has been;
- to document and provide feedback on lessons learned and best practices generated by the sub-programme during their implementation;
- to identify unintended results that emerged during implementation (beyond what had initially been planned for);
- to identify other factors that contributed to the outcomes, if any; and
- to identify key adaptations in response to unforeseen circumstances; and
- to ascertain whether UNDP's partnership strategy has been appropriate and effective.

Special focus was given during the evaluation process to explore the following issues:

- Skills transfer from the UNVs to locals and vice-versa;
- The efficiency and effectiveness of the promotion of volunteerism amongst local medical staff and professionals, and the public;
- The role of sub-programme stakeholders;
- The organizational capacity of the sub-programme in achieving stated outcomes and objective; and
- Conclusions, recommendations, and lessons learned from the sub-programme enable the necessary changes to reach expected results.

Moreover, the outcome evaluation questions addressed how the program activities relate to changes in KASA (knowledge, attitude, skills, and aspirations), behaviours, and functioning of participants. In other words, this evaluation exercise determined if UNV/UNDP interventions brought about KASA and behaviour changes as the main measure of program effects on participants.

2.1.8. Deliverables of the evaluation

The deliverable of the evaluation will be a comprehensive analytical report to be submitted to the UNDP M&E Officer for approval and dissemination to relevant parties.

2.1.9. Organisation and responsibility of the evaluation mission

The evaluation was commissioned by the UNDP Country Office, Pretoria under the supervision of the M&E Officer, Mr Frederick Shikweni, and the main coordinator in Limpopo was the PMU Manager, Mr Joseph Mhlaba. An independent consultant, Dr Faniel Sahle Habtemichael, was appointed to conduct the evaluation and has fulfilled the requirements as stipulated in the ToR. The PMU office in Limpopo also assisted in coordination of the field visits.

2.1.10. Evaluation time frame

The sub-programme evaluation was conducted during November and December 2011 and took 50 working days until the submission of the final report as indicated in Table 8 below.

Table 8. Evaluation time frame.

Stage	Main Tasks	Working days required (man days)
Phase I	Briefings of evaluator and collection of documents	1
	Finalising the evaluation design and methods and preparation of roadmap	2
	Designing and preparation of data collection tools	3
	Presentation of evaluation methodology and data collection tools to UNDP	1
Phase II	Desk review of sub-programme documents and reports as provided by UNDP	3
Phase III	Evaluation mission (field visits to UNV placements for data collection in Polokwane), UNDP Country Office, and follow up telephonic interviews	20
Phase 4	Analysis and drafting of report	15
	Finalising and submitting the evaluation report to UNDP	5
	Total	**50**

2.1.11. Evaluation methodology

The evaluator developed a methodology that responds to the key issues and the requirements and expectations as set out in the Terms of Reference. This involved formulating an evaluation strategy that best achieved the objectives of the evaluation.

The evidence base for the evaluation included literature review, sub-programme documentation review, interviews, and focus group discussions. Closed-ended questionnaires were also used as a triangulation method. The evaluator would have wanted to use preliminary meeting of stakeholders (including authorities from the Provincial Department of Health, hospital management of regional and tertiary hospitals) to present the methodology and research tools in order to get feedback before the actual field work starts. However, this was not possible due to the constraint of time.

The sub-programme document does not have all the required performance indicators (activity/process, output, and outcome) for the objectives and outcomes, and the evaluator had to develop them before conducting the field work.

2.1.11.1. Documentary review

The evaluator had preliminary meeting at the UNDP Country Office in Pretoria and collected the required sub-programme documents and reviewed them before developing the questionnaire. This included UNVs Conditions of Service for international UNV volunteers, UNDP Support to the Health Sector in Limpopo: Phase III Programme Document, previous sub-programme evaluation and quarterly reports, and other relevant literature.

2.1.11.2. Sampling approach and data collection

The evaluator had a meeting with the PMU office in Polokwane to discuss about the scheduling of the site visits and directions to the hospitals. He obtained coordinates from the office and managed to visit all hospitals where UNVs were placed.

Due to the nature of the sub-programme the sampling method adopted was non-probability, mainly purposive and convenience. Respondents were categorised into four groups depending

on their homogeneity, and doctors from the same department, nurses who closely work with the UNVs, clinical managers and hospital chief executive officers (CEOs) were interviewed separately. All UNVs who were available at the workplace at the time of the visit were interviewed; one who was at a conference was also interviewed telephonically. Relevant staff from UNDP, Provincial Department of Health, and PMU were also interviewed. The questions were organised along themes as shown in Table 9. The full questionnaire is attached as Annex II .

Table 9. Evaluation theme and respondent categories.

Evaluation Theme	Purpose	Respondent groups			
		UNVs	Hospital management and partners[9]	Co-workers	
				Local doctors	Nurses
Achievement of sub-programme objectives	These set of questions address if objectives, as stipulated in the sub-programme document, were achieved	•	•	•	•
Achievement of sub-programme outcomes	These set of questions address if outcomes, as stipulated in the sub-programme document, were achieved	•	•	•	•
Administrative efficiency	The aim of these questions was to understand the efficiency and quality of management responses to issues of UNVs as they emerge during the process	•	•		
Relevance	The purpose of these questions was to determine the relevance, sustainability, challenges, and lessons learned	•	•	•	•

All of the questions were open- and closed-ended. The closed- ended questions were attitudinal administered by respondents while the open-ended questions were presented by the evaluator during the focus group discussions.

[9] Provincial Department of Health; PMU; UNDP Country Office

2.1.11.3. Limitation of the evaluation

The sub-programme does not have a full-fledged M&E framework and it has been difficult to assess progress against baseline. This was compounded by the absence of sufficient databases with baselines in hospitals to measure the actual contribution of UNVs in service delivery.

Hospitals did not have sufficient information about the expected results of the sub-programme and, hence, they have not been tracking achievements against sub-programme indicators. The evaluator found it very difficult to get reliable information based on statistical evidence on the actual contributions of the sub-programme. For example, hospitals do not have complete information including on patient waiting time, reduction of child and maternal mortality rates because of the UN intervention, health professionals' retention rate, etc. Furthermore, hospitals do not report on the performance of UNVs quarterly, they only report when they finish their contracts. This makes it difficult to keep track and provide up-to-date information on the actual contributions and changes brought about by the UNVs.

Section 3: KEY EVALUATION FINDINGS and ANALYSIS

3.1. Profile of the UNVs doctors

A total of 41 UNVs are currently deployed in 14 hospitals (two Tertiary, five Regional, and seven District). Their distribution is 9 UNVs in Tertiary, 19 in Regional, and 13 in district hospitals. 29 UNVs, i.e. 71% of them were appointed and deployed in this Phase III while the rest 12, i.e. 29% in the previous phases (see Table 10 & Table 11).

Majority of the UNVs are Filipinos (11), followed by Russians (8), Indians (5), Ukrainians (4), Pakistanis (2), Myanmar (2), and Bangladeshi, Canadian, Dutch, Egyptian, Nigerian, Sierra Leonean, Sudanese, Tanzanian, and Ugandan.

Table 10. UNVs currently under the sub-programme (end of December 2011)

No.	Gender	Nationality	Specialisation	Duty Station (Hospital)	Appointment date	Contract Expiry date
1	F	Filipino	Anaesthesia	St Ritas	09/ 2011	09/2012
2	M	Ukrainian	Anaesthesia	Philadelphia	07/ 2007	07/ 2012
3	F	Filipino	Anaesthesia	Tshilidzini	09/ 2011	09/ 2012
4	M	Ukrainian	Anaesthesia	Elim	11/ 2006	11/ 2012
5	M	Russian	Anaesthesia	Polokwane/ Mankweng	09/ 2011	09/ 2012
6	M	Myanmar	Anaesthesia	Mokopane	12/2011	12/2012
7	M	Sudan	Anaesthesia	Tshilidzini	10/2011	10/2012
8	M	Indian	Cardiologist	Polokwane/Mankweng	09/ 2008	09/ 2012
9	M	Indian	Cardiologist	Polokwane/Mankweng	11/ 2011	11/ 2012
10	F	Filipino	Dermatologists	Tshilidzini	09/ 2006	09/ 2012
11	F	Russian	Endoscopy	Mokopane	02/ 2008	02/ 2012
12	M	Filipino	Family Medicine	Mecklenburg	08/ 2008	08/2012
13	F	Bangladeshi	Family Medicine	Zebediela	07/ 2008	07/ 2012
14	M	Filipino	Family Medicine	Tshilidzini	09/ 2006	09/ 2012
15	M	Pakistani	Family Medicine	Siloam	10/ 2010	10/ 2012
16	M	Pakistani	Family Medicine	Sekororo	09/ 2011	09/ 2012

No.	Gender	Nationality	Specialisation	Duty Station (Hospital)	Appointment date	Contract Expiry date
17	M	Nigerian	Family Medicine	Dilokong	12/2011	12/ 2012
18	M	Sierra Leonean	Family Medicine	Sekororo	10/ 2011	10/ 2012
19	F	Tanzanian	General Practitioner	Mecklenburg	12/2011	12/2012
20	M	Egyptian	General Surgery	St Ritas	09/ 2011	09/ 2012
21	M	Indian	General Surgery	Mokopane	10/ 2011	10/ 2012
22	M	Russian	General Surgery	Letaba	08/ 2011	08/ 2012
23	M	Filipino	General Surgery	Tshilidzini	09/ 2011	09/ 2012
24	M	Russian	General Surgery	Tshilidzini	07/ 2011	07/ 2012
25	M	Dutch	General Surgery	Lebowakgomo	12/2011	12/ 2012
26	M	Filipino	General Surgery	Tshilidzini	10/ 2011	10/ 2012
27	M	Canadian	Internal Medicine	St. Ritas	06/ 2011	06/ 2012
28	F	Ukrainian	Internal Medicine	Elim	07/ 2011	07/ 2012
29	M	Filipino	Internal medicine	Polokwane/Mankweng	04/2011	04/ 2012
30	F	Ukrainian	Internal Medicine	Polokwane/Mankweng	10/ 2011	10/ 2012
31	M	Russian	Neurologist	Polokwane/Mankweng	05/ 2011	05/ 2012
32	F	Indian	Obstetrics and Gynaecology	Polokwane/Mankweng	09/ 2006	09/ 2012
33	M	Ugandan	Obstetrics and Gynaecology	Sekororo	07/ 2011	07/ 2012
34	F	Russian	Obstetrics and Gynecology	Letaba	08/ 2011	08/ 2012
35	F	Filipino	Obstetrics and Gynecology	Letaba	09/ 2006	09/ 2012
36	M	Filipino	Ophthalmology	Elim	08/ 2007	08/ 2012
37	M	Indian	Ophthalmology	Polokwane/Mankweng	04/ 2010	04/ 2012
38	M	Russian	Orthopaedic Surgery	Polokwane/Mankweng	05/ 2011	05/ 2012
39	M	Filipino	Paediatrics	St. Ritas	07/ 2007	07/2012
40	M	Myanmar	Paediatrics	Letaba	04/ 2011	04/ 2012
41	F	Russian	Paediatrics	Lebowakgomo	11/ 2011	11/ 2012

Table 11. Summary of the UNVs profile currently under the sub-programme (end of December, 2011)

Gender	
Female	12
Male	29
Nationality distribution	
Bangladeshi	1
Canadian	1
Dutch	1
Egyptian	1
Filipino	11
Indian	5
Myanmar	2
Nigerian	1
Pakistani	2
Russian	8
Sierra Leonean	1
Sudan	1
Tanzanian	1
Ugandan	1
Ukrainian	4
Total	**41**

Distribution of specialisation	
Anaesthesia	7
Cardiology	2
Dermatology	1
Endoscopy	1
Family Medicine	7
General Surgery	7
Internal Medicine	4
Neurology	1
Obstetrics and Gynaecology	4
Ophthalmology	2
Orthopaedic Surgery	1
Paediatrics	3
General Practitioner	1
Total	**41**

Distribution in health facilities	
Dilokong	1
Elim	3
Lebowakgomo	2
Letaba *(Regional)*	4
Mecklenburg	2
Mokopane *(Regional)*	3
Philadelphia *(Regional)*	1
Polokwane & Mankweng *(Tertiary)*	9
Sekororo	3
Siloam	1
St Ritas *(Regional)*	4
Tshilidzini *(Regional)*	7
Zebediela	1
Total	**41**

Table 12, shows the deployment of UNVs in tertiary, regional, and district hospitals by area of specialisation that has been fairly done according to the needs and vacancies of the health facilities.

Table 12. Deployment of current UNVs.

Hospitals	Area of specialisation													
	Anaesthesia	Cardiology	Dermatology	Endoscopy	Family Medicine	General Surgery	Internal Medicine	Neurology	Obstetrics & Gynaecology	Ophthalmology	Orthopaedic Surgery	Paediatrics	General Practitioner	Total
Dilokong					1									**1**
Elim	1						1			1				**3**
Lebowakgomo						1						1		**2**
Letaba (Regional)						1			2			1		**4**
Mecklenburg					1								1	**2**
Mokopane (Regional)	1			1		1								**3**
Philadelphia (Regional)	1													**1**
Polokwane & Mankweng (Tertiary)	1	2					2	1	1	1	1			**9**
Sekororo					2				1					**3**
Siloam					1									**1**
St Ritas (Regional)	1					1	1					1		**4**
Tshilidzini (Regional)	2		1		1	3								**7**
Zebediela					1									**1**
Total	**7**	**2**	**1**	**1**	**7**	**7**	**4**	**1**	**4**	**2**	**1**	**3**	**1**	**41**

As shown below (Figure 5), majority of the UNVs are specialists of Family Medicine, General Surgery, and Anaesthesia (17% each); followed by Obstetrics and Gynaecology, and Internal Medicine (10%each). The rest have specialisations in Paediatrics (7%); Cardiology, and Ophthalmology (5% each); Dermatology, Endoscopy, Neurology, Orthopaedic Surgery, and General Practitioner (2% each).

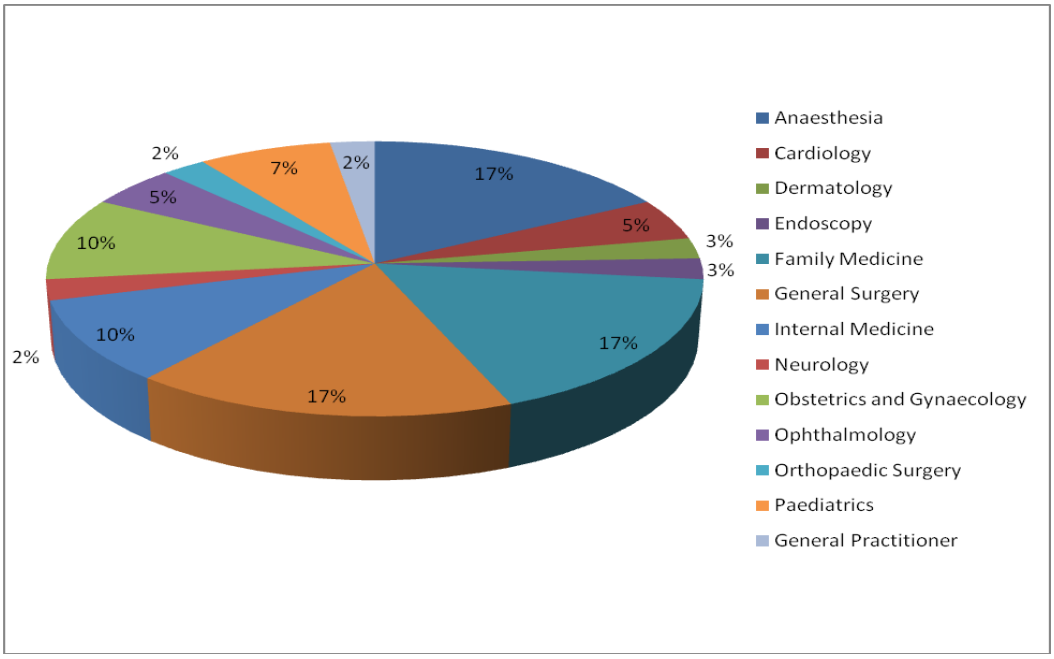

Figure 5. UNVs area of specialisation.

3.2. Sub-programme objectives

The evaluation for the sub-programme was pursued under the following key objectives of the sub-programme as stated in the Programme Support Document (PSD):

a) Recruitment and deployment of health professionals
b) Providing care and support to UNVs
c) A successfully implemented mentorship programme
d) A successful volunteerism programme to enhance commitment of local health professionals to serve in disadvantaged areas as a result of an increased appreciation of volunteerism
e) A successfully institutionalised retention strategy for local doctors and health personnel

To determine if the activities (processes) on track to produce the stated sub-programme objectives and thereby contribute to outcomes, the evaluator developed performance indicators for each objective. This was evaluated from the perspectives of the UNV doctors, co-workers (hospital management, doctors, and nurses who closely work with the UNVs), and UNV Programme Partners under various subthemes.

3.2.1. Recruitment, selection, and deployment of UNV health professionals

This subsection assesses the efficiency and effectiveness of the selection, appointment, and deployment of UNVs against the set target, as well as the professional quality of UNVs as perceived by co-workers.

Indicators
• Number of appointed UNVs against target • Sufficiency of induction procedures • Optimality of deployment • Staff perception of UNVs skills • Staff perception of UNVs work ethic

3.2.1.1. Number of appointed UNVs against target (achievement of output)

Table 13. Comparison between planned and actual UNVs appointed during Phase III.

Health professionals	Year 1 target Nov 2009-Dec 2010			Year 2 target Jan 2010-Dec 2011			Two-year Total		
	Planned	Appointed	Variance	Planned	Appointed	Variance	Planned	Appointed	Variance
Medical doctors	60	4	-56	30	31	0	90	35	-55
Clinical Engineers	4	0	-4	4	0	-4	8	0	-8
Pharmacists	15	0	-15	15	0	-15	30	0	-30
Specialist nurses	5	0	-5	10	0	-10	15	0	-15
Total	84	4	-80	59	31	-29	143	35	-108

The sub-programme had plans to appoint 60 and 30 medical doctors during 2010 and 2011 respectively. However, while the PMU could appoint all as planned in 2011, it could only appoint 4 out of the 60 that were planned for 2010. There were also plans to appoint 8, 30, and 15 clinical engineers, pharmacists, and specialist nurses respectively during November 2009-December 2011, but none was appointed (see Table 13).

Complete data is not available for the Phase I of the sub-programme. However, according to the available data a total of 36 UNVs (medical doctors) were appointed during Phase I and Phase II, and 35 in Phase III that make a total of 71 (see Figure 6) appointed since the beginning of the sub-programme. In terms of appointment performance Phase II did well as 34 out of the projected 40 (i.e. 85%) could be imported and deployed in hospitals.

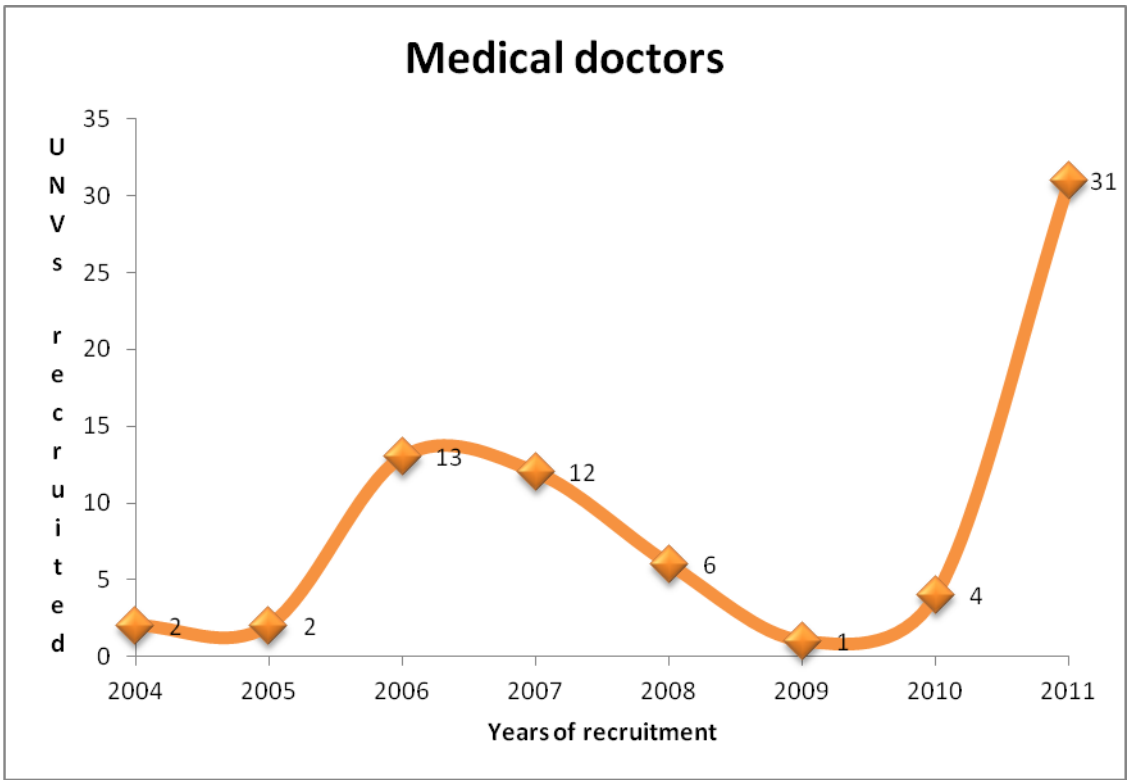

Figure 6. UNVs appointed over the years (2004-2011).

The appointment and deployment of the UNVs have been fluctuating over the years; after a steady decline from 2006 to 2009, there was a dramatic increase in 2011.

Majority of the current UNVs (27 out of 41), i.e. 66%, were appointed in 2011 as shown in Table 14.

Table 14. Year of appointment of current UNVs.

1st & 2nd Phases			3rd Phase		Total
2006	**2007**	**2008**	**2010**	**2011**	
5	3	4	2	27	**41**
12%	7%	10%	5%	66%	**100%**

3.2.1.2. Sufficiency of induction procedures

Respondent categories		Highly insufficient	Insufficient	Uncertain	Sufficient	Highly sufficient	Total
UNVs[10]		2	14		7	3	26
Co-workers	Management[11]	3	4	2	5	3	17
	Doctors[12]	1	12	3	5	4	25
	Nurses[13]	3	16	8	8	5	40
Total		**9**	**46**	**13**	**25**	**15**	**108**
%		8%	43%	12%	23%	14%	100%

This question was posed to all respondent categories (UNVs, hospital management, local doctors and nurses). They were asked to give their assessment of the induction procedures and about half (51%) felt that it was either 'Highly Insufficient' or 'Insufficient' while 12% were uncertain. 37% indicated that it was either 'Highly Sufficient' or 'Sufficient'.

UNVs were less satisfied with the induction procedures than the other groups with 62% of them expressing as 'Highly Insufficient' or 'Insufficient', followed by doctors (52%), nurses (48%), and management (41%).

3.2.1.3. Optimality of deployment of current UNVs

Respondent categories		Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Total
UNVs		2	4	2	14	4	26
Co-workers	Management	1	7		9		17
	Doctors	1	4		15	5	25

[10] Thirty-two (32) UNVs participated in the focus group discussions. However, only 26 completed the questionnaire—two could not complete because of language problem, and four were called for emergency to attend patients.

[11] Twenty (19) CEOs & clinical managers (Management) participated in the discussions but only 17 completed the questionnaire.

[12] Thirty (30) Doctors participated in the discussions but only 25 completed the questionnaire.

[13] Fifty-seven (57) Nurses participated in the discussions but only 40 completed the questionnaire.

Respondent categories		Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Total
	Nurses		2	9	19	10	40
Total		**4**	**17**	**11**	**57**	**19**	**108**
%		4%	16%	10%	53%	18%	100%

A question was directed to respondents to know their level of agreement in the optimality of the deployment Of UNVs. Majority of the respondents (71%) either 'Strongly agreed' or 'Agreed' that UNVs were deployed to where they were most needed, while only 20% thought otherwise. The distribution of these latter respondents is skewed as it is mostly the management category that felt the deployment was not optimal, i.e. almost half of the surveyed management 'Strongly disagreed' or 'Disagreed' in the deployment process.

3.2.1.4. Staff perception of UNVs skills

Respondent categories		Very unsatisfied	Unsatisfied	Uncertain	Satisfied	Very satisfied	Total
Co-workers	Management		5	4	5	3	17
	Doctors	4	5	3	12	1	25
	Nurses		2	13	15	10	40
Total		**4**	**12**	**20**	**32**	**14**	**82**
%		5%	15%	24%	39%	17%	100%

A question was also posed to co-workers to capture their perception on the knowledge and skills of the UNVs in relation to their prior expectations. Majority (56%) were either 'Very satisfied' or 'Satisfied' with the knowledge and skills possessed by UNVs. Only 20% of the respondents held the view that UNVs did not meet their expectations, though 24% (most of them nurses) were uncertain. Majority of the unsatisfied were their peers (local doctors) who closely worked with the UNVs.

3.2.1.5. Staff perception of UNVs work ethic

Respondent categories		Very poor	Poor	Uncertain	Good	Very good	Total
Co-workers	Management		1		11	5	17
	Doctors		1		20	4	25
	Nurses				12	28	40
Total		**0**	**2**	**0**	**43**	**37**	**82**
%		0%	2%	0%	52%	45%	100%

Respondents were asked to express their views on the work ethic of UNVs and 97% rated them as either 'Very good' or 'Good', while a negligible percentage (2%) had a different opinion and indicated that it was poor. None was uncertain.

3.2.1.6. Discussions

This section will contain only the indicators where the sub-programme has shown some strengths and/weaknesses.

(i) Strengths

a) Achievement of the output target

The sub-programme has shown some progress in recruiting, selecting, and deploying UNVs according to its plan for the year 2011 though it could not compensate for the backlogs of 2010. Though the appointment, selection, and deployment of the sub-programme has been fluctuating over the years, after a steady decline from 2006 to 2009, it showed dramatic increase in 2011.

b) Optimality of deployment

The sub-programme was successful to deploy the UNVs as they arrived to where they were mostly needed. The UNV mix is quite diversified in 13 specialised areas and they were deployed on the basis of the vacancies hospitals had.

c) Knowledge, skills, and work ethic of UNVs

With few exceptions the sub-programme was able to appoint UNVs with high professional calibre. Most of the co-workers witnessed that the UNVs were emotionally stable and matured and they had high admiration for their work ethic. The impressive work ethic that the UNVs have was appreciated by many as some of the respondents expressed it as, *'By the mere fact that they work hard, we thought they were highly paid…We believe that doctors live in luxury, we cannot imagine that they are volunteering.'*

Respondents further described them as:

> UNVs are respected for their professional approach to work, and they are extremely committed, they work for long hours until they finish the job at hand without complaining. Once they start they never leave a job unfinished…. Even volunteerism cannot describe them well because they do not do as they wish, they are selfless… They are precious assets to us, if someone is to take them we will cry…Can't they remain here until death?

Valuing highly the performance of a UNV, one clinical manager also said, *'The absence of the volunteer means a big loss. In her outreach duties she sees 60 patients per visit. She is indispensable, though she is one the value she brings is bigger than one.'*

The UNVs' role cannot be overemphasised, they are really making substantive differences—they are saving lives. They '*Come early and knock off late'* was the general expression given to them for their commitment to work—without exception this was the case in the 14 hospitals the evaluator visited.

(ii) Weakness

a) Achievement of the output target

The selection and appointment process of UNVs has been very slow. The sub-programme could not appoint UNVs according to its plan and is far behind its specified targets. It appointed and deployed only 38% of the planned medical doctors, and none of the clinical engineers, pharmacists, and specialist nurses. In fact during the first year of this Third Phase only 7% of the target was met which was of much concern.

Some of the challenges mentioned by the PMU were that:

- Although the programme manager was placed in 2009 he was only functional from June 2010 onwards. There was no PMU team before June 2010.
- The ToR for the UNVs that were supposed to be appointed was not approved by the DoH up to the end of 2010.
- The Programme Steering Committee was not functional and there was lack of guidance for the operations of the sub-programme.

Since 2006, the PMU has coordinated and served as a secretariat for all UNV interviews together with the respective clinicians assigned by the Department of Health. However, the selection process experienced challenges as there were incidents when some UNVs were screened without the participation of the clinicians. Furthermore, the evaluation found that some of the UNVs were even not interviewed at all. The probabilities of missed opportunities to select the best candidates can be high if the important step of interviewing is not designed properly.

The PMU's response to the abandonment of the interview by respective medical professionals was that the difficulty of convening a panel of interviewers, language barriers for some applicants, and the difficulty of verification of who was being interviewed (in telephonic interview there is a danger that some interviewees may be represented by others). However, shortcut to selection by not following the required interview procedures is not an option at all. The PMU should consider looking at ways to address the challenges as interviews are critical steps of selection.

The recruitment, selection, and appointment process had some practical challenges as well. When the Headquarter (Bonn) sent the documents of applicants, the PMU started contacting them. However, it was found out that some were not contactable, and others had difficulties in getting a certificate of good standing depending on the circumstances of their countries—security, unavailability of medical council, and bureaucratic hurdles. Many also dropped out from the process during the 3-5 months selection and appointment process because of engagement in other obligations. Furthermore, the approval process

from the Provincial DoH was also another factor of delay. The PMU indicated that after it submitted its selection of UNVs it took several months for approval. However, it may be worth mentioning that there is an improvement now and there are no more delays on the side of the Department with regard to approvals.

It has also been problematic to recruit clinical engineers, pharmacists, and specialist nurses. According to the South African regulations nurses are required to sit for board exams and they have to send their documents to South African Quality Assurance (SAQA), and the response takes about a month. The exam takes approximately three weeks which is taken in intervals at a charge of R2000; this is not convenient to most potential applicants. For the pharmacists there is no opportunity for volunteerism, they have to go for full accreditation; and clinical engineers are very scarce in the job market as they are highly paid in the developed countries. The sub-programme document could have foreseen these challenges before setting unrealistic targets.

b) Induction procedures

Although some respondents (37%) indicated that induction was either 'Highly Sufficient' or 'Sufficient,' it was found out during the discussions that they did not fully understand what induction procedures should entail. Their response solely depended on the limited introduction of UNVs to hospital staff and not on the required standardised procedures at the provincial hospital. Some of the UNVs who had a positive rating on the induction were probably from the previous phases who had undergone through better induction processes.

In the previous phases the sub-programme used to give sufficient induction in the Tertiary hospitals in Polokwane and Mankweng to familiarise UNVs with the work procedures, prevalent diseases and their medication, and societal culture. However, this practice was discontinued in this Phase III and UNVs were directly sent from the PDoH to the district and regional health facilities where induction procedures are not well structured.

As a result of the unstructured and insufficient induction procedures there were UNVs that experienced discomfort of the sudden and unfamiliar cultural environment. This, some respondents argued, has led to slow adjustment to work environment in some instances.

There were also times local doctors and UNVs argued on the disparity of medical procedures in South Africa and other countries that could have been ironed out through induction.

c) Optimality of deployment

As the following examples show there were suboptimal usages of skills, and misallocation of UNVs that needed improvement in the appointment and deployment processes.

- Some UNVs were not appointed for their area of specialisation and their deployment resulted in underutilisation of their skills. For example, an internal medicine specialist was appointed as a rheumatologist. Furthermore, in Polokwane/Mankweng hospital there were three cardiologists but there was no unit or department for cardiology, and they were working in internal medicine, and OPD.
- Relating to this, one UNV said '*The transfer of skill is coming to us (UNVs) because we are filling the gap where locals do not want to work. For example, I am a gastrologist but I am working in renal.'* But the hospitals accept them and deploy them irrespective of their specialisations, because, as one clinical manger said, '*Any doctor adds value as long as he is not dangerous.'* There could be some truth here, but the issue of optimal utilisation of scarce skills should be taken into account.
- Similarly, there was a case of a UNV's deployment in a hospital where his specialisation was not prioritised that lead to underutilisation of skills. A neonatologist was working as a paediatrician because they did not have one. This neonatologist could have been deployed more productively to his area of specialisation.
- There were some concerns especially by hospital management and doctors that rural hospitals were understaffed and should have been prioritised in the deployment of UNVs. Many district hospital management and doctors felt that tertiary hospitals (Polokwane and Mankweng) should not compete with district hospitals to get UNVs because they relatively had more chance to employ local doctors. However, the PMU argues that the doctors deployed to Polokwane are highly specialised that they cannot work anywhere else other than the Tertiary hospitals. Others might have been there because of family issues.

- Some UNVs complained on the areas they were assigned to work. In Polokwane hospital the Renal Department is a public-private partnership and UNVs were assigned to work there. But the Department had set certain conditions that discriminated some patients which was, according to the UNV, contrary to their spirit of volunteerism. The UNVs reiterated that they were supposed to work in public health facilities where all people had access to health care without any conditionality.

d) Knowledge, skills, and work ethic of UNVs

Selection and appointment of the right skills have been indicated above as one of the main strengths of the sub-programme. However, not all UNVs had the expected skills as there were some who struggled to cope with the existing medical practice and technology that was at a higher level in South Africa. For example, ophthalmology is more advanced in South Africa than many other developing countries from where UNVs came. According to the doctors in the Department of Ophthalmology, South Africa's approach is outcome based (e.g. operate, remove the cataract, and restore vision to the highest percentage possible) as opposed to other developing countries from where the UNVs came which was output based, i.e. the focus is to operate, and remove the cataract—regardless of the percentage of vision restored.

Two of the UNV ophthalmologists in Polokwane/Mankweng hospitals could not use laser in their practice and took time to familiarise themselves as their way of doing was outdated. They used to go to outreach but after complaints they stopped them so that they could practice only at the tertiary hospitals under close supervision. The hospital doubted if they were really qualified ophthalmologists. This was a typical indication that the selection process had to be reviewed.

Few other hospitals also did not have confidence in the skills of some UNVs and they restricted them to the OPD. These unsatisfactory performances of some UNVs led to the termination of contracts and resignations as described in the subsequent sections.

3.2.2. Care and support to UNVs

Indicators
• Percent of hospitals that refer to supporting documents in managing UNVs • Efforts to nurture security and comfort • Speed and quality of management (hospital management, UNDP and PMU) response to reported complaints • Level of support by management to update their skills • Timeliness of getting work permits, HPCSA registration, UNV ID cards

3.2.2.1. Reference to the document 'Conditions of Service for international UNV volunteers' in the management of UNVs

Respondent categories	Yes	No	Total
Management	1	16	17
%	6%	94%	100%

Management of all hospitals were asked if they had referred to the document 'UNVs Conditions of Service for international UNV volunteers' as a guideline to managing UNVs. However, almost all, i.e. 94% indicated that they had not referred to such a document because they did not have it.

3.2.2.2. Feeling of security in the work and living place

	Highly insecure	Insecure	Neither secure nor insecure	Secure	Highly secure	Total
UNVs	5	1		18	2	26
%	19%	4%	0%	69%	8%	100%

This question was directed only to the UNVs and 77% (20 out of 26) felt either 'Highly secure or 'Secure.' Only 6 expressed that they had concerns about security issues.

3.2.2.3. Speed and quality of management response to reported UNV issues

These questions were not included in the closed-ended questionnaire but were addressed during the focus group discussions to probe how the quality of management responses had been.

a) Hospital management's quality of response

Respondent categories	Highly unsatisfied	Unsatisfied	Moderately satisfied	Satisfied	Highly satisfied	Total
UNVs	1	10	3	11	1	26
%	2%	23%	9%	56%	9%	100%

12 out of 26 (65%) UNVs are either 'Highly satisfied' or 'Satisfied', while three were 'Moderately satisfied' by management's response. However, 11 out of 26 UNVs (25%) expressed that they were either 'Highly unsatisfied or 'Unsatisfied ' by management's response to their issues.

b) Programme management's (PMU) quality of response

Respondent categories	Highly unsatisfactory	Unsatisfactory	Moderately satisfied	Satisfactory	Highly satisfactory	Total
UNVs	11	9	2	4	-	26
%	42%	35%	8%	15%	-	100%

The biggest dissatisfaction expressed by the UNVs was on the efficiency and quality of PMU's responses. More than three quarters (77%) of UNVs were either 'Highly unsatisfied' or 'Unsatisfied' with PMU's response to their issues. Only 15% indicated that they were 'Satisfied.'

3.2.2.4. Support to update the skills of the UNVs

Respondent categories	Highly unsatisfactory	Unsatisfactory	Moderately satisfactory	Satisfactory	Highly satisfactory	Total
UNVs	3	8	4	10	1	26
Management	1	4	2	7	3	17
Total	**4**	**12**	**6**	**17**	**4**	**43**
%	9%	28%	14%	40%	9%	100 %

Majority of hospital management (10 out of 17) perceived that the support given to update the skills of UNVs was either 'Highly satisfactory' or Satisfactory.' The number of UNVs that felt either 'Highly unsatisfactory/unsatisfactory' or 'Highly satisfactory/satisfactory' was equally divided (11 out of 26 each).

3.2.2.5. Overall assessment of the timeliness of getting work permits, HPCSA registration, UNV ID cards

Respondent category	Highly unsatisfactory	Unsatisfactory	Moderately satisfactory	Satisfactory	Highly satisfactory	Total
UNVs	14	8	3	1		26
%	54%	31%	12%	4%	0%	100 %

85% (22 out of 26) of the UNVs felt that the timeliness of getting their permits and required registrations was either 'Highly unsatisfactory' or 'Unsatisfactory', while three indicated that it was 'Moderately satisfactory'. Only one felt it was 'Satisfactory.'

3.2.2.6. Discussion

(i) Strengths

a) Security and comfort

Despite resource challenges, most of the hospitals provided the UNVs with relatively appropriate housing, transport to shopping and places of worship. There were private security companies and SAPS that patrolled the hospital compound where the UNVs worked and lived. Except the one indicated below, in the 'weaknesses' section, there were no major security issues raised.

There had been also great respect, friendliness, and an approach of tolerance from staff to UNVs that created a conducive environment for work. It could therefore be concluded that UNVs did not have any problems of interacting with local staff and felt secured and comfortable all the time in the work places.

b) Level of support by management to update their skills

Many of the hospitals did not make distinctions between UNVs and local doctors and sent UNVs to some conferences and workshops from their own budget. The UNVs were not also left out from the participatory processes of knowledge enhancement in the workplaces. In the hospital they were seen as any local doctor and were allowed to participate in all work related discussions, and management. For example, one UNV was a chairperson of 'Adverse Event Committee;' and another head of 'Paediatrics.'

(ii)Weaknesses

a) Reference to supporting documents in managing UNVs

One of the biggest weaknesses in the management of UNVs was the absence and lack of reference to supporting documents on how UNVs should be governed.

Almost all hospital management did not refer to two vital documents—a) The 'UNDP Support to the Health Sector in Limpopo: Phase III Programme Document,' and b)

'Conditions of Service for International UNV Volunteers' as a basic reference to managing UNVs. The absence of or lack of reference to these documents had contributed to many of the weaknesses mentioned in this evaluation document.

A large number of the hospital management indicated that it didn't know the objectives of the sub-programme, but were happy to receive additional manpower of course. The challenge, however, came when management wanted to handle various UNV issues. The hospital management and doctors complained that they did not have any reference on how to deal with UNVs including understanding their expected roles, application of the compensatory time off (CTO), leave, etc. Many hospitals raised their concerns by saying, *'We have difficulty in dealing with the UNVs, because we do not have any reference for their conditions of service.'*

The PMU claimed that it has distributed the 'Conditions of Service for International UNV Volunteers to hospitals. Indeed there were indications that this document was distributed as the evaluator saw this document in some hospitals. Moreover, upon handing over the UNVs to the hospitals, the PMU informs hospital management about the expected roles of the UNV doctors and discusses the conditions of their service relevant to the hospital. However, there might be some challenges as there had been management turnover and with that institutional memory could have been lost. Be that as it may, the onus was on the PMU to make sure that the current management possessed and made reference to these key documents as guidelines in their day-to-day encounter with the UNVs, as part of monitoring exercise. On the other hand, hospital management should also have requested for the documents, but only some of the surveyed hospitals indicated that they have Conditions of Service for International UNV Volunteers, and yet they did not make it available to doctors and nurses as a common reference for interactions in the work place.

One clinical manager said:

> We do not have their Conditions of Service, so we cannot have retention strategy, and specific skills development plan as we do not have any guidelines including the sub-programme document itself... We do not know what the deliverables and the expected outcomes of the sub-

programme are.' Still another added, 'We do not have guidelines so we have challenges in understanding how UNV leaves are to be implemented.'

b) Feeling of security and comfort

The evaluator observed a grave security concern in one hospital where it was vulnerable to any transgressions. There was no lock in one door and there was only one key to the other door where some of the UNVs lived. Without any lock and without the knowledge who possessed the spare key for the other door they were and felt very insecure[14]. Given the South African security context this was unacceptable. Furthermore, their security concern was also heightened when two close by houses were robbed recently.

Similarly, in the same hospital there were no sufficient lights on the road that go from the doctors' residences to the health facilities and they felt insecure whenever they were called for emergency during the night. Especially, there were snakes in the hospital compound (full of trees) that made dangerous to walk in dark; and despite repeated appeal to the authorities no action was taken. It is worth noting here that this situation affects UNVs and local doctors equally.

The issue of accommodation was also another area of inconvenience experienced by few UNVs. There was an instance where sharing of accommodation between different cultures and religions that resulted in conflict between the UNVs. Because of such inconveniences some UNVs were not encouraged from bringing their families.

c) Speed and quality of management response to reported complaints

One of the serious dissatisfactions expressed by the UNVs was centred around inefficiency and unclarity of the management regarding extra hours worked, and to a certain extent the VLA as indicated below.

[14] Given the severity of the security concern the evaluator opted not to wait until the report was finalised and immediately notified the Provincial Department of Health during the evaluation process. Accordingly the Department took immediate action and started communicating the hospital on the issue.

(i) The utilisation of 'extra hours worked' was differently managed by different hospitals as they did not refer to the 'Conditions of Service for International UNV Volunteers,' and PMU guidelines. According to the Conditions of Service for International UNV Volunteers,

> *If a UNV volunteer is obliged to work regularly beyond the official working hours, she/he may be granted CTO equal to the number of extra hours worked in accordance with the local practice of the host agency. However, no payment in lieu of CTO can be made.*

Despite this call there was no written guideline developed to operationalise the Conditions of Service customised to local practice. As a consequence, hospital management was not sure how to handle this issue and there were unresolved arguments between management and UNVs. The resulting confusion had led to four different approaches: a) some hospitals allowed UNVs to accumulate the extra hours worked and gave them CTO for as long as two months (three months with their annual leave) b) others did not allow extra hours worked to be accumulated and gave CTO monthly c) still others did not put UNVs on call because they were not sure how to manage the extra hours if UNVs were not to be compensated financially d) in some hospitals the UNVs did not count the calls against CTO but this was not sustainable as they had already given warning that they would stop it because they were exhausted, '*by the sleepless nights that are not appreciated*' as they preferred to express it. One female doctor put it this way:

> I had been on duty call for three years. I did not know that locals were compensated for calls and by the time I knew I lodged my formal complaints to hospital management, UNDP, and PMU, but no response... I was exploited and as a result I developed heart problem and other complications. I told the hospital management that I was sick and couldn't take any more calls but they insisted that I should… It took long before I was relieved from calls.

This disparity of managing *the number of extra hours worked* caused resentment among the UNVs that required urgent management attention. The PMU said it had given hospitals a guideline to utilise CTO immediately and might not be accumulated. On the contrary, UNVs felt that they should not be compelled and be left free to decide when to take the CTOs. One of the UNVs said, '*We are taking CTO, but not to our convenience because we are called to fill wherever there are gaps... We must take it in our own time, management must not dictate us.'* As a management response some hospitals decided to take UNVs out of the duty

call plan. However, this was not the best option as it was allowing a scarce resource to be idle—a resource that could save lives.

The disparity and confusion of handling UNVs issues and its negative effects boils down to the need for strengthening the PMU's monitoring capacity to ensure the possession and enhance adherence to the vital documents for proper guidance. One of the UNVs expressed his grievance, *'Because of inefficient, and insensitive management attitude of the sub-programme I would have left long ago, but I do not want to dishonour my commitment and profession.'*

The applications of these non-standardised and inefficient approaches of handling UNVs issues boils down to to the need for strengthening the PMU's monitoring capacity to ensure the possession and enhance adherence to the vital documents for proper guidance.

(ii) The issue of VLA was also a point of concern that most UNVs raised. The VLA remained the same over the years while the cost of living has rose sharply.

(iii) There were areas that need attention on the issue of VLA transfer as well. All UNVs were concerned about the money lost in exchange from USD to local currency (Rand) and back to USD. UNVs suggested that their accounts be opened in Hong Kong and Shanghai Banking Corporation (HSBC) or Standard Bank that deal with foreign currency and not in First National Bank (FNB).

(iv) UNVs request for some benefits (e.g. buying duty free items) didn't get any response. Though there was no independent confirmation they said that UNVs in other countries enjoyed this benefit. This benefit was removed from South Africa in 2009.

d) Support to update the skills of the UNVs

Hospital managements' support for skills development was mixed. Although some UNVs were content with what the hospital did for them including sponsoring for workshop attendance, majority felt neglected and said that preferences were given to locals. The issue

of to whom preference was given was difficult to substantiate; however, it was an indication that there were areas of improvement in this aspect.

Generally, respondents noticed a deterioration of support to upgrade skills in this Third Phase of the sub-programme. Even the contractual entitlements for attending a conference once per annum had not been honoured smoothly. There were complaints on the lack of coordination and efficiency that included too late approval of the conference, approval to irrelevant conference, and no chance to a conference or workshop. It could be cited from one UNV as,

> In five years time I did not go to any conference. I was once given a chance and opted to go to a surgical conference. However, suddenly one morning they told me to go for a conference to HIV/AIDS to Cape Town. I did not go. First it was not my preference (area of practice), and second it was all of a sudden. I also had a child and where could I leave my child as no ticket was issued to him.

The UNVs further complained that they did not attend courses as required for doctors in order to be in good standing by international standards. These are a) Basic life support (BLS) once per two years (a one-day course), and b) Advanced cardiac life support (ACLS) once per three years (three-day course).

On top of the other challenges mentioned above, the funding issue had also a role to play in the operations of the sub-programme. The programme management indicated there was funding challenge that affected workshops, as promises from funders did not materialise. There was severe challenge of timely releasing of funds, for example, according to the programme management in 2011 only 7 million out of 29 million was made available. Though this did not affect the recruitment and selection process it had negative impact on other sub-programme related activities.

e) Overall assessment of the timeliness of getting work permits, HPCSA registration, UNV ID cards

There were serious administrative issues that affected UNVs' optimal performance and negatively influenced their decision whether to continue volunteering. The inefficiency for

professional registration and permits were appalling to the extent that they put the sustainability of the sub-programme at risk.

Some of the dissatisfactions shared by most UNVs are summarised below:

> We do not have HPCSA registration, and UNDP card [either expired or not issued]…Our Temporary Residence permit (TRP) is expired and not renewed. Without the HPCSA registration, we should not legally be practicing… We want to go home for holiday but we do not have legal documents to travel as they are expired, we are like prisoners…No renewed TRP for our children's university registration… We are thrown away risking arrest, and vulnerable to deportation.

Other examples of inefficiency can also be cited from a UNV who could not have access to UNV website, and said: *'I did not have ID and password for six months to access the Volunteer Reporting System [for initial and final report].'*

According to the responses from programme management there were some procedural challenges that contributed to the delays of permits and licenses. UNVs had to get accreditation permit only after they came to South Africa. This was a 'confirmation letter of assignment in South Africa' issued by the Department of International Relations and Cooperation (DIRCO). DIRCO used to accept the request for accreditation permit from UNDP but later it decided to accept only from New York and that should be signed by one specific person. If that specific person was not available the signing could be dragged delaying the whole process.

Other challenge indicated was that there was no UNV Programme Officer that could oversee the programme's performance at the UNDP Country Office. The sub-programme officer in the PMU was also vacant. These vacancies have contributed to administrative delays and underperformance of the sub-programme.

3.2.3. Transfer of knowledge and skills through a mentorship programme

Indicators
• % of the surveyed hospitals that have mentorship programme • Extent of utilisation of UNV knowledge and skills • Sufficiency of knowledge and skills transfer • Mutuality of interest in skills transfer

3.2.3.1. % of the surveyed hospitals that have mentoring programme

Respondent category		0%	1-24%	25-49%	50-75%	76-100%
Management	Formal mentoring	14	0	0	0	0
	Informal mentoring	14		0	0	0

All of the surveyed hospitals where the UNVs were deployed did not have a mentorship programme.

3.2.3.2. Extent of utilisation of UNV knowledge and skills

Respondent categories		Very low	Low	Uncertain	High	Very high	Total
UNVs		2	14		10		26
Co-workers	Management		7		10		17
	Doctors		9	3	11	2	25
	Nurses	1	5	9	8	17	40
Total		**3**	**35**	**12**	**39**	**19**	**108**
%		3%	32%	11%	36%	18%	100%

The utilisation of UNVs knowledge and skills as perceived by most respondents was positive. 54% (58 out of 108) thought it was either 'Very high' or 'High.' However, most UNVs (62%) felt their knowledge and skills was not optimally used.

3.2.3.3. Sufficiency of knowledge and skills transfer

Respondent categories		Highly insufficient	Insufficient	Moderately sufficient	Sufficient	Highly sufficient	Total
UNVs		9	5	3	7	2	26
Co-workers	Management	1	4	1	10	1	17
	Doctors	1	13	1	9	1	25
	Nurses	2	8	8	14	8	40
Total		**13**	**30**	**13**	**40**	**12**	**108**
%		12%	28%	12%	37%	11%	100%

The knowledge and skills transfer from UNVs to locals and vice-versa, as perceived by 48% of respondents (62 out of 108) was either 'Highly sufficient' or 'Sufficient,' while 14% felt it was 'Moderately sufficient'. However, 40% (43 out of 108) expressed that it was either 'Highly insufficient' or 'Insufficient.' From the respondent categories management (65%) and nurses (55%) were more positive about the sufficiency of skills transfer. However, majority (56%) of the doctors and UNVs (54%) felt that it was either 'Highly insufficient' or 'Insufficient.'

3.2.3.4. Mutuality of interest of knowledge and skills transfer between local health professionals and UNVs?

Respondent categories		Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Total
	UNVs	2	12	5	5	2	26
Co-workers	Management		4	4	8	1	17
	Doctors	1	8	12	4		25
	Nurses	3	15	11	7	4	40
Total		**6**	**39**	**32**	**24**	**7**	**108**

Respondent categories	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Total
%	6%	36%	30%	22%	6%	100%

42% (45 out of 108) of the respondents 'Strongly disagreed' or 'Disagreed' of the mutuality of interest in the skills transfer and a substantial number (30%) were 'Uncertain.' About half of the UNVs didn't agree that there was a shared interest and five were 'Uncertain.' Management was more positive and about half of them held the view that the skills transfer was on the right track.

3.2.3.5. Discussion

(i) Strengths

a) Knowledge and skills transfer

The sub-programme had created an environment of efficient knowledge and skills transfer by bringing together a pool of diverse skills from many countries. Irrespective of whether health workers took advantage of it or not the sub-programme was a dynamic interface between locals and UNVs to share experiences and was a shortcut to reach multiple sources of knowledge.

The basic requirement of a GP in district hospitals was to practice in all basic specialisations. This rural health care system created the opportunity for exposure to a variety of health services that could sharpen the skills of doctors as they all worked as specialists with the assistance of UNVs. But the skills transfer was mutual as UNVs also learned through the interaction with local doctors.

In some hospitals where interns were deployed the skills transfer was more structured (e.g. Elim) and UNVs role was strategic and well appreciated as some clinical managers said, *'without them the training program will collapse.'* In Elim hospital the UNV contributed to the accreditation of the hospital, and he was the head of a unit.

There were other dramatic achievements in the front of knowledge and skills transfer, especially in Lebowakgomo hospital where the UNV trained a local anaesthetist, introduced semi-formal discussions in anaesthesia, gave weekly academic training to interns. As a result he was awarded the best doctor by the hospital and was nominated for the province. The HPCSA also awarded the hospital for its best services including anaesthesia. Similarly, in Philadelphia hospital the nurses indicated that the equipment for endoscopy was idle because there was no one to operate it. The UNVs came and started operating while training others. The hospital staff expressed the indispensable role of the UNV as, *'if he leaves major surgery will be at stake.'*

Similarly, there were some other pockets of excellent examples of skills transfer. In Letaba hospital one local doctor got diploma because of UNV coaching on obstetrics and gynaecology.

Furthermore, there new services were introduced to some district hospitals. For example, in Sokororo district hospital the UNVs started treating hydrocele, hernia, and appendicitis, and people started flowing to the hospital.

In their effort to introduce new experiences UNVs were not always well received as the hospital system was policy driven, and therefore, UNVs were required to comply with the existing protocols. Despite to some resistance to new clinical procedures there were some UNV initiatives that were adopted and increased new services in the district and regional hospitals. For example in the field of anaesthesiology and surgery, the UNVs:

- Introduced new simple way of doing things that didn't involve complicated machines but having the desired results. Before the introduction of this technique, whenever the machine was broken operation in the theatre used to stop (by an anaesthetist).

- Introduced Sevoflurane (a sweet-smelling, nonflammable, highly fluorinated methyl isopropyl ether used for induction and maintenance of general anaesthesia. Together with desflurane, it replaced isoflurane and halothane in modern anaesthesiology). The hospital bought it upon his recommendation and is functioning well (by an anaesthetist).

- Started high care, and a skills development programme (by an anaesthetist).
- Brought new skills like intubation anaesthesia, BSL and ATLS (by an anaesthetist).
- Introduced tramadol and was found to be a better option, previous doctors used petedine (by an anaesthetist).
- Established Ear, nose and throat (ENT) clinic, and took new initiatives including breast cancer surgery, paediatric surgery, and orthopaedic surgery (by surgeons).

(i) Weaknesses

a) Mentoring programme

The sub-programme had fallen short of developing a mentoring programme and consequently, in all hospitals the knowledge and skills transfer was not structured and not systematically implemented, i.e. no mentor-protégé relationship was established. That was why the sub-programme could not make any influence on the mode of transfer of skills. Therefore the usual routine methods, including on the job training during ward rounds, doctors' daily meetings for case discussions (problem based teaching), and some theoretical presentations were dominant. Hence, the skill transfer was not as efficient as envisioned by the sub-programme designers.

There were also some challenges, including lack of motivation to learn, and continuous reshuffling of staff that affected learning in some hospitals. Many of the doctors had the opinion that lack of appreciation to some of the UNVs skills had also impacted on the enthusiasm to learn from them. The work load was also cited as a barrier to skills transfer as doctors were overwhelmed by day-to-day work and did not have time for training.

Moreover, language (especially those from Russia and Ukraine) was a barrier to impart knowledge. This issue of language was also a challenge in prescriptions, as some drugs had different trade names it was difficult for hospitals to let them practice on their own. In anticipation of this challenge the UNV sub-programme programme had made provision for language training and there was budget allocated for it, however, most hospital management were not aware of this opportunity and no one took advantage of it.

b) UNV knowledge and skills utilisation

There were some concerns about the optimal utilisation of UNV knowledge and skills. UNVs had been mainly taken as additional workforces and most of their roles were limited to the service delivery and efforts to systematically transfer skills were minimal.

3.2.4. Promotion and appreciation of volunteerism by local professionals

Indicators
• Percent of hospitals that have volunteerism programme • Availability of manual for volunteerism • Number of health facilities hosting volunteers • Number of local volunteer health professionals • Number of events organised to encourage volunteerism • Number of partnerships for volunteerism

3.2.4.1. Availability of a volunteerism programme

Respondent categories	Indicators	Yes	No
Management	Availability of a volunteerism programme	0	17

It was found that all of the hospitals did not have a volunteerism programme.

3.2.4.2. Manual for volunteerism

Respondent categories	Yes	No
Management	0	17
%	0%	100%

All management respondents indicated that there had not been any manual prepared for volunteerism.

3.2.4.3. Hospitals with and without UNVs

	Hospitals			Total	%
	District	Regional	Tertiary		
Hospitals where UNVs are deployed	7	5	2	14	38
Hospitals where UNVs are not deployed	23	0	0	23	62
Total	**30**	**5**	**2**	**37**	**100**

UNVs were deployed in seven district, five regional, and two tertiary hospitals. That is, in 30% (7 out of 23) of the districts, and all regional and tertiary hospitals had UNVs.

3.2.4.4. Local health professionals as volunteers

Respondent categories	Yes	No
Management	0	17
%	0%	100%

There were no local health professionals working as volunteers in the surveyed health facilities.

3.2.4.5. Events organised that may encourage volunteerism

Respondent categories	Highly unsatisfied	Unsatisfied	Neither satisfied nor dissatisfied	Satisfied	Highly satisfied	Total
UNVs	5	21				26
%	19%	81%				100%

This question was posed to UNVs only as it was more relevant to them. Majority (81%) were 'Unsatisfied' while the rest were 'Highly unsatisfied' with events that could encourage volunteerism.

3.2.4.6. Partnerships for volunteerism

Respondent categories	Yes	No
Management	0	17
%	0%	100%

There were no partnerships established to promote volunteerism.

3.2.4.7. Discussion

(i) Strengths

According to the PMU it had been trying to build partnership of volunteerism, and started communicating with the Hospitals Association of South Africa regarding assistance in training of nurses, doctors, and CEOs by volunteering in government hospitals. This was a move to the right direction and a realisation that volunteerism could not be sustainable without the participation of civil society.

(ii) Weaknesses

a) Manual for volunteerism

There was no manual for volunteerism that hospitals could use as a guideline and reference to promote volunteerism. The absence of this document meant denying the sub-programme a strategic tool towards the achievement of its outcomes.

b) Events to encourage volunteerism

There was no effort to promote volunteerism in the hospitals. In most hospitals UNVs were not even well introduced as volunteers let alone to promote the cause they stood for. In some instances the management of the hospital (usually the clinical manager) introduced the UNVs to colleagues as volunteers and sometimes as any other doctors where they had to introduce themselves as volunteers during the course of their interaction. Sometimes they were introduced only to the departments where they were assigned and not to the entire hospital staff.

In many of the surveyed health facilities, staff therefore thought that the UNVs were employed by the government or by the United Nations (UN). It was quite amazing to find hospitals staff that had not been aware of the presence of UNVs doctors around them. As an example, a nurse in Mankweng hospital who worked there for five years alongside the UNVs, didn't not know that she was working with UNVs until the time of this interview.

The sub-programme, therefore, did not help develop any sense of volunteerism as no effort had been done to introduce the concept of volunteerism. During the discussions some of the staff asked the evaluator *'how is it possible to be a volunteer without full compensation?'* The challenge was that UNVs were introduced as any other doctor, not including the values they carry. The UNV said, *'When I tell them about my status they say why should you volunteer?*'

Even the hospitals that introduced the UNVs as volunteers did not explain what volunteerism was all about and how it could be related to the context of the health profession. When the evaluator explained to the staff during his focus group discussions one participant expressed her admiration. '*Wow! This volunteerism is like the spirit of Batho Pele, we do not know that volunteerism is going on in our hospital. These UNVs are too committed, they do not seem like not being fully paid…If they were introduced to us properly as volunteers we would also be prepared what to do.'*

The promotion of volunteerism could take many forms, e.g. UNV events could highlight the visibility of volunteerism; however, no advantage was taken to make use of the budget that was available from UNV Headquarter (Bonn) for the purposes of UNV events. The PMU did not come up with plans to celebrate the 10th anniversary of the International Volunteers Day (IYV+10) despite high expectation from the volunteer doctors. According to the UNVs:

> It is shame that South Africa did not celebrate the International Volunteers Day on the 5th of December 2011, 2010, and 2009. It could have been a good promotion for volunteerism. We cannot understand why there is such disinterest; the spirit of volunteerism must not die in this country.

This lack of acknowledgement from the responsible parties and subsequent absence of campaigning for volunteerism was not surprising that most local government authorities and communities around the hospitals also do not know that there was voluntary activity going on in the hospitals.

c) Partnerships for volunteerism

There was no partnership for volunteerism yet except the one mentioned above which is in its initial stage. The spirit of volunteerism could not be inculcated and not be sustainable unless it had had partners from all walks of life: government, businesses, non-governmental organisations (NGOs), community-based organisations (CBOs), and faith-based organisations (FBOs). The sub-programme missed a viable strategy towards its outcome by not building a solid foundation of partnership. The project document itself was also vague on how the volunteerism could be promoted.

3.2.5. Institutionalisation of a retention strategy for local doctors and health personnel

Indicators
• Availability of an institutionalised retention strategy

3.2.5.1. Institutionalised retention strategy

Respondent categories	Yes	No
Management	0	17
%	0%	100%

There was no institutionalised and implemented retention strategy in hospitals and nothing to report on the above indicator developed by the evaluator.

3.2.5.2. Discussion

(i) Weaknesses

Having a clear retention strategy that is institutionalised is a sine qua non for keeping local doctors permanently, and UNVs beyond their one year contracts. This would involve focusing on preventing as well as addressing issues of dissatisfaction and implementing effective skills development programmes. However, the DoH, hospitals, and PMU did not have retention strategies either for locals or UNVs.

One clinical manager expressed why there was no retention strategy for UNVs as:

> We cannot have retention strategy for UNVs because we do not have control over them. We know nothing about them, we do not report on their performance as they are seen as temporary additional workforce... There is no communication about the sub-programme itself.

Consequently, there were insufficient requests for contract renewal by UNVs, and large outflow of local doctors.

3.3. Sub-programme outcomes

The sub-programme outcomes as outlined in the programme document are:

a) Improved healthcare service delivery in Limpopo Province
b) Increased culture of volunteerism
c) Improved retention rate of health professionals

3.3.1. Improved health care service delivery

Indicators
• Changes in KASA, and behaviour • Mortality rate (maternal and child) • Patient waiting time • Referral rate

3.3.1.1. Changes in KASA (knowledge, attitude, skills, and aspirations) and behaviour

Respondent categories		Insignificant	Medium	Significant	Uncertain	Total
UNVs		3	11	8	4	26
Co-workers	Management		12		5	17
	Doctors	1	8	2	14	25
	Nurses		27	10	3	40
Total		**4**	**58**	**20**	**26**	**108**
%		4%	54%	19%	24%	100%

This question was posed to determine if the UNVs interaction with the locals brought any changes in knowledge, attitude, skills, aspirations, and behaviour on the local medical staff. Majority, that is 54% of respondents, indicated that there was medium change, while 19 % said there was significant change. A very small percentage (4%) felt that the change was not significant, while 24% respondents were not certain. From the respondent categories, the doctors were less positive about the changes in KASA and behaviour—only 8% perceived that there was significant change.

3.3.1.2. Improvement of mortality rate that may partially be attributed to UNVs

Respondent categories		Highly insufficient	Insufficient	Uncertain	Sufficient	Highly sufficient	Total
UNVs				14	9	3	26
Co-workers	Management		3	5	9		17
	Doctors	1	5	5	11	3	25
	Nurses	1	1	9	16	13	40
Total		**2**	**9**	**33**	**45**	**19**	**108**
%		2%	8%	31%	42%	18%	100%

There was a general observation by majority of respondents that maternal mortality declined after the arrival of UNVs, though a significant number (31%) were 'Uncertain.' 60% of the 108 respondents saw the decline as either 'Highly sufficient' or 'Sufficient.' This

observation was shared by more than half of each respondent category (Management, Doctors, and Nurses). Most UNVs were 'Uncertain' because they did not have the historical data.

3.3.1.3. The improvement of child mortality rate that may partially be attributed to UNVs has been:

Respondent categories		Highly insufficient	Insufficient	Uncertain	Sufficient	Highly sufficient	Total
UNVs				17	7	2	26
Co-workers	Management		3	7	7		17
	Doctors	1	4	7	11	2	25
	Nurses	1	1	12	15	11	40
Total		**2**	**8**	**43**	**40**	**15**	**108**
%		2%	7%	40%	37%	14%	100%

There was also almost similar observation by majority of respondents that there was improvement in the child mortality due to the presence of UNVs. 51% observed that the improvement was either 'Highly sufficient' or 'Sufficient'. However, a substantial number of respondents (40%) was 'Uncertain,' out of which UNVs were majority.

3.3.1.4. Decrease of patient waiting time and referral rate

Respondent categories		Highly unsatisfactory	Unsatisfactory	Uncertain	Satisfactory	Highly satisfactory	Total
UNVs		1	1	4	20		26
Co-workers	Management		5		11	1	17
	Doctors	1	2	3	16	3	25
	Nurses		2	6	18	14	40
Total		**2**	**10**	**13**	**65**	**18**	**108**
%		2%	9%	12%	60%	17%	100%

After the intervention of the programme, the patient waiting time and referral rate were perceived to be improved. The improvements were either 'Highly satisfactory' or 'Satisfactory' to the majority (77%) of the respondents while few (12%) were 'Uncertain.' Although to majority of each respondent category the improvement of service delivery was substantial, a higher percentage of Nurses (80%) felt that the patient waiting and referral rates were greatly decreased.

3.3.1.5. Discussion

(i) Strengths

a) Changes in KASA and behaviour

Though it required a critical mass of input and activities to bring about a visible change in KASA and behaviour, there were some indications of attitudinal change in commitment, and devotion to work by locals that could reasonably be attributed to the role of UNVs. They inculcated the attitude of work ethic, more sense of duty and responsibility for patients into the local health workers that anyone who came into contact with them couldn't deny. One of the co-workers expressed her observation as: "*When UNVs work during lunch time the locals are ashamed to leave them alone… They say, how can we go for lunch while the UNVs are saying 'let's finish the job at hand?'*" And still some nurses witnessed, *'We can observe that two local doctors have adopted the UNV style of working (i.e. staying longer at work to finish what is in process; availing themselves in time of emergency; etc).'*

There were also other behavioural changes. In some hospitals the local staff were not familiar to work with foreigners and distanced themselves from UNVs. As the interaction with UNVs increased they developed a positive attitude towards these expatriates and realised that they could benefit from them and started asking work related questions. As a result of the mutual interaction and influence of one UNV anaesthetist, two community service doctors specialised in anaesthesia which they never thought of before.

b) Mortality rate; Patient waiting time; Referral rate

Due to the deployment of UNVs the doctor-patient ratio improved to a certain extent. Hence, the patient waiting time was substantially reduced resulting in lower death rate and less community complaints. Almost all respondents stated their observation as, *'Patients used to die on their way to regional and tertiary hospitals. But now the referral rate has been substantially reduced because hospitals started to give diversified services in terms of quantity and quality due to UNVs that have saved many lives.'*

The doctors and management agreed that one of the main causes of maternal death was lack of skills in anaesthesia. To highlight the challenge of skills in anaesthesia one doctor said, *'Inappropriate use of anaesthesia kills more people than taxi drivers in South Africa.'* Though it may be difficult to get statistical evidence to validate this assertion it dramatised clearly the consequence of the dire skill shortage in anaesthesia in the country. Anaesthesia related death rates have been significantly reduced because of the intervention of the sub-programme; specifically reduction of maternal mortality was significant. Moreover, in terms of MDGs some of the UNVs were involved directly or indirectly in alleviating child mortality and treating HIV/AIDS patients.

(i) Weaknesses

a) Changes in KASA and behaviour

The low profile given to volunteerism, and lack of appreciation thereof, had a negative effect on the enthusiasm to learn from UNVs. For UNVs to be influential and be seen as models and therefore impact on the attitude, aspiration, and behaviour their volunteerism should have been formally acknowledged and treated accordingly. Though they were making some impact the hospitals did not get the full potential of UNVs to bring about the required changes in KASA and behaviour.

b) Effectiveness of services

The misallocation of doctors to areas where they were not specialised was prone to affect service delivery. For example, the cardiologists who were working in internal medicine could not be as effective as if they were working in their field.

3.3.2. Improved culture of local volunteerism for better health service delivery

Indicators
• Level of appreciation for volunteerism by staff and management

3.3.2.1. Level of appreciation for volunteerism by staff and management

Respondent categories		Very low	Low	Uncertain	High	Very High	Total
UNVs		8	15	1	2		26
Co-workers	Management	3	3	2	7	2	17
	Doctors	1	12	3	9		25
	Nurses	20	13	4	3		40
Total		**32**	**43**	**10**	**21**	**2**	**108**
%		30%	40%	9%	19%	2%	100%

It is worth noting that 70% of respondents perceived that volunteerism was 'Very lowly' or 'Lowly' acknowledged and appreciated by local medical staff.' Only 21% felt that it was either 'Very Highly' or 'Highly' acknowledged'. Greater percentage of nurses (33 out of 40) followed by UNVs (17 out of 26) felt that volunteerism was acknowledged by hospital staff.

3.3.2.2. Discussion

(i) Weaknesses

a) Acknowledgment and appreciation given to volunteerism by the hospital staff

The PMU, DoH, and the hospitals did not have a volunteerism programme, partnership that was focussed on the local health workers, and did not establish any partnership with the private sector and civil society in the province. In this regard the sub-programme could not achieve its stated outcomes of improved culture of volunteerism.

Given that there was no proper induction and campaign for volunteerism the appreciation of volunteerism could be said almost nonexistent. It was found that no one was aware of the voluntary work that had been done in the hospitals. As indicated above there were no formal events organised to honour those who were volunteering, and thereby increasing staff awareness of volunteerism. As a result volunteers felt they were taken for granted. They say, *'We came here to assist not for a career, and we will not stay long. Nobody appreciates our volunteerism, as nothing has been done for its visibility.'*

In lieu of appreciation UNVs got disapprovals to their volunteerism that defeated the values of their mission. They quoted a typical attitude towards volunteerism from one local doctor as:

> But you are youngsters why do you opt to volunteer?…You are crazy, you should look at your pocket, why are you working here for $2 000 while you can work in your country (USA) for $10 000…Here you are getting a peanut, Your VLA is what I spend in one shopping mall at a time…Are you not getting food in your country?... Don't you have respect in your country?...Or you must be very rich that you could volunteer... You should save your status as a profession.

These sentiments of lack of appreciation to their volunteerism made UNVs feel as secondary doctors. As a response to this degradation one UNV said, *'To avoid being looked down, I started to explain myself not as a volunteer but as a doctor that came to see South Africa.'*

The neglect to acknowledge and campaign for volunteerism resulted in low appreciation of volunteerism. Co-workers cited examples when local staff were asked to volunteer to an old age outreach that was declined. Similarly, when some local doctors were invited to help in some wards they hardly showed readiness to volunteer. It can therefore be argued that the appreciation for volunteerism, in words and deeds, had a long way to go that required systematic, sustained, and intersectoral intervention.

3.3.3. Improved retention rate of health professionals

Indicators
• Percentage of interns who after completion of their internship decided to work in Limpopo

- Percentage of community-service doctors who after completion of their duties decided to work in Limpopo
- Percentage of UNVs who applied for permanent job after completion of 6 years contract
- Percentage of UNVs' request for contract renewal

Improved retention rate was one of the outcomes of the sub-programme and the indicators are outlined above. Attempts were made to get the retention rates of medical doctors in the province; however, it was not possible to get statistical information neither from the provincial PDoH nor the hospitals to substantiate the claimed high outflow of local doctors. The following section will therefore focus on the UNVs retention rate.

To put the retention rate into perspective let's see the total number the sub-programme had appointed, UNVs termination rate of UNVs (2006 - 2011), UNVs resignation rate, the UNVs who were under the sub-programme during the evaluation period, ex-UNVs who were permanently employed by hospitals, UNVs who were appointed in the Third Phase and left the sub-programme, the total years of service of those who completed their contract and were repatriated, area of specialisation of those who completed their contract and repatriated, and the years of service of those who were still under the sub-programme.

3.3.3.1. Total number of UNVs appointed and still volunteering

Appointed UNVs from Phase I-III (2004-31/12/2011)	Resigned	Terminated by management	Repatriated after finishing contract	Employed permanently in the hospitals after serving for the maximum permissible six years.	Still volunteering in the province (31/12/2011)
71[15]	3	3	21	3	41

[15] It was not possible to get complete data from the beginning of the programme; most available data is from 2006 onwards.

From 2004 up to 31/12/2011 the sub-programme appointed and deployed 71 UNVs. From these, three resigned; three had their contract terminated; 21 repatriated after finishing their contract; and three permanently employed after serving the maximum permissible six years; and 41 were providing service under the sub-programme in district, regional and tertiary hospitals.

3.3.3.2. Ex-UNVs who were employed permanently after completion of six years of service

Specialisation	Country of origin			Total
	Russia	*Ukraine*	*Ethiopia*	
Anaesthesia	1	1	1	3

Out of the 71 totally appointed UNVs since 2004 (according to available data), 30, that is, 42% already left the sub-programme. However, three of them completed the maximum permissible volunteerism of six years and were retained as permanent staff by the hospitals.

3.3.3.3. Termination rate of UNVs (2006 - 2011)

Specialisation	Country	Number	Reason for termination	Year of service
Dermatology	India	1	Unsatisfactory performance	1
Family medicine	DRC	1	HPCSA registration declined due to board exam failure	1
Anaesthesia	Ukraine	1	Personality issues	1
Total		**3**		

From the UNVs that were appointed in all phases of the sub-programme (according to available data) the contracts of three (dermatologist, family medicine specialist, and anaesthetist) were terminated by management in the duration of one month up to one year for unsatisfactory performance, and personality issues. Two were assigned in a tertiary, and one in a district hospital, all were males.

3.3.3.4. Resignation rate of UNVs (2006 - 2011)

Specialisation	Country	Number	Reason for resignation
General Surgery	India	1	Family related
General Surgeon	Egypt	1	Complaint about banking system in South Africa
Ophthalmology	Filipino	1	Sickness
Total		**3**	

According the PMU's data base two general surgeons, and one ophthalmologist resigned from the sub-programme after volunteering for some months.

3.3.3.5. UNVs appointed in the Third Phase and who left the sub-programme

Resigned	Terminated	Repatriated after finishing one year contract	Total
3	2	2	7

From the 35 UNVs who were appointed in the Third phase seven (20%) had left the sub-programme (3 resigned; 2 terminated; and 2 their contract was not renewed) before this evaluation period. Two of those who resigned were for family related issues and one disappointed on VLA deposit methods.

3.3.3.6. Years of volunteerism of those who completed their contract and repatriated

Years of volunteerism				Total UNVs
1 year	2 years	3 years	4 years	
10	5	2	4	21
48%	24%	10%	19%	100%

About half of those who left the sub-programme, worked only for one year, and about a fourth for two years.

3.3.3.7. Area of specialisation of those who completed their contract and repatriated

Area of specialisation										Total
Anaesthesia	Cardiology	Epidemiology	Family medicine	General surgery	Internal medicine	Obstetrics and Gynaecology	Orthopaedics	Radiology	Urology	
8[16]	1	1	2	3	2	1	1	1	1	21
38%	5%	5%	10%	14%	10%	5%	5%	5%	5%	100%

38% of those who did not want to renew their contracts further were anaesthetists, 14% general surgery, 10% family medicine, and the rest (5% each) from various specialisations.

3.3.3.8. Years of volunteerism of the available UNVs.

Duration in the sub-programme						Total
>0<1 year	>1<2 years	>2<3 years	>3<4 years	>4<5 years	>5<6 years	
4	23	2	4	3	5	41
10%	56%	5%	10%	7%	12%	100%

From the UNVs who were still under the sub-programme, majority (23 out of 41) volunteered for more than one and less than two years; only 5 out of 41 for more than five and less than six years.

3.3.3.9. Discussion

(i) Strengths

The sub-programme was successful to retain some of the UNVs for at least over a year. Out of 41 UNVs who were volunteering under the sub-programme during the evaluation period,

[16] One of them is employed in other province in South Africa

23 renewed once; two renewed twice; four renewed thrice; three renewed four times; and five renewed five times. However, even this very limited retention rate could not be fully attributed to the sub-programme's operations as UNVs had different motives to volunteer and continue volunteering. Following are some responses to the question 'Why are you volunteering?'

- I want to enhance my professional skills through the exchange of knowledge with international surgeons, especially as the Third Phase focuses on skills transfer.
- To work in big international organisations like the UN as it makes it easier and quicker to go out of one's country.
- It is out of humanitarian reasons; the satisfaction I get from helping others is incomparable.
- I am a surgeon in the USA, but got training of ENT in Philippines. This makes it difficult to practice it in the USA as I was trained in a developing country. Then I decided to go to developing countries to get the chance to practice.
- UNV opens opportunities to see many places and cultures in the world. It is an honour to work with UN.
- The status of UNV is respectful as it is a noble idea.
- My religion (Islam) is a motive to volunteerism. It says '….*if any one saved a life, it would be as if he saved the life of the whole people'* Al- Quran 5:32.
- In Hinduism it says '*if you get blessings from the patients it is more than money*.' I work on that principle and I never leave patients.
- I am fulfilling my father's wish who told me to do so.
- I am from a war country (Uganda), I always wished to share the fruits of our struggle.
- I have no interest to be a volunteer. I came here because I get more money than I did at home.
- For me it is like a retirement service, love serving humanity. My husband is also a volunteer.
- To be different, not to be like any other doctor.
- To satisfy my internal spirit by helping HIV/AIDS victims densely found in South Africa.

- The friendliness and welcoming atmosphere of hospitals.

(i) Weaknesses

Lack of an institutionalised retention strategy in hospitals was one of the main weaknesses of the sub-programme. Retention of local doctors had been a problem, to the extent that it became difficult to run internship programmes in hospitals.

The retention of medical doctors (local and UNVs), mainly in district and regional hospitals was continuous challenge in the province. There was a unanimous agreement among hospital management, doctors, and nurses that hospitals suffered from acute shortages of medical doctors and one of the big challenges was that they did not continue working after completion of their community service and internship. This was despite the financial and non-financial incentives available to them to work in rural health facilities.

Similarly, the environment was not also conducive for retention of UNVs because of the administrative inefficiencies in the sub-programme. Especially, many of the UNVs expressed their dissatisfaction and indicated their unwillingness to continue volunteering. They indicated that they didn't want to put others in an unfavourable situation and would not invite volunteers from their countries. In fact the retention rate was already low: 38% of those who were appointed and deployed left the sub-programme; almost half of the UNVs who were repatriated had not renewed a second year contract; and those who decided to volunteer up to the maximum permissible years (six years) were only three.

Most, which is 38%, of those who did not want to renew their contracts further were anaesthetists. This was of great concern since anaesthesia was one of the scarcest skills in district and regional hospitals. The few remaining UNV anaesthetists are highly demanded and revered.

Understandably, this high turnover of UNVs had costed the sub-programme substantial amount of resources. Given that the selection, and appointment process was very slow the advantage of retention could not be overemphasised. Moreover, the net cost of non-financial resources was very high, i.e. the experiences UNVs get in the hospitals was a big

loss to the province as the sub-programme had to replace them with new ones who had to start afresh and struggle to acclimatise.

In contrast to the previous Phases, there were higher rates of resignation and termination of UNVs who were appointed in Phase III. From the 35 UNVs who were appointed in Phase III the contract of three was terminated and other three resigned because of unsatisfactory performance, complaints, sickness, and family related problems. However, from those 36 UNVs who were appointed before Phase III only the contract of one was terminated, and none resigned.

The overall retention rate of UNVs was very low which could reasonably be partially attributed to the absence of a retention strategy, low acknowledgment and appreciation of volunteerism, and dissatisfaction in care and support given to them while in duty, and limitations in the selection and deployment processes. However, it could not be denied that there were other personal, social, and economic factors that affected their choices. Nevertheless, it could well be presumed that if proper procedures were followed and the required care and support provided the termination and resignation rates would be lower.

Section 4: CONCLUSIONS

This section presents the overall assessment of the sub-programme's performance based on the key results that have been achieved or not achieved.

a) **Relevance of the intervention**: Limpopo is one of the provinces in South Africa where there is an acute shortage of medical doctors particularly in rural areas. This was mainly because local doctors had not been eager to work in the rural areas and as a result left district hospitals without adequate health services. There was also a trend of reluctance by interns and community service workers to work in district hospitals. These hospitals were already characterised by huge outflow of doctors despite the financial and no-financial incentives available. Regardless of the poor standards of health in rural communities, health practitioners were always under-represented. Hence, people in rural areas had more difficulty in accessing health workforce services than those living in cities. In this context, the sub-programme had been appropriately designed to offset the skill shortages and backlogs of service delivery in rural areas and will remain to be extremely relevant for some time to come.

b) Achievement of objectives and progress towards outcomes: The sub-programme was successful in improving service delivery, mainly in the reduction of mortality rate and patient waiting time in a province where the health care system had been at a relatively low level. There was a moderate achievement in the two-way skills transfer where local health workers and UNVs had been gaining knowledge and skills from the interaction of the pool of diverse specialists. Apart from some areas where more could be done, the sub-programme had deployed technically competent medical professionals that were perceived to have made a real difference in the improvement of service delivery in the district hospitals.

However, most of the objectives were not met, as the sub-programme had been far from reaching its recruitment target in terms of quantity and quality of health professionals. The main shortcomings were absence of a campaign for volunteerism to enhance commitment of local health professionals, mentorship programme for a structured and efficient skills transfer, and the retention strategy to influence medical professionals to continue working

in the district hospitals. Therefore there was no visible evidence of efforts to achieve most of the sub-programme's objectives in the visited hospitals.

c) **Performance of partners**: Partners' roles and responsibilities were clearly stated in the programme document. Accordingly, the UNDP through its PMU and the Country Office made efforts to screen and import international UNVs though it could not meet the specified targets.

The Department of Health of Limpopo has been more or less effective in the placement of the UNV doctors to district regional and tertiary hospitals according the needs of the health facilities.

The Programme Board, as the steering committee of the programme, was required to meet regularly to review work plans, review quarterly plans, and oversee implementation of the sub-programme. However, these Board meetings were not held regularly and the Board membership turnover was high. These had affected the performance of the sub-programme where the PMU was left without strategic guidance for its operations.

Other challenges include that the facilitation for licensing, permits, and VLAs (by UNDP, DIRCO, HPCSA) was not efficient enough to induce satisfactory performance by the UNVs.

d) Sustainability of results: The UNVs sub-programme showed tremendous results in service delivery as evidenced by shortened patient waiting time and reduced mortality rates. One of the main pillars for sustainability, skills transfer, however, was not structured and not as efficient as expected. Furthermore, the retention strategy had not been developed yet, and there was no active implanting of volunteerism in local doctors. Hence, given its mode of operations the sub-programme's results could not be qualified as fully sustainable because there had not been guarantee for the sustainability of the momentum achieved.

e) Overall assessment:

	Project Review Criteria	Ratings[17]						
		HS	S	MS	MU	U	HU	NA
1	Implementation approach			x				
2	Country ownership/drivers					x		
3	Outcome/Achievement of objectives				x			
4	Stakeholder participation/public involvement						x	
5	Sustainability				x			
6	Replication approach		x					
7	Cost-effectiveness							
8	Contribution to human rights and gender equality		x					
9	Monitoring and evaluation					x		

[17] HS= Highly Satisfactory; S=Satisfactory; MS=Marginally Satisfactory; MU=Marginally Unsatisfactory; U= Unsatisfactory; HU= Highly Unsatisfactory; NA= Not applicable

Section 6: LESSONS LEARNED and RECOMMENDATIONS

There are a number of lessons to be learned from the performance of this sub-programme as outlined below.

6.1. Lessons learned

a) Recruitment, selection and deployment of UNV health professionals

- **Overestimation of targets leads to lack of focus.** Targets may be ambitious but they should be achievable. Given the stringent criteria from the South Africa Department of Health to import health professionals, it was possible yet to recruit a single clinical engineer, pharmacist or specialist nurse through the sub-programme. The scarcity of these types of professionals in the job market must have been factored into the planning process. The planning had to also take into consideration the local and international contexts in which it was operating, to correctly foresee the challenges and avoid setting unrealistic targets. Setting targets that cannot be achieved undermines the credibility of the targets, and leads to lack of focus and inefficient allocation of resources.
- **Abandoning proper selection procedures results in the selection and appointment of unsuitable doctors and sub-optimal use of resources.** The PMU resorted to interviewing candidates by its administrative staff instead of respective clinical staff, who would have been in a better position to screen the required specialists. This was not an efficient way of appointing medical personnel as it could result in the selection of less qualified and/or less relevant specialists/doctors at the expense of better and/or relevant specialists/doctors. Occasionally there were some UNVs that had been appointed and deployed outside their areas of specialisations; and contracts of very few others were also terminated because of underperformance.
- **Lack of induction policy leads to an incomplete induction process.** The induction process was desirable for both the UNVs and local staff. The complete induction process assists to fully integrate existing hospital staff with UNVs and enables UNVs to be effective in their performance and embed into the culture of the hospitals as

soon as possible. Incomplete or a lack of proper induction procedures can result in discomfort, culture shock, and challenges in adjustment to clinical procedures among UNVs. Unaware of the sub-programme itself, hospital staff had not been for the UNVs' arrival and did not have an understanding of what the UNVs' role should be and how UNVs fit into the system. Therefore, an induction policy is desirable for staff, UNVs, and service delivery.

b) Care and support to UNVs

- **Lack of reference to sub-programme's supporting documents seriously limits the care and support given to UNVs.** Almost all hospitals operated without making reference to the basic documents of the sub-programme, namely, a) *The UNDP Support to the Health Sector in Limpopo: Phase III Programme Document,* and b) *Conditions of Service for International UNV Volunteers* as a basis to manage UNVs. This had been, however, a basic requirement and the absence of appropriate reference to sub-programme documents negatively affected (including inefficiency and confusion, dissatisfaction) the quality of response by hospital management to UNVs complaints.
- **Unduly bureaucratic procedures are limiting UNVs performance:** The unreasonably long time taken to renew licences and permits had affected UNVs' performance and contributed to the dissatisfaction with the sub-programme. This adds to the reluctance to continue volunteering and may have wider ramifications when resulting in the shrinkage of the pool of potential applicants to volunteer as it portrays a bad image of South Africa.

c) Transfer of knowledge and skills

- **The UNV sub-programme is an efficient platform for the mutual exchange of knowledge and skills through a dynamic interaction of diverse skills from many countries.** The sub-programme had become a melting pot, and new knowledge and skills emerged at a slow pace though. However, without the introduction of a systematic mentoring, the skills transfer will not be efficient and it will be difficult for

the sub-programme to move from mere gap filling to capacity development. In the district hospital environment where medical personnel are overstretched by day-to-day work, skills transfer will be very limited unless systematically organised in a mentor – protégé relationship.

d) Promotion of volunteerism culture for local professionals

- **A volunteerism program cannot be successful without an active campaigning.** The campaign for volunteerism took a back seat as the focus had been on service delivery. The commitment of UNVs was a showcase of tolerance, and a demonstration of the possibility of working in unfavourable conditions for the betterment of health, irrespective of ethnicity. The shelf life of the spirit of volunteerism must not be limited to the duration of the sub-programme but must initiate commitments that can be honoured permanently. The UNVs had already shown the feasibility of volunteerism in practice by committing themselves to serve communities and share knowledge which was an indication of the possibility of having local volunteers to improve the health care system.
- **Partnership is essential for volunteerism.** The sub-programme document was short of indicating the need for partnership with the private sector and civil society to promote volunteerism and hospitals were left to operate in silos to achieve such a big undertaking that had developmental effects not only in the province but the nation in general. Chances are slim for the province to successfully promote volunteerism without partnering with the private sector and civil society in the whole country.

e) Implementation of a retention strategy is required to minimise the outflow of health professionals from the province. The sub-programme and the hospitals did not effectively implement a retention strategy, and this might contribute to insufficient requests for contract renewal by UNVs and low retention rate of local doctors.

f) Health care service delivery

- **The UNV sub-programme has been an efficient stopgap measure of responding to unmet health care needs, which otherwise may have led to loss of lives in Limpopo.** However, the efforts to attract volunteers as required were not successful, meaning that reliance on volunteerism is not the best option to address the backlogs of health service delivery.
- **The UNV sub-programme is a shortcut to bring changes in people's attitudes and behaviours.** UNVs inculcated the attitude of work ethic, more sense of duty and responsibility for patients into the local health workers that no one who came into contact with them can deny.

g) Ownership and shared vision for the sub-programme enhances the sub-programme's ability to progress towards its outcomes. The hospitals viewed UNVs only as workhorses and not as instruments of capacity building that had to leave a sustainable legacy of skills and the spirit of volunteerism. Except in service delivery, hospital staff did not actively participate in the achievement of the other objectives and outcomes of the sub-programme. Surprisingly, most were not even aware of the sub-programme itself.

h) Monitoring and evaluations

- **Without a built-in monitoring and evaluation framework, the sub-programme cannot measure the contribution of UNVs towards its objectives and outcomes.** Apart from the monthly reports and visits, the sub-programme did not have a monitoring system to track progress and early notification of issues that may arise in the process. Some of the major challenges of the sub-programme were the absence of M&E framework to efficiently and effectively develop indicators; measure progress against baseline; monitor the working conditions, performance, complaints, and to take immediate corrective actions. Limited communication between the PMU and the UNVs also resulted in the accumulation of unresolved issues, to the extent that UNVs resented their presence in South Africa. This can undermine service

delivery performance and the recruiting capacity of the PMU because unsatisfied UNVs are more likely to underperform and badmouth to potential applicants.

6.2. Recommendations

a) Appointment and deployment of health professionals

- **Develop complete screening procedures for selecting appropriates candidates.** The sub-programme should prepare and use volunteer interview and screening plans and develop selection tools and procedures appropriately. Appointing the most suitably qualified UNVs can best be done through interviewing the properly recruited doctors. This is a more efficient way for using available resources than dealing with the consequences of poor selection that may result in resignation and termination of contracts. The PMU has to convene a panel of clinical specialists as it used to do in the previous Phases. Inconvenience of bringing together the required panel of health specialist as interviewers, should not at all be a reason for abandoning the interview process.
- **Revise appointment targets.** It was not possible to recruit any from the clinical engineers, pharmacists, and specialist nurses because of scarcity in the job market, lengthy, and inconvenient procedural requirements from the South African government. The sub-programme should revise its target for recruiting these professionals, and focus on appointing other medical doctors that can be relatively more available in the market. For those UNVs, e.g. pharmacists, who require a qualifying examination, the HPCSA should consider to have examination centres outside of South Africa. This can result in reaching the appointment targets and assist to acquire professionals that the sub-programme could not recruit for many years.
- **Induction should be a mandatory step of the deployment.** Induction should be a structured and guided by policy, mandatory step, never to be skipped, in the deployment process that has at least three-pronged purposes.

Firstly, it helps UNVs to adjust to the country's health care system, preferably initiated at the Provincial Hospital and continued in district/regional hospitals , to maximally contribute to the high quality of care which patients and other service users expect; to understand South African disease patterns and treatment procedures; and avoid confusion and anxiety of the sudden and unfamiliar cultural environment.

Secondly, it helps the Provincial Hospital to ensure that UNVs meet and match the required standards, iron out differences of clinical procedures; and get opportunity for quick and direct observation to assist in the deployment process according to their individual skills and traits.

Thirdly, it helps co-workers to have a clear understanding of expected UNVs' role and how UNVs fit into the system.

b) Providing care and support to UNVs

- **Make reference to sub-programme documents.** The *UNDP Support to the Health Sector in Limpopo: Phase III Programme Document*, and *Conditions of Service for International UNV Volunteers* are the two basic documents that hospitals must depend on for their understanding of the project objectives and outcomes, and administering the UNVs. The PMU must make sure that every hospital is in possession of these basic documents and monitor that they are adhered to. The absence of or no reference to these documents in the hospitals has given rise to many of the limitations identified, including a lack of full ownership, insensitiveness, and discrepancy of treatment to similar UNV issues. Possessing these tools (documents) will assist hospital management to identify and unblock bottlenecks in their day-to-day engagement with the UNVs.
- **Explore best practices across the UNV system.** It is to the benefit of the sub-programme for the PMU to know how other countries are dealing with some issues so that it can consider some best practices. This includes VLA transfers and deposit methods, tax exemption privileges, celebrations of International Volunteers Day, and

utilisation of extra hours worked (though this is indicated in the Conditions of Service).

- **Consider increasing incentives:** There is a wide gap between VLA and the salary of local doctors in South Africa, while in many other countries the gap is much narrower (in some African countries VLA for UNVs is more than their local doctors' salaries). In this context, it is an impressive privilege that hospitals have provided UNVs with free accommodation.

  Furthermore, in the light of the philosophy that satisfied workers are more productive it can be suggested that UNDP negotiate with UNV Headquarter to allow hospitals to compensate UNVs for extra hours worked. This option, that benefits patients more than the UNVs, can save many lives by allowing full utilisation of UNV skills rather than letting them remain idle outside the normal working hours. Hospitals must consider taking advantage of the UNVs availability around the hospitals because, unlike many local doctors who do private practices, most of the UNVs do not go anywhere after-hours and over weekends. Given the acute shortage of health professionals in the disadvantaged areas, these critical life saving resources should be fully utilised with reasonable incentives.

  UNDP can also consider other incentives, like facilitating credit opportunities to buy cars and laptops (including Internet connectivity solutions) as part of the package of care and support for UNVs.

- **Ensure rapid turnaround times for licensing and permits.** One of the big challenges of the sub-programme is inefficiency in HPCSA registration and temporary residence permits and therefore an effort must be made to ensure a better coordinating mechanism among responsible parties (including UNDP New York, DIRCO, and HPCSA) to streamline processes. Inefficiency in this regard can lead to losing applicants to other posts, because the global job market for health care workers is highly competitive.
- **Enhance recognition and appreciation for volunteerism.** UNVs crave for recognition and appreciation for their unique contributions and they want to be valued by all

stakeholders. As one of the biggest rewards to volunteers, there should be formal recognition of volunteerism including organising a national version of UNV day with enhanced publicity through various events. There should also be informal recognition of volunteerism by co-workers spontaneously expressing gratitude to UNVs in their day-to-day activities. Similarly, even 'courtesy calls' by PMU, UNDP, and Provincial DoH could signal recognition and can work wonders.

The combined effect of formal and informal recognition can create a culture of appreciation in hospitals where UNVs are respected and valued for their contributions, resulting in a deeper sense of connectedness to the sub-programme and its mission. This in turn results in increased retention, and improved quality of work in the treatment of patients. According to Patton[18] (2002:7-8):

> How people are treated affects how they treat others. If staff members are treated autocratically and insensitively by management, with suspicion and disrespect, staff will treat clients the same way. Contrariwise, responsiveness reinforces responsiveness, and empowerment breeds empowerment.

Care and support to UNVs will therefore result in better care and support to patients.

c) Implementation of a mentorship programme

- **Develop strategies for mentorship.** As mentoring is a powerful method for capacity development, the sub-programme should assist and ensure the development of a mentorship strategy to systematically transfer skills from UNVs to locals and vice versa. Depending on the availability of mentors, hospitals can have different models, including one-to-one mentoring; group mentoring; self-directed mentoring (use of technology to monitor skills enhancement); and cross-hospital mentorship (staff of different hospitals mentored together). Without such a structured mentor- protégé relationship, skills transfer cannot be efficient. Skills transfer is one of the main components for sustainability that ensures the life of the sub-programme after it comes to an end. A conducive environment must be created for UNVs to play an

[18] Patton, M. Q. 2002. *Qualitative research and evaluation methods*. 3rd ed. Thousand Oaks: Sage Publications.

active role in the promotion for sustainability by training, mentoring, and coaching. This is done parallel to the community service, and internship programmes.

The mentorship strategy can involve identification of suitable mentors (local health professionals and UNVs); development programme for potential mentors; identification of groups who need mentoring and auditing their needs and requirements; determination of the extent of inclusion of professional/technical coaching in the mentoring programme; communication of sub-programme objectives and provision of guidelines; and monitoring and evaluation with appropriate performance indicators.

d) Promotion of a volunteerism culture for local professionals

- **Build partnership for volunteerism.** Given the socio economic situation of the country, it is an uphill struggle to impart the culture of volunteerism in South Africa. It is therefore almost impossible to promote volunteerism in isolation and the PMU and the Provincial PDoH have to win a shared vision and develop partnership strategies to work with the private sector and civil society where health professionals can come to the public hospitals for assistance and capacity building. Health professionals can also go to private hospitals for similar purposes so that there can be mutual exchange of knowledge and skills on a voluntary basis. The volunteerism partnership should also include retired doctors, nurses, and health technologists.

  This approach can work only if the sub-programme develops guiding principles and conditions for partnership-building activity, construct communication networks among partners and stakeholders, and cultivate partner interest and involvement.

- **Volunteerism should start within health facilities internally**. It is vital for the UNVs themselves to be vehicles of the campaign of volunteerism by creating an environment where they can play active roles in the sub-programme. The communities that are served by the hospitals must be informed about the sub-programme so that they not only acknowledge and appreciate volunteerism but

become active participants in the process. This promotion for volunteerism culture should result in existing health workers volunteering for some unpaid hours in their place of work. The sub-programme should have orientation sessions on Volunteer Management Theory that empowers hospital management on how to work with volunteers.

e) Retention strategy for health professionals

- **Effectively implement a retention strategy.** Having an institutionalised retention strategy is a *sine qua non* for keeping local doctors more permanently, and UNVs beyond their one year contracts. This would include focusing on preventing as well as addressing issues of dissatisfaction, financial and no-financial incentives, and implementing of effective skills development programmes.

f) Monitoring and evaluation framework

- **Develop an M&E framework.** To ensure that, if the appropriate inputs and activities (appointing the right skills, conducting appropriate induction, providing care and support, acknowledging and appreciating volunteerism), and outputs (performance, achievement of objectives) are in place, a robust monitoring and evaluation framework should be designed at the very beginning of the sub-programme and updated annually. This could involve including the development of verifiable indicators, gathering of baseline data to measure progress, and benchmarking to develop a standard of service delivery. The absence of a robust M&E framework and costed M&E work plan, to track performance and send warning signals that require immediate attention, is one of the weaknesses of the sub-programme.

  As part of the M&E framework the PMU can consider to request quarterly UNV reports from hospitals, in addition to its monthly reports. Though hospitals report when UNVs had finished their contracts, this is not sufficient because it is difficult to keep track and to provide up-to-date information on the actual contributions and changes brought about by the UNVs. Not reporting UNVs performance quarterly, together with their co-workers, can raise the feeling on UNVs that their service is

undervalued and not taken seriously. Quarterly reporting can also assist hospital management to enhance the sense of ownership and connectedness with the sub-programme.

Annexes

Annex I. Terms of Reference[19]

Outcome Evaluation of UNDP's Capacity Development Programme for the enhancement of service delivery through good governance and capacity development in South Africa

Background and Programming Context

In 2007, a Common Country Programme Action Plan (CCPAP) was developed by government of South Africa and the UN in consultations with key stakeholders. The Plan was developed based on government national development processes, policies and programmes aimed at improving performance of state services. At the request of government, the UN commissioned national research institutions to undertake research study that identified country's priority needs. The recommendations of the study were reviewed extensively in collaboration with government, NGOs, CSOs, private sector, UN and other stakeholders. This prompted the government to conduct its own Country Analysis (CA) within the context of achieving the MDGs, South Africa's Vision 2014 and national development plans. The CA formed the basis for development cooperation in the country with all stakeholders including the UN. The CA led to the development of United Nations Development Framework (UNDAF) for 2007 – 2010.

UNDP developed a programme for 2007 – 2010 with five outcomes that were within the context of the UN reform processes, changing global aid architecture and global policy perspectives emanated from 2000 millennium summit and commitment to the achievement of the MDGs by 2015. The programme and its outcomes were also aligned to the priorities of the South African government aimed at improving service delivery of basic services particularly to the marginalized and vulnerable groups in the three provinces of Limpopo, KwaZulu-Natal and Eastern Cape.

UNDP has been working with key Ministries providing technical expertise in supporting the service delivery commitments of the government especially at provincial and local levels. UNDP provided

[19] This ToR includes other projects that are not covered in this report; there will separate reports for them

technical assistance in assessing service delivery constraints and contributed in strengthening the capacity of the state and its implementing partners in the following areas:

- Institutional and human capacity needs to promote capacity development and sustainability provincial and local levels.
- Strengthen capacity for strategic planning, monitoring and evaluation by providing technical support to enhance capacity for M&E within the Offices of the Premiers.
- Strengthen capacity to implement policy frameworks by providing support for the conceptualization, establishment and management of provincial learning/local government leadership academies as public service delivery development institutions.
- Promote advocacy and mainstreaming of MDGs, human rights and gender equality into Government Development Plans and Processes.

While some programme activities were successfully implemented during the programme cycle, some programme areas were not fully implemented nor started. These were due to various reasons including among others the re-profiling process that took place in 2007, the development of the CCPAP and the resignation of the RR and DRR in 2008, UNEG exercise that was conducted and the appoint of DRR in 2009, and the reposition process that took in 2010 under the leadership of the new RR.

Some of the key achievements of the programme implementation include:

- In collaboration with the StatsSA, UNDP supported the domestication of MDGs which resulted in promoting inclusive stakeholder participation and ownership of the MDGs process and reporting in the country. The production of the MDG Country Report-2010 has been a participatory process that involved national and provincial spheres of government, civil society, and business. To ensure quality of the report, seven MDGS Sectoral Working Groups, and a National Stakeholder Coordinating Committee were constituted to validate the report in collaboration with Cabinet.

- UNDP supported the process of building coalition around the MDGs in the country through the facilitation of a strong partnership between governments, CSOs and the academia on the MDGs. SANGOCO, for instance was involved in the MDGs domestication process.

- UNDP in collaboration with the RBA initiated partnership with United Nations Department of Economic and Social Affairs (UNDESA) on a project called “Realising the MDGs through

socially inclusive macroeconomic policies" to support South African Government in pro-poor policies and programmes. The partnership had two objectives. First, evaluating and analysing the determinants of achieving the MDGs and generating various strategic options including optimisation of resource allocation for the timely achievement of the MDGs. Second, developing Government capacity on evidence-based policy analysis that would feed into decision making process.

- UNDP in collaboration with other UN agencies organised a high-level advocacy on MDGs during the 2010 FIFA World Cup that involved renowned African artists.
-
- In KZN, UNDP in collaboration with The Office of the Premier has been providing technical support for the establishment of monitoring and evaluation system essential for tracking progress including MDGs. In 2009, UNDP conducted a comprehensive Capacity Needs Assessment of Monitoring and Evaluation Systems in KwaZulu-Natal including assessment of capacity requirement (human, institutional, and systems) with a view to determining the most appropriate strategies to institutionalize M&E for tracking the MDGs and related development outcomes. In 2010, UNDP also conducted a rapid assessment on community-based M&E capacity in Nkandla Municipality in KZN. The lesson from these processes was expected to pave the way to the possible scaling up to other local government units. As part of the M&E support to the province, UNDP supported KZN to establish the following:
    - the provincial Nerve Centre as an automated and integrated information management system for monitoring and evaluating government service delivery in KwaZulu-Natal and the implementation of the performance management system to promote transparency and accountability, and
    - the KwaZulu-Natal Public Service Training Academy as a centre for human capacity development in the province. The academy has been focusing in research and training to strengthen the co-ordination of developmental assignments, the identification of needs, mentoring and coaching, as wells as knowledge exchange of international best practices

- In Limpopo, UNDP initiated and supported a partnership programme with the Department of Health and Social Development which began in 2002. The aim of this collaboration is to assist the Government of Limpopo in addressing the shortage of health personnel caused by brain- drain and to building capacity of health professionals to improve service delivery and management of health care in the province. The First two Phases of the programme focused

on the recruitment and placement of doctors. An independent evaluation of this programme was conducted in 2009 to assess the strengths and weakness as well as lessons learnt in supporting and promoting volunteerisms in the province. The programme currently has 38 doctors recruited placed in 14 hospitals of the province. About 20 more doctors are expected to join the programme before the end of this year. In this current phase (Phase III) which began in October 2009, in addition to the recruitment and placement of volunteers, the scope of the programme has expanded to include:

- Health Planning Support Programme (Health economics): The purpose of this sub-programme is to strengthen health service planning, capacity of local health personnel at policy and planning level, through the analysis, development and institutionalization of effective Health Planning. A consultant has been recruited and is currently finalizing the implementation as well as waiting for the department to establish a steering committee to support this programme.

- Knowledge management and leadership development: The purpose is to establish a Health Knowledge Management Centre/s to systematically generate, collect, store and utilize information to inform strategic planning processes. This sub - programme, also facilitates "knowledge development and exchange platform", to enhance knowledge sharing between local and international practitioners. A leadership development programme is being implemented for relevant local Senior Managers to improve on overall departmental performance.

- Monitoring and evaluation, which includes the domestication of MDGs: The purpose of this sub-programme is to establish the provincial Department of Health and Social Development M&E system to improve on service delivery, accountability and strategic planning. It will also assist with the domestication of MDGs within the Limpopo DoHSD. A consulting firm has been recruited to develop the M & E system, and currently UNDP is finalising a contract.

UNDP is currently in the process of soliciting the services of a qualified service provider to conduct an outcome evaluation of its contribution to the Government efforts in improving service delivery in the country. This entails assessing UNDP's support in strengthening the capacity of the government of South Africa on strategic planning, monitoring and evaluation, promoting advocacy for mainstreaming MDGs, human rights, south-south cooperation, and gender equality.

2. Purpose of the Evaluation

This evaluation is being undertaken to evaluate the collective outcomes of the four years (2007 - 2010) of UNDP's contribution in **enhancing service delivery through good governance and capacity development in South Africa.** There have been delays in conducting this evaluation due to the repositioning process that took place in 2010 which resulted in the development of a new programme direction based on the recommendation of the of the 2007 – 2010 UNEG report. The country office is currently implementing the new programme starting from 2011 and ending 2012. The implementation is in line with the extension of the UNDAF process in 2011 to 2012. The evaluation report will present findings, conclusions, good practices, lessons learned, and recommendations. The evaluation results will be used by UNDP to improve its development partnership support services to the Government of South Africa to achieve its national development aspirations including the acceleration of the achievement of the Millennium Development Goals (MDGs) by 2015. The financial and technical resources of this evaluation will be devoted from programmes and projects that are contributing to the achievement and realization of this outcome.

3. Evaluation scope and objectives

This evaluation is expected to assess the outcomes of the programmes and projects that UNDP has been implementing in collaboration with the Office of the Premier in KwaZulu-Natal (KZN) and the Department of Health and Social Development in Limpopo. This will include assessment of the effectiveness, relevance and sustainability of the monitoring and evaluation project in KZN (Provincial Departments and three municipalities, Nerve Centre, and the Public Service Training Academy), and the UNV doctors' project in Limpopo. The evaluation is also expected to assess UNDP's contribution to the MDGs domestication and reporting process led by Statistics South Africa. This will include evaluation of the UN joint MDGs advocacy campaign conducted during the 2010 FIFA World Cup, and the domestication of the MDG targets and indicators at national and provincial levels, Realising the MDGs through socially inclusive macroeconomic policies, mainstreaming of human rights, south-south cooperation, and gender equality in programme implementation. The evaluation will also collate and analyse lessons learned and good practices obtained during the period of implementation that can be further rolled out to other parts of the country. The evaluation will cover a period from 2007 to 2010 of programme implementation.

Specifically this outcome evaluation has the following objectives:

(i) to analyse and evaluate the effectiveness of the results that the projects have been able to achieve against the objectives, targets and indicators stated in the project document;

(ii) to assess the effectiveness of the work and processes undertaken in the projects as well as the performance of all the partners involved in the project implementation;

(iii) to assess whether the programme/project is the the appropriate solution to the identified problem(s);

(iv) to determine the projects' relevance, and sustainability of results and benefits

(v) to provide feedback and recommendations for subsequent decision making and necessary steps that need to be taken by the national stakeholders in order to ensure sustainability of the project's outcomes/results;

(vi) to reflect on how efficient the use of available resources has been;

(vii) to document and provide feedback on lessons learned and best practices generated by the projects during their implementation;

(viii) to identify unintended results that emerged during implementation (beyond what had initially been planned for);

(ix) to identify other factors that contributed to the outcomes, if any; and

(x) to identify key adaptations in response to unforeseen circumstances; and

(xi) to ascertain whether UNDP's partnership strategy has been appropriate and effective.

(xii) to assess sustainability of results and benefits

4. Evaluation questions

The following outcome evaluation questions have been defined to generate appropriate information about the effective implementation of the programmes and envisaged outcomes. The proposed questions would help to provide relevant information to make decisions, take action, and add to knowledge. These outcome evaluation questions include:

- Were inputs sufficient and used efficiently?
- Were stated outcomes or outputs achieved?
- What progress toward the outcomes has been made?
- What factors have contributed to achieving or not achieving the intended outcomes?
- Are there unintended outcomes?
- To what extent has UNDP outputs and assistance contributed to outcomes?
- Has the UNDP partnership strategy been appropriate and effective?
- What factors contributed to effectiveness or ineffectiveness?
- Are the interventions relevant, effective and sustainable?

However, the evaluation team is expected to add and refine these questions in consultation with key stakeholders.

5. Methodology

An evaluation approach is indicated below, however, the evaluation team is responsible for revising the approach as necessary. Any changes should be in-line with international criteria and professional norms and standards (as adopted by the UN Evaluation Group). They must be also approved by UNDP before being applied by the evaluation team.

The evaluation must provide evidence-based information that is credible, reliable and useful. It must be easily understood by project partners and applicable to the remaining period of the project duration.

The methodology to be used by the evaluation team should be presented in the report in detail. It shall include information on:

- Documentation review (desk study) - the list of documents to be reviewed will be provided in advance by the Project Implementation Unit;
- Interviews will be held with the following organisations and individuals at minimum:
  - for the Monitoring and Evaluation, interviews will be held with the manager and staff of the Nerve Centre in the Office of the Premier in KZN; the manager and staff at the Public Service Training Academy in KZN; All KZN Provincial Departments, selected District and Local Municipalities, and selected consultants involved in key project assignments;
  - for the MDGs project, interviews will be held with the National Statistics System Division (staff in Stats SA, the Office of the Premier in KZN, National MDG Sectoral Working Groups, National Coordinating Committee, and Report Drafting Team)
  - in Limpopo, interviews will be held with the Programme Management Unit (PMU) including management staff and consultants, UNV doctors and the designate programme staff in the Department of Health and Social Development in Limpopo
- Field visits;
- Questionnaires;
- Participatory techniques and other approaches for the collection and analysis of data.

The consultants should also provide **ratings** of Project achievements according to Project Review Criteria. Aspects of the Project to be rated are:

1	Implementation approach
2	Country ownership/drivers
3	Outcome/Achievement of objectives (meaning the extent to which the project's development objectives were achieved)
4	Stakeholder participation/public involvement
5	Sustainability
6	Replication approach
7	Cost-effectiveness
8	Contribution to human rights and gender equality
9	Monitoring and evaluation

The ratings to be used are:

HS	Highly Satisfactory
S	Satisfactory
MS	Marginally Satisfactory
MU	Marginally Unsatisfactory
U	Unsatisfactory
HU	Highly Unsatisfactory
NA	Not applicable

6. Evaluation products (deliverables)

The key evaluation products that the evaluation team is expected to produce should include:

- **Evaluation inception report -** An inception report will be prepared by the evaluators before going into the full fledged evaluation exercise. It should detail the evaluators' understanding of what is to be evaluated and why, showing how each evaluation question will be answered by way of: proposed methods; proposed sources of data; and data collection procedures. The inception report should include a proposed schedule of tasks, activities and deliverables,

designating a team member with the lead responsibility for each task or product. The purpose of the inception report is to provide an opportunity to verify and share the same understanding about the evaluation and clarify any misunderstanding at the outset.

- **Draft evaluation report -** The programme unit and key stakeholders in the evaluation will review the draft evaluation report to ensure that the evaluation meets the required quality criteria.
- **Final evaluation report.**
- **Evaluation brief and other knowledge products** or participation in knowledge sharing events, if relevant.

7. Evaluation team composition and required competencies

The evaluators selected should not have participated in the project preparation and/or implementation and should not have conflict of interest with project related activities.

The evaluation team will be composed of one Team Leader and one National Consultant. The evaluators shall have prior experience in evaluating similar projects. Former cooperation with UNDP is an advantage.

The selection of consultants will be aimed at maximising the overall "team" qualifications and competencies in the following areas:

(i) At least Masters education (preferably in Development and Public Management, Public , Policy Analysis, or related fields in social science);
(ii) Recent experience with result-based management evaluation methodologies;
(iii) Experience applying participatory monitoring approaches;
(iv) Experience applying SMART indicators and reconstructing or validating baseline scenarios;
(v) Recent knowledge of the UNDP Monitoring and Evaluation Policy;
(vi) Recent knowledge of UNDP's results-based evaluation policies and procedures
(vii) Demonstrable analytical skills;
(viii) Work experience in relevant areas for at least 8 years;
(ix) Experience with multilateral or bilateral supported capacity development projects;
(x) Project evaluation experiences within United Nations system will be considered an asset;
(xi) Excellent English communication skills (oral and written).

The evaluators must be independent from both the policy-making process and the delivery and management of assistance. Therefore, evaluators who have had any direct involvement with the

design or implementation of the project will not be considered. This may apply equally to evaluators who are associated with organisations, universities or entities that are, or have been, involved in the project policy-making process and/or delivery of the project. Any previous association with the project or other partners/stakeholders must be disclosed in the application.

If selected, failure to make the above disclosures will be considered just grounds for immediate contract termination, without recompense. In such circumstances, all notes, reports and other documentation produced by the evaluator will be retained by UNDP.

VI. Evaluation team – specific tasks

The Team Leader will have overall responsibility for the delivery and quality of the evaluation products. Specifically, the Team Leader will perform the following tasks:

- Lead and manage the evaluation mission;
- Design the detailed evaluation scope and methodology (including the methods for data collection and analysis);
- Decide the division of labor within the evaluation team;
- Conduct an analysis of the outcome, outputs and partnership strategy (as per the scope of the evaluation described above);
- Draft related parts of the evaluation report; and
- Finalise the evaluation report.

The National Consultant will provide input in reviewing all project documentation and will provide the Team Leader with a compilation of information prior to the evaluation mission. The National Consultant will perform tasks with specific focus on:

- Review documents;
- Prepare a list of the outputs achieved under project;
- Organise the mission programme and provide translation/interpretation when necessary;
- Participate in the design of the evaluation methodology;
- Conduct an analysis of the outcome, outputs and partnership strategy (as per the scope of the evaluation described above);
- Draft related parts of the evaluation report;
- Assist Team Leader in finalising document through incorporating suggestions received on draft related to his/her assigned sections.

The evaluation will be conducted in accordance with the principles outlined in the UNEG 'Ethical Guidelines for Evaluation:

- Independence
- Impartiality
- Transparency
- Disclosure
- Ethical
- Partnership
- Competencies and Capacities
- Credibility
- Utility

8. Evaluation ethics

The evaluators must read and familiarise themselves with the evaluation ethics and procedures of the UN System to safeguard the rights and confidentiality of information, for example: measures to ensure compliance with legal codes governing areas such as provisions to collect and report data, particularly permissions needed to interview or obtain information about children and young people; provisions to store and maintain security of collected information; and protocols to ensure anonymity and confidentiality.

9. Implementation arrangements

The principal responsibility for managing this evaluation lies with UNDP South Africa Country office. UNDP South Africa will contract the evaluators and ensure the timely provision of per diems and travel arrangements within the country for the evaluation team. UNDP will liaise with the evaluators to set up stakeholder interviews, arrange field visits, coordinate with the Government, etc.

10. Timeframe, resources, logistical support and deadlines

The evaluation will be completed in a period of about 36 days, from the date of commencement. The report shall be submitted to the UNDP South Africa Country Office.

Prior to approval of the final report, a draft version shall be circulated for comments to government counterparts, project team and UNDP South Africa. If any discrepancies have emerged between the

findings of the evaluation team and the aforementioned parties, these should be explained in an annex attached to the final report.

Table 1: The activities and timeframe are broken down as follows:

Activity	**Timeframe and responsible party**
Desk review	3 days by the Team Leader and National Consultant
Briefings for evaluators	1/2 day by the UNDP procurement Unit
Field visits, interviews, questionnaires, de-briefings	4 days by the Team Leader and National Consultants
Preparation of first draft report	4 days by the Team Leader and National Consultant
Review of preliminary findings with project stakeholders through circulation of the draft report for comments, meetings and other types of feedback mechanisms	10 days UNDP South Africa Office and Government Counterparts
Incorporation of comments from project stakeholders and submission of second draft report	2 days by the Team Leader and National Consultant
Review and preparation of comments to second draft report	10 days UNDP South Africa Office, and Government Counterparts
Finalisation of the evaluation report (incorporating comments received on second draft)	2 days by the Team Leader and National Consultant
Stakeholder Validation Workshop of the evaluation report	½ day facilitated by the Team Leader

11. Format of Final Report:

The key product expected from this programme evaluation is a comprehensive analytical report in English that should, at least, include the following contents:

- Title and opening pages
    - Name of the evaluation intervention

- Names and organizations of evaluators
- Acknowledgements

- Table of contents
- List of acronyms and abbreviations
- Executive Summary
- Introduction
- Description of the intervention
- Evaluation scope and objectives
- Description of the evaluation methodology
  - Findings and conclusions
  - Programme Relevance
  - Programme Results: Progress towards Programme Outcome
  - Programme Efficiency and Effectiveness

    -Internal programme efficiency

    -Partnership strategy
  - Changes in context and outside of programme control
  - Sustainability of results
- Recommendations
- Lessons Learned (including good practices and lessons learned)
- Annexes: ToRs, field visits, people interviewed, documents reviewed, etc.

All interested applicants should submit: a recent CV; a brief outline of the evaluation approach and methodology; period of availability, a proposed budget for the assignment implementation to: www.undp.org.za. **Application deadline: 31 October 2011.**

Annex II.

Questionnaire used in the evaluation

a) Interview with the Hospital management; UNVs, and hospital staff, and UNDP

A. Managing inputs and processes *(Give reasons for your responses where appropriate)*

	Respondents[20]
Recruitment, Induction, and Deployment	
What challenges are there in the following UNV processes? a) Recruitment b) Deployment	Management; UNVs; Staff
How do you assess the induction procedures (introduction to work environment, staff and community, etc)? Did the UNVs experience any cultural shock? If any what were the management responses and results?	Management; UNVs
Were there any challenges in verification of UNV documentation and qualifications? If any, were there negative consequences? How were they addressed?	Management
Was the recruitment and selection of the UNVs done on the basis of gap analysis to reflect the actual needs of the hospitals with the right mix of skills?	Management
Has the deployment of the UNVs been optimal (i.e. deployed in hospitals where they are mostly needed)?	Management; UNVs
How do you assess the sub-programme's support to update the skills of the UNVs? Challenges and management response?	Management; UNVs
What efforts have been done to maintaining physical, and emotional wellbeing of the UNVs? Was there any security problem? If any, how was it addressed?	Management; UNVs
What new ways of working have been introduced by the UNVs? If any, how do you assess the receptivity and encouragement given to these?	Management; UNVs; Staff
Do the UNVs have any chance to participate in the hospital management? If yes, in what form?	Management; UNVs
Do you have regular meetings with UNVs across the province? How often?	UNVs
Has there been any administrative issues that negatively influence your performance? (e.g. travel, documentation, dependants, VLA, etc.) How were they addressed?	Management; UNVs
How do you assess the UNV's capacity to transfer their knowledge and skill? How do you assess staff readiness to learn and receptivity?	Management; Staff
What is the motive of you working as a volunteer?	UNVs

[20] Management=Hospital CEO & clinical manager; Staff = Hospital health professionals (doctors and nurses)

	Respondents[20]
Management support	
How do you assess management support for UNVs from the following bodies been sufficient? (hospitals, PMU, Limpopo Department of Health, UNDP, Headquarter—Bonn).	UNVs
Can you mention, if any, unclarity of stakeholder roles in the sub-programme? Any consequences?	Management; UNVs

B. Activities and their outputs

	Respondents
Is there a sub-programme and implementation framework (plans, targets, etc.) for knowledge and skills transfer? Discuss on the aspects of job training; mentoring; and formal training for local staff? Any challenges? Does this include the facilities where UNVs were not deployed?	Management; UNVs
Have there been campaigns to promote volunteerism? If yes, who conducts them and who are the targets? The strategies? How often do they happen? Explain any challenges and how they were addressed? If not, what are the plans?	Management; UNVs
Can you explain if there are *initiatives, services*, and *results* that can exclusively be attributed to UNVs?	Management; UNVs; Staff

D. Outcome

	Respondents
Can you say service delivery has been enhanced in the hospitals due to UNVs? Discuss the specific aspects of improvement that can be attributed to UNVs.	Management; UNVs; Staff
What changes did you notice in local staff as a result of participating in the UNV sub-programme? Discuss against the following dimensions:	Management; UNVs; Staff
Knowledge (*learned information; etc*.)	
Attitude (opinions; feelings; *the spirit of volunteerism; perspectives; etc.*)	
Skill (*mental and physical abilities to use new or alternative practices; improvement of performance; etc*.)	
Aspiration (*ambitions; hopes; desires; increased demand; etc*.)	
Behaviour (*patient care; etc*.)	
Discuss the speed with which skill transfer is achieved. Identify, if any, obstacles and the way they have been addressed. Results?	Management; UNVs; Staff
Is the community aware of the UNVs? How? Do patients observe the difference between a volunteer and a paid doctor, if any? Has the UNV volunteerism any influence inside and/or outside the medical profession?	Management; UNVs; Staff

	Respondents
Is there readiness of local health professionals to work in disadvantaged areas? Does the UNV sub-programme so far have any influence on the attitude of local doctors regarding volunteerism?	Management; Staff
Have any of the previous UNVs decided or shown interest to continue working in Limpopo? Why or why not?	Management; UNVs; Staff
Have there been any positive changes in retaining medical professionals after the intervention of UNVs? If so, can it be attributed to this sub-programme? Why or why not?	Management; UNVs; Staff
Discuss in what ways the MDGs have been addressed (maternal mortality; child mortality; HIV/AIDS). Any supporting data?	

E. Emergence

	Respondents
What unexpected has happened in the context and results chain of the sub-programme? E.g. *Context* (change in policy; political, economic, or social environment; public attitudes; partners' roles; etc); *Inputs*; *Activities*; *Outputs*; *Outcomes*)? If any discuss what adaptive measures have been taken by management and staff?	Management; UNVs
What other activities have been done by Provincial Government and Departments or other bodies (political parties, youth league, CSOs, etc.) to bolster volunteerism in the province?	Management; UNVs

F. Monitoring and evaluation

	Respondents
Is there an M&E component to the sub-programme? If so is there an M&E framework? If not how do you measure if resources have been optimally used and targets met?	Management

G. Overall assessment

	Respondents
How do you assess the project design? Was it participatory? Any challenges?	Management
How do you assess the performance of the UNV doctors to bring about the intended result of the sub-programme? Is the sub-programme running according expectations?	Management
Do you think this volunteerism will be sustainable with lasting legacies? What signs are there for the sustainability/unsustainability?	Management; UNVs; Staff
What is your view on terminating, continuing or expanding the sub-programme? Why do you think so?	Management; UNVs; Staff
What lessons can we learn from this UNV sub-programme?	Management;

	Respondents
	UNVs; Staff
Do you have any recommendations for improving this sub-programme? What changes do you want to see (from the hospital management; sub-programme management)	Management; UNVs; Staff

b) Interview with the PMU, and UNDP

Recruitment, Induction, and Deployment	
1.	Do you think the UNV recruitment process is efficient (how long does it take to recruit and deploy a UNV)? • What are the challenges? • What is the role of the Head quarter (Bonn)? In the recruitment process? • What have you done to improve it? • Do you have arrangements with UNDP CO to do pre-assignment briefings, including assistance for a peer-to-peer briefing? • How do you make sure that the interviewee is the right person in telephonic interview? Do you use UNDP CO in other countries for interviews?
2.	The targeted professionals are medical doctors and allied health professionals (nurses, pharmacists and clinical engineers). • Challenges of not recruiting the required number of these? • How likely is the target to be met? • Why do recruit from Africa while the programme document states that "refrain from recruiting personnel from other African countries"
3.	How sufficient was the induction and cultural orientation process when UNVs are directly sent to duty stations? • What are the procedures and challenges?
4.	Does the UNV contract specifically state that they have to work in rural areas?
5.	Has there been any experience of mismatch between formal qualifications and actual knowledge and skills? • If any, what steps were taken? Any termination of contract and why?
6.	Does the UNV contract specifically state that they have to work public service only, and in public private

	partnership?
7.	Is the fund allocated to the sub-programme sufficient? • Any challenges? • Are there efforts to raise fund locally? • Why couldn't you appoint a UNV sub-programme officer?
Care and Support	
8	Do you distribute the "Conditions of Service for International UNV Volunteers" to hospitals? • How do you make sure if they make use of it?
9.	What specific plans are there or will there be to improve living conditions of UNVs (housing, transport…)? • Get together? • Why was the UNV day not celebrated in South Africa ? • Why are some UNVs living in guesthouses? Wasn't renting houses/flats cheaper?
10.	What specific plans are there for capacity development of UNVs? • How do you ensure that they are not left out from the general capacity development plan of the hospitals?
11.	Does the UNDP CO coordinate other UN agencies in the country to reach a common policy on the use of CTO (compensatory-time-off) by the UNV volunteers?
Health Care Service Delivery	
12	What monitoring plan or framework do you have for the UNV project? (can I have a copy?). • Do you have monitoring visit reports that include concrete actions taken to address identified challenges? • Reporting templates and feedback? • Ongoing monitoring visits and consultancy? • Can you send me your annual work plan? • How much specific budget is allocated to M&E?
13	Do you have plans to improve retention rate of UNVs? • What are they? • How many have completed 6 years and how many have permanently employed?

14.	What plans do you have to solve the "Working hours and compensatory time-off"? (there are different approaches in hospitals)
15	How long does it take to renew contract and HPCSA registration, and TRP? ID? • Challenges and management response? • Banking system, the issue of having dollar account?
Skills Transfer	
16.	What specific plans are there or will there be to improve systematic skills transfer from UNV to locals and vice versa?
Promoting Volunteerism	
17.	What are your strategies to promote the spirit of volunteerism? (now it is not happening). Which partners have you identified for this purpose? Challenges and response?
Management response by the Programme Board	
18.	How often does the Board (DoH, UNDP, PMU) meet? Is it regular?
19.	Have quarterly, annual reports been regular? Annual evaluations?
20.	Responses based on quarterly, annual progress and financial reports? Any adjustments done based on the reports?
21.	Why couldn't you appoint a UNV sub-programme officer?
22.	Do you regularly prepare Quarterly narrative financial report?
23.	Audit report?

c) Interview with the Provincial Department of Health, Limpopo

Recruitment, Induction, and Deployment	
1.	How participatory was the programme development process? Were the hospitals involved, e.g. to identify their specific needs?
2.	Do you think the UNV recruitment process is efficient? How likely is the target to be met? • What are the challenges? What have you done to improve it?
3.	How sufficient was the induction and cultural orientation process?
4.	Has there been any experience of mismatch between formal qualifications and actual knowledge and skills? If any, what steps were taken?
5.	Is the fund allocated to the sub-programme sufficient?
Care and Support	
6.	What specific plans are there or will there be to improve living conditions of UNVs (housing, transport…)?
7.	What specific plans are there for capacity development of UNVs?

Health Care Service Delivery	
8.	What monitoring plan or framework do you have for the UNV project? (can I have a copy?)
9.	What are your strategies to improve retention rate of UNVs? For local health professionals?
10.	What plans do you have to solve the "Working hours and compensatory time-off"? (there are different approaches in hospitals)
Skills Transfer	
11.	What specific plans are there or will there be to improve systematic skills transfer from UNV to locals and vice versa?
Promoting Volunteerism	
12.	What are your strategies to promote the spirit of volunteerism? Which partners have you identified for this purpose?

d) Closed-ended questions for UNVs, hospital management and staff

Did you participate in the previous UNV evaluation? Yes ☐ No ☐

Recruitment, Induction, and Deployment:

Please indicate to what extent you agree or disagree with the following statements.

	Strongly disagree	**Disagree**	**Uncertain**	**Agree**	**Strongly agree**
UNV recruitment process is efficient					
The induction process in the hospitals was satisfactory					
UNV deployment process is optimal (according to the need and demand of hospitals)					
The skills that the hospital is getting from the UNVs is the most required					
The skills that the hospital is getting from the UNVs is the right mix					
Some of the skills that the hospital is getting from the UNVs overlap with the skills the hospital already has					
Some UNV skills are underutilised					
I feel secure in the place where I live *(N.B. UNVs only)*					

Skills transfer

Please express your degree of agreement regarding the transfer of knowledge and skills from UNVs to locals.

	Strongly disagree	**Disagree**	**Uncertain**	**Agree**	**Strongly agree**
There is planned and systematic skills transfer to local staff					
UNVs are more interested in skills transfer than locals					
Locals are more interested in skills transfer than UNVs					

Service delivery due to the sub-programme

	Highly insufficient	**Insufficient**	**Uncertain**	**Sufficient**	**Highly sufficient**
Improvement of the efficiency of service delivery					
Improvement of the quality of service delivery					
UNVs new ways of service delivery					
Improvement of maternal mortality					
Improvement of child mortality					

Miscellaneous

Please indicate to what extent the following statements are sufficient.

	Highly insufficient	**Insufficient**	**Uncertain**	**Sufficient**	**Highly sufficient**
The induction procedures (to familiarise with work environment and societal culture) were					
The support given to update the skills of the					

	Highly insufficient	**Insufficient**	**Uncertain**	**Sufficient**	**Highly sufficient**
UNVs *(N.B. not for Staff)*					
UNVs' participation in hospital management					
Hospital management response to reported UNV issues					
Sub-programme management response to UNV issues *(N.B. only to UNVs & Management)*					
The usage of UNVs knowledge and skills in the hospital has been					
UNVs role in reducing HIV/AIDS					

Annex III. Interviewees

1. Hospitals

Hospitals	UNV Doctors	Hospital staff		
		CEO/Clinical Manager	**Doctors**	**Nurses**
Elim	• Dr. I. Danylenko • Dr. T. Benicio • Dr. R. Borys	• Dr. J. Nkuna • E. Makatu	• Dr. O Matha	• M. Shitwayu • L. Mgari • T. Hobyane
Lebowakgomo	• Dr. A.T. Abner • Dr Dr. G. Yudin	• Dr. J.Kganane	• Dr. M. Tijale	• T. Ratau • Mokgokong • A. Shaku
Letaba ***(Regional)***	• Dr. S. Nikiforov • Dr. L. Nikiforov	• Dr. A. Naude	• Dr. J. Miles • Dr. L. bopape	• G. Bangiw
Mankweng ***(Tertiary)***		• Dr. R. Mahladi	• Dr. A. Bvumbi	• M. Maloba • M. Mauka • P. Mapldo • M. Ramone
Mecklenburg	• Dr. J. Bautista,	• S. Moobi • Dr. M. Sithole	• Dr. A Fhima	• T. Olbakoane • M. Ramoshaba • M. Maduane • I. Malakj
Mokopane ***(Regional)***	• Dr.B. Galina • S. Sharma	• Dr. S. Ndhamb • M. Ralefe	• Dr. A. Mahmood • Dr. B. Tivala	• T. Makhado
Philadelphia ***(Regional)***	• Dr. K. Andriy • Dr. A. Hassen	• Dr. R. Kuwate	• Dr. F. Mukenge • Dr. G. Pietz • Dr. D. Pols • Dr. L. Rasnokeng • Dr. M. Itsweng • Dr. V. Fatunla • Dr. N. Masondo • Dr. M. Hlatsling • Dr. Mahlang • Dr. N. Hlatshwalu • Dr. P.Membock	• M. Mashaba • A. Matea • H. Mothogwane • N. Mogale
Polokwane ***(Tertiary)***	• Dr. M. Asha • Dr. M. Rajeev • Dr. J. Hubahib • Dr. N. Rozumyk • Dr. S. Bocharov • Dr. K. Kumar • Dr. D. Sergey	• M. Monale	• Prof. D. Nesengani • Prof. Neluheni • Dr. M. Gibango • Dr. M. Bhuiyan	• Gemuller • R. Makibelo • J. Mathobela • G. Koma • M. Malahlela • T. Setati • K. Makwelo • M. Mbombi
Sekororo	• Dr. P. Mulindwa • Dr. K. Inamullah • Dr. A. Minah	• Dr. H. Omiakwe		• K. Santho • M. Makuoba • T. Sihlangu • M. Sekgoka • M. Maake • R. Melembe • N. Mudau
Siloam	• Dr. S. Mehmood	• M. Mufamadi • Dr. D. Moon		• L. Mashaw • M. Moshapo

1. Hospitals				
Hospitals	**UNV Doctors**	**Hospital staff**		
		CEO/Clinical Manager	**Doctors**	**Nurses**
				• G. Rambulana • H. Khaku • T. Demana • T. Denga • N. Netsha
St Ritas ***(Regional)***	• Dr. J. Ontoy • Dr. a. Ahmed • Dr.T. Emam	• M. Ratlabala • Dr. Monale	• Dr. Adebolajo • Dr.K. Dominique • Dr. M. selahle • Dr. S. Mahlangu • Dr. M. Barna	• M. Maboko • M. Phaahla • T. Phetla • M. Mamushi • N. Mphela • M. Mamosebo • N. Matlala • M. Madiba
Tshilidzini ***(Regional)***	• Dr. L. Marjorie • Dr. R. Renato • Dr. D. Nikolay • Dr. A. Cortez • Dr. R. Jason	• Dr. Mulani	• M. Mugadeb	• M. Mulaudi • L. Rathanga • I. Mathani • M. Ndwahmbi • T. Tsedu • T. Makumba
Zebediela	• N. Ahmed	• Dr. H. Tswame • Dr. T. Masemaur	• Dr. M. Mahlala	• R. Kekana

2. Other locations		
Individual	**Role**	**Institution**
Dr. V. Buthelezi	General Manager Hospital Services	Provincial Department of Health
Mr. Joseph Mhlaba	Programme Manager, UNDP Support to Health Sector in Limpopo (PMU)	UNDP PMU Office, Limpopo
Ms. Lusanda Monale	Programme & Administration Coordinator, UNDP Support to Health Sector in Limpopo	UNDP PMU Office, Limpopo
Mr. Khepi Shole	Assistant Resident Representative	UNDP Country Office
Mr. Frederick Shikweni	M&E Officer	UNDP Country Office
Ms. Lily De Gama	UNV Country Operations Assistant	UNDP Country Office