LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HEALTH

South Africa

Final Draft Report for the Terminal Evaluation of the UNDP Support to Health Sector in Limpopo Programme: Phase III

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Acknowledgments

I would like to thank the United Nations Development Programme (UNDP) for appointing me to conduct this terminal evaluation. It has been a learning experience and has given me invaluable insight into the realities and challenges faced by Limpopo Province in providing quality health care to its citizens.

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Lastly and most importantly, I would like to thank all those stakeholders who participated in the evaluation and who gave us valuable insight into what the programme has achieved, its challenges and the lessons that have been learnt.

Abbreviations and Acronyms

APP	Annual Performance Plan
CEO	Chief Executive Officer
CTO	Compensatory Time Off
DOH	Department of Health
HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
HPCSA	Health Professionals Council of South Africa
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
NDP	National Development Plan
OPD	Out-patient Department
STI	Sexually Transmitted infections
PMU	Programme Management Unit
PRODOC	Project Document
TB	Tuberculosis
TOR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
UNVs	United Nations Volunteers

Executive Summary

This terminal evaluation of the United Nations Development Programme (UNDP) Support to Health Sector in Limpopo Programme: Phase III covered a period of five years (2009-2014). Phase III was an extension of Phase I and Phase II and aimed at supporting the Government of South Africa to improve health care services in Limpopo Province.

Despite a considerable amount of progress made in improving the health sector, South Africa continues to face huge challenges. These are some of the challenges:

- HIV/AIDS and related diseases such as tuberculosis (TB) and sexually transmitted infections (STIs);
- Maternal and child morbidity and mortality;
- Non-communicable diseases (mainly related to lifestyle);
- Violence, injuries and trauma.

The main objective of the programme was to facilitate the recruitment and deployment of UN volunteer medical professionals in the rural areas of the province to address shortage of key health personnel due to high mobility of medical practitioners to greener pastures locally and internationally. 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 was to strengthen health service planning and the capacity of local health personnel at policy and planning level through the analysis, development and institutionalisation of effective health planning.
- Knowledge management and leadership development: The purpose of this sub-programme was to establish a Health Knowledge Management Centre/s to systematically generate, collect, store and utilise information to inform strategic planning processes. Furthermore, a leadership development programme was envisaged to enhance the skills of the relevant local Senior Managers and improve the overall performance within the department.
- Monitoring and evaluation, which includes the domestication of Millennium Development Goals: The purpose of this sub-programme was to establish the provincial Department of Health and Social Development M&E system to improve service delivery, accountability and strategic planning.

The purpose of the evaluation was to determine the collective outcomes of the five years of UNDPs' contribution to enhancing health service delivery through good governance and capacity development in Limpopo Province. Given the nature of the evaluation, a qualitative design and methodology were used. Key documents were reviewed and interviews held with a wide range of stakeholders.

The sampling method adopted is non-probability, mainly due to the size of the sample and time constraints. A purposive sampling technique has been applied. The sample was drawn from UNDP, Programme Management Unit's staff, Department of Health representatives, UNV Bonn, hospital managers and United Nations volunteers (UNVs). Care was taken to ensure that there was a good spread of tertiary, regional and district hospitals across the four districts in the Limpopo Province.

A total of 25 in-depth interviews were held and a pre-determined set of evaluation ethics adhered to throughout the study. The key limitations of the study were that some stakeholders had time constraints, others could not express themselves in English, whilst others did not secure good meeting rooms where interviews could be carried out without interruption.

Overall, the findings confirmed that the programme design was sound and the three additional sub-programmes (health planning; knowledge management and leadership; and monitoring and evaluation) would have complemented the primary programme on recruitment and placement of UNVs. The Project Document (Prodoc) fully describes the Program Logic in the form of Results and Resources Framework tables reflecting the sub-programmes. Outputs, activities, targets and tentative indicators have been developed.

A Project Steering Committee (PSC) comprising representatives of the Department of Health (DOH), the UNDP and the Project Management Unit (PMU) was envisaged and established but became dysfunctional in 2012 and 2013 respectively due to several challenges. This included, financial constraints due to the DOH been placed under administration, scheduled meetings not being adhered to, members being continuously changing and deployed members to the Committee not been decision makers. This was meant to provide leadership and guidance as well as policy advice and input regarding the overall implementation and running of the programme.

At the programmatic level, a PMU was established to oversee the day-to-day management of the programme. Due to the DOH being placed under administration, it could not secure funding for the other three sub-programmes and subsequently the PMU structure was reviewed to align with a narrow scope of work and it resulted in the PMU relieving the PMU Manager, and the Knowledge and Research Manager of their respective duties. This impacted negatively on the smooth and efficient running of the programme.

The Programme managed to recruit and place 40 UNVs against the target of 120. Despite only reaching 48% of the target, the services rendered by UNVs were well appreciated and acknowledged. Due to financial constraints, the additional three complementary sub-programmes (health planning; knowledge management and leadership; and monitoring and evaluation) could not be continued. In addition to financial constraints as a challenge that confronted the programme, the regulatory environment of the Health Profession Council of South Africa (HPCSA) made it difficult to attract, recruit and place doctors in the province. Over and above the regulatory environment, HPCSA was found to be dysfunctional by a ministerial task team which further compounded the recruitment of UNVs.

R50, 707,983 was spent for the duration of the Programme. The findings confirmed that it was money well spent given the negligible cost of recruiting and placing UNVs as compared to hiring a local doctor. The DOH could even be more efficient if it could explore ways and means of relocating PMU into its offices. This would allow PMU staff easy access to Senior Management, strengthen co-ordination and improve communication.

With regard to the relevance of the Programme, it was found that the programme responded directly to the needs of the Department and it is aligned with health priorities identified in the National Development Plan (NDP) Outcome 2, the Provincial Growth and Development Strategy Objective as well as Departmental Goals and Objectives. The Programme has been able to supplement the services rendered by the Department and increased both the quality and quantity of the provision of health services. Patient to doctor ratio improved. It decreased from 18:100,000 in 2011/2012 to 16:100,000 in 2012/2013.Furthermore, the average number of hours served by each doctor per hospital was 151 per month. This resulted in long queues at the out-patient departments (OPDs) been reduced and as a result there have been fewer complaints from the patients.

Transfer of knowledge and skills through training and mentoring has happened but this could be more structured to achieve maximum effect. This would contribute towards the sustainability of the programme from the point of view of technical knowledge and skills being transferred from UNVs to the local doctors. Six UNVs doctors have been retained from Phase III.

The Programme has had a positive impact and contributed immensely to the key indicators of the health status in the Province. According to the DOH Annual Performance Plan (APP), 2014/15, Tuberculosis (TB) Cure improved from 67.4% in 2008 to 76.6% in 2012. The number of TB patients with known HIV status has improved from 22.3% in 2008 to 92.6 % in 2013, while the quality of life of people living with HIV, including those on anti-retroviral treatment (ART), has improved from 67.1% in 2008 to 83.1% in 2012.

Other significant changes include the establishment of a diabetic clinic in Polokwane and Mankweng in response to the high prevalence rate of diabetic cases.

In conclusion, the programme design is solid and relevant and responds to existing needs. There are however areas that should be strengthened. This includes the re-establishment of a Project Steering Committee to provide leadership and guidance and increased stakeholder participation and ownership. There is an added responsibility of ensuring that adequate funds and budget is set aside for the smooth running of the programme.

The following recommendations of this study are based on the key findings and are derived directly or indirectly from the interviews with stakeholders. These recommendations build on the strengths and lessons of the past five years so as to maximise the programme's impact in Phase IV.

(1) Governance Structure**.** There is a need to re-establish a Programme Steering Committee with very clear terms of reference. The terms of reference should deal with challenges that have been identified such as composition of the committee, quorums, decision making by members and feedback mechanisms and frequency of meetings.

(2) Recruitment and Placement of UNVs**.** The three stakeholders, UNDP/UNV Office, UNV Bonn and DOH and PMU should explore writing up a recruitment process that specifies roles and responsibilities and related time frames for the deliverables. This will go a long way to managing the different expectations of all involved and lay the foundation to expedite the recruitment and placement processes.

(3) Knowledge and information sharing**.** The DOH should revive the annual meeting/workshop with all UNVs. This plays a crucial role in knowledge and information sharing and serves as a support mechanism for UNVs.

(4) One of the critical aspects of sustainability is transfer of knowledge and skills from UNVs to locals and vice versa. Mentoring is a critical vehicle to ensure that this take places, and thus it should be more carefully structured. Different models of mentoring should be explored, including one-to-one mentoring, group mentoring, and cross-hospital mentorship (staff of different hospitals mentored together.

(5) Extension Request. There is a need to streamline the processes and document the key steps and responsibilities of people involved to avoid lengthy bureaucratic processes.

(6) Robust induction and awareness-raising about the programme among hospital management and personnel is required. The induction should expose all stakeholders to the programme in its entirety. In addition, there must be a one-on-one session with hospital management not only to prepare them for the arrival of new UNVs but also for the hospital to share their limitations in terms of logistics, infrastructure and medical equipment.

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1. Introduction

This is a terminal evaluation report of the United Nations Development Programme (UNDP) Support to Health Sector in Limpopo Programme: Phase III that covers a period of five years (2009-2014). Phase III was an extension of Phase 1 and Phase II, and was aimed at assisting the Government of South Africa to improve health care services in Limpopo Province.

This report commences with a brief discussion of the programme's background context and purpose, after which the objectives and methodology of the evaluation are presented. The section thereafter reports on the evaluation findings according to key themes and the final section presents the conclusion, lessons learned and recommendations.

2. Background and Context

South Africa, despite its resources, continues to face unprecedented health challenges. As the National Development Plan (NDP) 2030 has correctly diagnosed, the health challenges being experienced in the country are not just medical. Behaviour and lifestyle also contribute to ill health. These are some of the challenges:

- HIV/AIDS and related diseases such as tuberculosis (TB) and sexually transmitted infections (STIs);
- Maternal and child morbidity and mortality;
- Non-communicable diseases (mainly related to lifestyle);
- Violence, injuries and trauma.

The vision for the country's NDP places emphasis on the following outcomes:

- Average male and female life expectancy at birth to be increased to 70 years by 2015;
- TB prevention and cure progressively improved;
- Maternal, infant and child mortality reduced;
- Prevalence of non-communicable chronic diseases;
- Injury, accidents and violence reduced by 50% from 2010 levels;
- Health system reforms completed;
- Primary health teams deployed to provide care to families and communities;
- Universal health coverage achieved;
- Posts filled with skilled, committed and competent individuals; and

- Significant reduction in the burden of disease.

It was within this context that Phase III was developed as an extension of Phase I and II of the project, the objective of which is to provide UNV/UNDP support to the Government of South Africa to improve health care service delivery in Limpopo Province. The programme was designed to respond to key challenges identified by the Limpopo Provincial Government. These include:

- Strengthening governance structures;
- Improving TB cure rates and outcomes of child, maternal and women's health;
- Improving quality care, particularly patient waiting times;
- Reducing the burden of diseases resulting from TB, malaria, HIV and AIDS, mental health and chronic diseases;
- Appropriate and responsive referral system;
- Training of adequate nurses and other health professionals to meet the provincial needs of service delivery;
- Shortages and difficulty in recruiting and retaining health professionals; and
- Integrated planning, monitoring and evaluation, and budgeting processes.

The main objective of the programme was to facilitate the recruitment and deployment of UN volunteer medical professionals in the rural areas of the province. 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 institutionalisation of effective health planning.
- Knowledge management and leadership development: The purpose of this sub-programme was to establish a Health Knowledge Management Centre/s to systematically generate, collect, store and utilise information to inform strategic planning processes. This sub-programme was aimed at facilitating a ''knowledge development and exchange platform'' to enhance knowledge sharing between local and international practitioners. Furthermore, a leadership development programme was envisaged to enhance the skills of the relevant local Senior Managers and improve the overall performance within the Department.

- Monitoring and evaluation, which includes the domestication of Millennium Development Goals: The purpose of this sub-programme was to establish the provincial Department of Health and Social Development M&E system to improve on service delivery, accountability and strategic planning.

3. Purpose, Objectives and Methods of the Evaluation

3.1 Purpose and Objectives

The purpose of the evaluation was to determine the collective outcomes of the five years (2009-2015) of the UNDP's contribution in enhancing health service delivery through good governance and capacity development in Limpopo Province. The evaluation report will present findings, conclusions, good practices, lessons learned and recommendations. The evaluation results will be used to improve Phase IV, which started in 2015 and will end in 2020.

The objective of this terminal evaluation was to determine the extent to which the programme objectives were achieved and assessed whether the programme has led to any other positive or negative outcomes. The evaluation also assessed programme performance and the implementation of planned programme activities and planned outputs against actual results. Furthermore, the evaluation assessed the extent and magnitude of any programme impacts to date and the likelihood of future impacts.

3.2 Methodology and Sample

A multi-method qualitative research methodology was adopted for this evaluation to respond to the key issues and deliverables as set out in the Terms of Reference (TOR). The TOR is attached as Appendix 1. The process and methods employed are described below.

3.2.1 Inception Meeting

An inception meeting was held with UNDP and PMU staff on 11 November 2015. This meeting informed the methodology, sample and instrument design. An inception report was then prepared as part of this deliverable for this activity. The inception report is attached as Appendix 2.

3.2.2 Document Review

Key and relevant documents were made available to be reviewed and enhanced the understanding of the programme and the context. The documents included Project Document Phase III: UNDP Support to Health Sector and the Annual Reports for 2010, 2011, 2012, 2013 and 2014 respectively. A list of documents reviewed is attached as Appendix 3.

3.2.3 Instrument Design

A comprehensive instrument was developed following the inception meeting and document review. The instrument is attached as Appendix 4.

Table 1 below shows the key evaluation themes, purposes and the stakeholder category.

Table 1: Evaluation theme and stakeholder categories

Evaluation Theme	**Purpose**	**Stakeholder**				
		UNDP/ PMU	UNV Bonn	DOH representatives	UNV doctors	Hospital management & staff
Institutional arrangements	Assess the adequacy of the institutional arrangements in place	*	*	*	*	*
	Stakeholder participation, ownership and drivers	*	*	*	*	*
	UNDP supervision and support	*			*	*
Implementation approach	Look at the design of the programme	*	*	*		
	Monitoring and evaluation	*	*	*	*	*
Effectiveness	Assess the extent to which outputs have been achieved	*	*	*	*	*
	Recruitment and deployment of health and allied professionals	*	*	*	*	*
	Successful volunteerism programme	*	*	*	*	*
	Retention rate of health professionals and interns	*		*	*	*
Efficiency	Determine the costs and cost sharing	*		*		
	Financial management and co-financing arrangements	*		*		
Relevance	Assess the relevance of the programme	*	*	*	*	*
	Responsive to needs and government priorities	*	*	*	*	*
	Alignment with	*		*		

	Government policy					
Sustainability	Determine sustainability issues - financial, socio-political, institutional frameworks and governance	*	*	*		
	Catalytic role/replication approach	*	*	*		
Lessons Learnt	Key lessons learnt	*	*	*	*	*
Recommendations	Develop recommendations	*	*	*	*	*

3.2.4 Interviews

Stakeholders' interviews were conducted with the UNDP, the UNV Office, UNV Bonn, the Programme Management Unit (PMU), UNV doctors, and the designated programme staff in the Department of Health, including hospital management.

3.2.5 Validation Workshop

A validation workshop will be held in Limpopo to allow key stakeholders to engage with the draft report and make meaningful input and recommendations.

3.3 Sample

Sampling choices were determined by the purpose of the evaluation, convenience and the need for simplicity and cost effectiveness. The sampling method adopted was non-probability, mainly due to the size of the sample and time constraints. A purposive sampling technique was applied.

The sample was drawn from the UNDP, the PMU's staff, the UNV Bonn, DOH representatives, hospital CEOs and Clinical Managers, and UNVs. Care was taken to ensure that there was a good spread of tertiary, regional and district hospitals across the four districts in the Limpopo Province. A list of stakeholders interviewed is attached as Appendix 5. Table 2 below shows the representation of stakeholders interviewed.

Table 2: Respondents from UNDP/PMU, Department of Health and UNV Bonn

Stakeholder Group	Method	Number
UNDP/UNV Office	Interview	3
PMU	Interview	1
DOH representatives	Interview	4
UNV Bonn	Skype interview	4

UNVs and Hospital Management

Name of Hospital	Type of Hospital	District	Stakeholder Group	
			CEO/Clinical Manager	UNVs
Polokwane	Tertiary	Province/Capricorn	1	3
Botlokwa	District	Capricorn	2	1
Letaba	Regional	Mopani	0	3
Tshilidzini	Regional	Vhembe	1	0
Mecklenburg	District	Sekhukhune	2	0
Total			6	7

Please note that at Tshilidzini and Mecklenburg Hospitals, at the time of interviews there were no more UNVs.

3.4 Evaluation Ethics

The following UNDP's ethical guidelines for evaluation were adhered to throughout the study: Independence, Impartiality, Transparency, Disclosure, Ethics, Partnership, Competencies and Capacities, Credibility, and Utility.

3.5 Limitations of the Study

- One limitation of the study was that some UNVs were not fluent in English, requiring the evaluator to spend time with them. This could have resulted in interviewer or interviewee fatigue.
- Another limitation was that some respondents, especially CEOs and Clinical Managers, given the nature of their job did not adhere to the time agreed upon and in some instances had time constraints.
- There were also instances where some hospitals could not secure meeting rooms ahead of the scheduled meetings. As a result, sessions were held in their offices and were not without disturbances such as telephones ringing and staff members walking in and out of the office. In some instances the interviewed staff members would walk in and out of the room while attending to some of their work.
- Although some documents were requested from the DOH respondents during interviews, these documents were not readily available to be engaged with during the session. In some instances, attempts to secure the documents shortly after the meeting were not successful.

4. Findings: Programme Performance

4.1 Programme Design/Implementation Approach

The UNDP Support to the Health Sector was borne out of an agreement between the Department of Health in Limpopo and the UNDP and was intended to support health care service delivery in the province of Limpopo. The UNDP support stems from a cooperation agreement signed in 1994 to provide South Africa with development assistance. The Province of Limpopo is an exemplary province in the country that welcomed the support to its Health Sector. The Project Document was signed off on 2 September 2009 by UNDP and Limpopo DOH representatives

Implementation of Phase III began in October 2009 and was conceptualised with four complementary sub-programmes in mind. This phase is an extension of Phase I and Phase II which were implemented in sequence from 2002. Phase III comprised the following programmes:

Sub-Programme 1: Recruitment and placement of volunteers

This sub-programme is the foundation of the entire programme, and was implemented through the two phases mentioned above. The objectives of this sub-programme were:

- to recruit volunteer doctors abroad and place them in needy Limpopo hospitals;
- for UNVs and health professionals to work with local hospital management to improve health facility performance in terms of the organisational management, learning and the professional growth of local health personnel;
- to institutionalise the local volunteerism programme.

Sub-Programme 2: Health Planning Support Programme (Health Economics)

Its objective was to appoint a health economist to strengthen health service planning, capacity of local health personnel at policy and planning levels, through analysis, development and institutionalisation of effective health planning.

Sub-Programme 3: Knowledge management and leadership development

It was envisaged to establish a Health Knowledge Management Centre to systematically generate, collect, store and utilise information to inform strategic planning processes. This programme was aimed to facilitate knowledge sharing between local and international practitioners. A leadership development programme was also planned to enhance the capacities of relevant local Senior Managers to improve on overall departmental performance.

Sub-Programme 4: Monitoring and evaluation, which includes the domestication of MDGs

The sub-programme was introduced to assist with the establishment of the provincial Department of Health Service Delivery (DOHSD) M&E System to improve on service delivery, accountability and strategic planning. It was also aimed to assist with the domestication of MDGs within the Limpopo DOH.

In short, the design of the project with all the sub-programme outputs was structured to achieve the following results:

- increased retention rate of health professionals;
- improved quality and quantity of the health care service;
- increased appreciation of volunteerism by health professionals to serve Limpopo;
- improved use of information for planning, knowledge sharing and leadership development;
- increased capacity to conduct monitoring and evaluation.

The Project Document fully describes the Program Logic in the form of Results and Resources Framework tables reflecting the sub-programmes. This could however be expanded and reviewed on an annual basis to reflect changing circumstances. There was an attempt to create the indicators for outputs and outcomes to establish the basis for a theory of change. There was a clear integration of the Logical Framework with the Departmental strategic goals.

The Monitoring and Evaluation system was in place, but due to the withdrawal of the sub-programme on M&E, it was not as effective as it should have been. PMU conducted quarterly visits as part of the monitoring process, gathering reports from institutions, consolidating them and sharing them with the DOH. Data from this report has been compiled from events and issues gleaned from meetings with doctors at institutional level.

While there was agreement on the project design and the interconnectedness of the sub-programme, many of the key activities to achieve the desired results could not be realised.

One of the glaring implementation challenges faced by the programme was the stifled execution of sub-programmes 2, 3 and 4. These were intended to run concurrently with the main sub-programme 1, but because of the downsizing of the programme and reduction of funds by the government in 2011-12 and 2012-13 the envisaged results could not be achieved.

Implementation Approach

The delivery of this project is carried out through the Programme and Administration Coordinator, with support and oversight from UNDP Pretoria. As envisaged in the programme design, each sub-programme was supposed to have a technical manager. For instance, the Knowledge Management Programme Officer was employed to run the Knowledge Management Programme and Leadership sub-programme, and the Health Economist the Health Planning sub-programme. While the former was appointed but relieved of his duties in September 2012, the latter never got deployed. In addition, the Programme Manager for the PMU also vacated the position in November 2012. This was mainly due to inability by the DOH to secure funding for the other three programmes, which resulted in the restructuring of the PMU.

Both the UNDP and the Department also provide supervisory and technical support to the programme. The DOH served as the focal point within the Department to drive the implementation of the programme through the hospitals. The PMU was first established at the beginning of Phase II, at the request of the DOH. Prior to its establishment, the project was managed through the UNV Programme Office. This was done to strengthen the project management capacity and ensure proximity of communication with DOH and expedite the recruitment processes. UNDP also assigned a focal point to provide technical and supervisory support for the implementation of the programme.

4.2 Institutional Arrangements and Programme Management

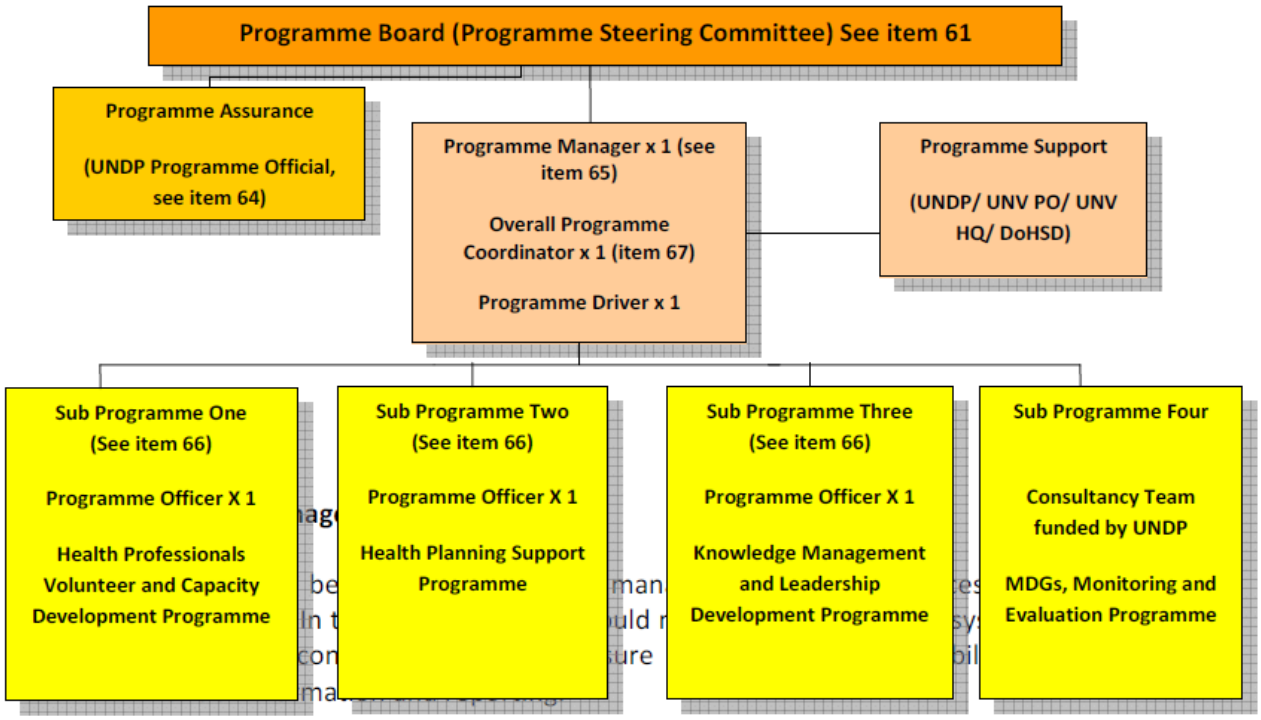
The DOH is responsible for the political leadership and strategic focus of the programme, including placement of the UNVs within the health facilities in the province. The policy and advisory role on strategic issues and oversight lies with the Project Steering Committee (PSC). See the envisaged Organogram in Figure 1 below. The PSC comprised the DOH, UNDP and PMU Manager (ex-officio). Allocation of funds, project reviews, approvals, progress reports and challenges facing the project are issues to be discussed in the PSC meetings.

The evaluation found that this important governance structure was dysfunctional towards the latter years of Phase III, i.e. 2012 and 2013 respectively. It only met once in 2013. There were several factors that contributed to this, including the following:

- financial constraints as a result of the Department being put under administration;
- scheduled meetings were either not adhered to or they did not quorate;
- Decisions taken at the meetings were not followed through and no feedback mechanisms;
- Changing of the focal person within the department without a proper hand-over;
- members of the committee were continuously changing, which affected follow ups and feedbacks on decisions taken; and
- some deployed members were not decision-makers and as a result important decisions could not be taken.

The dysfunctionality of the PSC resulted in it failing to take advantage of the opportunity to exchange information, plan together and jointly resolve pertinent issues that arose during implementation. For example, the Department and UNDP acknowledged that either party would in some cases only learn about project issues at the exit point of the contractual relationship with the doctor rather than in the formative stages. In addition, information was not shared timeously, resulting in coordination challenges and delays in issue-resolution.

Figure 1: Programme Management Arrangements



At the programmatic level, a Project Management Unit was set up in June/July 2010 to coordinate the day-to-day activities of the programme. Initially, it employed four staff members, namely, the Programme Manager, Programme Officer for Knowledge Management, Programme and Administration Coordinator, and the Programme Driver. As one respondent aptly put it, "The establishment of the PMU was a brilliant idea since it came from Government realising that they will not be able to manage and co-ordinate all the tasks for the effective and efficient smooth operation of the programme".

Unfortunately, due to financial challenges and the subsequent suspension of sub-programmes 2, 3 and 4, there was staff rationalisation to align the PMU structure to its narrow scope of work and that led to the Programme Manager and Programme Officer being released from their posts in 2012/13. The Overall Coordinator and Programme Driver are the only ones currently running the Polokwane UNDP office with support from the UNDP focal person.

This had a negative impact on the delivery of the programme. As one respondent put it, "The response rate became slow and UNVs that were earmarked to join the programme lost interest".

4.3 Effectiveness

Output 1: 192 Health and Allied Professionals recruited and deployed in Limpopo Province

In total there were 40 doctors (representing 48%) recruited and deployed in Limpopo across 16 hospitals during Phase III. Table 3 below shows the number and hospitals where they were deployed. The target for doctors was 120. The map below indicates where the doctors were placed. The recruitment of 12 clinical engineers, 40 pharmacists and 20 specialist nurses could not be achieved through this programme as the respective Councils for Pharmacists and nurses do not have provision for ''volunteer'' category in their respective registration process.

The respondents emphasised the need for the DOH to continue to conduct telephonic and Skype interviews to assess the technical and language abilities of the potential candidates. Given the security risks posed by recruiting foreign nationals and the high level of terrorism worldwide, respondents raised the possibility of involving state security agencies in the recruitment process.

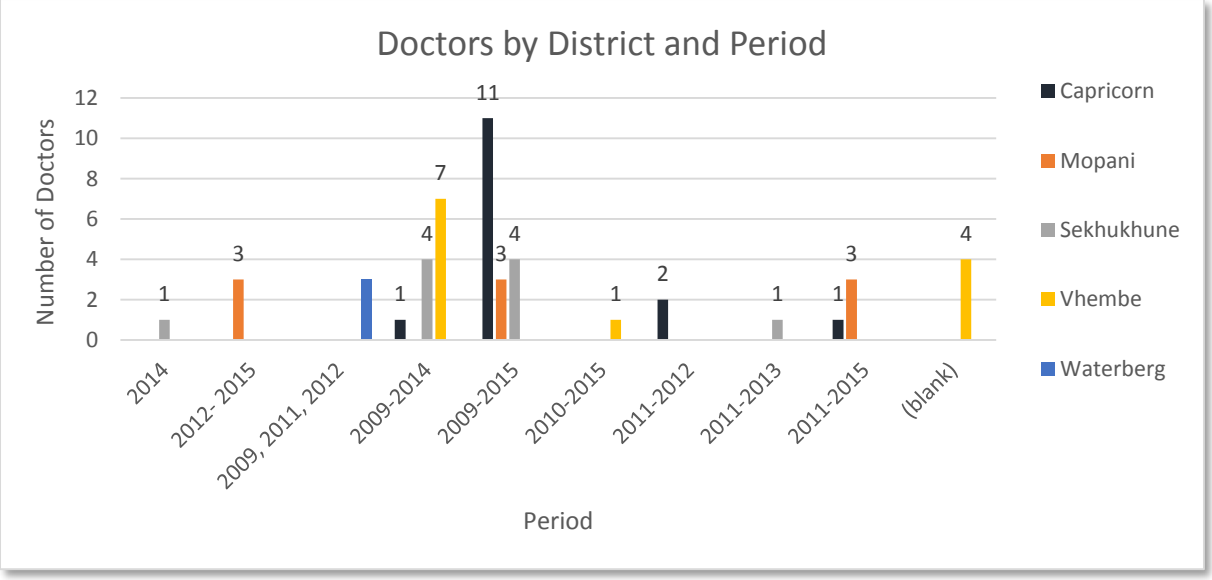
Some of the key challenges that hampered the achievement of the output include:

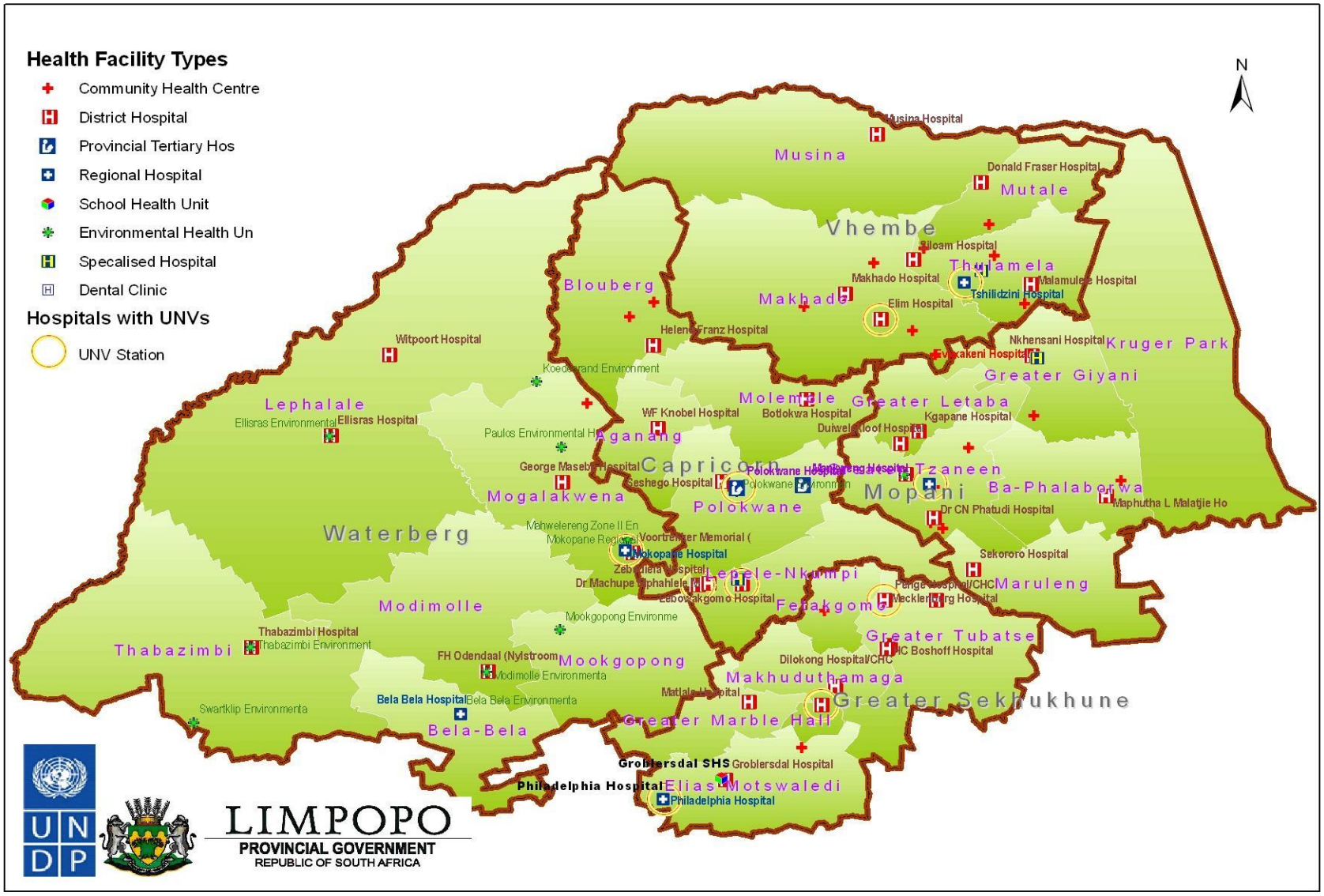
- financial constraints due to the DOH being placed under administration which lead to the moratorium on the recruitment of doctors;
- the delay by DOH in transferring funds on time;
- In 2011 and 2012, there were doctors who were recruited without interviews and some were not suitable;
- regulatory frameworks for the South African Nursing Council and Pharmacists Council, which do not provide for the volunteer status of nurses and pharmacists; This required potential candidates to write and pass Board Exams in South Africa in order to be recruited into the programme. As one respondent put it '' to follow through this process would have been an expensive exercise for this programme''
- additional verification process by the Educational Commission for Foreign Medical Graduates (ECFMG) to accredit doctors to practice in South Africa; and,
- new regulations introduced in July 2013 by the HPCSA required the verification of qualifications and were met with a slow response rate. Over and above, a ministerial committee has found the HPCSA to be '' in a state of multi-system organizational dysfunction'' which resulted in the body's failure to function effectively. (Mail and Guardian Online, 05, Nov, 2015).

Table 3: List of hospitals hosting UNV doctors in Phase III

Hospital	District	Periods	No. of doctors
Lebowakgomo	Capricorn	2011-2012	2
Zebedia	Capricorn	2009-2014	1
Botlokwa	Capricorn	2011-2015	1
Polokwane	Capricorn	2009-2015	11
Sekororo	Mopani	2011-2015	3
Letaba	Mopani	2009-2015	3
Maphutha Malatji	Mopani	2012- 2015	3
Mokopane	Waterberg	2009, 2011, 2012	3
Elim	Vhembe		4
Siloam	Vhembe	2010-2015	1
Tshilidzini	Vhembe	2009-2014	7
Jane Furse	Sekhukhune	2014	1
St. Ritas	Sekhukhune	2009-2015	4
Dilokong	Sekhukhune	2011-2013	1
Mecklenburg	Sekhukhune	2009-2014	3
Philadelphia	Sekhukhune	2009-2014	1

Figure 1: Number of Doctors by District and Period




Health Facility Types
Community Health Centre
District Hospital
Provincial Tertiary Hos
Regional Hospital
School Health Unit
Environmental Health Un
Specalised Hospital
Dental Clinic
Hospitals with UNVs
UNV Station
N
Musina
Mutale
Vhembe
Thulamela
Blouberg
Makhado
Kruger Park
Greater Giyani
Lephalale
Molemole
Greater Letaba
Capricorn
Tzaneen
Mopani
Ba-Phalaborwa
Mogalakwena
Polokwane
Waterberg
Lepele-Nkumpi
Maruleng
Modimolle
Fetakgomo
Greater Tubatse
Thabazimbi
Mookgopong
Makhuduthamaga
Greater Sekhukhune
Greater Marble Hall
Bela-Bela
Elias Motswaledi
Musina Hospital
Donald Fraser Hospital
Siloam Hospital
Makhado Hospital
Malamulele Hospital
Tshilidzini Hospital
Elim Hospital
Witpoort Hospital
Helen Franz Hospital
Nkhensani Hospital
Koedoesrand Environment
WF Knobel Hospital
Botlokwa Hospital
Kgapane Hospital
Ellisras Environmental
Ellisras Hospital
Paulos Environmental Ha
Seshego Hospital
Dr CN Phatudi Hospital
Maphutha L Malatjie Ho
Mokopane Hospital
Sekororo Hospital
Dr Machupe Ephahlele
Thabazimbi Hospital
Thabazimbi Environment
FH Odendaal (Nylstroom
Dilokong Hospital/CHC
Bela Bela Hospital
Bela Bela Environmenta
Swartklip Environmenta
Groblersdal SHS
Groblersdal Hospital
Philadelphia Hospital
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Output 2: 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

Apart from the number of doctors decreasing from time to time due to repatriation, the appreciation of the presence of the UNV doctors by all stakeholders, especially hospitals, cannot be overstated. As one respondent put it, “an extra pair of hands of any doctor is a blessing” to the CEO, clinical managers, and nursing staff. In some instances, like in Mecklenburg hospital, the doctors were readily available and willing to see patients whether or not it was outside of working hours. That spirit of volunteerism has encouraged other younger doctors to stay a bit longer in the rural hospitals by observing the dedication of the UNV doctors to the local hospitals. As a result, as one clinical manager observed, “more patients were saved, queues were shortened and more operations were undertaken”.

The volunteerism spirit has also rubbed off on other stakeholders who were involved in the programme. As one respondent commented that “South Africans are used to thinking of a volunteer as someone unskilled and unemployed. It has made me think about doing something in my community when I see the passion and commitment of these doctors.”

Output 3: A successfully implemented mentorship programme

The programme is recruiting highly professional, specialist doctors with the aim of transferring knowledge and skills to young doctors locally. It was found that the mentorship programme may not be as structured as intended and yet it appears to be working at two different levels.

Typically doctors have daily meetings with their Head of Department to discuss clinical issues and procedures that may have been performed or are to be performed. These meetings bring about a sufficient exchange of information between local doctors and UNV doctors. They create an opportunity to interrogate different approaches to medical problems and learn from each other’s expertise.

At another, more structured level, doctors usually work in teams or are paired to work together for a specified period. In some hospitals this is done on a rotational basis to encourage cross-pollination of skills and knowledge. The rotation is constructed on a need-to-know basis whereby:

- young local doctors or interns at the height of their learning curve acquire new skills or knowledge from foreign experienced doctors;
- UNV doctors who are appreciative of the comprehensive knowledge base of local doctors also learn new things from them;
- at a specialist level, the protocols for certain procedures vary from country to country and knowledge is transferred among team members.

The UNV doctors have also indicated that their availability has made it possible for interns and community service doctors to learn from them. It is generally understood that it may not be possible to take on interns in hospitals where supervising/mentoring doctors are lacking.

The missing link in this output is the tool to harvest new knowledge and trends generated from these modes of exchange. If this is to be achieved then it is critical that the knowledge management nerve centre is implemented.

Output 4: A successfully institutionalised retention strategy for local doctors and health personnel

The retention of doctors, whether of intern doctors or doctors completing their period of community service, is challenging in some respects and the DOH is still grappling with this issue. There are some hospitals that have less retention capacity and others that are retention magnets either by default or design. The dominant external factors affecting retention are the locality of the hospital. If the hospital is too rural and the accommodation is not up to the standard expected by the doctors, there is a tendency for doctors not to stay longer in such places. The depth of the rural environment on its own is at the heart of the brain drain. In skills development terms, it is referred to as relative scarcity when suitably qualified people that are available have a preference of geographic location.

Some hospitals have not yet benefited from infrastructure revitalisation. Houses developed for accommodation are either few or in a state that does not meet all the specifications expected by the doctors or hospitals. The shortage of medical equipment, the amount of surgical equipment in a state of disrepair, as well as insufficient infrastructure to cater for the high volume of patients, are common disincentives for retention and continuation of voluntary work. There was one hospital sampled that has no space for doctors to rest, write reports or meet during working hours.

This underscores the importance of health planning and reinforced the complementarity and soundness of the programme design of Phase III which had additional sub programmes.

Output 5: Institutionalisation of a roadmap for effective health planning

There was no data gathered to measure this output and its effectiveness. This is the one area that was affected by lack of funding in that the position of Health Economist to impact policy and planning was never effected.

Output 6: A functional Information Nerve Centre

The purpose of this activity was threefold. Firstly, the UNDP provided technical assistance in creating platforms for the exchange of information and knowledge, and facilitated collaboration between health professionals. These platforms will encourage and stimulate the transfer of tools and skills to enhance the development of individual and organisational capacity for improved health service delivery in Limpopo.

Secondly, technical assistance was provided for the establishment of a resource centre which will systematically generate, collect, store and utilise information to inform strategic planning processes. The Centre will also be responsible for facilitating health-related seminars to improve knowledge sharing and exchange.

Thirdly, the UNDP will facilitate the development of a strategy, and support the implementation of, a leadership and capacity development programme for Senior Managers to holistically improve the performance of the Department of Health in Limpopo.

Due to financial constraints, the establishment of the nerve centre never took place, with the exception of the appointment of a Programme Officer in July. This appointment lasted until December 2010.

Output 7: The enhancement of M&E

The intention to establish an M&E system is well-documented in the project document. From the DOH, institutional management and doctors there is consistent anecdotal evidence that with an M&E system in place there is improved service delivery from doctors and hospital management, and a stronger chance of achieving the relevant MDG.

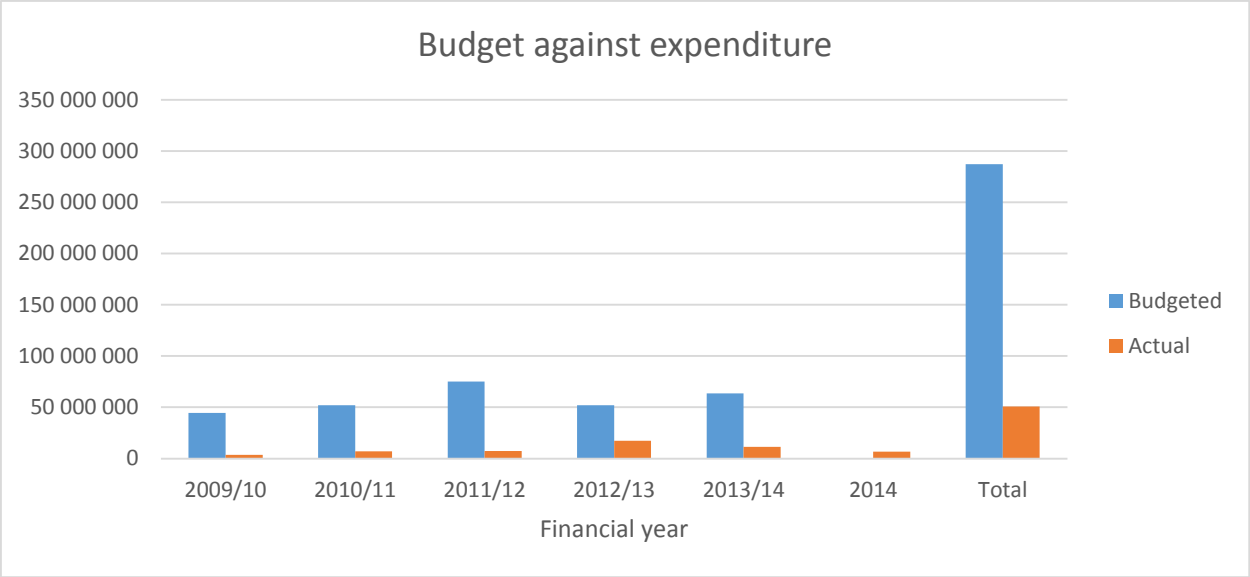
4.4 Efficiency

At the time of conceptualisation the approved budget for the roll-out of Phase III was set at R287,133,000 (USD 36,300,000). The contribution made by the DOH for the duration of the programme amounted to R50, 707,983. It had a shortfall of R236 425 017.

It is acknowledged that the DOH should have provided more funding had it not been for the two-year period of austerity brought about by the Department being placed under administration.

Budget against Expenditure

Year	Budgeted	Actual	Shortfall
2009/10	44 630 400	R 3 748 888	R 40 881 512
2010/11	51 960 700	R 7 115 124	R 44 845 576
2011/12	75 055 900	R 7 500 000	R 67 555 900
2012/13	51 968 700	R 17 500 000	R 34 468 700
2013/14	63 517 300	R 11 500 000	R 52 017 300
2014		R 6 717 971	R -6 717 971
Total	R 287 133 000	R 50 707 983	R 236 425 017



The policy directed at overtime appears to be a good attempt to manage costs even though it has limitations. CTO serves to give doctors leave in lieu of overtime. Indeed time off provides opportunity for medical officers to rest and recharge, but it can also be counter-productive by taking doctors away from treating patients. Furthermore, the absence of doctors due to leave puts pressure on those doctors who remain at work. There is also a perception among UNV doctors that local doctors do receive monetary compensation for overtime and therefore they (UNVs) are being discriminated against. The perception of unequal treatment seems to create animosity and unnecessary tension.

There is no doubt that the government is achieving more with less. For Phase III, the average costs at an exchange rate of R10.23 were as follows:

- volunteer doctor with no dependant: USD 1,879 = R19,222
- volunteer doctor with one dependant: USD 2,129 = R21,780
- volunteer with two or more dependants: USD 2,329 = R23,826
- settling in: USD 4,041 = R41,339
- dependant arrival: USD 1,333 = R13,636

Compared to the costs of local doctors employed on a full time basis as shown below, the costs of recruiting and placing UNVs is negligible. This is particularly so given the fact that majority of UNVs are specialists with vast knowledge and skills with potential to earn high salaries.

Category	Grade	April, 2013	April,2014
Medical Intern	1	R332 622	R357 237
	2	R337 611	R362 595
Medical Officer	3	R736 518	R719 019
Medical Specialist Grade 1	1	R747 564	R802 884
	2	R758 781	R814 932

Source: Department of Public Service Administration, Salary Scales of employees covered by Occupation Specific Dispensations, Circular 2 of 2014.

Finally, one opportunity that should be explored to cut costs is to position the PMU within the DOH. With the current set up of only two officials employed by the UNDP, the size of the required office will not be excessive. This will be an opportunity to save on rental and other related costs. All savings that are realised from this arrangement can be made available to the project budget. Furthermore, it will make it easier for PMU staff to have access to senior management, which could lead to an improvement in coordination and communication.

4.5 Relevance

The responsiveness of the needs and alignment of the programme to Government priorities has been established. This programme responds directly to the acute shortage of medical doctors, particularly in rural areas. The recruitment and placement of volunteer doctors has contributed immensely in making health care accessible to rural residents.

Queues were cut short or managed better because the patient-to-doctor ratio improved. The average number of hours served by each doctor per hospital is 151 per month. Over time, due to increased service volumes, the doctor-to-patient ratio has decreased from 18:100,000 in 2011/12 to 16:100,000 in 2012/13 (Annual Report, 2013/2014).

In Polokwane a surgeon estimated that “through their efforts up to 10 patients are operated on per week”. In Letaba a surgeon noted that “at least 13 patients were operated on per week”. In both Polokwane and Mankweng, with the support of the hospital management the UNVs established diabetic clinics. Through these establishments the two internal medicine specialists are each able to see between 30 and 50 patients per week. It is noteworthy that the establishment of the clinic was championed by the UNVs as a result of a high incidence of diabetes in patients. The clinic is attended twice a week by UNV internal medicine specialists.

UNV doctors have also managed to create a good sense of health service delivery for some hospitals. Their presence has attracted patients from far-flung areas (self-referrals). As one respondent commented, “after hearing that the hospitals have recruited UNV doctors that are skilled, patients tend to travel from all areas to receive treatment”.

Clinical managers have also praised the presence of the UNV doctors, irrespective of the numbers deployed to their hospitals. The UNVs are seen as invaluable support to their interns, nursing staff and patients. The mere presence of an extra doctor in the staff complement is cherished. If the doctor is a specialist the importance or weight accorded to that doctor rises exponentially. These anecdotes shared during interviews have underscored the severity of the shortage of specialists in Limpopo.

The one hospital unit that has benefited immensely is the Out-patient Department (OPD). On average, 500 cases are attended to at the OPD of the hospital per month. Due to the improved ability to treat patients and the speed at which queues are reduced, the knock-on effect is that the number of complaints from patients has drastically decreased. As a result of more people being treated since the arrival of UNV doctors, the patients' satisfaction index is presumed to be high. It was said by one respondent doctor that "the less doctors you have in a hospital the less attractive the hospital becomes for potential recruits because the potential incumbents take it that they will be overworked, they will not be supported adequately and that the opportunity to learn from other doctors is diminished."

The table below is a summary of the contribution to the strategic goals.

Programme Contribution to provincial and national strategies

UNDP Support	DoHSD Strategic Goals 2010/11	National Department of Health Ten Point Plan	National Government Outcome No. 2
Immediate Outcomes	**Intermediate Outcomes**	**Final Outcomes**	**Strategic Impact**
✓ Increased culture of volunteerism ✓ Improved hospital performance vis-ὰ-vis organizational management and development ✓ Improved Doctor-patient ratio ✓ Improved knowledge and access to health related information ✓ Diversification and increase in the number of health professionals	✓ Effective corporate governance is provided ✓ Appropriate human resource management and development is provided ✓ Sound financial management practice is promoted ✓ Comprehensive HIV and AIDS, TB, STI and other communicable diseases programmes are implemented ✓ Districts Health Services and Primary health Care services are strengthened ✓ Quality of health care is improved ✓ Emergency medical services are improved ✓ Tertiary services are developed ✓ Infrastructure development and maintenance is improved	✓ Strategic leadership and creation of a social compact for better health outcomes; ✓ National Health Insurance (NHI) implemented; ✓ Improved quality of health services; ✓ Overhauled healthcare system ✓ Improved human resources, planning, development and management; ✓ Revitalized infrastructure ✓ Accelerated implementation of programmes for HIV and AIDS, STIs, TB and associated diseases; ✓ Mass mobilization for better health for the population; ✓ Reviewed Drug Policy; and ✓ Strengthened research and development	A long and healthy life for all South Africans".

4.6 Sustainability

The issue of retention is a key factor for the success of the project in Limpopo because of the province's predominantly rural nature. It has an estimated population of 5 million people, 40 hospitals, 22 health centres and 416 clinics. Due to the mobility of health professionals, a dire shortage of health professionals severely compromises the province's capacity for health care service delivery.

There is agreement from all stakeholders that the resources to support the UNDP programme must be improved if the project is to be continued. The financial and non-financial (governance, human resources management and development) support must be in place whether or not UNVs are deployed. While it is true that the cost of retention is less than the cost of recruitment in the long term, it is also true that resources invested today will show savings in later years. Affording UNVs the opportunity to attend medical conferences, seminars or training workshops is a welcome gesture that will not only benefit the doctors involved but the very hospitals at which they are deployed to provide health care services.

These doctors have a fixed contract regulated through corporate agreements with South Africa, and therefore from the point of view of the Department, retention is not the key driver of the programme. Perhaps what is important is to ensure that all volunteers are encouraged and motivated to finish their tenure before being repatriated. Some have been repatriated earlier for personal reasons or because of poor selection processes, while many others have managed to serve their full period of volunteership.

Training more internal doctors and deploying them appropriately to be supervised by UNV doctors will create an internal base and sustain the project even after the withdrawal of UNVs. It is believed that the University of Limpopo is being accredited to train doctors from 2016, and that should go a long way to increase the supply of doctors in the province. The better throughput of doctors, the more UNVs will be required at rural bases to attract and mentor upcoming doctors.

The other critical element of sustainability is mentoring, which has been discussed under the effectiveness component.

During Phase III, the following doctors have been retained both in Limpopo and North West Province, which bodes well for continuity and sustaining the level of health services being provided in those regions.

No.	Name of doctor	Name of hospital	Area of specialisation	District	Years served	Retained
1	Abner Kebede	Lebowakgomo	Anaesthesia		7	2011
2	Rajeev Misra	Polokwane	Cardiology		6	2015
3	Asha Misra		Obstetrics and Gynaecology		6	2015
4	Borys Ryabchiy		Anaesthesia		6	2013
5	Grygory Yudin		Anaesthesia		6	2009
6	Alexander Bogoslovskiy		Anaesthesia		2	2009
7	Galina Bogoslovskaya		Cardiology	Capricorn	3	2010
8	Imam Tawheed	St. Ritas	General Surgery	Sekhukhune	2	2015
OTHER PROVINCES						
9	Andriy Kharchenko	North West			6	2013
10	Ilya Golovin	North West			2	2009

Respondents identified the following key factors as critical for the model to be replicated:

- There must be a real, justifiable need for the model to work, for instance, a shortage of doctors due to factors such as rural conditions. These conditions must precipitate relative or absolute scarcity. The latter situation relates to instances where suitably qualified people are not available at all.
- Financial Resources and Human Resources: that is, money and doctors including allied professionals.
- A responsive recruitment system with reasonable turnaround times, ideally less than six months.
- Deployment of doctors on a hospital need-informed basis, i.e. quantity of medical officers and their areas of specialisation must match the defined need.
- Consistent support system for the Department and the hospital management both in terms of revitalisation of hospitals and furnishing adequate equipment.
- Strong leadership with appreciation of good corporate governance and what is happening on the ground. There must be an active champion of the course and a focal-point person.
- Clear communication channels between stakeholders and doctors on the ground must be transparent, consistent and efficient.
- Doctors should be allowed to bring their families, especially spouses. Their spouses should have access to work and their children access to schools.
- Mutual respect and cooperation between the doctors, hospital management and the leadership.
- A dedicated person with understanding of volunteers must be deployed to the HPCSA to handle volunteer registration and understand the spirit of volunteerism.
- Easing some of the stringent rules for foreign qualified doctors who have been practicing for many years to get around the HPCSA Board exam requirements for licensing.
- There must be a focal-point person, and when the person is changed a proper handover must be done.

- Review and elevation of the HPCSA registration status from “volunteer” to Medical doctor, through the alignment of the programme with the existing government bilateral agreements like Cuba and Tunisia.

4.7 Impact

From the Department of Health Annual Plan 2014/2015, the following key achievements were noted.

- TB case detection has improved from 21,849 in 2008 to 19,513 in 2013;
- TB cure rate has improved from 67.4% in 2008 to 76.6 % in 2012
- Smear conversion rate has improved from 59% in 2008 to 683% in 2012
- TB defaulter rate has reduced from 8.2 % in 2008 to 5% in 2012
- Number of TB patients with ‘known’ TB status has improved from 22.3% in 2013
- Number of HIV positive TB patients, including those on ART, has improved from 67% in 2008 to 83.1 % in 2012.

While the above achievements cannot be attributable to UNVs alone, it coincided with the period under review of Phase III, and respondents acknowledged the huge contribution that UNVs have made.As one respondent put it ‘’ the health sector in the province is in chaotic state but can you imagine how it would be without the contribution made by UNV’s’’.

The establishment of the Diabetic Clinics in Polokwane and Mankweng spearheaded by UNVs with the support of the DOH has provided much needed support to patients suffering from diabetes.

In some hospitals, the presence of UNVs helped develop tertiary services. For instance, Polokwane Provincial Hospital has a neurosurgeon in the form of a UNV doctor. As a result, the specialist surgeon mentored up to four doctors during the phase in question. As in other hospitals, the mentoring is driven by a rotational pairing system which facilitates skills transfer until “the learning doctor is able to perform the new skills independently”. The quarterly evaluation of personnel is able to confirm and report on capacity development of the doctors.

One of the greatest risks lies in the inability to retain trained specialists because once they qualify they tend to move to greener pastures by taking overseas jobs, joining the private sector or migrating to more urbanised environments. This unforeseen impact creates a vicious cycle in the supply and demand of clinicians.

There has been an instance of unforeseen security risks posed by some doctors even though the recruitment is done in good faith. In some instances these doctors are not who they claim to be, which means recruitment and vetting must be strengthened.

It was also not foreseen that the political and economic climate in the Limpopo Province would severely affect the sustainability of the project. Having the DOH under administration contributed to the government's budget cuts to the project which in turn affected the staff retention at the UNDP PMU office (two staff members were retrenched) and generated high mobility of staff within the Department. It also caused a lot of anxiety amongst the UNVs.
These factors negatively impacted the programme's implementation as well as UNVs perception of the South African government.

In Letaba there is a sense among clinicians that the population surrounding the hospital is larger than they can handle. They feel that the changes are insignificant given that the doctor-patient ratio is not strong. However, they feel they have educated and mentored interns and many other doctors that pass through the hospital every three months. Part of the challenge is the mobility rate of personnel, doctors, interns and staff, who tend to remain only for about three months before moving elsewhere.

5. Conclusions and Rating of Programme Implementation

This section presents the overall assessment of the sub-programme's performance based on the criteria listed below.

Programme design and implementation approach: The Programme responds to a critical shortage of medical doctors, particularly in rural areas. It is therefore responsive to the needs of Limpopo Province and is aligned with government priorities at both national and provincial level. The outputs, targets, activities and tentative indicators have clearly been spelt out. Within this context, the programme will remain relevant for some time to come.

Country ownership/drivers: The programme has been designed and is led by the DOH. The involvement of stakeholders through the Project Steering Committee with clear Terms of Reference and comprising key decision-makers across different units within the DOH could be strengthened.

Achievement of objectives: Three sub-programmes, namely health planning, knowledge management and leadership development, and monitoring and evaluation, could not be achieved, mainly because of financial constraints. The recruitment and placement of UNVs was to a large extent achieved, although the target of 120 was not.

This has contributed to improving the provision of health care services, including the reduction of the TB cure rate, a reduction in the patient waiting time, and the establishment of diabetic clinics in Polokwane and Mankweng.

Sustainability: One of the main pillars of the sub-programme dealing with transfer of skills and mentoring could be strengthened to ensure it happens in a more structured manner.

Replication Approach: This programme could easily be replicated in other provinces, provided essential elements are in place, such as functional institutional arrangements and governance structures, a focal person to drive the programme, adequate funding, and a conducive environment for UNVs to perform their work.

Cost effectiveness and cost sharing: The sub-programme has undoubtedly proved that it involves value for money, and this could be strengthened by ensuring that the PMU is located within the Department. This will ensure easy access of PMU staff to senior management within the DOH and so improve coordination and communication and expedite decision-making processes. The biggest challenge with regard to efficiency has been the financial constraints which made it difficult to continue to recruit and place doctors, and expand the programme in general. In addition, it caused a lot of anxiety among the UNVs and could have affected their productivity levels.

Contribution to human rights and gender equality: Section 27 of the Constitution of the Republic of South Africa, Act 108 of 1996, sets out a number of rights with regard to health. The National Development Plan envisaged a health system that works for everyone, produces health outcomes and, most importantly, is not out of reach, especially for the many people who reside in far-flung areas of the country's provinces. Most rural areas in Limpopo, like all other rural provinces, have a high proportion of women and children, and they are therefore the main beneficiaries of health services.

Monitoring and evaluation: The sub-programme dealing with monitoring and evaluation and the domestication of Millennium Development Goals could not be achieved due to financial constraints. The LOG frame with clear outputs, activities, targets and tentative indicators makes it possible to assess the programme's performance. At the facility level, this could be strengthened by ensuring that regular performance appraisals of UNVs is conducted and, where there are problems, that they are dealt with swiftly rather than postponed until the time when extensions are requested.

UNDP supervision and support: Despite the loss of two key staff members, the PMU has continued to make quarterly visits to every facility and gather monthly reports on the performance of each UNV.

These visits have enabled the PMU to deal with any problems that are being experienced and to ensure open channels of communication and feedback are maintained within the DOH.

Overall assessment:

- Rating as per the criteria below

HS - Highly satisfactory

S - Satisfactory

MS - Marginally satisfactory

MU - Marginally unsatisfactory

U - Unsatisfactory

HU - Highly unsatisfactory

NA - Not applicable

	Project Review Criteria	Ratings						
		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 of the programme		X					
6	Catalytic role/Replication approach		X					
7	Cost effectiveness and cost sharing				X			
8	Contribution to human rights and gender	X						

	equality							
9	Monitoring and evaluation			X				
10	UNDP supervision and backstopping		X					

6. Lessons learned

A number of lessons can be learned from the implementation and performance of this programme, as outlined below:

- **Programme Design and Implementation Approach**: The design of the programme needs to ensure that problems are diagnosed and that proposed interventions respond to the needs of the Department and, most importantly, to the programme's beneficiaries. Establishing proper institutional arrangements is key to an effective and efficient programme.
- **Communication**: Communication is an essential ingredient of a successful programme. Both stakeholders and in particular hosting health facilities should be properly briefed about the objectives of the programme and its requirements.
- **Sustainability:** The lesson emerging from the programme is that sustainability should be seen in its wider context, not only in terms of finances. Transfer of skills and mentoring is a key component of sustaining the efforts and achievements made in the programme.
- **Monitoring and evaluation**: The importance of monitoring and evaluation cannot be overemphasised. This includes the development of log frames identifying outputs, outcomes and impacts to be achieved. In addition, baseline targets and indicators have to be developed to ensure that programme's performance can be fully accounted for.
- **Target setting** should not be done in isolation of the complex regulatory environment that the programme operates under. It is important to take into account what has been achieved in the previous phases of the Programme and understand the regulatory processes that could impact on the achievement of the target.

7. Recommendations

The UNDP Support to the Health Sector in Limpopo: Phase III, which was undertaken from 2009 to March 2015, has had a very positive impact on the DOH and more importantly on the rural communities that are being served by these facilities. The programme has ended but has been continuing as Phase IV since April 2015, and will end in 2020. The following recommendations build on the strengths and lessons of the past five years so as to maximise the programme's impact in Phase IV.

7.1 Governance Structure. There is a need to re-establish a Programme Steering Committee with very clear terms of reference. The terms of reference should deal with challenges that have been identified such as composition of the committee, quorums, decision making by members and feedback mechanisms and frequency of meetings.

7.2 Recruitment and Placement of UNVs. The three stakeholders, UNDP/UNV Office, UNV Bonn and DOH and PMU should explore **writing up a recruitment process** that specifies roles and responsibilities and related time frames for the deliverables. This will go a long way to managing the different expectations of all involved and lay the foundation to expedite the recruitment and placement processes. Furthermore, the introduction and acceptance of doctors showing direct interest in the programme needs to be clarified. Those who have applied, it is important that their applications should be followed up by UNV Bonn.

7.3 Knowledge and information sharing. The DOH should revive the annual meeting/workshop with all UNVs. This plays a crucial role in knowledge and information sharing and serves as a support mechanism for UNVs.

7.4 One of the critical **aspects of sustainability** is transfer of knowledge and skills from UNVs to locals and vice versa. Mentoring is a critical vehicle to ensure that this take places, and thus it should be more carefully structured. Different models of mentoring should be explored, including one-to-one mentoring, group mentoring, and cross-hospital mentorship (staff of different hospitals mentored together.

7.5 Extension Request. There is a need to streamline the processes and document the key steps and responsibilities of people involved to avoid lengthy bureaucratic processes.

7.6 Robust induction and awareness-raising about the programme among hospital management and personnel is required. The induction should expose all stakeholders to the programme in its entirety. In addition, there must be a one-on-one session with hospital management not only to prepare them for the arrival of new UNVs but also for the hospital to share their limitations in terms of logistics, infrastructure and medical equipment.

Annexures

Appendix 1: Terms of Reference

Appendix 2: Inception Report

Appendix 3: List of Documents reviewed

Appendix 4: Instrument Design

Appendix 5: List of Interviewees

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APPENDIX 1

TERMS OF REFERENCE

For

Terminal Evaluation of the UNDP Support to Health Sector in Limpopo Programme: Phase III

AUGUST 2015

vii) TERMS OF REFERENCE

Background and Programming Context

The UNDP Support to the Health Sector in Limpopo programme is the third phase of the UNV Support to the Health Sector in Limpopo. It is an extension of Phase I and Phase II, aimed at assisting the Government of South Africa to improve health care services in Limpopo Province. The health sector has been affected by a chronic deficit of health professionals, as a result of brain drain, the remoteness of the region and more attractive incentives elsewhere and abroad. The objective of the programme is to facilitate the recruitment and deployment of UN volunteer medical professionals in the rural areas of the province.

In this current phase (Phase III), 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.

- *Knowledge management and leadership development*: The purpose is to establish a Health Knowledge Management Centre/s to systematically generate, collect, store and utilise information to inform strategic planning processes. This sub - programme, is aimed at facilitating "knowledge development and exchange platform", to enhance knowledge sharing between local and international practitioners. Furthermore, a leadership development programme is envisaged to enhance the skills of the relevant local Senior Managers and improve the overall performance within the department.

- 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.

Amongst the various implementation challenges of the programme, financial constraints related to the administration process instituted within the department as well as the high mobility of staff led to the suspension of three sub-programmes, impeding substantial progress of the program.
A mid-term evaluation was conducted in 2011, to assess the strengths, weakness as well as lessons learnt in supporting and promoting volunteerisms in the province. By 2014, the

programme had recruited and placed 40 doctors who were placed in 14 hospitals across the province.

UNDP is currently in the process of soliciting the services of a qualified service provider to conduct an end of programme evaluation. The evaluation will assess the overall contribution of the programme to the Government of Limpopo efforts in improving health service delivery as set out in the programme document, in particular, strengthening the capacity of the Department of Health on strategic planning, monitoring and evaluation, promoting advocacy for volunteerism, MDGs domestication, human rights, south-south cooperation, and gender equality.

viii) Programme Expected Outputs

- 192 Health and Allied Professionals recruited and deployed in Limpopo Province
- 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
- A successfully implemented Mentorship Programme
- A successfully institutionalized Retention Strategy for local doctors and health personnel
- Institutionalization of a Roadmap for effective Health Planning
- A functional Information Nerve Centre
- Monitoring and Evaluation enhanced

ix) Executing Arrangements

The programme is executed by Limpopo Department of Health, with internal support by the 14 hospitals where UNV doctors are deployed across the province. The Programme Management Unit (PMU), located in Limpopo Province provides overall co-ordination of the programme and facilitates effective engagement with the Department, hospital managers and UNV doctors serving across the entire province.

A Programme Steering Committee is instituted to oversee the programme on behalf of the UNDP and Government to ensure synergy and integration in the planning and execution of the programme sub- components. The Programme Steering Committee, as the supreme decision-making body of the programme, is composed solely of representatives of the UNDP and the Department of Health. The Committee is responsible for providing strategic oversight, whilst reviewing progress and results of the programme activities. .

UNDP acts as Secretariat of the Committee. During the execution of the programme, decisions of the Programme Steering Committee are made through consultation and on the basis of consensus by all parties.

x) Budget

The total programme budget at the time of signing of the programme document by the Limpopo Department of Health and UNDP was US$ 36,300,000, however, due to financial constraints, the Department has contributed a total of ZAR 47,364,012 or US$ 5,967,613.17.

2. Purpose of the Evaluation

This evaluation is being undertaken to evaluate the collective outcomes of the four years (2009 -2015) of UNDP's contribution in enhancing health service delivery through good governance and capacity development in Limpopo Province. The evaluation report will present findings, conclusions, good practices, lessons learned, and recommendations. The evaluation results will be used for the development of the new programme which will start in 2015.

3. Evaluation scope and objectives

The objective of this terminal evaluation is to determine the extent to which the programme objectives were achieved, or are expected to be achieved, and assess whether the programme has led to any other positive or negative outcomes. If possible, the extent and magnitude of any programme impacts to date will be documented and the likelihood of future impacts will be determined. The evaluation will also assess programme performance and the implementation of planned programme activities and planned outputs against actual results.

4. Evaluation questions

The evaluation will focus on the following key questions:

1. How effective was the programme in increasing retention rate of Health Professionals and interns in the Province.
2. To what extent has the programme improved quality and quantity of health care service delivery in the Province
3. How effective was the programme in promoting volunteerism and a commitment of local Health and Allied Professionals to serve in Limpopo.
4. To what extent was the programme successful in improving the use of information for planning, monitoring and evaluation
5. How effective was the programme in increasing the capacity to conduct monitoring and evaluation

The analysis of impact and outcomes achieved should include, *inter alia*, an assessment of the extent to which the programme has (1) improved mechanisms for co-operation in the management of the programme, and; (2) The "achievement" indicators and verifiers provided in the log frame of the programme document should be used together with the evaluation parameters specified below.
The evaluation shall make recommendations that may contribute to the assessment and development of the Programme Document for the 4th Programme Cycle. Furthermore, the evaluation should highlight lessons learned - both the positive as well as the negative, geared towards enhancing planning and implementation of future programs and programmes.

The evaluation should also include a breakdown of final actual costs and cost-sharing for the programme prepared in consultation with the relevant stakeholders. The evaluation shall comment on financial management and co-financing arrangements.

5. Methodology

This terminal evaluation will be conducted as an in-depth evaluation using a participatory approach whereby Programme Manager and the UNDP focal Point and other relevant staff are kept informed and regularly consulted throughout the evaluation. The evaluators will liaise with the Programme Manager any logistical and/or methodological issues to properly conduct the review in as independent a way as possible. The Programme Manager will assist with the planning and necessary logistic arrangements to support the final agreed programme and demonstration site visits.

The findings of the evaluation will be based on the following:

1. A desk review of programme documents including, but not limited to:

    a) The programme documents, outputs, monitoring reports (such as progress and financial reports to UNDP and the Department annual Programme Implementation Review reports), mid-term evaluation, and relevant correspondence.

    b) Review of specific products including but not limited to technical publications, knowledge documents and meeting reports, case studies, methodological guidelines, strategies and recommendations, and public awareness materials in relation to the planned products and outputs detailed in the programme document;

    c) Reports from the Steering committee and Programme Management Unit (PMU)

    d) Other material produced by the programme or partner organisations

e) Feedback from stakeholders: and Senior Government Personnel both decision makers and managerial level; hospital staff & managers, local communities and other partners engaged in demonstration site and pilot activities.

2. Interviews with the Programme Management Unit (PMU) including UNDP management, staff and consultants, UNV doctors and the designate programme staff in the Department of Health in Limpopo, including hospital managers and staff.

3. The evaluators shall consult other relevant stakeholders and target audiences (e.g. key Departments of the Ministries of Health in the province, policy makers, members of the programme steering committee, representatives of hospitals, representatives of local communities, private sector partners, donors, and other UN Agencies and organizations etc.). Examples and evidence of the use of programme products by key target audiences shall be verified and reported wherever possible.
4. Interviews with the UNV staff in the UNDP Country Office and Bonn as necessary.

6. Key Evaluation principles

In attempting to evaluate any outcomes and impacts that the programme may have achieved, evaluators should remember that the programme's performance should be assessed by considering the difference between the answers to two simple questions ***"what happened?***" and ***"what would have happened anyway?"***. These questions imply that there should be consideration of the baseline conditions and trends in relation to the intended programme outcomes and impacts.

In addition, it implies that there should be plausible evidence to attribute such outcomes and impacts to the actions of the programme.

Sometimes, adequate information on baseline conditions and trends is lacking. In such cases this should be clearly highlighted by the evaluator, along with any simplifying assumptions that were taken to enable the evaluator to make informed judgements about programme performance.

In a nutshell, 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

7. Programme Evaluation Parameters

The consultant should provide **ratings** of Programme achievements according to Programme Review Criteria. Aspects of the Programme to be rated are:

1 Implementation approach
2 Country ownership/drivers
3 Outcome/Achievement of objectives (meaning the extent to which the programme's major objectives were efficiently and effectively achieved)
4 Stakeholder participation/public involvement
5 Sustainability of the programme outcomes focusing on financial, socio-political, institutional frameworks and governance
6 Catalytic role/Replication approach
7 Cost-effectiveness and cost sharing
8 Contribution to human rights and gender equality
9 Monitoring and evaluation
10 UNDP supervision and backstopping

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

7. Evaluation products (deliverables)

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

- Evaluation inception report - An inception report will be prepared by the consultant before going into the full-fledged evaluation exercise. It should detail the evaluator' 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.

- 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 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.

8. Required competencies

The consultant selected should not have participated in the project preparation and/or implementation and should not have conflict of interest with project related activities. The evaluator 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 Master's Degree, 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 5 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 consultant must be independent from both the policy-making process and the delivery and management of assistance. Therefore, a consultant who has had any direct involvement with the design or implementation of the project will not be considered. This may apply equally to evaluator who is 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.

9. Evaluation report format and review procedures

The report should be brief, to the point and easy to understand. It must explain; the purpose of the evaluation, exactly what was evaluated and the methods used. The report must highlight any methodological limitations, identify key concerns and present evidence-based findings, consequent conclusions, recommendations and lessons. The report should provide information on when the evaluation took place, the places visited, who was involved and be presented in a way that makes the information accessible and comprehensible. The report should include an executive summary that encapsulates the essence of the information contained in the report to facilitate dissemination and distillation of lessons.

Evidence, findings, conclusions and recommendations should be presented in a complete and balanced manner. The evaluation report shall be written in English, be of no more than 50 pages (excluding annexes), use numbered paragraphs and include:

(i) An **executive summary** (no more than 3 pages) providing a brief overview of the main conclusions and recommendations of the evaluation;

ii) **Introduction and background** giving a brief overview of the evaluated programme, for example, the objectives and status of activities;

iii)**Scope, objective and methods** presenting the evaluation's purpose, the evaluation criteria used and questions to be addressed;

iv). **Programme performance and impact** providing factual evidence relevant to the questions asked by the evaluator and interpretations of such evidence. This is the main substantive section of the report and should provide a commentary on all evaluation aspects (A - F above).

v) **Conclusions and rating** of programme implementation success giving the evaluator's concluding assessments and ratings of the programme against given evaluation criteria and standards of performance. The conclusions should provide answers to questions about whether the programme is considered good or bad, and whether the results are considered positive or negative;

vi). **Lessons learned** presenting general conclusions, based on established good practices that have the potential for wider application and use. Lessons may also be derived from problems and mistakes. The context in which lessons may be applied should be clearly specified, and lessons should always state or imply some prescriptive action. A lesson should be written such that experiences derived from the programme could be applied in other programmes or at portfolio level;

xi) **Recommendations** suggesting *actionable* proposals regarding improvements of the current programme. They may cover, for example, resource allocation, financing, planning, implementation, and monitoring and evaluation.

Recommendations should always be specific in terms of who would do what, provide a timeframe, and a measurable performance target. In general, Terminal Evaluations are likely to have very few (only two or three) actionable recommendations;

xii) **Annexes** include Terms of Reference, list of interviewees, documents reviewed, brief summary of the expertise of the evaluator / evaluation team, a summary of cost-sharing information etc. Management responses to the evaluation findings may later be appended in an annex.

10. Review of the Draft Evaluation Report

Draft reports submitted to UNDP will be shared with the corresponding focal point in the Department for initial review and consultation. The UNV staff is allowed to comment on the draft evaluation report. They may provide feedback on any errors of fact and may highlight the significance of such errors in any conclusions. The consultation also seeks agreement on the findings and recommendations. UNDP collates the review comments and provides them to the evaluators for their consideration in preparing the final version of the report.

All UNDP Evaluation Reports are subject to quality assessments by Evaluation Office. Evaluation quality assessment criteria will be used as a tool for providing structured feedback to the evaluator.

11. 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.

12. 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.

13. Resources and schedule of the evaluation

The evaluation will begin on 15 September 2015 and end on 15th October 2015. The evaluator will submit a draft report on 30 October 2015 to UNDP.

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

Activity	Timeframe and responsible party
Desk review	4 days by the Consultant
Briefings for evaluators	1 day by the UNDP procurement Unit
Field visits, interviews, questionnaires, de-briefings	5 days by the Consultant
Preparation of first draft report	5 days by the Consultant
Review of preliminary findings with project stakeholders through circulation of the draft report for comments, meetings and other types of feedback mechanisms	5 days UNDP South Africa Office and Government Counterparts
Incorporation of comments from project stakeholders and submission of second draft report	3 days by the Consultant
Review and preparation of comments to second draft report	2 days UNDP South Africa Office, and Government Counterparts
Finalisation of the evaluation report (incorporating comments received on second draft)	5 days by the Consultant
Stakeholder Validation Workshop of the evaluation report	1 day facilitated by the Consultant

14. Submissions of Final Terminal Evaluation Reports

The final report shall be submitted in electronic form in MS Word format and should be sent to the following persons: Mr. Walid Badawi (UNDP Country Director)

All interested applicants should submit: a recent CV; a proposal outlining of the evaluation approach and methodology; period of availability, a proposed budget for the assignment implementation to: procurement.za@undp.org.

Application deadline: 04 September 2015.

South Africa

Appendix 2

Inception Report for the Terminal Evaluation of the UNDP Support to Health Sector in Limpopo Programme: Phase III

November, 2015

Submitted by Andries Mangokwana

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Abbreviations

CEO	Chief Executive Officer
DOH	Department of Health
M & E	Monitoring and Evaluation
PMU	Programme Management Unit
UNDP	United Nation Development Programme
UNVs	United Nations Volunteers

Draft Report-Terminal Evaluation of the UNDP Support to Health Sector in Limpopo Programme: Phase III

Introduction

This inception report serves further to consolidate the proposal sent on the 04th September,2015 and a meeting held with United Nation Development Programme(UNDP)and Programme Management Unit(PMU) staff on the 11th November,2015.It provides details of the finalised evaluation approach, methodology and sample; the key evaluation questions and the work plan. It also contains the draft instruments for data collection for both UNDP and PMU staff, United Nation Volunteers (UNV), Department of Health (DOH) and hospital management representatives.

Purpose and Objectives of the Evaluation

The purpose of the evaluation is to determine the collective outcomes of the four years (2009-2015) of UNDP's contribution in enhancing health service delivery through good governance and capacity development in Limpopo Province. The evaluation report will present findings, conclusions, good practices, lessons learned and recommendations. The evaluation results will be used to improve Phase 1V, which has started in 2015-2020.

The objective of this terminal evaluation is to determine the extent to which the programme objectives were achieved and assess whether the programme has led to any other positive or negative outcomes. If possible, the extent and magnitude of any programme impacts to date will be documented and the likelihood of future impacts will be determined. The evaluation will also assess programme performance and the implementation of planned programme activities and planned outputs against actual results.

Approach and methodology

Qualitative data collection

Documents received and reviewed

The table 1 below captures the list of documents that has been received to date.

Name of the Document	Received
Annual Report-January-December,2010	Yes
Annual Report- January-December,2011	Yes
Outcome Evaluation: Part One,December,2011	Yes

Interviews

Stakeholders' interviews will be conducted with Programme Management Unit (PMU) including UNDP management and staff, UNV doctors and the designate programme staff in the Department of Health including hospital managers and where feasible staff.

Validation Workshop

A validation workshop will be held in Limpopo to allow key stakeholders to engage with the draft report and make meaningful input and recommendations.

Data Collection Instruments

One comprehensive data collection instrument has been designed and it is attached as Appendix 1.

Sample

Sampling choices were determined by the purpose of the evaluation, convenience and the need for simplicity and cost-effectiveness. The sampling method adopted is non probability mainly due to the size of the sample and time constraints. A purposive sampling technique has been applied.

The sample would be drawn from UNDP, Programme Management Unit's staff, Department of Health representatives, Hospital Managers and UNVs. Care has been taken to ensure that there is a good spread of tertiary, regional and district hospitals across the four Districts in the Limpopo Province. Table 2 respondents to be interviewed.

Table 2: Respondents from UNDP/PMU and Department of Health

Stakeholder Group	Method	Number	Comments
UNDP/PMU	Interview	3	Programme Manager, Monitoring & E valuation (M& E) Manager
Department of Health (DOH) representatives	Interview	2	Management and Programme staff

UNVs and Hospital Management & Staff

Stakeholder Group		**Name of the Hospital**	**Type of Hospital**	**District**	**Comments**
UNV Doctors	Hospital Staff-Ceo/Clinical Manager and staff	Polokwane	Tertiary	Province/Capricorn	Where it is feasible, joint interview with UNVs stationed at the same hospital will be held
		Botlokwa	District	Capricorn	
		Letaba	Regional	Mopani	
		Tshilidzini	Regional	Vhembe	
		Mecklenburg	District	Sekhukhune	

Evaluation themes and stakeholder categories

Table 3 below shows the key evaluation themes, purpose and the stakeholder category.

Table 3: Evaluation theme and stakeholder categories

Evaluation Theme	**Purpose**		**Stakeholder**		
		UNDP/PMU	Department of Health Representatives	UNV Doctors	Hospital Management & Staff
Institutional Arrangements	Assess the adequacy of the institutional arrangements in place	*	*	*	*
	Stakeholder participation, ownership and drivers	*	*	*	*
	UNDP Supervision and support	*		*	*
Implementation Approach	Look at the design of the programme	*	*		
	Monitoring and Evaluation	*	*	*	*

Effectiveness	Assess the extent to which outputs have been achieved	*	*	*	*
	Recruitment and deployment of health and allied professionals	*	*	*	*
	Successful Volunteerism programme	*	*	*	*
	Retention rate of Health Professionals and interns	*	*	*	*
Efficiency	Determine the costs and cost sharing	*	*		
	Financial management and co-financing arrangements	*	*		
Relevance	Assess the relevance of the programme	*	*	*	*
	Responsive to need and Government Priorities	*	*	*	*
	Alignment to the Government Policy	*	*		
Sustainability	Determine sustainability issues- financial, socio-political, institutional frameworks and governance	*	*		
	Catalytic	*	*		

	role/replication approach				
Lessons Learnt	Key lessons learnt	*	*	*	*
Recommendations	Develop recommendations	*	*	*	*

The above evaluation themes will enable the consultant to provide ratings of Programme achievements according to Programme Review Criteria. Aspects of the Programme to be rated are:

- Implementation approach
- Country ownership/drivers
- Outcome/Achievement of objectives
- Stakeholder participation/public involvement,
- Sustainability of the programme outcomes on financial, socio-political, institutional frameworks and governance
- Catalytic role/replication approach
- Cost effectiveness and cost sharing
- Contribution to human rights and gender equality
- Monitoring and evaluation
- UNDP supervision and backstopping

Deliverables

The following are the deliverables for this evaluation:

- **Evaluation inception report** - It should detail the evaluator' understanding of what is to be evaluated and why, showing how each evaluation question will be answered by way of proposed methods and data collection procedures. The inception report should include a proposed schedule of tasks, activities and deliverables.
- **Draft evaluation report** - The programme unit and key stakeholders will review the draft evaluation report to ensure that the evaluation meets the required quality criteria.
- **Final Evaluation Repor**t- This will incorporate the feedback received from the draft report and detailed methodology, key findings, lesson learnt and recommendations.

Time frame/Work plan

The evaluation has commenced on the 09th November and it is scheduled to be completed on the 11th December as shown below in Table 4.

Table 4: Evaluation Time Frame

No	Activity	Output	Time
1	Contractual Agreements finalised	Signed Contract	08 November,2015
2	Inception Meeting	Clarified scope of work and deliverables	11 November,2015
		Agreed methodology and sample size and list of documents	
3	Gathering and reviewing documents	Better understanding of the environment and project	On-going
4	Inception Report	Detailing methodology and sample size, evaluation matrix and work plan	17 November,2015
		Submit Inception Report and 1st Invoice	
		Incorporating comments received into Inception Report	20 November,2015
5	Instrument Design	Instrument Designed Finalised and incorporated into the Inception Report	17 November,2015
6	Prepare Fieldwork Logistics	Making appointments and booking accommodation for data collection	18-20 November,2015
7	Field work Conducted	Interview with PMU & Department of Health Representatives & Polokwane Hospital	23 November,2015
		Capricorn District- Polokwane & Botlokwa Hospital	24 November,2015
		Vhembe District- Tshilidzini	25 November,2015
		Mopani District-Letaba	26 November,2015
		Sekhukhune District- Mecklenburg	27 November,2015
8	Data Capturing and Analysis	Data captured and analysed using key themes	28-29 November,2015

9	Draft a Final Report	Draft Report Drafted	30November- 03 December,2015
		2nd Invoice Submitted	03 December,2015
10	Validation Workshop	Present the Draft Report to the stakeholders	04 December,2015
11	Final Report Prepared	Final Report prepared incorporate client's comments	07-08 December,2015
		Submission of the Final Report	11 December,2015

Appendix 3

List of Documents reviewed

1. Annual Report, UNDP Support to the Limpopo Health Sector, Jan-Dec, 2010

2. Annual Report, UNDP Support to the Limpopo Health Sector, Jan-Dec, 2011

3. Annual Report, UNDP Support to the Limpopo Health Sector, Jan-Dec, 2012

4. Annual Report, UNDP Support to the Limpopo Health Sector, Jan-Dec, 2013

5. UNDP Support to the Health Sector in Limpopo-Health Professionals Volunteerism and Capacity Development, Outcome Evaluation: Part One, December 2011, Dr Faniel Sahle Habtemichael

6.2014 Limpopo Health Annual Report

7. Project Document Phase 3, UNDP Support to the Limpopo Health Sector

8. Health Budget Speech, 2015-2016

Appendix 4: Instrument

TERMINAL EVALUATION OF THE UNDP SUPPORT TO HEALTH SECTOR IN LIMPOPO: PHASE III

Interview Schedule for UNDP, PMU, UNVs, UNV Bonn, DOH and Hospital Management

Interviewee Details:

Name of Interviewee :

_____

Designation :

_____

Date of Interview: _____

Physical address :

_____

Land line :

_____

Mobile no :

_____

E-mail address :

_____

Introduction:

- The evaluation is being commissioned to obtain an independent perspective on the collective outcomes of the four years (2009-2015) of UNDP's contribution in enhancing health service delivery through good governance and capacity development in Limpopo Province.
- The focus of the evaluation will be on successes, challenges, lessons learned and recommendations
- The evaluation results will be used to improve Phase 1V, which has started in 2015-2020.
- Your identity will remain anonymous – I will not include your name in the report, so please be open and honest with me. There are also no right and wrong answers, it is your OPINION that counts.

May we proceed?

1. Background and History of the Programme

1.1. Tell me about your role in the UNV Support to the Health Sector in Limpopo?

1.2. What is the Programme all about- Expected outputs?

2. Programme Design/Implementation Approach

2.1. What were some of the key pillars of the programme that worked well?

2.2. What were the challenges with regard to how the programme was designed?

2.3. Did the programme had a LOGFRAME indicating the results at different levels to be achieved (Question for UNDP/PMU and DOH only)

2.4. What Monitoring and Evaluation system and capacity are in place? (Question for UNDP/PMU and DOH only)

3. Project Management & Institutional Arrangements

3.1. What institutional arrangements were put in place for programme delivery?

3.2. How has the project been managed in terms of the following: Leadership, Communication & teamwork?

3.3. What is the nature of the involvement of stakeholders and how effective is their involvement?

3.4. What support systems exists? Are they working well?

4. Effectiveness

4.1. To what extent are the project outputs achieved? Probe for recruitment and deployment of health and allied professionals, successful volunteerism programme, retention rate of health and allied professionals an interns.

4.2. To what extent has the programme improved quality and quantity of health care service delivery in the Province?

4.3. How has implementation taken place? What went according to plan and what did not?

4.4. What were the key enablers and barriers in meeting project outputs?

5. Efficiency

5.1. How much did each partner (UNDP and DOH) contribute over the period of Phase III (2009-2005)?

(Question for UNDP/PMU and DOH only)

5.2. Would you say that resources for delivering this project have been well managed and utilised? Explain.

5.3. What could have been done to make implementation more efficient / cost friendly (time & labour) and achieved same results?

6. Relevance

6.1. How does the project fit into the broader priorities/mandate/policy of the Limpopo Government- DOH?

6.2. To what extent has the Programme being able to respond to the needs of the beneficiaries/patients?

7. Sustainability

7.1. To what extend do you think that the programme benefits are likely to continue and be resilient to risks over time and after external support has been withdrawn?

7.2. What are your strategies to improve retention rate of UNVs? (Question for DOH only)

7.3. What is needed in order to guarantee the sustainability of the programme? Are these in place and what is still needed?

7.4. Can this programme be replicated, say in another Province? What should be in place to make it a success?

8. Impact

8.1. What are the most significant changes that have been brought about by this Programme?

8.2. Are there signs of foreseen or unforeseen positive or negative impacts? Explain

9. Overall Impressions

9.1. What would you regard as the main **successes** of the Programme?

9.2. What would you regard as the main **challenges**?

10. Lessons learnt

10.1 What are the main **lessons** learnt?

11. Recommendations

11.1 What recommendations would you make to improve Phase 1V?

Thank you very much for your time and effort!

Appendix 5

List of interviewees

Name of the Person	Institution	Position	Date of the interview
Eunice Mojapelo	Department of Health	Senior General Manager-Corporate Services	23/11/2015
Dr. Nkadimeng	Department of Health	Senior General Manager-Health Services Branch	23/11/2015
Dr. Kgaphola	Department of Health	General Manager -Health Services Branch	23/11/2015
Dr. Ledwaba	Department of Health	Acting HOD	23/11/2015
Lusanda Monale	PMU	Programme and Admin Manager	23/11/2015
Dr. Seate	Polokwane Hospital	CEO	24/11/2015
Yryna DanyLenko	Polokwane Hospital	Medical Intern	24/11/2015
Sergey Delinikaitis	Polokwane Hospital	Orthopaedic	24/11/2015
Jerome Mbhib	Polokwane Hospital	Medical Intern	24/11/2015
Dr. Mugivhi RJ	Botlokwa Hospital	CEO	24/11/2015
Chokoe ME	Botlokwa Hospital	Health	24/11/2015
Dr. Adelago	Botlokwa Hospital	Health	24/11/2015
Mr Khepi Shole	UNDP	Head of Programme Support Unit	25/11/2015
Mr Frederick Shikwele	UNDP	M&E Manager	25/11/2015
Dr. Mukwevho N.N	Tshilidzini Hospital	Clinical Manager	25/11/2015
Dr. Liouduila Nikifozova	Letaba Hospital	Gynaecologist	25/11/2015
Dr.Sergei Nikifozova	Letaba Hospital	General Surgeon	25/11/2015
Dr. Sergii Zhyrnyy	Letaba Hospital	General Surgeon	25/11/2015
Ms Lily Da Gama	UNV Office	Programme Assistant	27/11/2015
Robert Palmer	UNV Bonn	Portfolio Manager	27/11/2015
Agnes Katabaro	UNV Bonn	Portfolio Associate	27/11/2015
Matildah Nyaho	UNV Bonn	Recruitment Assistant	27/11/2015
Robert Swinkels	UNV Bonn	Volunteer Recruitment	27/11/2015
Ms. Seemela	Mecklenburg Hospital	Area Manager/ Acting Deputy Manager	27/11/2015
Ms. Mampane PD	Mecklenburg Hospital	Acting Senior Clinical Manager	27/11/2015