Integrating Climate Change into the Management of Priority Health Risks in Ghana Project (PIMS 3796) Terminal Evaluation

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Final Evaluation Report

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ACRONYMS

Acronym	Definition
AAP	UNDP Ghana Africa Adaptation Programme
CSM	CerebroSpinal Meningitis
Danida	Danish International Development Agency
EPA	Environmental Protection Agency
GEF	Global Environment Facility
GHS	Ghana Health Service
GIS	Geographic Information System
GoG	Government of Ghana
GSGDA	Ghana Shared Growth and Development Agenda
HSMTDP	Health Sector Medium Term Development Plan
ICC	Interagency coordination committee (district level)
KOIKA	Korean International Cooperation Agency
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
MOH	Ministry of Health
MTR	Mid-Term Review
PIU	Project Implementation Unit
PMT	Project Management Team
PSC	Project Steering Committee
RSIMD	Research, Statistics and Information Management Directorate (of the MOH)
SCCF	Special Climate Change Fund
SMART	Specific, Measurable, Attainable, Relevant, Time-bound
TAC	Technical Advisory Committee
TE	Terminal Evaluation
ToRs	Terms of reference
UNDP	United Nations Development Programme
WHO	World Health Organization of the United Nations

EXECUTIVE SUMMARY

1. In Ghana, a national climate change vulnerability and adaptation assessment undertaken in 2008 concluded that Ghana faces deteriorating human health as a result of climate change impacts. In order to start the process of adapting the health sector in Ghana to the growing challenges associated with climate change, the Government of Ghana and UNDP submitted a proposal for the project Integrating Climate Change into the Management of Priority Health Risks in Ghana to the SCCF/GEF. The project objective is to identify, implement, monitor, and evaluate adaptations to reduce current and likely future burdens of malaria, diarrheal diseases, and meningococcal meningitis in Ghana.
2. The objective of this Terminal Evaluation (TE) is to provide a comprehensive and systematic accounting of performance at the end of the project cycle, considering the totality of the effort from project design, through implementation to wrap up, also considering the likelihood of sustainability and possible impacts. The evaluation approach included an in-depth review of project and contextual documentation, in-depth interviews and focus group discussions, and on-site visits to demonstration districts in 2 districts. The TE took place between December 2015 and February 2016.
3. This document is the draft TE report submitted for comments and clarification to project stakeholders.

Project design

4. As was already concluded in the project mid-term review, the project conceptualization and design process was overall good and participatory. However, a number of weaknesses appear (unacceptably long design phase, poor attention given to operational matters, effort given to mobilizing co-financing). Some of those weaknesses could, and should, have been addressed, probably during the inception period
5. The Project Document provides a good and adequate description of the Project context, in terms of development in Ghana, climate change, the health sector and the interactions between climate change and health. It also adequately sets the scope of the Project and provides adequate justification for the use of Government, SCCF and UNDP resources.
6. Many elements of the strategy and approach are well thought through and clear, and the project objective seems mostly appropriate given the starting point and the resources available.
7. The M&E plan is reasonably conceived and budgeted for, but the logical framework presents numerous weaknesses: among other things, the links between Outcomes and Outputs and the overall Objective are not sufficiently clear, and many of the proposed indicators are not SMART[1]..
8. Risks and assumptions are not properly captured in the Project Document. There are two sets of risks and assumptions which do not articulate properly and some externalities, such as the possible effect of an economic crisis, are absent.
9. There is no strong evidence that planning documents have utilized lessons learned/recommendations from previous Projects as inputs to planning and defining the Project strategy.
10. National stakeholders confirmed that the process to prepare the Project was inclusive and participatory, and this is reflected in the Project Document.

[1] SMART – Specific, Measurable, Attainable, Realistic, Time-bound.

11. The Project Document sets out the basics of the management/implementation framework but it does not provide sufficient detail. Evidence collected suggest that roles and responsibilities of the main stakeholders in project implementation were far from being clear at project start. Had these management arrangements been properly defined, important troubles, frustrations and delays could have been avoided.

12. The replication approach is considered very weak in the Project Document, as it does not foresee how the Project lessons and experiences can (or should?) be replicated.

13. Given the skills and competences required for this project, UNDP was the appropriate institution for implementing it. However, it would have benefitted from strong technical partnerships with certain institutions in those areas were UNDP skills were weaker. For example, stronger technical involvement of WHO in some activities (i.e. beyond participation to the Project Steering Committee and Technical Advisory Committee) may, in this regard, have been beneficial.

14. Finally, linkages between project and other interventions within the sector are rather weak, with no clear plan in the PRODOC nor any reference to this in the inception report.

Project implementation

15. Overall, there are examples of adaptive management during project implementation, which contributed to some of the project successes (e.g. teleconsultation centres). However, decisions were mostly taken without a formal discussion and approval by the PSC (or at least they are not captured in PSC meetings minutes), which is an important management weakness. In addition, there has been no formal management response and follow-up of the recommendations made by (i) the 2013 Project Management Review, and (ii) the MTR. Those two documents were major inputs to project management and one can regret the low consideration they have been given in the end.

16. The project has involved and used the skills of a variety of stakeholders, although primarily governmental (at both national and district level). A strength has been to involve the various sectors at the district level; this aspect does not appear so clearly at the regional and national levels however. Significant outreach and public awareness campaigns have been organised in the different districts, including communication material, radio programmes, demonstrations, education campaigns in schools, communities, and targeting specific people like hair dressers and people with a direct impact on hygiene. More cooperation could have been developed with national and local (non-governmental) organisations in order to better coordinate respective interventions and relay key messages.

17. The total project budget, including co-financing, is estimate at US$53,259,197, a bit below the Prodoc estimate (US$57,401,328). Given the GEF SSCF and UNDP actual disbursements and the uncertainty in assessing the actual level of co-financing, the final project budget can be considered as in line with the initial plan.

18. Although the mentioned co-financing are actual, it can be regretted that technical collaboration between the Project and those co-financiers has been very limited (WHO, AAP, Danida) and that synergies have not been sought for more systematically.

19. There is no evidence that the M&E framework was actually used during implementation as a management tool. Data has not been collected systematically to inform indicators. Reporting has occurred but quality is unequal.

20. Overall, monitoring and evaluation has been rather poorly implemented over the project duration. As already highlighted in the MTR, the project lacks a standard, formal monitoring system – through which systematic reports are submitted to high level project management and used as a basis for decision-making. There is a strong case here for a recommendation on training UNDP and project staff to M&E, its use in GEF projects and how it supports project management.

Project Results

21. Relevance: The Project objective and outcomes are relevant and do support the environment and sustainable development objectives of Ghana. At the district level, there are many examples of direct benefits form the project to local communities. Overall, the project has helped to fill a gap by addressing climate change vulnerability of the health sector in Ghana. It has highlighted the link between climate change patterns and health issues, in particular the need to increase resilience of the health system to climate extreme events

22. Effectiveness: The achievement of the project objective and outcomes can be rated as "Moderately Satisfactory": a lot has been done in terms of knowledge production, training and awareness raising, but a lot remains to be done in order to ensure that the information produced and the tools tested are properly integrated into health management systems in Ghana, systematically replicated in all districts/regions of the country and that interactions with all relevant sectors into climate change and health issues are effective.

23. Efficiency: The important delays in project execution, difficulties in having a functioning governance structure and operational cooperation between project partners, the poor use of management tools, result in a rather unsatisfactory implementation of the project in terms of efficiency. Given the good level of expenditures and mobilization of co-financing, overall rating is qualified as "Moderately Unsatisfactory".

24. Country ownership: Country ownership has been rather good but more institutions and development partners (international organisations and NGOs) could have been involved in project delivery.

25. Mainstreaming: Mainstreaming of other UNDP priorities, such as poverty alleviation, improved governance, the prevention and recovery from natural disasters, and women's empowerment is relatively good in the Project. Alignment with UNDAF, CPAP and Strategic Plan Environment and Sustainable development is very good.

26. Sustainability: The Project Document a section 'Sustainability and replicability' is not robust. Apart from building capacities of staff at various levels, there are no examples of actions implemented to avert sustainability risks. The likelihood of continued benefits after the GEF project ends is very uncertain, as it highly depends on the willingness and the capacity of MOH and GHS to build on project achievements, to use the studies and tools created, to maintain the services put in place, and to extend them to other districts and regions of the country.

27. Catalytic effect: The catalytic potential is quite high, with many activities having the potential to be reinforced, extended and replicated across the country. Project closure is a critical moment for future impacts the project might, or might not have. Depending on the actions taken now, the results may be catalytic (i.e. scaled-up and replicated), just sustainable, negligible or even fail if project achievements are not taken up by stakeholders

28. Impacts: Project impacts include reinforced health surveillance systems and saved lives at the district level, and a better understanding of the link between climate change and health, as well as climate change mainstreaming into health policies and strategies, at the national level. Overall, the project has contributed to reduce vulnerability to climate change of the health sector in Ghana. Although most of the potential impacts need to be confirmed and strengthened in the near future, they are significant. Shall the involved stakeholders achieve to build on project achievements and extend nationally the results obtained in the pilot districts, many other impacts should be visible in the next few years

Conclusions and recommendations

29. After the many challenges and delays of the first years, the Project has finally been able to find its mode of operation and has delivered a number of interesting achievements. As concluded in the end-of-project

report, "Integrating climate change into the management of health priorities has become possible as a result of access to information on climate change and health, improvement in health systems to accommodate new demands imposed by climate change, adequate capacity of health care providers to identify, implement, monitor, and evaluate adaptations to reduce current and likely future burdens of malaria, diarrheal diseases, and meningococcal meningitis in Ghana and commitment by the Ministry of Health to incorporate climate change issues in is programming".

30. Implementation has however been rather hectic and there a lot to be learned from this experience for ensuring a smoother implementation of future projects. Lessons relate in particular of the governance structure and the need to clearly define the roles and responsibilities of each project partner; they also relate to project manager itself, with the need to clarify rules, procedures and expectations from UNDP/GEF and from the involved national instructions at project start, with the delivery of trainings as necessary, including on M&E.

31. Better achievement of the project objectives and stronger results would certainly have been reached without those implementation and management problems. They also hinder the sustainability, future impacts and replication potential of the project results, which highly depend on the willingness and the capacity of Ghanaian institutions to build on the project experiences and knowledge to engage all districts and regions of the country into climate change adaptation.

32. This project is important to the Ghanaian health sector. Needs are important and climate change reinforces vulnerability of the populations. The tools put in place and the demonstration activities implemented have the potential to greatly improve disease surveillance and health management in the country. The opportunity should not be missed.

33. From the analysis conducted, the TE has extracted 7 lessons learned from this project (see section 3.4.2) and draws 3 main recommendations aiming to ensure Project sustainability and replication, and improve the quality of future UNDP/GEF projects :

R1 As mentioned in the report, sustainability of the results achieved by the project and realisation of its replication potential highly depend on local institutions' capacity to actually take on post-project initiatives. A lot can be done, among other things, in (i) operationalizing the teleconsultation centres and putting in place such centres in all districts/regions of the project; (ii) developing and updating regularly vulnerability maps to main diseases across the country as was tested in the pilot districts; (iii) reinforcing inter-sectoral cooperation for a comprehensive approach of health; and (iv) managing climate vulnerability information and knowledge products through a practical and easy to access knowledge management system.

The **TE recommends that PSC members work jointly on an exit strategy for the project**. Such strategy would include a detailed work plan of activities to ensure continuity and replication of project outcomes in order to enhance the Ghana health system resilience to climate change. Such a plan would set a clear distribution of roles and responsibilities for each activity, with a clear governance framework established. It would also seek to identify potential funding sources for each activity, some of which may be funded by external sources, including from climate finance (e.g. the Green Climate Fund). The exit strategy process could consist in an initial meeting to define the activities needed for sustaining the main project results and make sure the tools developed during the project are implemented. Each PSC member could then work on some sections of the exit strategy and then meet for a second time in order to agree on the governance framework (who leads the process? How are responsibilities distributed?), the financial means available for each of the defined activities, and actions to be taken in order to raise funding sources. UNDP has a role to play to mobilize PSC members on this process.

The following Project outputs should be duly considered for sustainability and replication in the exit strategy:

- ORT corners: ensure provision of medicine where ORT corners are in place, and install ORT corners in all health centres of the country.
- Teleconsultation: the use of mobiles phones is already effective. First, GHS should make sure phone credits continue to be provided regularly and that broken phones are duly replaced. Secondly, teleconsultation centres are in place but not fully operational, as some training of staff was still missing at the time of the TE mission. Given the investments already engaged, it is very important that those centres become fully operational shortly. The scaling up of teleconsultation centres to all the regions of the country should be duly considered, given the high benefits reporting by this activity.
- Risk maps and knowledge management: given the complexity of updating such maps, consider setting-up a web platform were districts can upload there data every month and automatically get the vulnerability maps in return. A central team at the national level should be trained on GIS tools, licenses for GIS software acquired, and the proposed web-platform put in place. Such web platform could also include a number of knowledge products and tools (e.g. the screening tool) in order to facilitate knowledge management and dissemination. A specialised consultant should be able to put this in place and train people within relatively short delays.
- Education campaigns: a lot of the material developed can be re-used in the future in order to maintain a momentum on climate change adaptation, and replicate to other districts of the country.
- Multi-stakeholder platforms: the relevance of interagency coordination committees has been proven by the Project, given the inter-sectoral nature of climate vulnerability and resilience. Consider putting in place such committees in every district and region of the country, and ensure a similar body is activated at the national level. At the district level, it may be considered relevant to use the emergency preparedness committees already in place, giving them clear responsibility on climate change issues (which entails preparing specific terms of reference and delivering short trainings on climate change as necessary).
- Screening tool: based on the final report *Development of a gender sensitive climate resilience screening tool for the health sector*, decide how the tool should be used to monitor and improve climate resilience of the health system in all of the country's districts. Define responsibilities, budgets and timing.

R2 In future projects**, make sure to set very clearly, and get validated, the governance structure of the project,** with clear roles and responsibilities established for each partner institution. As far as possible, this should be done during project formulation. However, it must be re-clarified and reconfirmed during the inception phase of the project, and it is very important to put the necessary effort at this key moment. Assigned roles and responsibilities must fit with each institution national role and capacities, and validation should occur at a sufficiently high level to avoid any further contestation. This applies in particular to the health sector where the delineation of responsibilities between the MOH and GHS does not seem to be totally clear.

R3 Effectiveness and efficiency of the project highly depend on the capacities of the project management team. **In such projects, it should be considered to offer a full training to the team put in place regarding project management along UNDP/GEF procedures**, including M&E and results based management. This can be done rather easily by hiring a project management expert with strong UNDP/GEF experience. Additional support along the project duration can also greatly enhance the quality of project management and reporting. Sometimes, a chief technical advisor is hired for this purpose. In smaller projects, an initial training, with then short yearly support missions, could be considered.

Table ES1. Evaluation ratings[2]

Criteria	rating	Comments

[2] See corresponding sections in the main text of the report for details on how ratings have been set.

1. Monitoring and Evaluation: Highly Satisfactory (HS), Satisfactory (S) Moderately Satisfactory (MS), Moderately Unsatisfactory (MU), Unsatisfactory (U), Highly Unsatisfactory (HU)		
Overall quality of M&E	MU	-
M&E design at entry	U	The links between Outcomes and Outputs and the overall Objective are not sufficiently clear. Monitoring indicators from the Project Document were not effective for measuring progress and performance, nor were they SMART
M&E Plan Implementation	MU	No evidence of use of the M&E plan, and in particular the results framework, over the Project duration.
2. IA& EA Execution: Highly Satisfactory (HS), Satisfactory (S) Moderately Satisfactory (MS), Moderately Unsatisfactory (MU), Unsatisfactory (U), Highly Unsatisfactory (HU)		
Overall quality of Implementation / Execution	MU	
Quality of UNDP Implementation	MU	Low capacity to clarify procedures and adapt to local context in order to enable Project implementation
Quality of Execution - Executing Agency	MU	Lack of formality in the way the EA executed the Project and limited planning and coordination capacities
3. Outcomes: Highly Satisfactory (HS), Satisfactory (S) Moderately Satisfactory (MS), Moderately Unsatisfactory (MU), Unsatisfactory (U), Highly Unsatisfactory (HU)		
Overall Project Outcome Rating	MS	-
Relevance Project rated 'RELEVANT'	HS	Project is highly relevant to sustainable development objectives of Ghana and filled a gap by linking climate change and health.
Effectiveness	MS	Outcomes 1 is rated 'MS', Outcome 2 'S' and outcome 3 'MU'
Efficiency	MU	The important delays in Project execution, difficulties in having a functioning governance structure and operational cooperation between Project partners, the poor use of management tools, result in a rather unsatisfactory implementation of the Project in terms of efficiency. However, given the good level of expenditures and mobilization of co-financing, overall rating is qualified as "Moderately Unsatisfactory" rate
4. Sustainability: Likely (L); Moderately Likely (ML); Moderately Unlikely (MU); Unlikely (U).		
Overall likelihood of risk to sustainability	ML	-
Financial resources	ML	There is currently no financial plan to ensure sustainability of Project achievements, but Project partners hope that financial support sources will be identified.

Socio-political	L	Risk to sustainability is rather low on the socio-political side. There is sufficient public/stakeholder awareness in support of the project's long-term objectives
Institutional framework and governance	ML	There is a risk of lack of leadership after the project end. The MOH has been the project lead but logically, many of the activities and further developments should be implemented by GHS. A institutional framework would need to be put in place so it is made clear who is in charge of what after project end.
Environmental	L	Project outcomes mostly aim to increase resilience to environmental risks, so there is no new threat on this aspect.

1. INTRODUCTION AND BACKGROUND

1. Climate change, including climate variability, has multiple influences on human health. This is understood to include both direct and indirect impacts. This is expected to include alterations in the geographical range and in the transmission of vector-, tick-, and rodent-borne diseases and food- and waterborne diseases, and changes in the prevalence of diseases associated with air pollutants and aeroallergens. Climate change may alter or disrupt natural systems, making it possible for diseases to spread or emerge in areas where they had been limited or had not existed, or for diseases to disappear by making areas less hospitable to the vector or the pathogen.[3]

2. In Ghana, a national climate change vulnerability and adaptation assessment (undertaken in 2008 as part of the preparation of Ghana's Second National Communication to the UNFCCC) revealed the expected substantial impacts of climate change on the national economy, with clear evidence that many of the key economic assets – the coastal zone, agriculture and water resources – will be negatively affected. Moreover, social development, in terms of poverty reduction, health and women's livelihoods, were also found to be affected. This assessment concluded that Ghana faces deteriorating human health as a result of increased incidence of diseases and reduced access to water and food compounded by the disruption of the delivery of health services, for example flooding of health facilities, and the loss of transport infrastructure.

3. In order to start the process of adapting the health sector in Ghana to the growing challenges associated with climate change, the Government of Ghana (GoG) and UNDP submitted a proposal for the Project Integrating Climate Change into the Management of Priority Health Risks in Ghana to the SCCF/GEF. The GEF CEO endorsed the Project proposal in November 2010.

4. The baseline situation at project formulation is described in the Project Document as one in which health care in Ghana in general remains poor. A large percentage of the country's health burden is caused by climate-sensitive diseases such as malaria, diarrhoeal diseases and meningitis. The project document adds that "there are significant regional differences in health indicators for these diseases, with the northern regions mostly having a higher incidence of disease. Climate change projections for the country indicate a significantly increased burden of these climate-sensitive diseases. In the absence of any intervention, the situation will become increasingly grave, given that health policy and the already overstretched health systems do not yet factor these climate-related health risks into planning and implementation."

5. The Project Document identifies three underlying causes of the problem this Project seeks to address:

   - Underlying cause 1: The capacity of key stakeholders to respond to climate change-related health risks and to incorporate adaptation measures into the planning and implementation of health policies, strategies, programmes, projects and initiatives is still limited, and measures to date have been isolated and reactive.

   - Underlying cause 2: There are inadequate systems for surveillance, early warning and response to key climate-related diseases such as malaria, diarrhoeal diseases and meningococcal meningitis; and the links between national and district health structures for the management of climate-related diseases are weak.

[3] Opening paragraphs adapted from Project Document

- Underlying cause 3: Information management and dissemination of climate change-related health risks is not carried out systematically and lessons learned are not captured in a way that facilitates broader sharing.

6. This Project proposed an alternative scenario in which GEF funds are used strategically to develop systems and response mechanisms to strengthen the integration of climate change risks into the health sector. Critical barriers were to shift the response capacity of the health sector in Ghana from being reactive towards being more anticipatory, deliberate and systematic.

7. The Project objective is to identify, implement, monitor, and evaluate adaptations to reduce current and likely future burdens of malaria, diarrheal diseases, and meningococcal meningitis in Ghana, priority climate change related health issues identified by national stakeholders. This was to be achieved through strengthening technical capacities of health sector workers to manage climate change-related health risks. Pilot interventions in Keta District (Volta region), Gomoa West/Apam District (Central Region), and Bongo District (Upper East Region) were to demonstrate the effectiveness of improved disease surveillance and response in reducing the burden of climate-sensitive diseases.

8. In order to attain this Project objective, activities are being implemented in three components, and three outcomes are to be achieved, as presented in Table 1.

Table 1. Project components and outcomes

Component	Outcome
1. Strengthen technical capacities to manage climate change-related health risks	1. Improved national and local health technical sector capacity to plan for and manage climate change related alterations in the geographic range and/or incidence of climate-sensitive health outcomes, including malaria, diarrhoeal diseases and meningococcal meningitis
2. Climate change health risk mainstreamed into decision-making at local and national health policy levels	2. Mechanisms established for cross-sectoral coordination to support climate change-resilient health policy formulation and implementation at national and local policy-making levels.
3. Information management and effective dissemination of climate change health risk knowledge base.	3. 'Lessons learned' collected and knowledge management components established

9.

The Project is funded by the Special Climate Change Fund (SCCF) of the Global Environment Facility (GEF). The Project began implementation in September 2011 (one year after GEF CEO endorsement) and officially closed in June 2015 (December 2015 for administrative closure by UNDP) after two no-cost extensions. Indeed, the Project was originally set to end in December 2013. It was first extended for 6 months, and then extended for another year until June 2015. The picture below illustrates how late have the Project activities started for example, in Gomoa West district The Project mid-term review was finalised in January 2014.

10.

Photo 1 Project start in Gomoa West district, dated 24 May 2013

11. The Project was executed jointly by the Ministry of Health (MoH) and Ghana health services (GHS).. Other key partners were the Environmental Protection Agency (EPA), the World Health Organisation (WHO), the Ministry of Environment Science and Technology and the Ministry of Finance and Economic Planning, all members of the Project Steering Committee.

12. The project's initial total budget is US$ 57,401,328, from which GEF financing is US$ 1,718,182 and co-financing is 55,683,146. Main co-financers include UNDP, EPA, Danida, WHO. Co-financing is mostly constituted of on-going projects/initiatives and general support to the health sector which all contribute to the baseline situation of the project.

2. SCOPE, OBJECTIVES AND METHODS

2.1. Objectives and scope of the terminal evaluation

13. As indicated in the UNDP Guidance for Conducting Terminal Evaluations[4], the objective of the Terminal Evaluation (TE) is to provide a comprehensive and systematic accounting of performance at the end of the Project cycle, considering the totality of the effort from Project design, through implementation to wrap up, also considering the likelihood of sustainability and possible impacts. The TE must:

- Assess accomplishments and in particular assess the implementation of planned Project outcomes against actual results;
- Synthesize lessons that can help to improve the selection, design and implementation of future GEF financed UNDP activities;
- Contribute to the overall assessment of results in achieving GEF strategic objectives aimed at global environmental benefit;
- Gauge the extent of Project convergence with other UN and UNDP priorities, including harmonization with other UN Development Assistance Framework (UNDAF) and UNDP Country Programme Action Plan (CPAP) outcomes and outputs.

14. On the basis of evidence gathered during the evaluation process, the evaluator presents evaluation findings and draws out lessons learned and practical recommendations for future Projects. Evaluation findings are presented along fours main sections:

1. Project Design/formulation
2. Project implementation
3. Project results
4. Conclusions, recommendations and lessons learned

Project results are analysed along the 5 OECD DAC criteria: relevance, effectiveness, efficiency, sustainability, and impact. The aspects of country ownership, mainstreaming and catalytic role are dealt with separately.

Box 1. UNDP Evaluation criteria

1. Relevance

- The extent to which the activity is suited to local and national development priorities and organizational policies, including changes over time.
- The extent to which the project is in line with the GEF Operational Programs or the strategic priorities under which the project was funded.

2. Effectiveness

- The extent to which an objective has been achieved or how likely it is to be achieved.

3. Efficiency

[4] Guidance for Conducting Terminal Evaluations of UNDP-supported, GEF-financed projects, UNDP Evaluation Office, 2012.

- The extent to which results have been delivered with the least costly resources possible; also called cost effectiveness or efficacy.

4. Results

- The positive and negative, foreseen and unforeseen changes to and effects produced by a development intervention.
- In GEF terms, results include direct project outputs, short to medium-term outcomes, and longer term impact including global environmental benefits, replication effects and other local effects.

5. Sustainability

- The likely ability of an intervention to continue to deliver benefits for an extended period of time after completion.
- Projects need to be environmentally, as well as financially and socially sustainable.

2.2. Evaluation Approach

2.2.1. Data Collection

15. Both primary and secondary data were be collected through different channels:

- ***Documentary analysis***. Key Project design and implementation documents were desk reviewed in order to properly understand the context and situation of the Project to date and start feed-in the evaluation framework, identifying information gaps and data collection needs.
- ***In-depth interviews***. These were primarily semi-structured, and were conducted with a large array of Project stakeholders. Secondary data was obtained mainly from UNDP country office, the Project management team, and relevant partners and organizations. Primary data was gathered through qualitative and quantitative methods, including desk reviews and semi-structured interviews. The in-country mission enabled the evaluator to meet with the main stakeholders involved in the Project as well as to observe sub-offices, locally installed equipment and training. The complete list of people interviewed and met is contained in annex 3).
- ***On-site visits and focus group discussions***. The mission upcountry enabled site visits and interviews/focus groups with District Health Stakeholders, in particular district Health Directorates and local Hospital Administrators. The purpose of these visits was to acquire information from different sources in order triangulate (i.e. cross-check) information and answer the evaluation questions on the basis of evidence. This approach also favours the participation and inclusion of stakeholders from different sectors, including Project managers, local implementation teams and beneficiaries.

2.2.2. Data Analysis and Interpretation

16. At this stage, the evaluator compiled and analysed all collected data on progress towards meeting the Project targets, intermediate results achieved, and gaps reported, if any. Quantitative data, where applicable, was analysed with the appropriate tools. In order to ensure that the information was collected and cross-checked by a variety of informants, data triangulation has been a key tool for the verification and confirmation of the information collected. Findings were related to pertinent information through interpretative analysis, which applied both deductive and inductive logic. This systematic approach ensures all the findings, conclusions and recommendations are substantiated by evidence.

2.2.3. Sampling

17. According to the Project Document, the choice of the three selected regions for the Project (Upper East region, Central region and Volta region) was made on the basis of criteria agreed with key stakeholders, including the following:

- *Prevalence of relevant diseases*: Upper East Region- high prevalence of CerebroSpinal Meningitis (CSM) and Malaria; Central Region- high incidence/epidemics of diarrhoeal disease, with endemic malaria.
- *Climate change impacts*: the Upper East Region and Volta Region are Projected to experience significant climate change impacts such as flooding;
- *Poverty incidence*: the incidence of poverty is higher than the national average in the Upper East and Central regions (as is the case in the Upper West and Northern regions).

18. Three districts have been chosen at Project formulation to implement the Project activities:

- The **Keta District** was selected as the pilot district in the Volta Region, largely based on the high incidence of epidemics of diarrhoeal disease;
- The **Gomoa West district** was selected in the Central region as one of the pilot districts after discussions with the national, regional and district level directorates, based on criteria decided at the January 2010 stakeholder workshop;
- The **Bongo district** was selected as it had been the most affected by CSM in the 2010 outbreak in the Upper East Region.

19. The Mid-Term Review (MTR) mission visited the Keta district only, due to very limited time in country. For the TE, it seemed relevant to visit all three locations. However, given distances and time available (and the fact that flights to northern Ghana were cancelled at that time due to meteorological conditions), it was decided to visit Gomoa West and Keta districts physically, and organise telephone interviews with Bongo district stakeholders.

2.3. TE Phasing

2.3.1. Inception Phase

2.3.1.1. Documentation review

20. The initial documentation review allowed the evaluator to clarify the context around the Project and identify the main challenges of the evaluation mission and information gaps to be completed. A more in-depth analysis of all Project's key documents, terms of reference (ToRs), reports, activity documentation at national and district levels (training reports, minutes of meetings, etc.), and all the other documents provided by the UNDP was then conducted along the mandate duration.

2.3.1.2. Preparation of the TE matrix

21. On the basis of the initial documentation review, an evaluation matrix was elaborated during the inception phase. The evaluation matrix is a key tool for data collection and analysis. It includes the evaluation questions as set in the terms of reference, following the four sections proposed, i.e. Project formulation, Project implementation, and Project results, assessed along the 5 OECD DAC criteria (relevance, effectiveness, efficiency, sustainability and impact). The evaluation matrix details the most relevant

qualitative and quantitative indicators that will inform on the review questions, data collection methods and information sources. It is contained in Annex 1.

2.3.1.3. Inception report

22. Based on the literature review and first contacts with key informants, the inception report was prepared. It reflects the improved understanding of the assignment and incorporates a detailed work plan for the mandate.

2.3.2. Data Collection Phase

2.3.2.1. Country visit

23. A 12-days mission to Ghana was organized in order for the evaluator to understand the key determinants of the Project implementation history, the strengths and weaknesses of the Project as regards the country/local situation and context, and how beneficiaries and other key stakeholder perceive the Project relevance, results, effectiveness, efficiency and sustainability. The field visits also helped the evaluator to assess the limits of local challenges, cross-cutting issues and possible ways for improvement. At the end of the evaluation mission, a wrap up discussion was organized with the UNDP country office to present initial findings.

Photo 2. Focus group discussion conducted in a health centre in Keta district

2.3.3. Data Analysis and Reporting Phase

2.3.3.1. Data analysis and triangulation of information

24. This stage included, among others, the comprehensive analysis of key relevant quantitative and qualitative data through the integration and comparison of findings from field-work (focus groups and direct observation), interviews, and documentation review, respectively. The evaluator ensured the verification of data and the articulation of key findings and lessons learned in order to assess progress toward reaching outcomes, and formulate conclusions and recommendations.

2.3.3.2. First draft TE report

25. The evaluator has prepared this **first draft evaluation report**, addressing the key review questions as set in the ToRs and presenting the scope and methods and the review findings, conclusions, lessons learned, and recommendations. As required by UNDP/GEF evaluation guidelines, this report is structured around four main sections, namely (i) Project design/formulation; (ii) Project implementation; (iii) Project results; and (iv) Conclusions, recommendations and lessons learned. UNDP, the Project team and Project partners will review this draft TE report and provide the evaluator with consolidated comments, clarification points, factual information and relevant observation.

2.3.3.3. Final TE report

26. After the necessary discussions and clarifications, consolidated comments will be duly taken into account in the preparation of the final TE report. The TE report will be submitted 15 days after actual receipt of consolidated comments. It will include, whenever possible, clarification points, factual information as well as relevant observations, views and suggestions expressed by the Project partners.

3. TERMINAL EVALUATION FINDINGS

3.1. Project design/formulation

27. As was already concluded in the project mid-term review, the project conceptualization and design process was overall good and participatory. However, a number of weaknesses appear (unacceptably long design phase, poor attention given to operational matters, effort given to mobilizing co-financing). Some of those weaknesses could, and should, have been addressed, probably during the inception period

28. The Project Document provides a good and adequate description of the Project context, in terms of development in Ghana, climate change, the health sector and the interactions between climate change and health. It also adequately sets the scope of the Project and provides adequate justification for the use of Government, SCCF and UNDP resources.

29. The Project design/formulation phase has been deeply analysed during the MTR. Therefore, it is not relevant to remake this work here but rather summarize the main findings and bring in any new elements collected during the TE. The information below has been structured according to UNDP/GEF guidelines.

3.1.1. Analysis of Results Framework/indicators

30. The Project Objective is to identify, implement, monitor, and evaluate adaptations to reduce current and likely future burdens of malaria, diarrhoeal diseases, and meningococcal meningitis. As stated in the MTR, this objective seems mostly appropriate given the starting point and the resources available to the Project.

31. The results framework defines three components, expected to result into three outcomes:

- Outcome 1: Improved national and local health technical sector capacity to plan for and manage climate change related alterations in the geographic range and/or incidence of climate-sensitive health outcomes, including malaria, diarrhoeal diseases and meningococcal meningitis
- Outcome 2: Mechanisms established for cross-sectoral coordination to support climate change-resilient health policy formulation and implementation at national and local policy-making levels.
- Outcome 3: 'Lessons learned' collected and knowledge management components established

32. Commenting on the initial results framework of the Project Document, the MTR found that the links between Outcomes and Outputs and the overall Objective are not sufficiently clear. Outcomes 1 and 2 both relate to types of capacity building - the distinction between them is not clear. There is no convincing argument that the outputs would lead to the Outcomes. It further states that some items seem to be missing from the logical framework.[5] Therefore, M&E design at entry is rated as 'Unsatisfactory'.[6]

33. Monitoring indicators from the Project Document were not effective for measuring progress and performance, nor were they SMART[7]. Indeed, as the analysis realised in the MTR shows (MTR Table 1. Assessment of Indicator Framework), several of the indicators do not satisfy the basic role of an indicator – they do not indicate the result they are supposed to. Several indicators do not appear particularly useful. Also, some aspects of the Project are not covered by any indicator.

[5] See MTR for further details, section II.1.2
[6] Over a 6pt rating scale: Highly Satisfactory (HS); Satisfactory (S); Moderately Satisfactory (MS); Moderately Unsatisfactory (MU); Unsatisfactory (U); Highly Unsatisfactory (HU).
[7] SMART – Specific, Measurable, Attainable, Realistic, Time-bound.

34. The Project Document provides some detailed guidance on the approach to monitoring, evaluation and reporting, including details of responsibilities, as well as a reasonable budget. This M&E plan is well-conceived and sufficiently budgeted to monitor results and track progress toward achieving objectives.

3.1.2. Assumptions and Risks

35. The Project Document also covers assumptions and risks. The section on Risks and Assumptions in Part 2 describes five assumptions and includes a table with ten risks. These risks are assessed as being low, medium and high. The Strategic Results framework has three assumptions and seven risks. So there are two sets of risks and assumption in the Project Document[8]. Although there is some correlation between these two sets of risks and assumptions, they are different in many ways and do not articulate properly.

36. Externalities, such as the effects of climate change, are captured in risk n°9: "Evaluation of the climate change risks resulting in the emergence of new strains of diseases, e.g. CSM." Other externalities, such as the effect of an economic crisis (or, as currently the case, low oil prices affecting Ghana budget), are not captured.

37. There is no indication how the assumptions and risks identified have helped to determine activities and planned outputs. The Project Document does not clarify either how the risks/assumptions are to be used in Project management or in the Project assurance.

3.1.3. Lessons from other relevant Projects (e.g., same focal area) incorporated into Project design

38. There is no strong evidence that planning documents have utilized lessons learned/recommendations from previous Projects as inputs to planning and defining the Project strategy. It was however mentioned during interviews that the initial choice to work with 3 demonstration districts is a result from the experience of the African Adaptation Programme, which ended in 2012 and was implemented by the Environmental Protection Agency (EPA).

39. The MTR also highlights that the Project Document places great emphases on the Project Inception period, and that is a lesson learned from previous UNDP/GEF Projects in many countries. In particular, given the lengthy period taken to identify, design, appraise and start-up GEF/LDCF Projects, it is necessary at Project Inception to review the Project approach and the Project strategies, and to ensure that all stakeholders are appropriately on board. There is some evidence however that this lessons was not properly applied to this Project.

3.1.4. Planned stakeholder participation

40. The main stakeholders identified in the Project Document are:

- The Ministry of Health (MOH) is responsible for all policy, planning and supervision of the health sector in Ghana. It is the National Implementation Partner for the Project and a key Project co-financer. Within MOH, the Research, Statistics and Information Management Directorate (RSIMD) has been nominated to lead Project implementation.
- The Ghana Health Service (GHS) is responsible for the implementation of policy in the health sector in Ghana. The GHS rolls out most health sector activities across the country. GHS has an operational network that reaches to local communities through the District and Regional offices. This provides a

[8] MTR, 2014

two-way mechanism for information exchange and learning between the grassroots and the GHS nationally. The GHS is supervised by MOH but does receive its operating budget directly from central government. At regional and district levels the GHS staff are also under the coordination of officers from the respective regional and district government.

- The Ministry of Environment, Science, Technology and Innovation (MESTI) is overall responsible for climate change in Ghana. Within MESTI, the Environment Protection Agency (EPA) is the UNFCCC focal point, responsible for all reporting on climate change and providing technical support to climate change mitigation and adaptation activities.
- UNDP, as GEF Agency, is ultimately responsible to the GEF for the successful implementation of this Project and playing a key role in management on the ground.

41. As was already the case during the MTR process, all concerned national stakeholders that were contacted confirmed that the process to prepare the Project was inclusive and participatory, and this is reflected in the Project Document. It included the participation of the various government departments (MOH, GHS and EPA), international partners (including WHO and Danida) and experts. As a result the Project Document includes an adequate analysis of the stakeholders.

42. However, it seems that Regional and District health sector workers were less involved during Project conception and design. An Annex to the Project Document provides the lists of stakeholders present at the consultation workshops and there is little representation of these stakeholders. Interviewees conducted tend to confirm that a large majority of people at the district level did not hear about the project before it actually started. However, the evaluator acknowledges that both of those evidences are weak: (i) People at district level may have been consulted outside the inception workshop, through other (and maybe informal) channels; (ii) most of the people met during the TE mission were not in place when the project was formulated; indeed turnover of staff in the districts revels quite high.

Photo 3. A community health centre in Keta district, managed by GHS.

3.1.5. Management arrangements

43. As exposed in the MTR, the Project Document covers management and implementation arrangements in Part 5. Annex 3 of the Project Document lists (in bullet point format) the key responsibilities of the Project steering committee, Project manager and programme associate.

44. The Project Document details the Project implementation arrangements as follows:

- The (UNDP/GEF) Regional Coordination Unit (RCU) provides technical guidance and shares experiences from similar Projects in Africa;
- The UNDP Country Office provides oversight to ensure programmer/Project assurance;
- The Ministry of Health (MOH) executes the Project;
- A Project Steering Committee (PSC), chaired by MOH, makes key decision and provides guidance and supports coordination;
- The Project Manager is responsible for the day to day management of the Project.

45. As concluded by the MTR, overall these arrangements are appropriate. However, there is no clarification of the role of the Project Management Team (PMT) (then the Project Implementation Unit (PIU)), in particular with respect to the PSC and to the Project Manager. Moreover there is no official record of the approval of the Inception Report (by the PSC) - hence there is no clear formal basis for the PMT.

46. Part 5 of the Project Document is generally clear and appropriate. It sets out the basic elements of the Project management/ implementation framework. However, it is less than one page in length, and so it provides very little detail on management/implementation arrangements. These are not elaborated further in any Annex. As a result, the Project Document does not clarify (and does not refer to any other document that would provide this information):

- The details of the process to prepare annual work plans, to prepare quarterly work plans, to prepare TOR for inputs/activities during the Project and to approve Project outputs;
- The roles and relationships vis-à-vis the district level activities;
- The financial modality to be used and whether UNDP or Government procedures shall be used;
- The role of the GHS and the rationale of choosing the MOH as the executing agency;
- The details of the allocation of roles between UNDP, MOH and the Steering Committee, nor the details of the allocation of roles within the various departments of MOH, including GHS.[9]

47. As this Project was considered to be innovative, and was the first Project under the UNDP sustainable development cluster with the MOH, and incorporated important partnerships (co-financers), we concur with the MTR saying that it seems neglectful to not provide full detail of the management/implementation framework, or to explain how and when these details will be developed.

48. Interviews repeatedly exposed a recurring challenge on the respective responsibilities of the MOH and GHS, which has negatively impacted the Project execution and Project ownership. The fact that the MOH took full responsibility of the implementation of the Project, while at the same time relying on GHS district-level services, thus by-passing national and regional level GHS services, has not been well understood and has created some confusion and delays during the Project inception period.

49. Whereas the key roles and responsibilities of the Project Steering Committee (PSC) are describe in annex 3 of the Project Document, this description is very short and lacks details on how it coordinates the role of the different Project partners, the work of the Project Implementation Unit (PIU) and who is the pilot. The PSC could have involved a wider range of stakeholders as well, including other line ministries, development partners and NGOs.

[9] Source: MTR

50. Interviewees revealed that the PSC was not really functional at the beginning of the Project. This is supported by the small number of PSC meetings over the project duration, as illustrated in the table below:

Table 2. Dates of workshops and PSC meetings

Event	Date of occurrence
Inception Workshop	29 September 2011
Inception report	December 2012
PCS 1	20 February, 2013
PCS 2	16 May 2013
PCS 3	20 June 2013.
PCS 4	12 March 2014
PCS 5	29 May 2015

51. From the above, we can see that:

- The inception workshop was organised right after project official start;
- But it took one year to finalise the inception period (inception report dated December 2012);
- Then, the first PSC meeting was only organised in February 2013, that is 1.5 year after the inception workshop;
- A total of 5 PSC meetings have been organised over the 4 years of the project, including 3 meetings between February and June 2013.

52. After the MTR, a Technical Advisory Committee (TAC) has been put in place in order to technically pilot activities, keeping the more strategic decisions to the PSC level. From the general opinion, the TAC has done a great job and TAC members were very visible in Project implementation. This really strengthened the Project in being able to articulate priority issues more clearly.

53. The TAC somehow replaced the functions of the Project Manager. Indeed, the PIU initially consisted of the Director of RSIMD, the Project Manager and the Project Associate. The latter two were employed by UNDP and based at GHS, which offered offices. When the Project Manager resigned mid-2014, the decision was not to replace him and rather ensure Project piloting with the Project Director and assistant, in close coordination with the TAC.

54. Interviewees also suggested that the focus of the Project, when formulated, on 3 diseases was not really appropriate, as those 3 diseases constitute only a small fraction of the climate change problem in the health sector. Some people saw the Project rather as a means to strengthen the health system generally, so there has been a challenge then in implementation, in articulating those two different approaches.

3.1.6. Replication approach

55. The Project Document proposes a section 'Sustainability and replicability' in Part2. However, it does not provide any indication on how lessons and experiences may be replicated in different geographic areas, or replicated within the same areas but funded by other sources. Indications such as knowledge transfer or expansion of pilot Projects are missing. Nevertheless, it does insist on capacity building activities, a key aspect of replicability, but does not link it to replicability in e.g. other districts of the country. Instead, it makes the link to replicability into other regions of the world through the Adaptation Learning Mechanism and the regional component of the Africa Adaptation Programme.

56. Another mention of replicability stands in the Summary of Baseline and Adaptation Alternative section of the Project Document, it is stated that activities under Project outcome 2 "will demonstrate the effectiveness of integrating climate risks and thus serve as models for replication."

57. Overall, the replication approach is considered very weak as it does not foresee how the Project lessons and experiences can (or should?) be replicated.

3.1.7. UNDP comparative advantage

58. This analysis was fully covered in the MTR, which concludes that UNDP masters most of the skills and competences required for this Project to a satisfactory level. It is unlikely that there is another agency that covers the required range more effectively than UNDP.

59. However, it is also clear that UNDP does not master all the required skills and competences to the required level. For those areas where Project Document, a partnership with WHO is indicated. However, this partnership has not become fully operational. This is unfortunate because WHO could have compensated for some of UNDP's insufficiencies.

3.1.8. Linkages between Project and other interventions within the sector

60. Part 2 of the Project Document includes a section on "Linkages with other initiatives and leveraging existing programmes in Ghana". However, this section (only 5 lines) is limited to the intention of the Project to promote better linkages with existing initiatives and programmes in Ghana. It does not provide any examples of other programmes or interventions from the government and development partners to which the Project will closely link. Rather, it expedites this strategic thinking to the inception phase of the Project. This aspect is not dealt with in the inception report however.

61. As was already concluded in the Project mid-term review, the Project conceptualization and design process was overall good and participatory. However, a number of weaknesses appear: first, the lengthiness of the design phase (over three years to prepare and finalize the PIF document and then almost a further two years to finalize the Project Document and start the Project) is unacceptably long. Second, too little attention was given to operational matters or to the Project implementation framework. Third, the amount of effort given to mobilizing co-financing - although ultimately over $50 million was mobilized, this mobilization did not tangibly contribute to the design of the Project. Some of those weaknesses could, and should, have been addressed, probably during the inception period, which would have possibly avoided the many implementation issues met by the Project.

3.2. Project implementation

Project implementation has been challenging over the Project duration, with many issues faced since the start in 2011. A great number of activities had in fact been implemented after the MTR, a moment when Project closure was considered due to the poor results achieved, in 2014 and 2015. This section deals with different aspects of the Project implementation.

3.2.1. Adaptive management

62. The Project Management Review conducted in 2013 came as a response to the "need for clarification and rationalization of the relative scope of responsibilities (MOH, GHS, PMU and UNDP) as well as the reporting responsibilities and accountabilities"[10]. This initiative from UNDP, in consultation with MOH and other partners, came as a management response to some of the institutional issues and challenges met by the Project. However, most of the recommendations in this review have not been fully implemented and monitored, for various likely reasons, among which:

    - Holding PSC meetings quarterly (recommendation n°1 of the Project review) seems to have been very difficult along the entire project duration, mostly due to PSC members' availability and commitment;
    - The project director accepted the principle of this Project review, but did not really agree with it, which has probably impacted on the implementation of its recommendations;
    - There is no record of the ToR for this Review being assessed and/or approved by the PSC. There is no record of the final report, or of its recommendations, being reviewed and/or approved by the PSC, although it was referred to in the PSC meeting of February 2013. A formal review and approval of both the TOR and of the final report for such an important initiative would have been essential.

63. Most of the stakeholders interviewed consider however that the Review has contributed to improving implementation, but not so significantly.

64. One of the conclusions of the MTR is: "if, within twelve weeks, the Project is not confirmed to be firmly on track by MOH, GHS and UNDP at the ***highest*** level, the immediate closing of this Project should be considered". Given the critical situation of the Project at the time of the MTR, the MTR sets out 16 unusually prescriptive recommendations in chronological order.

65. Table 12 in Annex 10 provides a brief overview of how MTR recommendations have been implemented or not. For most of them, implementation has not occurred, or at least there is no evidence of implementation. Whereas one may argue that some of those recommendations were not appropriate, the lack of follow-up on these recommendations, absence of reporting on any formal discussions regarding those recommendations, gives the impression of a low consideration given to the MTR conclusions.

66. Produced end of April 2014, that is 3 months after the MTR report was released, the UNDP management response to the MTR synthesizes the 16 MTR recommendations into 5 main 'issues', and provides a number of key actions and comments. It considers some activities as 'completed', others are to be done. Among those, some do not seem to have been completed later on in the project (e.g. "3.3 Preparation of a comprehensive document on the climate-health nexus in Ghana"). Others, 'completed', have not been effective or at least their implementation is not documented (e.g. 'Project team agreed to a monthly reporting and review meetings' has not been translated into regular monthly reports). Overall, the UNDP management response is not very convincing. In addition, this document does not seem to have been subject to any further follow-up, and there is no indication of any proper follow-up of MTR recommendations by the PMU and the PSC themselves.

67. Therefore, we can conclude that although alarming, the MTR recommendations were not properly implemented, at least for most of them, and the proposed management response to the MTR report, elaborated by UNDP, is rather weak. In the PSC meeting immediately after the MTR report/was delivered (dated 12 March 2014), no comments to the MTR report were made, whereas a major task of this PSC was to actually organise a point-by-point response through a work plan to put the Project back on track. It was reported to the TE consultant that a technical meeting was organized between UNDP and the MOH to

[10] 'Report on Review of Project Management Arrangements and Structure", dated April 2013.

discuss on how to respond to the comments and recommendations of the MTR and the changes in the project management and logframe. However, there is no proper record of the discussions held during the meeting, nor any follow-up of the MTR recommendations in subsequent PSC/TAC meetings.

68. During this PSC meeting, a change of significant importance was decided however in proposing to set-up a Technical Advisory Committee (TAC)[11] to support activity implementation. The rationale of this decision is not exposed in the minutes of the PSC meetings, but this decision was influenced by the MTR and interviews suggest that the idea was to better use the technical expertise of local institutions, favouring stronger collaboration on the Project and providing better technical guidance to the Project. From the information collected, it seems that the TAC also came as a palliative to a rather inactive PSC.

69. Regarding the activities, outputs and outcomes of the Project, modifications have occurred but they are not clearly captured in the documents and minutes collected for this TE. From the interviews, the most important change seems to be the funding of 3 teleconsultation centres in the 3 pilot districts. This activity was not initially foreseen in the Project Document, and became one of the flagship interventions in the Project. During implementation, and in particular during a field visit to pilot districts of PSC members, at a time when some communities had been cut off from health facilities for weeks due to floods, the importance of communication has become obvious. Given some links between the MOH and the Novartis foundation on the Millennium Village initiative, which tested teleconsultations as a means to improve health services, it was decided to extend the test to the 3 pilot districts of the Project. Therefore, the Project first funded a large number of mobile phones loaded with credit for distribution to community health workers, and the equipment for 3 teleconsultation centres (phones, computers, etc.). Cooperation has been established with the Millennium Village Project so that they deliver training to selected health staff who will run the teleconsultation centres. This is a major adaptation of the Project to a need that had not been captured at Project design. The initiative has been successful, a short documentary from CCTV has been realized in Keta.

70. Another change illustrating adaptive management is discussed in the PSC minutes in March 2014. It relates to output 1.1 of the Project Document: "A national climate change and health inter-ministerial committee is established that includes key representatives from relevant programmes in Ghana". It is explained that the formation of the inter-ministerial committee needs to wait until post Project because certain structures need to be in place to facilitate the work of the committee. It was then decided that the Project would support the consultation process that will lead to the formation of the inter-ministerial committee.

71. **Overall, there is evidence that adaptive management has occurred during Project implementation, which contributed to some of the Project successes.** However, there is little evidence that those decisions were taken based on a formal discussion and approval by the PSC, although some of the changes made have been approved through annual work plans and were therefore implemented without waiting for the next PSC meetings[12]. The poor quality of PSC minutes may also explain this lack of evidence. In addition, the management response and follow-up of the recommendations made by (i) the 2013 Project Management Review, and (ii) the MTR is non-existent or weak. Those two documents were major inputs to Project management and one can regret the rather low consideration they have been given in the end, which gives an impression of low commitment from the main stakeholders, starting with the MOH.

[11] Proposed membership includes representatives from MoH (1/ Policy, Planning, Monitoring and Evaluation; 2/ Research Statistics and information management); GHS (1/ Planning, Monitoring and Evaluation; 2/ Disease Control; 3/Occupation Health and Environment); WHO; UNDP; PIU; EPA.

[12] The little number of PSC meetings organized over the project duration (5 in total) is a major failure of this project. Whereas one can understand the need for a quick management decision during implementation, there are ways to get some sort of approval. In addition, such need constitute a good reason for organizing more regular PSC meetings.

3.2.2. Partnership arrangements and stakeholders' engagement

72. Whereas a large number of background studies were implemented at the national level, most of the Project activities actually focused on the three pilot sites selected. In each of the pilot sites, various partners were involved:

- The district health services (local branch of GHS)
- The district hospitals
- The various community health centres, which are part of district health offices
- The district councils planning services
- The environment services
- The Agriculture/forest services
- The Education services

73. In each district, an Interagency Coordination Committee (ICC) has been put in place at the District Assembly in order to pilot Project activities in the district and ensure the wide contribution of all concerned sectors: health, environment, agriculture, district planning, education, disaster management. Although meetings of these committees have not been very regular in some districts and their role could certainly have been better played, interviews conducted and the minutes of meetings demonstrate a high commitment from the various representatives and an overall good collaboration on Project activities (e.g. information campaigns on climate change and health in schools, tree planting activities together with the agricultural services, etc.). A regret expressed during interviews is that district assemblies could have been more involved: they have duly been informed of the Project but they did not have their own work plan with regard to this Project. However, this would have required specific funding that was not available in the project budget.

74. Collaboration at the regional level appears to be much weaker. Apart from Bongo district, which has clearly collaborated with its regional services (Upper East Region) on some activities (in particular the teleconsultation centre), there are no real examples of an involvement of the regional level health (and other) services in the Project implementation. The role played by the Project focal persons in the three regions is unclear and is not documented.

75. Non-Governmental Organizations (NGOs) have been rarely associated to the Project. There is no significant example of cooperation developed with national or local NGOs, apart some interventions mentioned in the Bongo district for awareness creation. One argument is that NGO involvement requires some funds, but there could have been some discussion and technical exchanges with NGOS already involved in the health sector, or in sectors relating to the Project activities (e.g. education, tree planting, etc.) to make sure the work is coordinated and key messages are appropriately disseminated.

76. Cooperation with other national/international initiatives has occurred, although at a limited scale. In Keta district, were the Korean International Cooperation Agency (KOIKA) interventions in the health sector. The already mentioned cooperation with the Millennium village Project (Novartis foundation) on teleconsultations is another example.

77. Local communities were involved through the various information campaigns organized, the health volunteers in each community, and the work with school children. Training have targeted specific categories, in particular hair dressers (because they speak a lot and can relay hygiene messages!), teachers, traders, people who clean the communities (e.g. collect garbage) and other people with a direct impact on hygiene.

78. Outreach and public awareness campaigns were organized in the three districts. Numerous posters and flyers have been widely disseminated and demonstrations, radio programmes, and other awareness raising activities were conducted.

Photo 4. Campaign with school children (holding one of the Project posters) in Apam

79. Interviews revealed that collaboration with other government ministries was not very visible. Steps were taken to involve the EPA but its involvement has remained limited. Collaboration with other sectors has been rather poor at the national level. This could have been improved thanks to a PSC gathering institutions from more sectors (e.g. including representatives from the ministries of agriculture/forest and education)[13]. At the district level however, inter-sectoral collaboration seems to have been much stronger.

80. The inception report mentions that "a number of different institutions will assume various roles and responsibilities within the project". These are summarized below:

- Ministry of Health (MOH): project implementation
- Ghana Health Service (GHS): project implementation
- United Nations Development Programme (UNDP): implementation oversight to ensure programme/project assurance
- World Health Organization (WHO): technical backstopping
- Danida: Technical advisory role
- Dfid: Technical advisory role
- Universities and Research Institutions: Provide research support
- Others: other partners are likely to International Red Cross, International Red Crescent, National Disaster Management Organization (NADMO)

81. However, there is no indication of what the roles and responsibilities of each institution are, nor of the arrangements that should be put in place to actually activate cooperation between those institutions. Being part of the PSC could have been an option, but curiously, the PSC membership has remained limited to a small number of institutions directly involved in the Project.

82. **Overall, the Project has involved and used the skills of a variety of stakeholders, although primarily governmental (at both national and district level). A strength has been to involve the various sectors at the district level; this aspect does not appear so clearly at the regional and national levels however**. Another possible weakness revealed during the interviews is the excessive use of international expertise –

[13] The SC members belonged to MOH, UNDP, GHS, WHO and EPA only.

mostly due to procurement and administrative procedures in place - when such expertise would be present in country, in particular within government institutions. This can hardly be verified however.

3.2.3. Project Finance

83. This section has been prepared on the basis of the figures provided in the Project Document, in the MTR, and accounts from UNDP. Table 4 provides a summary of planned and actual expenditures over the Project duration. Two successive no-cost extensions have resulted in a Project spanning from 2011 to 2015, explaining the '0' planned expenditures in 2014 and 2015.

84. At the end of the Project, GEF SCCF funds disbursed total US$1,587,380, which is 92% of the initial budget. UNDP grant totalled US$268,171, which is 134% of initially planned contribution. EPA grant stands at 0, but the initial rationale of this grant, as presented in the Project Document, remains unclear, as it was not possible to get any information on the initial intentions of EPA in this regard. It seems that EPA contribution was rather seen as an in-kind contribution, and not a grant in fact. This in-kind contribution has not been estimated but could be rather substantial given EPA active role in mainstreaming climate change in Ghana.

85. Overall, SCCF financing has been rather well disbursed. UNDP co-financing is significant, and demonstrates the efforts done by the country office in having the Project delivered. This is particularly true for years 2014 and 2015, with a regular and significant increase in UNDP CO disbursements, as shows Figure 1.

86. Expenditure per Project outcome (Figure 2 and Table 3) is globally in line with the initial plan. A bit less has been spend on outcome 2 and more (from 5 to 8%) on Project management. Given the longer duration of the assignment, this increase in Project management expenditures seems reasonable.

Table 3. Planned and actual distribution of funds per Project outcome (in % of total expenditures)

	Project Document plan	Actual distribution
Outcome 1	32%	33%
Outcome 2	50%	43%
Outcome 3	13%	15%
Project Management	5%	8%

87. In the context of the GEF, co-financing has a very specific definition. It first and foremost refers to the financing associated with the baseline Project and any non-GEF financing associated with the incremental Project, committed as part of the initial financing package.[14] Apart from EPA and UNDP grant, all of the other co-financing sources were planned to be 'in-kind'. It is not always clear however how the level of these planned co-financing sources has been assessed at Project design phase.

88. The MOH co-financing has been estimated at US$2,117,646 in the Prodoc, based on the MoH budgets for the years covered. It has not been possible to verify actual figures during the evaluation mission, but given that the Project's duration has been extended to almost 5 years, it is very probable that the amount of co-financing estimated in the Project Document has been reached, considering the important contribution of the MOH to the baseline situation.

[14] Guidelines for Project Financing, GEF Council Meeting November 8-10, 2011 Washington, D.C.

89. The in-kind contribution of the UNDP Ghana Africa Adaptation Programme (AAP) Project was planned at US$300,000. There is no indication in the Project Document how this level was calculated. The AAP Project had a total budget of US$2,760,657. The main objective of AAP Ghana "was to ensure that Ghana has strengthened leadership skills, broadened and improved institutional capacity and financing mechanisms for addressing climate risks, and has demonstrated positive impacts in linking disaster risk reduction and climate change through the implementation of early warning systems"[15]. The health sector is part of various outputs of APP and the Keta district is one of the 5 districts selected by AAP. Therefore, it can be assumed that the AAP Project has contributed to strengthening the integration of climate change at all levels of national and district policies and programmes. It is very difficult to assess the level of this contribution, but the figure of US$300,000 does not seem unrealistic.

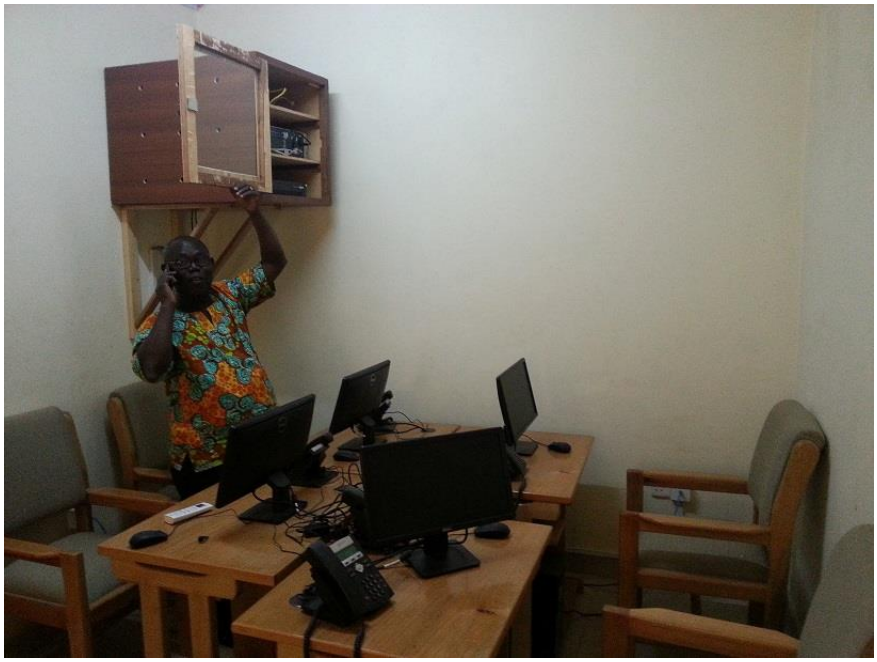
90. Danida support to the Ghanaian health sector is substantial and dates back to the mid-90s. In 2012, Danida's support to the health sector has entered its fifth and final phase, with a total budget of DKK 400 million (Approx. US$60 million) over five years (i.e. US$12 million per year). The support is in line with the National Health Policy and the Health Sector Medium Term Development Plan[16].This support clearly contributes to the baseline of the Project. The Project Document estimated that total co-financing would reach US$51,229,500. Considering years 2012 to 2015, we estimate the actual co-financing to US$48 million. Unfortunately, it has not been possible to meet with Danida in Accra to confirm those figures.

91. WHO support to the baseline situation of the Project is rather obvious given WHO activities in Ghana. Over the period 2011-2015, WHO has several million dollars per year in the Ghanaian health sector. There is no indication in the Project Document how the amount of US$986,000 has been assessed, but it is most probably on the lower range of the actual contribution of WHO to the baseline situation as well as to the incremental Project, through its support to the Health National Adaptation Plan (HNAP) and collaboration to the Health and Environment Strategic Alliance (HESA) Committee.

92. Other co-financing sources have been leverage during the Project duration, with contributions from (i) the Millennium village Project (funded by the Novartis Foundation), which has supported, and continues to support through trainings, the establishment of teleconsultation centres in the 3 districts; and (ii) KOIKA in the Keta district. It has not been possible, however, to obtained an estimate of the value of those additional co-financing.

[15] Africa Adaptation Programme on climate change Ghana final project review report, January 2013
[16] http://ghana.um.dk/en/danida-en/health-sector/

Photo 5. The teleconsultation centre in Apam, Gomoa West district



93. **Overall, the total Project budget, including co-financing, is estimate at US$53,259,197, a bit below the Project Document estimate (US$57,401,328). Given the GEF SSCF and UNDP actual disbursements and the uncertainty in assessing the actual level of co-financing, the final Project budget can be considered as in line with the initial plan.**

94. **Although the mentioned co-financing are actual, it can be regretted that technical collaboration between the Project and those co-financiers has been very limited (WHO, AAP, Danida) and that synergies have not been sought for more systematically.**

Table 4. Project financial delivery status

	2011		2012		2013		2014		2015		TOTAL	
	Plan[17]	Actual[18]	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Total GEF	583,828	43,699	585,827	518,407	548,527	364,410	0	324,063	0	336,800	1,718,182	1,587,380
Co-financiers:												
Total UNDP	88,000	44,807	56,000	12,714	56,000	45,759	0	74,627	0	90,264	200,000	268,171
MOH*											2,117,646	2,117,646
EPA											850,000	0
UNDP AAP*											300,000	300,000
DANIDA*											51,229,500	48,000,000
WHO*											986,000	986,000
TOTAL co-financing											55,683,146	50,685,817
TOTAL Project											57,401,328	52,273,197

*in-kind co-financing

[17] Planned amounts based on figures provided in the Project Document.
[18] Actual amounts, for GEF and UNDP CO, based on figures provided by UNDP CO as of 19 January 2016

Figure 1. GEF SSCF and UNDP CO expenditure per year

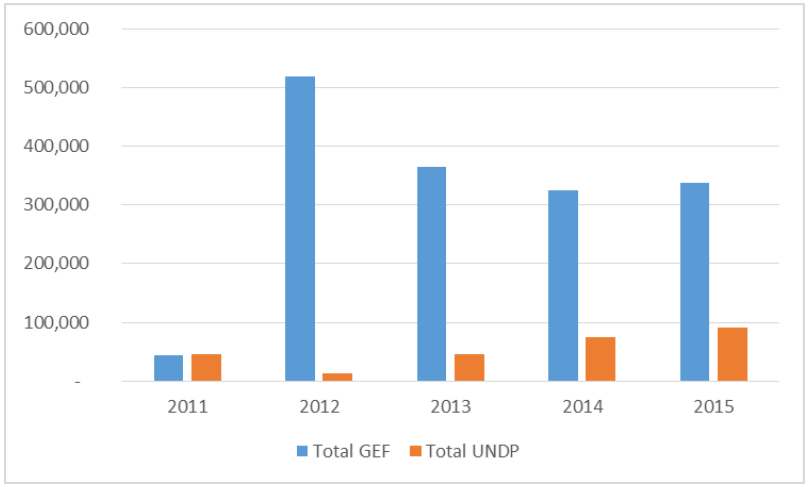


Figure 2. Actual expenditures per Project outcome

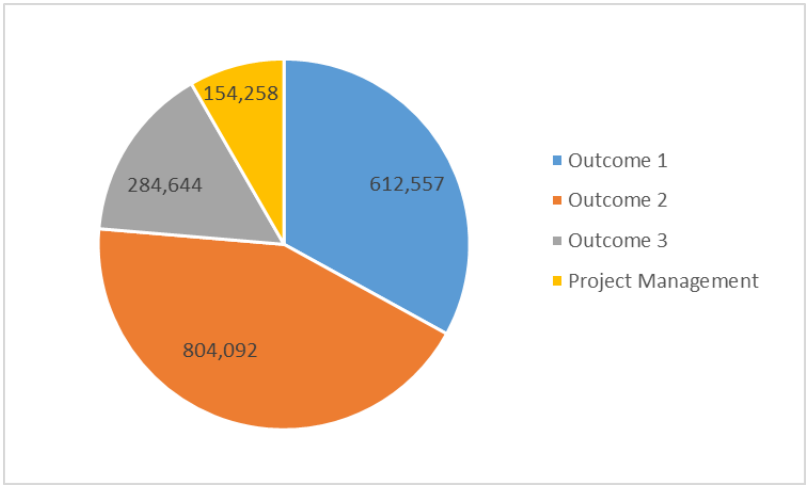


Table 5. Co-financing estimates as per UNDP/GEF format

Co-financing (type/source)	IA own financing (mUS$)		Government (mUS$)		Other sources (mUS$)*		Total financing (mUS$)		Total disbursemnet (mUS$)	
	Proposed	Actual	Proposed	Actual	Proposed	Actual	Proposed	Actual	Proposed	Actual
Grant	200,000	268,171	850,000	0			1,050,000	268,171	1,050,000	268,171
Credits							0	0	0	0
Equity							0	0	0	0
In-kind	300,000	300,000	2,117,646	2,117,646	52,215,500	52,215,500	54,633,146	54,633,146	54,633,146	54,633,146
Non-grant Instruments**							0	0	0	0
Other Types							0	0	0	0
Total	**500,000**	**568,171**	**2,967,646**	**2,117,646**	**52,215,500**	**52,215,500**	**55,683,146**	**54,901,317**	**55,683,146**	**54,901,317**

3.2.4. Monitoring and evaluation

95. There is no evidence that the M&E framework was actually used during implementation as a management tool. Data has not been collected systematically to inform indicators and many files have been lost when the Project manager resigned (computer apparently crashed and documents were lost with no back-up). The UNDP had 5 different Project officers to follow the Project over its entire duration, which has also resulted in losses of information. Given this turnover, the regular use of the logical framework as a management tool would have certainly enhanced the quality of Project management.

96. Effectiveness of monitoring indicators and M&E plan budget are dealt with in section 3.1.1.

97. Quarterly reports are available. However, they are very concise and do not report on the results achieved nor on the indicators of the logical framework.

98. A rather well built "end-of Project report" has been compiled. It provides a detailed summary of the Project achievements. We regret the lack of reference to the results framework itself however.

99. Annual Project Review/Project Implementation Reports (APR/PIR) are key reports to monitor progress made since Project start and in particular for the previous reporting period. The APR/PIR combines both UNDP and GEF's annual reporting requirements. A Project Implementation Review (PIR) document has been compiled annually. Those documents report on the level of achievement of the different outcomes of the Project, which is good. However, neither the quarterly nor the annual reports use the indicators from the Project Document or any other indicators to follow the Project

100. A Mid-Term Review report has been produced early 2014. The quality of this review is very good. The management response document from UNDP details a number of activities aimed at implementing the recommendations of the MTR. However, as already exposed in section 3.2.1, the proposed responses generally seem a bit weak, and some of them have not been implemented (e.g. "the PSC shall meet regularly": only 2 PSD were organised between January 2014 and the end of the Project in 2015).

101. There is no evidence of discussions on M&E reports with stakeholders and Project staff (not even in PSC meetings minutes), with the exception of the MTR but no comments were reported. Therefore there is no evidence of feedback from M&E activities to be used for adaptive management (see section 3.2.1 on management response to MTR).

102. Overall, monitoring and evaluation has been rather poorly implemented over the Project duration, and is therefore rated as 'Moderately Unsatisfactory'[19]. As already highlighted in the MTR, the Project lacks a standard, formal monitoring system – through which systematic reports are submitted to high level Project management and used as a basis for decision-making. There is a strong case here for a recommendation on training UNDP and Project staff to M&E, its use in GEF Projects and how it supports Project management.

[19] Over a 6pt rating scale: Highly Satisfactory (HS); Satisfactory (S); Moderately Satisfactory (MS); Moderately Unsatisfactory (MU); Unsatisfactory (U); Highly Unsatisfactory (HU).

3.2.5. Implementing Agency (IA) and Executing Agency (EA) execution, coordination, and operational issues

103. UNDP CO is the IA and the MOH is the EA. MOH has been chosen as the EA from the Project formulation phase. The perceived suitability and relevance of the choice of the MOH as the EA of the Project differs between people. Two main positions on this initial choice appeared during the evaluation mission:

- The MOH is in charge of research in the health sector, and this Project was considered a research pilot aimed to inform policy making. In this sense, the MOH is the suitable EA.
- The MOH is a policy institution, and Project execution must be devoted to its implementing arm, namely GHS, both at national and regional/district levels.

104. As stated in the end of Project report, "the Project had major challenges with cleared defined roles and responsibilities for the major stakeholders; UNDP, Ministry of Health, Ghana Health Service at the national level and regional and district health administrations at the sub national level.(…) Though some discussions had taken place between some representatives of the stakeholders mentioned above, there was a challenge on understanding each other's role"

105. Regrettably, incomprehension around this issue of the role of those two main Project partners created a lot of frustration and delays in Project execution. A lesson to be learned from this experience is the need to set-up a very clear management structure, that is shared by all, from Project formulation, and make sure it is reconfirmed at Project inception.

106. Staff resources placed by MOH as EA seem to have been mostly limited to the full engagement of the Project Director. Staff resources from UNDP are more difficult to assess given the important turnover in the Project officers in charge over the Project duration.

107. Testimonies on the initial capacities of the EA and the IA have been collected during the evaluation mission. Some examples are:

- Within the Ghanaian health sector, climate change was new to many and people had to first understand the issue.
- UNDP and MOH had not worked together before, and a common understanding of the planned activities, the institutions' respective administrative and financial management (including procurement) procedures, and respective expectations, were lacking.
- At Project start, UNDP was not conversant with arrangements within the health sector and lacked capacities.
- The internal capacities of the UNDP country office were not sufficient.
- Interviewees conclude that those issues constituted a major source of delays in Project execution.

108. However, it is also recognised that guidance from UNDP has been effective as regards Project expenditures, deliverables, time-span, and application of fiduciary rules and procedures.

109. Overall, it is clear that the actual role of UNDP CO in the Project has not been well understood by all, especially in the context of a NEX [20] Project. A lesson from this experience is that contractual, administrative and procurement procedures, as well as the respective roles and responsibilities of the IA

[20] UNDP National Execution modality

and the EA need to be well clarified from Project start in order to avoid unnecessary frustrations and delays in Project execution. The quality of UNDP implementation is rated as 'Moderately Unsatisfactory'[21].

110. At Project start, a management team was put in place, including the Project Director from MOH, a Project Manager and a Project Assistant. The latter two were employed by UNDP and located in GHS offices. It has been mentioned to the evaluator that the capacities of the Project Manager and Assistant needed to be raised at Project start, particularly regarding climate change.

111. When the Project manager resigned, it was decided that the Project Director would coordinate activities with the assistance from the Project Assistant. The efforts of the Project Assistant to catch the interest of all concerned stakeholders and to keep everyone informed on a regular and timely basis are widely applauded.

112. The scarce use of M&E tools, poor quality of minutes of PSC meetings, absence of TAC meeting minutes, very limited contents of quarterly reports, unclear roles and links between some of the studies produced as stated in the MTR, all contribute to a general impression of lack of formality in the way the EA executed the Project and limited planning and coordination capacities. The quality of execution of the EA is therefore rated 'Moderately Unsatisfactory'[22].

[21] Over a 6pt rating scale: Highly Satisfactory (HS); Satisfactory (S); Moderately Satisfactory (MS); Moderately Unsatisfactory (MU); Unsatisfactory (U); Highly Unsatisfactory (HU).
[22] Over a 6pt rating scale: Highly Satisfactory (HS); Satisfactory (S); Moderately Satisfactory (MS); Moderately Unsatisfactory (MU); Unsatisfactory (U); Highly Unsatisfactory (HU).

3.3. Project results

3.3.1. Relevance

114. The MTR has confirmed the relevance of the three Project outcomes in terms of increasing resilience in the health sector and so to adapting to climate change. The entire Project is oriented towards increasing resilience to climate events and their consequences (e.g. floods), through strengthened disease surveillance systems and capacity building. In this sense, the Project is highly relevant to the GEF climate change focal area. It should be noted that in 2010, this Project was one of the first of the kind dealing with health related impacts of climate change.

Photo 6. Flooding in Apam after a "light" rain

115. *Ghana Shared Growth and Development Agenda* (GSGDA), 2010-2013[23] places health as one of the 5 priority sector and specifically mentions the need to minimize climate change impacts on human health through improved access to healthcare. In line with this guiding document, Focus Area 6 of the *National Climate Change Policy* aims to "Address Impacts of Climate Change on Human Health". By raising awareness on climate change and health relationships and reinforcing disease surveillance systems, this Project supports the environment and sustainable development objectives of Ghana.

116. The Project is country driven: it has been executed by the GoG and national institutions have taken full leadership. One can regret the lack of engagement, or low ownership, of some institutional stakeholders such as EPA and other sector institutions, but this is mostly a result of inappropriate governance and management of the Project, as mentioned earlier.

[23] Medium-term national development policy framework. Government of Ghana National development planning commission (NDPC), September 7, 2010

117. Target beneficiaries at the district and regional levels are the local health services on the one hand, and local communities (final beneficiaries) on the other hand. In the three pilot districts, the TE mission and interviews confirmed the relevance of the support provided, and provided numerous examples of how local communities have benefitted from the interventions.

118. Major donor support to the health sector in Ghana is provided by Danida and WHO. The support from the Danish cooperation focuses on primary health care interventions aimed at the poor and most vulnerable people. The overall aim of the Danish support to the Ghanaian health sector is to contribute to poverty reduction and to the achievement of the Millennium Development Goals (MDGs). The programme is aligned to Ghana's poverty reduction strategy, which emphasizes the health sector as essential to socio-economic development by providing affordable quality primary health care to the Ghanaian population[24].

119. WHO Country Cooperation Strategic Agenda (2008-2013) defines 4 strategic priorities[25]:

- STRATEGIC PRIORITY 1: Contribute to the scale up of interventions to achieve the health related Millennium Development Goals;
- STRATEGIC PRIORITY 2: Intensify efforts to prevent and control communicable and non-communicable diseases
- STRATEGIC PRIORITY 3: Contribute to health system strengthening with a focus on primary health care
- STRATEGIC PRIORITY 4: Contribute to action on the social determinants of health

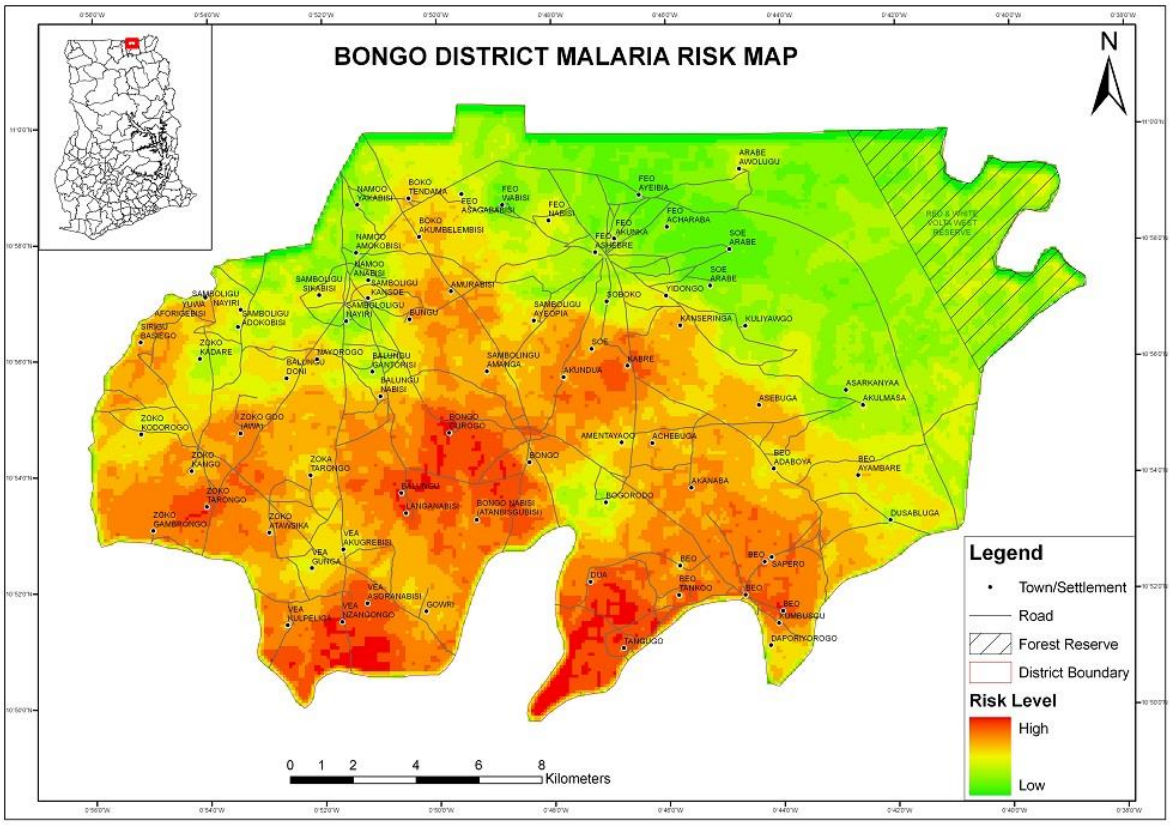
120. None of these programmes specifically address climate change impacts on health. Therefore, the Project has helped to fill a gap by addressing climate change vulnerability of the health sector in Ghana. It has highlighted the link between climate change patterns and health issues, in particular the need to increase resilience of the health system to climate extreme events (e.g. by developing teleconsultation centres providing health advice to communities isolated by flood events). Overall, the project is rated as 'Relevant[26]' and this relevance is rated as 'Highly Satisfactory'[27].

3.3.2. Effectiveness

121. Table 10 in Annex 8 provides a detailed assessment of the progress made toward the different outputs of the Project, at MTR and TE stages respectively. The analysis shows that outputs under component 1 were mostly achieved, but that in most cases achievements of the Project need to be reinforced, sustained and replicated. The MOH and GHS, together with sectoral partners such as EPA and others, have an active role to play in this regard. The same happens under component 2: the set Project outputs are mostly achieved, but further action needs to be taken with no delays in order to build on Project achievements and sustain and expand its gains. Outputs under component 3 show a lower level of achievement, with a number of challenges remains, as for example the need to ensure and maintain a proper integration of data on climate change-related risks from surveillance systems into health information management systems, at district, regional and national levels (output 3.1). The extension of pilot risk maps to other districts and regions of Ghana has also not occurred yet (see example on figure below).

[24] http://ghana.um.dk/en/danida-en/health-sector/
[25] http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_gha_en.pdf?ua=1
[26] On a 2-point Relevant/ Not Relevant scale
[27] Over a 6pt rating scale: Highly Satisfactory (HS); Satisfactory (S); Moderately Satisfactory (MS); Moderately Unsatisfactory (MU); Unsatisfactory (U); Highly Unsatisfactory (HU).

Figure 3. Bongo Malaria risk map



122. Table 11 in Annex 9 show the level of achievement of Project outcomes:

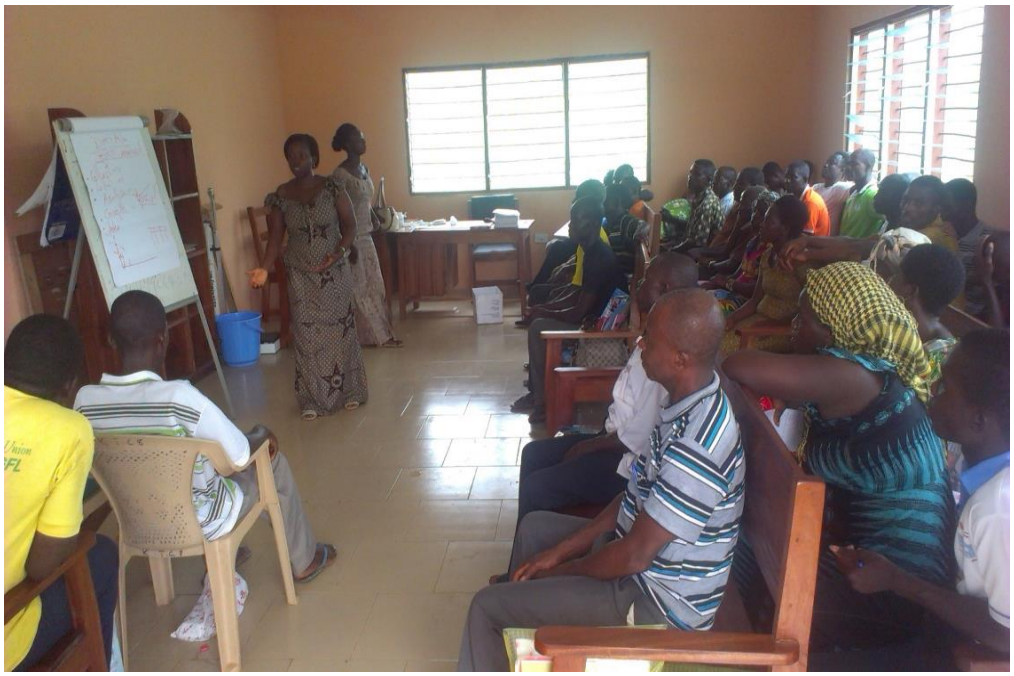
- Achievement of the Project objective is rated 'Moderately Satisfactory'[28]: The Project objective has been partially reached. Adaptation options to reduced vulnerability to climate change have been identified, implemented and monitored in the three pilot districts. More work is however necessary to reinforce the Project gains, ensure they are sustainable and replicate them to other districts and at the regional level.
- Outcome 1 is rated 'Moderately Satisfactory': Capacities at national and local level are definitely improved, but more could have been expected in terms of securing the sustainability of the activities implemented.
- Outcome 2 is rated 'Satisfactory': The TE confirms mechanisms are globally established. There are indications of the willingness to implement them and use the tools developed. This is in the hands of the MOH and GHS.
- Outcome 3 is rated 'Moderately Unsatisfactory': whereas knowledge production has occurred, there is no real knowledge management mechanism operational, and the risk is great that all of this knowledge just get lost or outdated in the coming years. In addition, the target of the first indicator of this outcome in the Results framework has not been reached: "By the end of the Project, at least 3 relevant departments regularly accessing climate change related risks information". There is no evidence of such system in place, where climate change risk information is regularly updated and made available to relevant departments through an accessible platform. As far as the second indicator is

[28] Over a 6pt rating scale: Highly Satisfactory (HS); Satisfactory (S); Moderately Satisfactory (MS); Moderately Unsatisfactory (MU); Unsatisfactory (U); Highly Unsatisfactory (HU).

concerned: "Number of lessons learned from Project activities synthesized and captured in a specific KM Facility", there is no evidence of an operational knowledge management facility in place.

123. Overall, the achievement of the Project objective and outcomes can be rated as "Moderately Satisfactory": a lot has been done in terms of knowledge production, training and awareness raising, but a lot remains to be done in order to ensure that the information produced and the tools tested are properly integrated into health management systems in Ghana, systematically replicated in all districts/regions of the country and that interactions with all relevant sectors into climate change and health issues are effective.

Photo 7. Training on active surveillance in Gomoa West district



124. Finally, there is no evidence of any risk management activities implemented during the Project. This is a result of the globally poor management of the Project and the non-utilization of classical Project managed tools like the logical framework and the risk and assumptions table.

3.3.3. Efficiency

125. Quality of results based management reporting is generally poor as exposed in section 3.2. With the exception of the MTR and the Project final report, management reporting does not properly report against Project results and the logical framework has not been used as a management tool.

126. Difficulties met by the main implementing partners (MOH, UNDP and GHS) in working together and understanding their respective administrative processes have resulted in huge losses of time in Project execution (for example, change on financial modalities[29])

127. Project expenditures (UNDP+GEF SCCF) have reached US$1,855,551, that is 97% of the initial plan. Co-financing, although it is difficult to assess the real support to Project activities achieved by this co-financing, has been achieved at 93%, which is good.

[29] Check MTR for details

128. Information collected during the TE mission suggest that the share of the budget actually spent at district level did not match the amount of work required and the local needs for good quality implementation of the activities. In addition, funds came often late and activities had then to be conducted within a very short time period. Financial data disaggregated by district/national levels is not available to confirm this. However, this situation is, regrettably, rather common in this type of Project; local beneficiaries often have the impression that money is spent easily in the capital city but small local needs cannot be covered for budgetary reasons.

129. Change in Project approach has occurred a number of times, but the most significant change was the decision to set-up the teleconsultation centres, which idea came from links with the Millennium village Project, as mentioned earlier. The high relevance of those centres is recognized and they constitute a major achievement of the Project, thus improving the efficiency of Project execution.

130. Partnership/linkages between institutions were encouraged, but were mostly effective at district level, where cross-sector cooperation has been stronger than at the national level.

131. It has not been possible during the TE to check the number of consulting days contracted to international versus national consultants. The review of the Project Documentation suggest it is rather balanced, but this is a very weak observation. Some people interviewed expressed regrets regarding the use of outsourced experts whereas in-government expertise was available (but not possibly mobilized due to, according to interviewees, UNDP/GEF administrative procedures).

132. Overall, the important delays in Project execution, difficulties in having a functioning governance structure and operational cooperation between Project partners, the poor use of management tools, result in a rather unsatisfactory implementation of the Project in terms of efficiency. Given the good level of expenditures and mobilization of co-financing, overall rating is qualified as "Moderately Unsatisfactory".

3.3.4. Country ownership

133. As discussed in section 3.3.1, the Project concept was clearly in line with development priorities and plans of the country. This has been unanimously confirmed during interviews realized for this TE.

134. Both the Project Steering Committee (PSC) and the Technical Advisory Committee (TAC) are composed of representatives of the following organisations:

- MOH
- UNDP
- WHO
- EPA
- GHS
- PIU

135. Normally, the people at the PSC are at a higher, policy level, than those of the TAC who are technical people, since both entities do not have the same objectives: one is piloting the Project, the other advising on execution. However, the high level members of the PSC often delegate their role to competent technical people. As a result, meetings of the two bodies were attended by the same people, more or less. This highlights the need to define members of such a PSC according to a number of agreed criteria regarding the suitability of chosen representatives: interest in the initiative, competence, availability, relevance of position to link with/influence the work of its institution, among others.

136. As can be seen, the represented institutions are the ones with a direct, or almost direct (WHO) role to play in Project implementation. This is fine for the TAC but the relevance of such a narrow PSC can be questioned. An important goal of the Project was to link climate change aspects to health concerns and management, and therefore interact with various sectors at district level to do so: education, agriculture,

planning, forest/wildlife were all represented in the ICCs in the 3 pilot districts. Why wasn't it the case at the national level? The PSC could have been composed of a much larger stakeholder base, including representatives of other sectoral ministries, and including development partners, in particular Danida and international and national civil society organizations working in the health sector.

137. In terms of Project guidance, having a larger PSC, meeting regularly (twice a year is a good pace as long as it is respected), and a reduced TAC operational team meeting at least every quarter (but could be every month, in particular when no Project manager is in place as was the case during the last 18 month of this Project), with clear respective roles and responsibilities, quality agendas and minutes of meetings, is a key aspect of Project efficiency.

138. As far as the TE could see, NGO involvement has been limited to few local cooperation experiences, as already mentioned.

139. Despite those rather negative aspects, country ownership has been strong on many other aspects:

- The Project was directly implemented by the MOH and the TAC, whose members were deeply committed to delivering;
- Implementation at the local level has been taken as an opportunity in the three pilot districts, who have used the Project funds to multiply training and awareness raising sessions across the districts' communities;
- The *Health Sector Medium Term Development Plan* does now include a strategy on climate change, and the health sector is duly integrated in the Ghana National Climate Change Strategy;
- The MOH has plans to pursue and extend many of the Project achievements, such as the health risk maps, the teleconsultation centres, ORT corners, etc.

140. Overall, given the above, country ownership can be qualified as moderately satisfactory.

Photo 8. ORT corner in Gomoa West district

3.3.5. Mainstreaming

141. Mainstreaming of other UNDP priorities, such as poverty alleviation, improved governance, the prevention and recovery from natural disasters, and women's empowerment, is an important aspect of UNDP-supported Projects. Table 6 shows how those different dimensions were taken into account by the Project.

Table 6. Mainstreaming of other UNDP priorities by the Project intervention

UNDP priorities	Project mainstreaming effect
Poverty alleviation	By reinforcing the Ghanaian health system, in particular as regards disease control and surveillance and health services delivery, the Project has an impact on the health situation of local community members and this does contribute to poverty alleviation.
Improved governance	At the district level again, by putting in place ICCs, the Project has improved local governance of health related problems and has re-established the link of the health sector to the other sectors.

Prevention and recovery from natural disasters	Disease outbreaks can be related to natural disasters: malaria, diarrhoea, are closely related to temperature and humidity, and an excess or lack of rain have a direct impact on those diseases prevalence. By raising awareness, training health workers, establishing ORT corners and teleconsultation centres, the Project helped communities to improve their resilience to natural disasters and to prevent disease outbreaks when they occur. The example of the Keta district, which had no case of cholera in 2014 when most districts around had significant outbreaks, is outstanding (although not scientifically proven yet)
Women's empowerment	The health sectors has a lot to do with women's empowerment, as women are the primary health carer in the communities. The various interventions aimed at improving health services in the districts mostly target women and children, who are the most vulnerable to the effects of climate change. District health workers (mostly female mid-wives and nurses) were trained and supported and themselves contributed to raising awareness of women on the effects of climate change and health.

142. Alignment with priorities set in the UNDAF, the Country Programme Action Plan (CPAP) and Strategic Plan Environment and Sustainable development is presented in the table below.

Table 7. Alignment with priorities set in the UNDAF, the CPAP and the Strategic Plan Environment and Sustainable development[30]

Alignment with:	
UNDAF CPAP outcome	Outcome 1: By 2010, the population of the people of Ghana, particularly those living in the most deprived districts whose right to health is fulfilled is increased
UNDAF CPAP Output:	Decrease in child morbidity and mortality in most deprived districts
UNDP Strategic Plan Environment and Sustainable Development Primary Outcome:	Strengthened capacity of developing countries to mainstream climate change adaptation policies into national development plans: this is the case for this Project in the health sector.
UNDP Strategic Plan Secondary Outcome:	Mainstreaming environment and energy: yes
Expected CPAP Outcome(s)	Sustainable use of natural resources and good environmental management promoted: yes
Expected CPAP Outputs:	National and local systems for emergency preparedness, disaster prevention: yes

143. From the elements exposed above, it can be concluded that the Project has successfully mainstreamed other UNDP priorities.

3.3.6. Sustainability

144. The Project Document proposes a section 'Sustainability and replicability' in Part2. According to this section, sustainability of the Project intervention will be ensured by the mainstreaming of health-related

[30] Source : End-of-project report, UNDP, 2015

aspects of climate change into the health and other sectors and the "use of the tool that will be developed to evaluate the effectiveness of current policies and measures to protect communities from climate sensitive diseases". However, the section does not include any plan for managing financial risks, socio-economic risks, institutional framework and governance risks and environmental risks. It does not include either any exit strategy. Consequently, this cannot be considered as a robust sustainability strategy.

145. Unforeseen barriers to sustainability arose during Project implementation, the main one being the lack of resources to actually sustain certain activities. For example, the ORT corners are in many places out of operations because they were not refilled with appropriate medicine. Another example is the use of risk maps: without a proper ArcGIS software[31] licence and continuous training of staff (especially where turnover is important), updating the risk maps will be more complicated and progressively set aside. Those are a few example that relate to available resources at MOH and GHS, but also links to those institutions capacity to organise and maintain this type of services. There is currently no financial plan to ensure sustainability of Project achievements, but Project partners hope that financial support sources will be identified.

Photo 9. Training on health risk mapping, Gomoa West district

146. Apart from building capacities of staff at various levels, there are no examples of actions implemented to avert sustainability risks. Again, poor management practices during Project implementation constitute the main reason for this.

147. Some factors are however likely to enable achievement of sustainable outcomes: the integration of climate change in to the *Health Sector Medium Term Development Plan* is one of them. The good results obtained in the districts (e.g. in terms of cholera cases) are also a strong incentive for the MOH and GHS to work hand in hand to the maintenance and replication of some interventions. In addition, the various studies conducted during the Project constitute a rich source of information to strengthen the Ghanaian health system.

148. Consequently, the likelihood of continued benefits after the GEF Project ends is very uncertain, as it highly depends on the willingness and the capacity of MOH and GHS to build on Project achievements, to use the studies and tools created, to maintain the services put in place, and to extend them to other districts and regions of the country.

[31] Geographic Information System / mapping tool

149. Table 8 below analyzes sustainability in regards to risks to sustainability in four categories: financial, socio-political, institutional framework and governance, environmental, and overall.

Table 8. Project sustainability rating

Risk	Comment	Rating[32]
Financial	There is currently no financial plan to ensure sustainability of Project achievements, but Project partners hope that financial support sources will be identified.	ML
Socio Political	Risk to sustainability is rather low on the socio-political side. There is sufficient public/stakeholder awareness in support of the project's long-term objectives	L
Institutional framework and governance	There is a risk of lack of leadership after the project end. The MOH has been the project lead but logically, many of the activities and further developments should be implemented by GHS. A institutional framework would need to be put in place so it is made clear who is in charge of what after project end.	ML
Environmental risks	Project outcomes mostly aim to increase resilience to environmental risks, so there is no new threat on this aspect.	L
Sustainability of Project outcomes (overall rating)		**ML**

150. Overall, sustainability of Project outcome is rated Moderately likely: there is potential and there seem to be willingness from main Project stakeholders to build on the Project results and reinforce them. However, there are two main risks to sustainability: the institutional framework and governance of future actions, and on how those actions will be financed. An exit plan for the Project should include a detailed work plan of activities to ensure continuity of project outcomes and build on those results to enhance the Ghana health system resilience to climate change. Such a plan would set a clear distribution of roles and responsibilities for each activity, with a clear governance framework established. It would also seek to identify funding sources for each activity, some of which may be funded by external sources, including from climate finance (e.g. the Green Climate Fund).

3.3.7. Catalytic role

151. As per UNDP/GEF evaluation guidelines, we have tried in this section to consider the extent to which the Project has demonstrated: a) production of a public good, b) demonstration, c) replication, and d) scaling up. We have done this in the matrix below.

[32] The rating scale is Likely (L); Moderately Likely (ML); Moderately Unlikely (MU); Unlikely (U). please see annex 7 for details on the rating scales used in the report

Table 9. Assessment of Project catalytic role

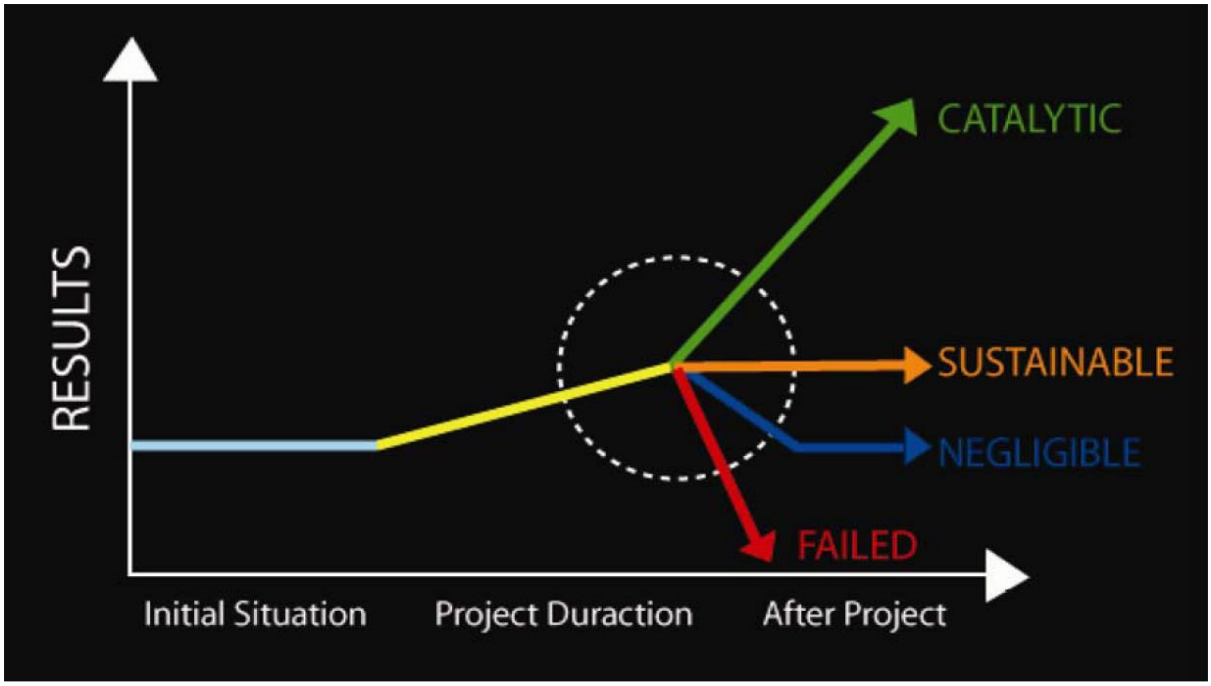
Catalytic result	Description[33]	Assessment of Project catalytic role
Production of public good	Approaches developed through the Project are taken up on a regional / national scale, becoming widely accepted, and perhaps legally required	A wide range of knowledge products, tools and feedback of experience from the pilot districts do constitute a public good that can be used by the government. Globally, awareness raising has been good and approaches developed through the Project are widely accepted.
Demonstration	Activities, demonstrations, and/or techniques are repeated within or outside the Project, nationally or internationally	The Project is considered as a pilot, with demonstration activities in three pilot districts. The intention is to repeat most successful activities to other districts/regions, but this has yet to be achieved.
Replication	Steps have been taken to catalyse the public good, for instance through the development of demonstration sites, successful information dissemination and training	Demonstration sites do exist through the pilot districts. Information and training have also occurred. It is not clear however how the MOH will find the resources to actually replicate Project activities.
Scaling up	The lowest level of catalytic result, including for instance development of new technologies and approaches. If no significant actions were taken to build on this achievement, the catalytic effect is left to 'market forces'	The HSMTDP defines 3 broad activities relating to climate change. One is "Scale-up the lessons learnt from the pilot sites in to implementable activities at the regional and district levels". However, scaling up will require resources.

152. Overall, we conclude that, partly due to the demonstration and pilot aspect of this Project, the catalytic potential is quite high, with many activities having the potential to be reinforced, extended and replicated across the country. The same applies to studies and tools developed at national level, which use would strongly enhance mainstreaming of climate change into the Ghanaian health sector. Whether this catalytic potential will be expressed or not depends on a number of factors, the main ones being the willingness of the MOH and GHS to take action and their actual capacity (in terms of available staff and financial resources) to do so.

153. The figure below illustrates how the results of such Project may benefit the country in the future. It shows that **Project closure is a critical moment for future impacts the Project might, or might not have. Depending on the actions taken now, the results may be catalytic (i.e. scaled-up and replicated), just sustainable, negligible or even fail if Project achievements are not taken up by stakeholders**.

[33] Guidance for conducting terminal evaluations of UNDP-supported, GEF-financed projects, UNDP Evaluation Office, 2012

Figure 4. Four possible results after a GEF project ends[34]



3.3.8. Impact

154. It is difficult to qualify Project results as long-term impacts at this stage. Impacts are usually more visible 2-5 years after Project closure, when a given situation can be related to the Project implemented a few years before. However, we tried to highlight some types of impacts of the Project at the local and national levels.

155. Direct impacts of the Project at the local level, in the 3 pilot districts, consist in:

- Reinforced health surveillance systems, with strong inter-sectoral cooperation, operational teleconsultation platforms, trained health workers and informed communities;
- Saved lives though the timely advices given to people (in particular women) thanks to the teleconsultation system, and through the better surveillance systems now in place

156. At the national level, most significant impacts are:

- The now well established and understood link between climate change and health within national institutions. This is very likely to remain in future years;
- The mainstreaming of climate change into health sector strategic documents.

157. The Project has contributed to reduce vulnerability to climate change of the health sector in Ghana. Although most of the potential impacts need to be confirmed and strengthened in the near future, they are significant. Shall the involved stakeholders achieve to build on Project achievements and extend nationally the results obtained in the pilot districts, many other impacts should be visible in the next few years. This Project, dealing with the health and climate change nexus, was a new area in 2010. It is now

[34] Source: Evaluation of the Catalytic Role of the GEF. A Qualitative Analysis of Terminal Evaluations. Avery Ouellette. October 2008.

obvious to many people that climate change has direct as well as indirect impacts on health and the health system, that need to be addressed appropriately.

3.4. Conclusions, recommendations and lessons learned

3.4.1. Conclusions

158. After the many challenges and delays of the first years, the Project has finally been able to find its mode of operation and has delivered a number of interesting achievements. As concluded in the end-of-project report, "Integrating climate change into the management of health priorities has become possible as a result of access to information on climate change and health, improvement in health systems to accommodate new demands imposed by climate change, adequate capacity of health care providers to identify, implement, monitor, and evaluate adaptations to reduce current and likely future burdens of malaria, diarrheal diseases, and meningococcal meningitis in Ghana and commitment by the Ministry of Health to incorporate climate change issues in is programming".

159. Implementation has however been rather hectic and there is a lot to be learned from this experience for ensuring a smoother implementation of future projects. Lessons relate in particular to the governance structure and the need to clearly define the roles and responsibilities of each project partner; they also relate to project management itself, with the need to clarify rules, procedures and expectations from UNDP/GEF and from the involved national instructions at project start, with the delivery of trainings as necessary, including on M&E.

160. Better achievement of the project objectives and stronger results would certainly have been reached without those implementation and management problems. They also hinder the sustainability, future impacts and replication potential of the project results, which highly depend on the willingness and the capacity of Ghanaian institutions to build on the project experiences and knowledge to engage all districts and regions of the country into climate change adaptation.

161. This project is important to the Ghanaian health sector. Needs are important and climate change reinforces vulnerability of the populations. The tools put in place and the demonstration activities implemented have the potential to greatly improve disease surveillance and health management in the country. The opportunity should not be missed.

3.4.2. Lessons learned

The analysis realised in the different sections of the TE have led to extract the following lessons learned:

LL1: In order to get the main project partners fully on board from project start, the Project Document must provide the full detail of the management/implementation framework, or at a minimum an explanation how and when these details will be developed, for example during the inception phase. At the end of the inception phase, each involved institution must have an understanding of its role and responsibilities in Project implementation, supported by a validated work plan.

LL2: Implementation of Project activities is often concentrated in the hands of few instructions and people. A possible way to ensure ownership and collaboration from a wider variety of stakeholders is to establish a rather large Project Steering Committee, meeting twice a year, and including different sectors from the government, development partners and relevant NGOs. Such Steering Committee has a role of overall guidance of the Project and validation of major strategic decisions or changes to project objectives/outcomes. It must however be seconded by a smaller, more executive and technical working group, with an advisory and validation role on project implementation matters, as has been the case with the TAC in the last two years of this Project.

LL3: In-kind co-financing by development partners and other institutions is not always well understood. As a result, it can be, as was in this Project, limited to the level of investment of a given partner in the baseline situation, or more generally in the concerned sector. A lesson is that for this co-financing to be effective, technical cooperation with the project and coordination of activities, organisation of joint events or joint initiatives, are necessary.

LL4 There is no evidence of any risk management activities implemented during the Project. This is a result of the globally poor management of the Project and the non-utilization of classical Project management tools like the logical framework and the risk and assumptions table. Risk management is an important element of good project management practices.

LL5 In terms of effectiveness, knowledge production is important but it should be properly planned and coordinated so that the different studies funded are well articulated between each other, and clearly articulated with the project objective and outcomes. Project management should effectively plan all of the studies to be done and develop detailed terms of reference for each one during the inception phase, in order to get a formal validation of the full lot of studies before actual implementation.

LL6 Information collected during the TE mission suggest that the share of the budget actually spent at district level did not match the amount of work required and the local needs for good quality implementation of the activities. A lesson is that a detailed budget allocation per activity/outcome may not be sufficient but that allocation per 'level' (i.e. national VS local) could also be fixed by the PSC, making sure there is a good balance between the levels of expenditure and the main project objectives.

LL7 UNDP/GEF project management procedures and financial rules are complicated. It is not easy for local institutions, recruited Project managers, to understand them, and use them properly. This has been strongly (and sadly) illustrated in this Project. The lesson is that proper training, clarification, and provision of guidelines and templates during project inception is necessary, with regular updates during project implementation. This also applies to the use of the Logical framework and implementation of the M&E plan during the project.

3.4.3. Recommendations

Looking forward, three main recommendations are proposed below, with the aim of ensuring Project sustainability and replication, and improving the quality of future UNDP/GEF projects.

R1 As mentioned in the report, sustainability of the results achieved by the project and realisation of its replication potential highly depend on local institutions' capacity to actually take on post-project initiatives. A lot can be done, among other things, in (i) operationalizing the teleconsultation centres and putting in place such centres in all districts/regions of the project; (ii) developing and updating regularly vulnerability maps to main diseases across the country as was tested in the pilot districts; (iii) reinforcing inter-sectoral cooperation for a comprehensive approach of health; and (iv) managing climate vulnerability information and knowledge products through a practical and easy to access knowledge management system.

The **TE recommends that PSC members work jointly on an exit strategy for the project**. Such strategy would include a detailed work plan of activities to ensure continuity and replication of project outcomes in order to enhance the Ghana health system resilience to climate change. Such a plan would set a clear distribution of roles and responsibilities for each activity, with a clear governance framework established. It would also seek to identify potential funding sources for each activity, some of which may be funded by external sources, including from climate finance (e.g. the Green Climate Fund). The exit strategy process could consist in an initial meeting to define the activities needed for sustaining the main project results and make sure the tools developed during the project are implemented. Each PSC member could then work on some sections of the exit strategy and then meet for a second time in order to agree on the governance framework (who leads the process? How

are responsibilities distributed?), the financial means available for each of the defined activities, and actions to be taken in order to raise funding sources. UNDP has a role to play to mobilize PSC members on this process.

The following Project outputs should be duly considered for sustainability and replication in the exit strategy:

- ORT corners: ensure provision of medicine where ORT corners are in place, and install ORT corners in all health centres of the country.
- Teleconsultation: the use of mobiles phones is already effective. First, GHS should make sure phone credits continue to be provided regularly and that broken phones are duly replaced. Secondly, teleconsultation centres are in place but not fully operational, as some training of staff was still missing at the time of the TE mission. Given the investments already engaged, it is very important that those centres become fully operational shortly. The scaling up of teleconsultation centres to all the regions of the country should be duly considered, given the high benefits reporting by this activity.
- Risk maps and knowledge management: given the complexity of updating such maps, consider setting-up a web platform were districts can upload there data every month and automatically get the vulnerability maps in return. A central team at the national level should be trained on GIS tools, licenses for GIS software acquired, and the proposed web-platform put in place. Such web platform could also include a number of knowledge products and tools (e.g. the screening tool) in order to facilitate knowledge management and dissemination. A specialised consultant should be able to put this in place and train people within relatively short delays.
- Education campaigns: a lot of the material developed can be re-used in the future in order to maintain a momentum on climate change adaptation, and replicate to other districts of the country.
- Multi-stakeholder platforms: the relevance of interagency coordination committees has been proven by the Project, given the inter-sectoral nature of climate vulnerability and resilience. Consider putting in place such committees in every district and region of the country, and ensure a similar body is activated at the national level. At the district level, it may be considered relevant to use the emergency preparedness committees already in place, giving them clear responsibility on climate change issues (which entails preparing specific terms of reference and delivering short trainings on climate change as necessary).
- Screening tool: based on the final report *Development of a gender sensitive climate resilience screening tool for the health sector*, decide how the tool should be used to monitor and improve climate resilience of the health system in all of the country's districts. Define responsibilities, budgets and timing.

R2 In future projects**, make sure to set very clearly, and get validated, the governance structure of the project,** with clear roles and responsibilities established for each partner institution. As far as possible, this should be done during project formulation. However, it must be re-clarified and reconfirmed during the inception phase of the project, and it is very important to put the necessary effort at this key moment. Assigned roles and responsibilities must fit with each institution national role and capacities, and validation should occur at a sufficiently high level to avoid any further contestation. This applies in particular to the health sector where the delineation of responsibilities between the MOH and GHS does not seem to be totally clear.

R3 Effectiveness and efficiency of the project highly depend on the capacities of the project management team. **In such projects, it should be considered to offer a full training to the team put in place regarding project management along UNDP/GEF procedures**, including M&E and results based management. This can be done rather easily by hiring a project management expert with strong UNDP/GEF experience. Additional support along the project duration can also greatly enhance the quality of project management and reporting. Sometimes, a chief technical advisor is hired for this purpose. In smaller projects, an initial training, with then short yearly support missions, could be considered.

4. ANNEXES

Annex 1. Proposed evaluation matrix

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
A- Project Design / Formulation				
Analysis of LFA/Results Framework (Project logic /strategy; Indicators)	• Were the Project's objectives and components clear, practicable and feasible within its time frame? • Were monitoring indicators from the Project Document effective for measuring progress and performance? Were they SMART?	• Coherence/difference between stated objectives and progress to date • Quality of monitoring indicators in the Project Document • Implementing entities' staff understanding of objectives, components, timeframe • Local implementing partners' understanding of objectives, components, timeframe	• Project planning documents • UNDP Staff (managers) • Local (Ghana) executing team and executing partners (at the national, regional and district levels)	• Documentation Review: planning and strategy documents • Interviews with UNDP and Project staff and executing partners
	• Is the M&E plan well-conceived and sufficient to monitor results and track progress toward achieving objectives?	• Existence and quality of baseline assessment, performance measurement framework/logframe, methodology, roles and responsibilities, budget and timeframe/workplan in planning documents	• Planning documents • Monitoring and reporting documents • UNDP staff • Local executing team	• Desk Review • Interviews with implementing and executing staff
Assumptions and Risks	• Were the Project assumptions and risks well articulated in the PIF and Project Document?	• Assumptions and risks stated in planning documents, with corresponding response methods/measures	• PIF and Project Document • Review procedures/planning meeting minutes/emails	• Desk review
	• Did stated assumptions and risks help to determine activities and planned outputs?	• Quality of risk management system(s) in place at appropriate levels of reporting, accountability • Use of assumptions or noted risks to tailor or adjust planned activities and outputs	• Project planning documents • Monitoring reports • UNDP Staff • Local executing team and executing partners	• Documentation Review: planning and monitoring documents • Interviews with Project staff and executing partners
	• Have externalities (i.e. effects of climate change, global economic crisis, etc.) that are	• Degree and nature of influence of external factors on planned activities	• Project planning documents • Monitoring reports • UNDP Staff	• Documentation Review: planning and monitoring documents

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	relevant to the findings been duly considered?	• Extent to which planning documents anticipated or reflected risks/externalities already faced during implementation to date	• Local executing team and executing partners	• Interviews with Project staff and executing partners
Lessons from other relevant Projects (e.g., same focal area) incorporated into Project design	• Were lessons from other relevant Projects properly incorporated in the Project design?	• Evidence of planning documents utilizing lessons learned/ recommendations from previous Projects as input to planning/strategy process	• Planning documents	• Desk review
Planned stakeholder participation	• Were the partnership arrangements properly identified and roles and responsibilities negotiated prior to Project approval?	• Evidence of local partnership (lack of) understanding of roles and responsibilities prior to and following Project approval • Coherence between nature and extent of Project Steering Committee (SC) responsibilities and roles, and Project needs and objectives	• Local executing team (Project staff) • UNDP staff • Local executing partners (at the national, regional and district levels; governmental and non-governmental stakeholders) • Planning documents • Initial workshops/planning meetings • Minutes of SC meetings	• Interviews • Desk review
Replication approach	• Was a replication approach clearly set?	• Replication approach clearly stated in planning documents, and means of enhancing replication during implementation stated	• Planning documents	• Desk review
Linkages between Project and other interventions within the sector	• Were other interventions within the sector clearly identified?	• Other interventions within the sector duly described and their possible linkages with the Project analysed	• Planning documents	• Desk review
UNDP comparative advantage	• Is UNDP comparative advantage clear on this Project?	• Extent to which UNDP comparative advantage is justified	• Planning documents • UNDP staff	• Desk review • Interviews
Management arrangements	• Were the capacities of the executing institution and its counterparts properly considered when the Project was designed?	• Evidence of scoping activity or assessment of executing agency's capabilities with respect to executing this Project • Number, extent and types of gaps between planned and available capacities by executing agencies	• UNDP staff • Local executing team and executing partners • Meeting minutes/emails leading to planning documents	• Interviews with UNDP and Project staff and executing partners • Desk review

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	• Were counterpart resources (funding, staff, and facilities), enabling legislation, and adequate Project management arrangements in place at Project entry?	• Coherence/extent of gap in timing between counterpart resource and institutional readiness and Project commencement	• Project staff • UNDP staff • Local executing partners (at the national, provincial and council levels; governmental and non-governmental stakeholders)	• Desk review • Interviews • Field visit
B- Project Implementation				
Adaptive management (changes to the Project design and Project outputs during implementation)	• What (if any) follow-up actions, and/or adaptive management taken in response to monitoring reports (PIRs)?	• Evidence of management response/changes in Project strategy/approach as a direct result of information in PIR(s)	• PRRs • PIRs • Workshops/Meeting minutes from technical group, steering committee, staff, stakeholders • AF management responses • LDCF management responses	• Desk review • Interviews with EA/IA Staff
	• Did the Projects undergo significant changes as a result of recommendations from workshops, the steering committee, or other review procedures?	• Number and quality of mechanisms for feedback and re-adjustment of Project strategy or approach • Responsiveness of Project team/ respective implementing bodies to recommendations made through review processes (including changes after the baseline report) • Origins of suggestions for significant Project changes (e.g. sources of recommendations)	• Local executing team • UNDP staff • Local executing partners (particularly government stakeholders) • Workshop/planning meeting minutes and action items	• Desk review • Interviews
	• If the changes were extensive, did they materially change the expected Project outcomes?	• Nature and degree of change in Project outcomes (activities, outputs) as a result of recommendations from review procedures	• UNDP staff • Local executing team • Local executing partners (particularly government stakeholders)	• Desk review • Interviews • Field Visit
	• Were the Project changes articulated in writing and then	• Number and type of approved Project changes that were put in writing for Steering Committee consideration	• Project monitoring and reporting documents (annual and quarterly reports)	• Desk review

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	considered and approved by the Project Steering Committee?	(number and type that were not put into writing and/or not approved)	• Workshop/planning meeting minutes and action items	
Partnership arrangements (with relevant stakeholders involved in the country/region) and stakeholders' engagement	• To what extent were effective partnership arrangements established for implementation of the Project with relevant stakeholders involved in the country/regions/ districts?	• Number and types of partnerships developed between Project and local bodies/organizations • Extent and quality of interaction/exchange between Project implementers and local partners	• Meetings/workshop minutes (Steering Committee) • Local executing partners • Project beneficiaries • Local executing team • UNDP Staff	• Desk review • Interviews with Project staff, executing partners and communities • Field Visit
	• Did the Project involve the relevant stakeholders through information sharing and consultation and by seeking their participation in Project design, implementation, and M&E? For example, did the Project implement appropriate outreach and public awareness campaigns?	• Number, type, and quality of stakeholder engagement at each stage of Project design, implementation and M&E • Changes in public awareness as a result of outreach/ communication by Project	• Local executing partners, including community members and groups, government stakeholders and other local stakeholder groups (non-government) • Local executing team • UNDP staff • Workshop/planning meeting minutes and action items	• Desk Review • Interviews • Field Visit
	• Did the Project consult with and make use of the skills, experience, and knowledge of the appropriate government entities, nongovernmental organizations, community groups, private sector entities, local governments, and academic institutions in the design, implementation, and evaluation of Project activities?	• Quality of consultations / feedback mechanisms/ meetings/ systems in place for Project implementers to learn the opinions of 1. Community groups 2. Local government 3. National government 4. Non-government groups 5. Other • Number and frequency of engagement with local stakeholders for consultation	• Local executing partners, including community members and groups, government stakeholders and other local stakeholder groups (non-government) • Local executing team • UNDP staff • Workshop/planning meeting minutes and action items	• Desk Review • Interviews • Field Visit
	• Were the perspectives of those who would be affected by Project decisions, those who could affect the outcomes, and those who could contribute information or other resources to the process taken into account while taking decisions (including relevant vulnerable	• Extent of beneficiary needs integrated into Project design (appropriateness of strategies chosen, site selection, degree of vulnerability of targeted Project sites, etc) • Evidence of participation from a wide range of stakeholder groups (in support and opposed to the Project)	• Local executing partners, including community members and groups, government stakeholders and other local stakeholder groups (non-government) • Workshop/planning meeting minutes and action items	• Desk Review • Interviews • Field Visit

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	groups and powerful supporters and opponents)?			
Project Finance:	• What are annual costs for implementation and what proportion is co-financing?	• Budget execution per year, activity • Amount of co-financing per year, activity	• Financial Audits • Annual reports, quarterly reports • UNDP staff • Local executing team	• Desk review • Interviews
	• Is there any variance between planned and actual expenditures? If there is, what is the explanation?	• Planned budget per year, activity • Actual budget execution per year, activity	• Financial Audits • Annual reports, quarterly reports • UNDP staff • Local executing team	• Desk review • Interviews
	• Is there any variation between expected and actual co-financing? If there is, what is the explanation?	• Planned co-financing per year, activity • Actual amount of co-financing per year, activity	• Financial Audits • Annual reports, quarterly reports • UNDP staff • Local executing team	• Desk review • Interviews
	• What resources has the Project leveraged since inception? (Leverage resources can be financial or in-kind and they may be from other donors, NGOs, foundations, governments, communities or the private sector)	• Amount of resources that Project has leveraged since inception (and source(s))	• Financial Audits • Annual reports, quarterly reports • UNDP staff • Local executing team	• Desk review • Interviews
	• What effect does co-financing have on Project performance, effectiveness?	• Number and extent of discrepancies between planned and actual executed activities, budget • Degree of integration of externally funded components into overall Project strategy/design	• Financial Audits • Annual reports, quarterly reports • UNDP staff • Local executing team	• Desk review • Interviews
Monitoring and evaluation: design at entry and implementation	• Was the logical framework used during implementation as a management and M&E tool?	• Extent of management use of the log frame (number and type of usage)	• UNDP staff • Local executing team and executing partners	• Documentation Review: planning and monitoring documents

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
				• Interviews with Project staff and executing partners
	• Was the M&E plan sufficiently budgeted and funded during Project preparation and implementation?	• Proportion of executed M&E budget against planned amount • Degree of adherence of the implementation of the M&E plan to intended timeline • Evidence of external factors that have affected M&E budget or timeline (and extent to which they were addressed in risk management plan)	• Planning documents • Planning meeting minutes/review procedures • Monitoring and reporting documents (quarterly, annual reports) • UNDP staff • Local executing team	• Desk Review • Interviews with implementing and executing staff
	• Are monitoring indicators from the revised logical framework effective for measuring progress and performance?	• Coherence between reported results (activities, outputs) and actual activities and outputs on the ground	• Local executing staff and partners • UNDP staff • Community stakeholders • Direct observation	• Interviews • Desk review • Field Visit
	• Does the Project comply with the progress and financial reporting requirements/ schedule, including quality and timeliness of reports?	• Proportion and types of reporting materials submitted a) correctly and b) on time • Quality of M&E/reporting materials	• Monitoring and reporting documents (quarterly, annual reports) • UNDP staff • Local executing team • GEF/UNDP reporting requirements	• Interviews • Desk review
	• Were monitoring and evaluation reports discussed with stakeholders and Project staff?	• Number and quality of meetings, workshops or other mechanisms used to share M&E materials with stakeholders and Project staff • Number of stakeholder and staff aware of M&E materials generated and/or lessons/findings they contain	• UNDP staff • Local executing team and partners • Minutes and attendance list of Project staff and stakeholders for meetings on M&E	• Interviews • Desk review
	• Was feedback from M&E activities used for adaptive management?	• Uptake of M&E/reporting information into management decision-making • Consistency of APR/PIR self-evaluation ratings with MTR and TE findings	• Monitoring and reporting documents • UNDP staff • Local executing team	• Desk review • Interviews with UNDP and Project staff

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
		• Example of discrepancies identified by the Project steering committee and addressed • Examples of changes made to Project implementation as a result of the MTR recommendations		
UNDP (Implementing Agency - IA) and Executing Agency (EA) / execution (*) coordination, and operational issues	• Have the IA and EA, respectively, placed sufficient resources on achieving Project results?	• Differences in actual and planned amount of budget and staff time devoted to the Project • Quality of supervision of IA and EA, respectively • Suitability of chosen executing agency for Project execution • Difference in actual and planned timetable for Project execution	• Project team members • UNDP staff • Local executing partners	• Interviews • Field Visit
	• Have management teams provided quality and timely inputs/responses to the Project team?	• Perceived timeliness of management response to Project team members' inquiries, needs • Perceived quality of management response to Project team members' inquiries, needs • Perceived quality of risk management by IA and EA • Evidence of quality (candor and realism) in annual reporting	• Project team members • UNDP staff • Local executing partners	• Interviews • Field Visit • Desk review
C- Project Results				
C1. Relevance: How does the Project relate to the main objectives of the GEF focal areas, and to the environment and development priorities at the national level?				
Is the Project relevant the GEF climate change focal area?	• How does the Project support the GEF CC focal area and strategic priorities	• Existence of a clear relationship between the Project objectives and GEF CC focal area	• Project Documents • GEF focal areas strategies and documents	• Documents • Analyses • GEF website • Interviews with UNDP and Project team
Is the Project relevant to Ghana's environment and sustainable development objectives? (see also C5)	• How does the Project support the environment and sustainable development objectives of Ghana?	• Degree to which the Project supports national environmental objectives	• Project Documents • National policies and strategies • Key Project partners	• Documents analyses • Interviews with UNDP and Project partners

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	• Is the Project country-driven? • What was the level of stakeholder participation in Project design? • What was the level of stakeholder ownership in implementation? • Does the Project adequately take into account the national realities, both in terms of institutional and policy framework in its design and its implementation?	• Degree of coherence between the Project and nationals priorities, policies and strategies • Appreciation from national stakeholders with respect to adequacy of Project design and implementation to national realities and existing capacities • Level of involvement of government officials and other partners in the Project design process • Coherence between needs expressed by national stakeholders and UNDP-GEF criteria		
Is the Project addressing the needs of target beneficiaries at the local and regional levels?	• How does the Project support the needs of relevant stakeholders? • Has the implementation of the Project been inclusive of all relevant stakeholders? • Were local beneficiaries and stakeholders adequately involved in Project design and implementation?	• Strength of the link between expected results from the Project and the needs of relevant stakeholders • Degree of involvement and inclusiveness of stakeholders in Project design and implementation	• Project partners and stakeholders • Needs assessment studies • Project Documents	• Document analysis • Interviews with relevant stakeholders
Is the Project internally coherent in its design?	• Are there logical linkages between expected results of the Project (log frame) and the Project design (in terms of Project components, choice of partners, structure, delivery mechanism, scope, budget, use of resources etc)? • Is the length of the Project sufficient to achieve Project outcomes?	• Level of coherence between Project expected results and Project design internal logic • Level of coherence between Project design and Project implementation approach	• Program and Project Documents • Key Project stakeholders	• Document analysis • Key interviews
How is the Project relevant with respect to other donor-supported activities?	• Does the GEF funding support activities and objectives not addressed by other donors? • How do GEF-funds help to fill gaps (or give additional	• Degree to which program was coherent and complementary to other donor programming nationally and regionally	• Documents from other donor supported activities • Other donor representatives • Project Documents	• Documents analyses • Interviews with Project partners and relevant stakeholders

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	stimulus) that are necessary but are not covered by other donors? • Is there coordination and complementarity between donors?			
Does the Project provide relevant lessons and experiences for other similar Projects in the future?	• Has the experience of the Project provided relevant lessons for other future Projects targeted at similar objectives?		• Data collected throughout evaluation	• Data analysis
C2. Effectiveness: To what extent have the expected outcomes and objectives of the Project been achieved?				
Has the Project been effective in achieving the expected outcomes and objectives?	• Has the Project been effective in achieving its expected outcomes? 1. Improved national and local health technical sector capacity to plan for and manage climate change related alterations in the geographic range and/or incidence of climate-sensitive health outcomes, including malaria, diarrhoeal diseases and meningococcal meningitis • 2. Mechanisms established for cross-sectoral coordination to support climate change-resilient health policy formulation and implementation at national and local policy-making levels. • 3. 'Lessons learned' collected and knowledge management components established	• Number and type of health sector policies and programmes relevant for climate sensitive health outcomes revised to address and respond to current and likely future health risks of climate change • Number of national and local health workers trained to identify and manage climate related diseases with increased capacity to apply new knowledge and skills as verified by tests, surveys, and interviews • Number and type of policies, programmes, and plans of MDAs for climate-sensitive health outcomes jointly revised by relevant institutions across sectors and at different levels to integrate climate and health related activities • Number and type of monitoring systems in place to measure climate change resilience in the health sector • Number of stakeholders served by improved climate change related risks data from updated information management Systems Number of Lessons learned from Project activities	• Project Documents • Project team and relevant stakeholders • Data reported in Project annual and quarterly reports	• Documents analysis • Interviews with Project team • Interviews with relevant stakeholders

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
		synthesized and captured in a specific KM Facility (e.g. ALM)		
How is risk and risk mitigation being managed?	• How well are risks, assumptions and impact drivers being managed? • What was the quality of risk mitigation strategies developed? Were these sufficient? • Are there clear strategies for risk mitigation related with long-term sustainability of the Project?	• Completeness of risk identification and assumptions during Project planning and design (see A) • Quality of existing information systems in place to identify emerging risks and other issues • Quality of risk mitigations strategies developed and followed	• Project Documents • UNDP, Project team, and relevant stakeholders	• Documents analysis • Interviews
What lessons can be drawn Regarding effectiveness for other similar Projects in the future?	• What lessons have been learned from the Project regarding achievement of outcomes? • What changes could have been made (if any) to the design of the Project in order to improve the achievement of the Project's expected results?		• Data collected throughout evaluation	• Data analysis
C3. Efficiency: Was the Project implemented efficiently, in-line with international and national norms and standards?				
Was Project support provided in an efficient way?	• Was adaptive management used or needed to ensure efficient resource use? • Did the Project logical framework and work plans and any changes made to them use as management tools during implementation? • Were the accounting and financial systems in place adequate for Project management and producing accurate and timely financial information? • Were progress reports produced accurately, timely and responded to reporting	• Availability and quality of financial and progress reports Timeliness and adequacy of reporting provided • Level of discrepancy between planned and utilized financial expenditures • Planned vs. actual funds leveraged • Cost in view of results achieved compared to costs of similar Projects from other organizations • Adequacy of Project choices in view of existing context, infrastructure and cost • Quality of results-based management reporting (progress reporting, monitoring and evaluation) • Occurrence of change in Project design/ implementation approach (i.e.	• Project Documents and Evaluations • UNDP Project team	• Document analysis • Key interviews

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	requirements including adaptive management changes? • Was Project implementation as cost effective as originally proposed (planned vs. actual) • Did the leveraging of funds (cofinancing) happen as planned? • Were financial resources utilized efficiently? Could financial resources have been used more efficiently? • Was procurement carried out in a manner making efficient use of Project resources? • How was results-based management used during Project implementation?	restructuring) when needed to improve Project efficiency • Cost associated with delivery mechanism and management structure compare to alternatives		
How efficient are partnership arrangements for the Project?	• To what extent partnerships/ linkages between institutions/ organizations were encouraged and supported? • Which partnerships/linkages were facilitated? Which ones can be considered sustainable? • What was the level of efficiency of cooperation and collaboration arrangements? • Which methods were successful or not and why?	• Specific activities conducted to support the development of cooperative arrangements between partners • Examples of supported partnerships • Evidence that particular partnerships/linkages will be sustained • Types/quality of partnership cooperation methods utilized	• Project Documents and evaluations • Project partners and relevant stakeholders	• Document analysis • Interviews
Did the Project efficiently utilize local capacity in implementation?	• Was an appropriate balance struck between utilization of international expertise as well as local capacity? • Did the Project take into account local capacity in design and implementation of the Project? • Was there an effective collaboration between	• Proportion of expertise utilized from international experts compared to national experts • Number/quality of analyses done to assess local capacity potential and absorptive capacity	• Project Documents and evaluations • UNDP • Beneficiaries	• Document analysis • Interviews

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	institutions responsible for implementing the Project?			
What lessons can be drawn Regarding efficiency for other similar Projects in the future?	• What lessons can be learnt from the Project regarding efficiency? • How could the Project have more efficiently carried out implementation (in terms of management structures and procedures, partnerships arrangements etc…)? • What changes could have been made (if any) to the Project in order to improve its efficiency?		• Data collected throughout evaluation	• Data analysis
C4- Country Ownership (relevance)				
Does the Project fit within stated sector development priorities?	• Was the Project concept in line with development priorities and plans of the country? (see C1)	• Coherence between Project objectives and national development objectives	• Government strategy and planning documents relative to DRR, adaptation, land-use/land management, development, MDGs • Project planning documents • Government partners • UNDP staff • Local executing team	• Desk review • Interviews
	• Were the relevant country representatives from government and civil society involved in Project implementation, including as part of the Project steering committee?	• Coherence between Project objectives and community-level (voiced) needs • Number and titles of representatives from a) government, b) civil society, present at workshops, planning meetings Proportion of steering committee members who represent a) government, b) civil society	• Local executing partners, particularly community members, CSOs and local non-government stakeholders, and local government stakeholders • Project monitoring and reporting information (workshop summaries, attendance lists, action items etc)	• Desk Review • Interviews • Field Visit
	• Was an intra-governmental committee given responsibility to liaise with the Project team,	• Existence of a communications/coordination body within the government to oversee and link various government offices relevant	• Local executing partners, particularly governments partners	• Desk Review • Interviews • Field Visit

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	recognizing that more than one ministry should be involved	to Project planning, implementation and intended outcomes Extent of influence and control of coordinating body to prompt/encourage convening or decision-making	• Project monitoring and reporting information (workshop summaries, attendance lists, action items etc) • UNDP staff • Local executing team	
	• Has the government enacted legislation, and/or developed policies and regulations in line with the Project's objectives?	Number and type of regulations, policies or other government initiatives that support Project activities/objectives	• Local executing partners, particularly governments partners • UNDP staff • Local executing team	• Desk review • Interviews
C5- Mainstreaming (relevance)				
Project terminal evaluations must assess how these Projects are successfully mainstreaming other UNDP priorities, including poverty alleviation, improved governance, the prevention and recovery from natural disasters, and women's empowerment				
Does the Project successfully mainstream other UNDP priorities, including poverty alleviation, improved governance, the prevention and recovery from natural disasters, and women's empowerment.	• Is it possible to identify and define positive or negative effects of the Project on local populations?	• Clear links between Project's intended outcomes and (potential) changes in local population perception of the links between health and CC • Evidence that intended outcomes (could/will) contribute to communities' ability to deal with natural disasters	• Local communities, partners • UNDP staff • Local executing team • Monitoring and reporting docs	• Interviews • Desk review • Field Visit
	• Is there evidence that the Project outcomes have contributed to better preparations to cope with natural disasters.	• Examples of disease outbreaks mitigated as a result of Project activities and outcomes	• Local communities, partners • UNDP staff • Local executing team • Monitoring and reporting docs	• Interviews • Desk review • Field Visit
	• Does the Project sufficiently incorporate gender issues?	• Proportion of executing partners, and participants of workshops, trainings or knowledge exchange who are female • Disaggregation of appropriate indicators by gender/sex • Evidence of activities that uptake gender issue into community or national level planning or activities as a result of the Project	• Agendas, attendance lists and other documentation from workshops, planning meetings and trainings • Project planning documentation • Monitoring and reporting docs • Local executing partners • Workshop/training participants	• Interviews • Desk review • Field Visit

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
	• Does the Project align with the priorities set in the UNDAF in Ghana, and the UNDP Country Programme Action Plan (CPAP) and its evaluation plan? (see C1)	• UNDAFF/CPAP priorities • Project objective and outcomes	• Project planning documentation	• Desk review
C6- Sustainability				
Sustainability is considered to be the likelihood of continued benefits after the GEF Project ends. Consequently the assessment of sustainability considers the risks that are likely to affect the continuation of Project outcomes. The GEF Guidelines establish four areas for considering risks to sustainability: Financial risks; socio-economic risk; institutional framework and governance risks; and environmental risks. Each should be separately evaluated and then rated on the likelihood and extent that risks will impede sustainability.				
To what extent are there financial, institutional, social-economic, and/or environmental risks to sustaining long-term Project results?	• Did the Project devise a robust sustainability strategy (in the planning stages)? Did it include a specific exit strategy?	• Existence of a plan for managing each: Financial risks; socio-economic risk; institutional framework and governance risks; and environmental risks • Number and extent of unforeseen barriers to sustainability that arose during implementation • Existence of an exit strategy	• Project planning documents • UNDP staff • Local executing team • Local executing partners • Project monitoring and reporting docs/data (quarterly and annual reports)	• Interviews • Desk review • Field visit
	• Did the Project implement its sustainability strategy?	• Degree of coherence between actions taken during implementation to avert sustainability risks and intended plan	• Project planning documents • UNDP staff • Local executing team and partners • Project monitoring and reporting docs/data (quarterly and annual reports)	• Interviews • Desk review • Field visit
	• What factors are in place that are likely to enable or hinder achievement of sustainable outcomes?	• Number and type of institutional arrangements, regulations, or policy changes that support the continuation of Project activities or results • Extent of Project outcomes' incorporation into community/household activities/planning • Use of expertise of trained individuals/ workshop participants/ implementation partners • Evidence of follow-on champions, funding or other sources of continuation	• Project planning documents • UNDP staff • Local executing team • Local executing partners (workshop participants, community members, etc.) • Project monitoring and reporting docs/data (quarterly and annual reports)	• Interviews • Desk review • Field visit
C7- Catalytic Role				

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
The evaluator should consider the extent to which the Project has demonstrated: a) production of a public good, b) demonstration, c) replication, and d) scaling up. Replication can have two aspects, replication proper (lessons and experiences are replicated in different geographic area) or scaling up (lessons and experiences are replicated within the same geographic area but funded by other sources).				
Production of public good (lowest level of catalytic result)	• Were any new technologies and approaches promoted? • Was the catalytic effect left to 'market forces'?	• Examples of new technologies and approaches promoted and used during Project implementation • Evidence of no action taken as regards the catalytic effect of the Project	• UNDP staff • Local executing team • Local executing partners (workshop participants, community members, etc.) • Project monitoring and reporting docs/data	• Interviews • Desk review • Field visit
Demonstration	• Have any steps been taken to catalyse the public good, for instance through the development of demonstration sites, successful information dissemination and training?	• Number and type of dissemination activities implemented • Number of demonstration sites • Number of trainings organised and number/type of participants in those trainings	• Agendas, attendance lists and other documentation from workshops, planning meetings and trainings • Project communications documentation • Monitoring and reporting docs • Local executing partners	• Interviews • Desk review • Field visit
Replication	• Are any activities, demonstrations, and/or techniques being repeated within or outside the Project, nationally or internationally?	• Examples of activities/Projects/techniques used in the Project and replicated in other Projects/initiatives (other geographical areas and/or funded by other funding partners)	• UNDP staff • Local executing team • Local executing partners (workshop participants, community members, etc.) • Project monitoring and reporting docs/data	• Interviews • Desk review • Field visit
Scaling up	• Are any approaches developed through the Project taken up on a regional / national scale, becoming widely accepted, and perhaps legally required?	• Examples of laws and regulations inspired by Project outcomes • Examples of large scale initiatives building on Project oucomes or methods	• UNDP staff • Local executing team • Local executing partners (workshop participants, community members, etc.) • Project monitoring and reporting docs/data	• Interviews • Desk review • Field visit
C8- Impact				
The evaluator should discuss the extent to which Projects are achieving impacts or are progressing toward the achievement of impacts among the Project beneficiaries. Impacts in the context of adaptation Projects refer to the extent to which vulnerability to climate change has decreased, as measured by the indicators included in the Results Framework, and other quantitative and qualitative information. Process indicators, such as regulatory and policy changes, can also be used to measure impact				

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
Are there indications that the Project has contributed to, or enabled progress toward, reduced vulnerability to climate change?	• Is the Project progressing toward achievement of intended impacts among Project beneficiaries?	• Number and extent of achievement of milestones toward achieving **process** indicators (regulatory, policy changes)[35]. • Number and extent of achievement of milestones toward meeting **impact** indicators (reduction in vulnerability)[36] • Evidence and extent of barriers *or* enabling conditions toward achievement of each key outcome	• Monitoring and reporting documents (quarterly and annual work plans) • UNDP staff • Local executing team • Local executing partners • Local stakeholders • Direct observation	• Interviews • Desk review • Field visit
	• Have there been any unintended results (positive or negative) and what were they?	• Number and type of co-benefits and/or other unplanned consequences from Project activities or outputs to date • Extent and nature of external factors' influence on Project progression toward intended results	• Monitoring and reporting documents (quarterly and annual work plans) • UNDP staff • Local executing team • Local executing partners • Local stakeholders • Direct observation	• Interviews • Desk review • Field visit
	• Were the Project concepts in line with development priorities and plans of the country?	• Coherence between Project objectives and national development objectives	• Government strategy and planning documents relative to DRR, adaptation, land-use/land management, development, MDGs • Project planning documents • Government partners • UNDP staff • Local executing team	• Interviews • Desk review
	• Were the relevant country representatives from government and civil society involved in Project implementation, including as part of the Project steering committee?	• Coherence between Project objectives and community-level (voiced) needs • Number and titles of representatives from a) government, b) civil society, present at workshops, planning meetings • Proportion of steering committee members who represent a) government, b) civil society	• Local executing partners, particularly community members, CSOs and local non-government stakeholders, and local government stakeholders • Project monitoring and reporting information	• Interviews • Desk review • Field visit

[35] All indicators defined in the results framework are process indicators.
[36] There are no impact indicators.

Evaluative criteria	Evaluation questions	Indicators	Information Source	Data Collection Method
			(workshop summaries, attendance lists, action items etc)	
	• Is there a functional intra-governmental committee to liaise with the Project team and connect various ministries/government offices involved in or affected by the Project?	• Existence of a communications/ coordination body within the government to oversee and link various government offices relevant to Project planning, implementation and intended outcomes • Extent of influence and control of coordinating body to prompt/encourage convening or decision-making	• Local executing partners, particularly governments partners • Project monitoring and reporting information (workshop summaries, attendance lists, action items etc) • UNDP staff • Local executing team	• Interviews • Desk review • Field visit
	• Has the government enacted legislation, and/or developed policies and regulations in line with the Project's objectives?	• Number and type of regulations, policies or other government initiatives that support Project activities/objectives	• Local executing partners, particularly governments partners • UNDP staff • Local executing team	• Interviews • Desk review

Annex 2. List of documents and websites consulted for the TE

Document name	Author / Organization	Publication Date
Africa Adaptation Programme on climate change Ghana final project review report	**UNDP**	January 2013
Annual work programme 2012-2013 and 2015	UNDP	n/a
Assessing the nature and quality of data from existing relevant surveillance systems for integrating climate change data into existing health information system	Mawuli Dzodzomenyo, School of public health	18 sept 2015
Assessment of Existing Relevant Climate, Health, Poverty and Vulnerability Information	Republic of Ghana, UNDP-GEF	undated
Capacity Assessment on Climate Change and Health Related Risks	Mike Walsh MIC and Associates	July 2012
Capacity building strategy on climate change and health related risks, final technical report	Republic of Ghana, UNDP-GEF	undated
Climate Change Health Risk Mapping Sub-National Climate Risk Maps for Ghana	Republic of Ghana, UNDP-GEF	undated
Climate change resilience in the health sector: the implications for the monitoring and evaluation system in Ghana	Kwame Quandahor	Undated
Determination of Optimal Institutional Coordination Mechanism for the Management of Climate Change Related Health Risks	Winston Adams Asante, Benjamin Gyampoh	January 2013
Development of a gender sensitive climate resilience screening tool for the health sector	Elizabeth Marcia Halm	31st October, 2014
Development Of Indicators For Measuring Climate Change Resilience In The Health Sector	Ministry of Health, Ghana	9 May 2012
Disease Surveillance Assessment in Response to Climate Change	Michael Jeroen Adjabeng	October 2014
End of Project report, integrating climate change into the management of priority health risk in Ghana.	Abena Dedaa Nakawa, Project Associate	September 2015.
Evaluation of the Catalytic Role of the GEF. A Qualitative Analysis of Terminal Evaluations. Avery Ouellette.	GEF Evaluation Office	October 2008

Gender Sensitive Climate Change Communication Strategy	Ministry of Health, Ghana	May 2012
Ghana climate Projections for health sector response	KNUST, Dr. Leonard K. Amekudzi	undated
Ghana National Climate Change Policy	Ministry of Environment, Science, Technology and Innovation	2013
Guidelines for the use of a gender sensitive climate resilience screening tool for the health sector	Elizabeth Marcia Halm	31st October, 2014
Guidelines for Project Financing, GEF Council Meeting November 8-10, 2011 Washington, D.C	GEF	2011
Guidance for Conducting Terminal Evaluations of UNDP-supported, GEF-financed projects	UNDP Evaluation Office	2012
Health Sector Medium Term Development Plan	MOH	-
Identification of best practices under the climate change and health Project and development of methods for their implementation, dissemination and incorporation into the health sector central database	Nana Ama Browne Klutse, Ph. D Ghana Space Science and Technology Institute	2015
Incorporating Gender-Sensitive Actions in the 2014-2017 Health Sector Medium Term Development Strategy	-	October, 2014
Integrating Climate Change Into the Management Of Priority Health Risks in Ghana Project (PIMS 3796). – Terms of Reference, Terminal Evaluation	UNDP	October 2015
Integrating climate change into the management of priority health risks in Ghana. Request for CEO Endorsement and Project Document.	UNDP/GEF	Sept 2010
Integrating Climate Change Into The Management Of Priority Health Risks In Ghana A Training Manual For Healthcare Providers And Volunteers	Republic of Ghana, UNDP-GEF	undated
List of SC and TAC members	UNDP	undated
Medium-term national development policy framework: Ghana shared growth and development agenda (GSGDA), 2010-2013	Government of Ghana, National Development Planning Commission (NDPC)	7 Sept 2010
Mid-Term Evaluation of the Project: Integrating Climate Change into the Management of Priority Health Risks in Ghana + Annexes and comments tracking	Dennis Fenton	January 2014
Minutes of PSC meetings	PIU	20 Feb 2013, 16 May 2013, 20 June 2013,

		12 March 2014, 29 May 2015,
National Climate Change Adaptation Strategy	CC DARE, UNDP-UNEP	undated
National Plan of Action for Health sector Adaptation to Climate Change in Ghana 2015-2019	-	n/a
Project balances 2011, 2012, 2013, 2014, 2015	UNDP	n/a
Project Implementation Review (PIR) 2015	UNDP	2015
Project inception report	UNDP	December 2012
Project-level evaluation. Guidance for conducting terminal evaluations of UNDP-supported, GEF-financed Projects	UNDP Evaluation Office	2012
Quarterly progress reports: 2012 Q1, Q2, Q3, Q4; 2013 Q1, Q2; 2014 Q3, Q4; 2015 Q1, Q2, Q3, Q4	UNDP	n/a
Reviewing the health Sector Medium Term Development Plan to incorporate climate change in health sector planning	Dr JAMES ANTWI	Oct 2015
Terms of Reference of Technical Advisory Committee	PIU	undated
Training Needs Assessment and Agenda for Training, Trainers' guide	Republic of Ghana, UNDP-GEF	undated
Various documents from the three districts, including minutes of meetings, training reports, risk maps	-	-

List of websites consulted

http://ghana.um.dk/en/danida-en/health-sector

http://ghana.um.dk/en/danida-en/health-sector/

http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_gha_en.pdf?ua=1

Annex 3. List of people interviewed

Name	Institution/Position
Abena Nakawa	Project associate, UNDP
Beatrice Heymann	Programme, Policy, Monitoring and evaluation unit - GHS
Stephen Kansuk	Project officer, UNDP
Namho Oh	Former Project officer, UNDP
Joseph BAFFOE	Principal Programme Officer, EPA climate change unit
Louis Kuukpen	Assistant country director, UNDP
Isaac Adams	Director of Research and Project Director, MoH
Awoonur William John Koku	Director of PPME, GHS
Akosua Kwakye	National programme officer, public health and environment, WHO
Felix Addo-Yobo	National Development Planning Commission (in charge of environmental policy
Edith Clarke	Programme manager, Occupational & Environmental Health Unit, GHS
Carl Osei	Deputy programme manager, Occupational & Environmental Health Unit, GHS
Emmanuel Kyeremanten-Amoat	Programme Manager, Occupational & Environmental Health Unit, GHS
Juliana Anam- Emerie	District Director of health Services, Bongo
Donatus Abaane	District Disease Control Officer, Project Focal Person, Bongo
Dr Amussa	Head, district health services, Gomoa West
Amy Takyi	Project focal point, district health services, Gomoa West
Daniel Baah Tenkorang	District planning officer, Gomoa West District Assembly
Clituh Bayor	Disease control officer, district health services, Gomoa West
Olivia Amoefi Adefo	Midwife, Apam health center, Gomoa West
Peter Bon-Forgon	Community health nurse, Apam health center, Gomoa West
Solomon Asiedu	Accountant, district health services, Gomoa West
Edward Owusu	Disease control officer, district health services, Gomoa West

Jerela Joseph Yaw	Municipal Disease control officer, Keta municipality
Dr Andrew Ayim	Municipal Director of Health Services, Keta
Mr Serene Akpanya,	Administrator, Municipal Hospital, Keta
Nurses, midwifes	Kedzi Health Center
Nurses, midwife, Outreach officers	Anyanui health center
Benjamin Yaw Manu	Former Project Manager, Project Implementation Unit

Annex 4. Interview protocols

The interview protocols presented below will be adjusted to each interviewee, taking into account his/her specific position vis-a-vis the Project, his/her expertise and function. Each interview will aim to be limited to a maximum of 15 questions, with the exception of the Project team, which will play a more significant role in providing information

A. Project Formulation

1. In your opinion was the Project designed realistically? (E.g. with respect to timeframe, objectives, indicators/M&E plan, other design elements)
2. How were the capacities of the local executing institution and partners (other national institutions, regional and district governments, etc) assessed? Were there any gaps between expected and actual capacities (or cases of exceeding expectations) needed for Project execution?
3. In your opinion, has the Steering Committee been responsive to the needs of the Project? What would improve their respective contributions?
4. Were counterpart resources (funding, staff, and facilities), enabling legislation, and adequate Project management arrangements in place at Project entry?
5. How do you understand your role in this Project? Are you aware of any gaps reported between expected and actual capacities (or cases of exceeding expectations) needed for Project execution or to fulfil your role?
6. What do you think are the main risks to the success of the Project? Have these risks been anticipated and managed appropriately?
   -

B. Project Implementation

7. How would you describe the relationship between Project executing organizations (Project management team at the MoH and other Ghanaian organizations)? How would you describe the nature and extent of interactions between the EA, the management team, the partner executing institutions (other national institutions, provincial and council governments…) and wider stakeholder groups?
8. Do you think the implementing agency (UNDP) has been sufficiently involved in ensuring the Project is implemented as planned? What is your opinion of its role and supervision (e.g. responsiveness, timeliness, quality of oversight, etc)?
9. How well is the Project managed by the team in place? Does it react appropriately to inquiries, difficulties, identified risks, and is it in a timely manner?
10. How were lessons learned from other past or on-going Projects in the region (or in a similar focal area) incorporated into this Project's design or management?
11. Do you know of any examples of lessons learned from other past or on-going Projects in the region (or in a similar focal area) that have been incorporated into this Project's design or management?
12. Do you think regular monitoring and reporting informs management decision-making? Can you give any examples of follow-up actions, and/or adaptive management taken in response to monitoring reports such as PIRs and MTR, for example?

13. How would you describe this Project's M&E system, and do you think it has been sufficient and appropriate to Project needs? Do you think M&E has been used according to plans (timeline, budget)? If not, why?

•

14. How were monitoring and evaluation reports disseminated and discussed with stakeholders and Project (AF/LDCF) staff? Were there any meetings, workshops or other mechanisms used to share M&E material?

15. Has the Project prepared and submitted good quality reporting material, and to what extent has it been delivered on time?

16. How has monitoring and other reporting information been disseminated and discussed with stakeholders? Were there any meetings, workshops or other mechanisms used to share M&E material?

17. Did the Project undergo significant changes as a result of recommendations from workshops, the steering committee, or other review procedures (internal or external)? Why were these changes recommended? Have the expected Project outcomes (or the likelihood of achieving them) been modified as a consequence of these changes?

18. Work session with finance officer and Project team:

    - Fill in tables on budget execution per year and activity:
        - Where do we stand as regards initial plans?
        - Do you have any figures on co-financing? How are co-financed activities integrated into Project strategy and implementation?
        - Is there evidence of resources leveraged since inception?
    - *Table of planned/achieved budget and staff time devoted to the Project*
    - *Table of planned/achieved outputs*

19. What are the differences in the anticipated set of stakeholders identified at Project design, and those actually involved in Project implementation? Do you think the Project has reached a sufficient number of relevant stakeholders?

20. Have you participated to any stakeholder engagement activities conducted? How many? Can you think of examples of how public awareness (of climate change, of vulnerability, of resilience of rural communities, etc) has been improved by the Project?

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C. Project Results

Relevance/Country ownership/mainstreaming

21. In your opinion, was the Project concept in line with development priorities and plans of the country? Does it respond to actual needs of the various categories of stakeholders (1. Community groups 2. Local government 3. National government 4. Non-government groups 5. Other donor-supported activities)?

22. Do you think all relevant stakeholders are actually involved in Project implementation, including as part of the Project steering committee? Are the expressed needs of communities sufficiently addressed by the Project?

23. What body or persons are responsible for communication/coordination between the various Project partners (among/between government entities/ministries, the Project management team, etc) and can this body/person prompt convening and/or decision-making? How are the proceedings of ST meetings communicated to a wider set of Project stakeholders?

24. To your knowledge, has the government enacted any regulations, policies or other initiatives that support Project activities or objectives? Could you please provide us with further details (name(s) of legislation, dates, purpose(s), etc)?
25. In your opinion, what are the effects (+ or -) of the Project on local populations in terms of understanding of the links between CC and health and ability to deal with natural disasters?
26. How are women and/or girls integrated into Project implementation? (e.g. number of women in Project team/workshops/trainings; examples of activities where gender issues are specifically considered)
27. Regarding financial aspects, is there any variance between planned and actual expenditures? If there is, what is the explanation? What resources has the Project leveraged? What was the effect of cofinancing on Project performance
    -

Effectiveness

28. In your opinion, has the Project been effective in achieving the expected outcomes and objectives?
29. How has risk and risk mitigation being managed
30. What lessons can be drawn regarding effectiveness for other similar Projects in the future?

Efficiency

31. In your opinion, was Project support provided in an efficient way in terms of use of financial resources, Project management and reporting?
32. Was Project implementation as cost effective as originally proposed? Could financial resources have been used more efficiently?
33. Which partnerships/linkages were facilitated? What was the level of efficiency of cooperation and collaboration arrangements? Which ones can be considered sustainable?
34. Did the Project efficiently utilize local capacity in implementation?
35. How could the Project have more efficiently carried out implementation (in terms of management structures and procedures, partnerships arrangements etc…)? what lesons can be learnt from the Project in this respect?

Sustainability

36. What do you think are the main risks and barriers to sustainability of Project results? Has the Project sufficiently planned for and/or managed these variables/conditions? How/in what ways? (link with indicator: Evidence and extent of barriers or enabling conditions toward achievement of each key outcome)
37. Can you cite any examples of specific actions (institutional arrangements, regulations, incorporation of Project activities into community/household activities/planning, identifying follow-on champions, financial allocations) taken to ensure sustainability of Project activities or results?

Catalytic role

38. Can you provide any examples of Project activities or outputs that were replicated in a different geographic area, or scaled-up in close proximity to Project sites?
39. Were there any capacity building activities for the purposes of replication? Have Project-trained individuals, institutions, or companies participated in the replication of activities?

Impact

40. What major regulatory or policy changes can be reported as a result of Project outcomes?
41. Can you cite any examples of a reduction of vulnerability to climate change as a consequence of Project activities?
42. Can you describe any other co-benefits and/or other unplanned consequences (+ or -) from Project activities or outputs to date?

Annex 6. Terms of reference of the TE

See PDF file

TDR.pdf

Annex 7. Rating scales

RATING OF PROJECT OBJECTIVES AND RESULTS

Highly Satisfactory (HS): The Project had no shortcomings in the achievement of its objectives, in terms of relevance, effectiveness or efficiency.

Satisfactory (S): The Project had minor shortcomings in the achievement of its objectives, in terms of relevance, effectiveness or efficiency.

Moderately Satisfactory (MS): The Project had moderate shortcomings in the achievement of its objectives, in terms of relevance, effectiveness or efficiency.

Moderately Unsatisfactory (MU): The Project had significant shortcomings in the achievement of its objectives, in terms of relevance, effectiveness or efficiency.

Unsatisfactory (U) The Project had major shortcomings in the achievement of its objectives, in terms of relevance, effectiveness or efficiency.

Highly Unsatisfactory (HU): The Project had severe shortcomings in the achievement of its objectives, in terms of relevance, effectiveness or efficiency.

Please note: Relevance and effectiveness will be considered as critical criteria. The overall rating of the Project for achievement of objectives and results **may not be higher** than the lowest rating on either of these two criteria. Thus, to have an overall satisfactory rating for outcomes a Project must have at least satisfactory ratings on both relevance and effectiveness.

RATINGS ON SUSTAINABILITY

Sustainability is generally considered to be the likelihood of continued benefits after the Project ends. Consequently the assessment of sustainability considers the risks that are likely to affect the continuation of Project outcomes. The GEF Guidelines establish four areas for considering risks to sustainability. Each should be separately evaluated and then rated as to the likelihood and extent that risks will impede sustainability. Rating system for sustainability sub-criteria

On each of the dimensions of sustainability of the Project, outcomes will be rated as follows.

Likely (L): There are no risks affecting this dimension of sustainability.

Moderately Likely (ML). There are moderate risks that affect this dimension of sustainability.

Moderately Unlikely (MU): There are significant risks that affect this dimension of sustainability

Unlikely (U): There are severe risks that affect this dimension of sustainability.

All the risk dimensions of sustainability are critical. Therefore, overall rating for sustainability will not be higher than the rating of the dimension with lowest ratings. For example, if a Project has an Unlikely rating in either of the dimensions then its overall rating cannot be higher than Unlikely, regardless of whether higher ratings in other dimensions of sustainability produce a higher average.

RATINGS OF PROJECT M&E

Monitoring is a continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing Project with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds. Evaluation is the systematic and objective assessment of an on-going or completed Project, its design, implementation and results. Project evaluation may involve the definition of appropriate standards, the examination of performance against those standards, and an assessment of actual and expected results.

The Project monitoring and evaluation system will be rated on 'M&E Design', 'M&E Plan Implementation' and 'Budgeting and Funding for M&E activities' as follows:

Highly Satisfactory (HS): There were no shortcomings in the Project M&E system.

Satisfactory(S): There were minor shortcomings in the Project M&E system.

Moderately Satisfactory (MS): There were moderate shortcomings in the Project M&E system.

Moderately Unsatisfactory (MU): There were significant shortcomings in the Project M&E system.

Unsatisfactory (U): There were major shortcomings in the Project M&E system.

Highly Unsatisfactory (HU): The Project had no M&E system.

"M&E plan implementation" will be considered a critical parameter for the overall assessment of the M&E system. The overall rating for the M&E systems will not be higher than the rating on "M&E plan implementation."

Annex 8. Assessment of Progress towards Outputs

Table 10: Assessment of Progress towards Outputs

Output	MTR: Progress and Comment[37]	TE progress and comments
Output 1.1 A national climate change and health inter-ministerial committee is established that includes key representatives from relevant programmes in the Ministry of Health, Ghana Health Service, WHO country office, Ministry of Environment Science and Technology, the National Climate Change Committee, the National Development and Planning Commission, and others.	One of the background studies (see II.2.2) assessed coordination mechanisms and made recommendations. No direct activities have been implemented yet.	Steering committee established but not very active nor very diverse in terms of membership, as mentioned earlier. After MTR, TAC established, working at technical level. Several TAC meetings organized (but no minutes made available). Effectiveness and quality of the work conducted by the TAC highlighted by numerous national and even district level stakeholders. Has allowed for real piloting of Project by a small group of technical people. Replaced in some ways the Project manager when he left. In addition, the Project worked with the Health and Environment Strategic Alliance (HESA) which was set up in response to the Libreville Declaration and hosted by the occupational and environmental health unit of the Ghana health Service and is supported by WHO
Output 1.2 Regional and district coordinating mechanisms strengthened for enhanced management of climate change-related health risks	One of the background studies (see II.2.2) assessed coordination mechanisms and made recommendations. An interagency coordination committee (ICC) has been supported in each of the three pilot districts. These are greatly appreciated and are making a difference (e.g. leading to joint planning of some relevant activities and sharing information). Many of the recommendations of the background study were not followed. There is no clear plan for sustainability of the ICC.	ICCs have been put in place in each district, enabling, through (rather) regular meetings, to adopt a joint approach to environmental degradation as it relates to health. In the three districts these committees are said to have enhanced collaboration between different agencies (health, environment, agriculture, education, etc.) and better structured their work. They are expected to continue their work (which has no financial implication), through regular meetings, after Project close: - In Bongo: the ICC and the district emergency preparedness committee were merged as membership was the same. To the emergency preparedness committee now specifically deals with CC issues as well. - In Gomoa West, the ICC is planned to meet regularly in future years.

[37] Please refer to menteind sections in the MTR document

Output	MTR: Progress and Comment[37]	TE progress and comments
		- In Keta, the ICC has been merged with the existing (but rather inactive) Public health emergency management committee (similar to Bongo), which is planned to meet regularly. The Project has strengthened collaboration across sectors. It is not evident that the coordination mechanism at the regional level has been strengthened.
Output 1.3 Training materials developed and delivered for health workers at the national, regional, district and sub-district levels to identify and respond to the current and likely future health risks of climate change on relevant diseases, including the differential impact on women and children	One of the background studies (see II.2.2) assessed training needs and developed related material. Training has been supported on a range of issues (management, climate change, surveillance, mapping, referrals and basic health care systems). Training has mostly focused on district level health workers (34) and community volunteers[38] (several hundred) and some regional / national stakeholders. Regional health workers and key District stakeholders from other sectors (Assembly, environment, education etc) have also benefitted from awareness raising and training. The training materials are incomplete (see II.2.2). The linkages between the concerned background study and the actual training are very weak – in fact the training material prepared under the Project is not used in the Project. The linkages between the concerned background study and other Ministry training and human resource development initiatives are not evident. The strategic nature of the training – i.e. how it links to an overall picture - is absent, and although all training is relevant, it appears somewhat ad hoc.	Same analysis as during MTR. Many relevant trainings realized. The MTR says "The strategic nature of the training – i.e. how it links to an overall picture - is absent, and although all training is relevant, it appears somewhat ad hoc". This remains at Project end, but interviews at district level suggest that each district teams have tried to adapt the trainings to the local needs, along the local health strategy. Some trainings were for example jointly delivered with those planned under other initiatives, thus liking the CC-health issues to other issues relating to disease surveillance and activities of the sub district heath facilities. The Project final report states "In all, the Project succeeded in training about 700 health workers at the national, regional, district and community levels in all three pilot districts to identify and manage climate health risk relative to each pilot district considering the three tracer diseases, malaria, diarrhoea and CSM". This exact number cannot be verified but the evidence collected (minutes of trainings and meetings, pictures) confirms this order of magnitude.

[38] The GHS uses the services of a large number of 'community based volunteers'. These are trained regularly and support surveillance. They are compensated for their work, but are not employees of GHS.

Output	MTR: Progress and Comment[37]	TE progress and comments
Output 1.4 Sub-national level climate change health risk maps developed that depict current and likely future areas vulnerable to diarrhoeal disease, malaria, and CSM.	One of the background studies (see II.2.2) prepared some district level maps for the three pilot districts and supported some initial related training and capacity building. Further training for district level health workers on risk mapping is planned for coming year. Some maps have been prepared, although mostly by external consultants, and as a one-off. As such, they are not of use to district health workers for planning, surveillance or risk monitoring. Multi-dimensional, inter-active, real-time maps would be required. General opinion is that they can be prepared by Regional (and not District) stakeholders.	District level maps prepared and staff trained to produce and update such maps (GIS training in particular). An ArcGIS training manual, titled *Introduction to GIS with ArcGIS 10.x for the Health Services* was also developed. District interviewees confirm those maps are useful to their work: it is a tool that highlights hotspots in terms of disease outbreaks, and can be used, if maintained over a certain period of time, to decide on local priority actions. It is also useful to make presentations and raise awareness. Two issues arise however: • District teams trained have not been provided with a software license (ArcGIS) due to its cost. Therefore, they rely on ArcGIS trial version, which is free for a period of 3 months, and must reload a new trial version (with a new email address) every three months. The trial version would also miss some useful functions. • Given the complexity of GIS, it seems rather clear that intensive training of some staff at the regional level, with ArcGIS licenses paid for, could have been more effective and sustainable. Districts could collect data according to a given format and send it weekly to regional offices for updating and communicating back the maps (through an online platform ideally, as suggested in the MTR). Overall, the maps do exist and are useful, but the sustainability of this activity will only be ensured if some more resources are made available for training and organizing maps updating at regional level.
Output 2.1: A strategy for mainstreaming climate change risks into health sector policies and measures is developed and implemented in collaboration with the Ministry of Health, Ghana Health Services, the Environmental Protection Agency and development partners in the Health and environment sector.	Project stakeholders (notably the Ministry of Health) have been involved in the preparation of the *Health Sector Medium Term Development Plan (HSMTDP), 2014–2017*, which, *for the first time*, has one strategy under one objective related to mainstreaming climate change into health sector. The aim is to prepare a mainstreaming	A study report on mainstreaming climate change, titled *Reviewing The Health Sector Medium Term Development Plan to Incorporate Climate Change in Health Sector Planning* and dated October 2015 has been produced. The study introduced that "after four years of the implementation of the pilot Project, the Ministry of Health has not been able to mainstream health related climate change activities. Therefore gaps between policy, evidence and practice on

Output	MTR: Progress and Comment[37]	TE progress and comments
	strategy – i.e. Output 2.1 is to be undertaken through HSMTDP 2014 – 2017. Although the Project has not played a direct role in the above, through its general support to MOH and its staff and associated awareness raising, some attribution can go to Project. Within the Project framework, collaboration with GHS and EPA on the above is not evident. There is no mechanism for ensuring that lessons learnt from Project (from the three pilot Projects or from international best practices) are fed into national strategy. Notably, there is no mechanism for ensuring that lessons learnt through the GHS local level offices will feed into national policy – as is the rationale for the pilot activities.	climate change and health and best practices that have been uncovered from the pilot studies may not be incorporated into the formal planning process of the entire health sectors". The Health Sector Medium Term Development Plan does now incorporate climate change. The health sector is also duly integrated in the Ghana National Climate Change Strategy, dated 2013. To some extent, the initiative of the Project has contributed to this, given that the same people from the ministry of health were involved in its preparation.
Output 2.2: Health Sector Medium Term Development Plan specifies gender-sensitive actions to address the health risks of climate change, and mechanisms for implementation.	This is partly covered by above. No gender specific activities have been implemented.	This is partly covered by above. The study report *Incorporating Gender-Sensitive Actions in the 2014-2017 Health Sector Medium Term Development Strategy*, October 2014, focuses on the impact of climate change on gender-sensitive issues in relation to Health Sector Medium Term Development Strategy. There is no indication however on how this report was used by the MoH and GHS to adapt the HSMTDP regarding gender so far. As it happens, within the HSMTDP, the strategy relating to climate change "Formulate national strategy to mitigate the effect of climate change related diseases" does not include any reference to gender issues.
Output 2.3: A gender-sensitive climate risk screening tool for the heath sector is developed	Work on indicators has commenced but is currently stalled. There is no information as to whether it is gender sensitive, but the ToR did call for this.	The document *Development of a gender sensitive climate resilience screening tool for the health sector* has been prepared in 2014. As an annex, a screening tool is proposed, consisting in a set of 59 questions/indicators covering the following thematic areas: • Governance

Output	MTR: Progress and Comment[37]	TE progress and comments
	No other direct activities related to this Output have been implemented yet.	• Demography and Human Resource • Socio-Cultural • Economic • Access to Health Care • Vulnerability • Epidemiology and Disease Control The tool enables to produce a radar chart giving the position of the district along the different thematic areas. It was tested in the 3 pilot districts. The report concludes that "It is possible to administer a simple tool at the district level to assess and help build the district resilience for a gender sensitive health system that can lend itself to local modifications and adaptations and yet make it also possible to compare performance across districts." The report also recommends that : • UNDP/MOH does everything possible to support the operationalization of the Tool and Guidelines • Regional Health Directorates administer the Tool to gauge the level of resilience of their districts. • The pilot Districts begin to use the Tool for self-assessment and improvement, particularly working through the ICC. Given the difficulty in implementing the tool based on this report, *Guidelines For The Use Of A Gender Sensitive Climate Resilience Screening Tool For The Health Sector* have been produced as a complement. Overall, the tool looks rather complete and detailed, but requires a significant level of effort to implement, which may not fit the available resources in the districts/MoH/GWS. Plans to disseminate the tool and use is at various levels of GHS exist, although for now they are part of the "unfinished agenda" of the Project.
Output 2.4: Methods and Indicators are identified to measure climate change resilience in the health sector.	Work on indicators has commenced but is currently stalled. No other direct activities related to this Output have been implemented yet.	Covered above
Output 2.5: Disease surveillance systems are strengthened to	District and community health infrastructure has been	Same as MTR.

Output	MTR: Progress and Comment[37]	TE progress and comments
better avoid, prepare for, and effectively respond to climate change-related health risks, to ensure coherent responses to emergencies and changing disease patterns; using CSM, diarrheal disease, and malaria as entry points.	strengthened with (i) training (ii) awareness raising (iii) an in-country learning trip to Amansie West (Ashanti Region) for pilot districts to learn about tele-consultation (iv) provision of mobile phones and other equipment (laptops and GPS) (v) logistical support to weekly district team (DHMT) meetings (vi) support to ORT corners. These activities contribute to strengthening local health infrastructure and therefore increasing resilience to climate change. However, the strategic nature behind these particular activities is not clear – e.g. why support to mobile phone referrals, why support to ORT corner? There is no end-points regarding strengthening the surveillance system and how this relates to climate change.	The Project has also supported the establishment of teleconsultation centres in the 3 districts. They consist in a facility with 4 computers and phones, run by trained heat staff and open 24/7, to which local health facilities will refer by phone in case of need. The teleconsultation centres will link up with hospital doctors as necessary. The facilities are in place in the three districts [39] and awaiting for staff training before they actually start activity.
Output 3.1: Data on climate change-related risks from surveillance systems integrated into health information management systems to facilitate regular evaluation of the distribution and patterns of climate sensitive health outcomes.	Currently, there is a national and a district information management systems for health. The MOH can ensure they are merged. Currently, data at district and lower levels is lacking. No specific activities towards this Output have been implemented yet.	A *Disease Surveillance Assessment in Response to Climate Change* has been conducted and delivered in October 2014 Recommendations include: • A working relationship with the Ghana Meteorological Agency needed to enable periodic regular accessibility to meteorological data for analysis on climate change. • A more anticipatory surveillance system needed for climate change outcomes for earlier response/interventions to be made. We could use the pattern exhibited by climatic variables to predict peaks of disease transmission rates. Study: *Assessing the nature and quality of data from existing relevant surveillance systems for integrating climate change data into existing health information system* delivered in September 2015. It is not clear

[39] In Bongo district, the facility has been transferred at the regional level so as to cover all the districts with one centralised teleconsultation unit.

Output	MTR: Progress and Comment[37]	TE progress and comments
		however how this study will contribute to the integration of climate change-related risks from surveillance systems integrated into health information management systems. Actual integration into health information management systems remains a challenge.
Output 3.2: Based on pilot studies, sub-national climate risk maps updated and disseminated.	See 1.4 above. The background study (see II.2.2) prepared some district level maps and initiated capacity building. It is not clear how this was 'based on the pilot studies'. The maps were prepared by external consultants as a one-off. As such, they are not of use to district health workers for surveillance or risk monitoring. Multi-dimensional, inter-active, on-line maps are required, and general opinion is that they can be prepared by Regional (not District) stakeholders.	See 1.4 There has been no apparent replication of the experience from the 3 pilot districts into other districts/regions of the country so far, although the intention is there.
Output 3.3: Best practices and lessons learned are recorded and disseminated, and the information is incorporated into national and local climate change and health action plans	Currently very few best practices and lessons learned have been generated – so it is too early to assess this Output. The Project website has been established and will be a useful platform for sharing when lessons are available.	Report *Identification of best practices under the climate change and health Project and development of methods for their implementation, dissemination and incorporation into the health sector central database* intends to highlight a number of successful activities implemented by the Project. It fails however to extract replicable lessons learned that can be used in future by the different Project stakeholders.
Output 3.4: Gender-sensitive information, education, and communication materials are created and disseminated to health and other stakeholders at different levels.	One of the background studies (see II.2.2) assessed current knowledge, attitudes and practices, particularly at community level. The same study also prepared a communications strategy. To some extent it looked at gender aspects. In parallel, the Project has supported awareness raising, mostly through its training and planning activities.	Same as MTR

Output	MTR: Progress and Comment[37]	TE progress and comments
	The background information generated by the study is good and could be most useful. The actual communication strategy prepared under the study is less useful and is not being used. The linkages between the work done under this Output and existing activities by the Ministry and GHS on communications are very weak.	

Annex 9. Matrix for assessing the achievement of outcomes

Table 11. Matrix for assessing the achievement of outcomes

GOAL/OBJECTIVE/Outcome	Performance Indicator	Baseline	End of Project target	End of Project status	TE comments	Rating
Project Objective: To identify, implement, monitor, and evaluate adaptations to reduce current and likely future burdens of malaria, diarrheal diseases, and meningococcal meningitis in Ghana	• National strategy developed for mainstreaming the health risks of climate change into health sector policies and programmes, with implementation of measures that reduce the number of current and likely future cases of malaria, diarrhoeal disease, and meningococcal meningitis related to climate change	• No national strategy for addressing the health risks of climate change No measures specifically designed to identify, monitor, or reduce the health risks of climate change	• National strategy developed for mainstreaming health-related climate change risks into policies and programmes • Sub-targets for specific measures to be further determined at Inception Workshop, given complexities with data that are still being resolved.	• A *National Plan of Action for Health sector Adaptation to Climate Change in Ghana 2015-2019 has been published*. • There are no sub-targets determined in inception report.	The Project objective has been partially reached. Adaptation options to reduced vulnerability to CC have been identified, implemented and monitored in the three pilot districts. More work is however necessary to reinforce the Project gains, ensure they are sustainable and replicate them to other districts and at the regional level.	MS
Outcome 1 Improved national and local health technical sector capacity to plan for and manage climate change related alterations in the geographic range and/or incidence of climate-sensitive health outcomes, including malaria, diarrhoeal	• Number and type of health sector policies and programmes relevant for climate sensitive health outcomes revised to address and respond to current and likely future health risks of climate change • Number of national and local health workers trained to	• Health sector policies and programmes not designed to specifically address the risks of climate change • No training programme for health workers on planning and managing climate sensitive diseases	• By the end of the Project, at least three health sector policies and programmes relevant for climate sensitive health outcomes revised	• Two policies have been directly impacted by the Project: the *Health Sector Medium Term Development Plan* and the *National Plan of Action for Health sector Adaptation to Climate Change in Ghana 2015-2019*	It is not clear how the first indicator actually relates to the outcome. Capacities at national and local level are definitely improved, but more could have been expected in terms of securing the sustainability of the activities implemented.	S

diseases and meningococcal meningitis	identify and manage climate related diseases with increased capacity to apply new knowledge and skills as verified by tests, surveys, and interviews		• At least 54 health workers per pilot district per year trained in planning and gender-sensitive management of climate-related diseases report effective application of new skills and knowledge, i.e. a total of 162 health workers per year, or 486 over the 3 years of the Project • By the end of the Project, at least three Sub-national climate change and health risk maps developed for diarrhoeal disease, malaria, and CSM	• The number of health workers trained has exceeded 54. • Climate risk maps have been developed and are used in the three pilot districts		
Outcome 2 Mechanisms established for cross-sectoral coordination to support climate change-resilient health policy formulation and implementation at national and local policy-making levels	• Number and type of policies, programmes, and plans of MDAs for climate sensitive health outcomes jointly revised by relevant institutions across sectors and at different levels to integrate climate and	• Health risks associated with climate change have not yet been consciously factored into plans, programmes and policies of health related MDAs	• By the end of the Project, Health Sector Medium Term Development Plan revised to address the health risks of climate change • At least three relevant policies/ programmes/ plans of	• *Health Sector Medium Term Development Plan* revised and does address health risks of CC (3 activities defined in this regard) • Status of this indicator is unclear	The TE confirms mechanisms are globally established. There are indications of the willingness to implement them and use the tools developed. This is in the hands of the MOH and GHS.	S

	health related activities • Number and type of monitoring systems in place to measure climate change resilience in the health sector		MDAs relevant to climate-sensitive health outcomes at different levels jointly revised • By the end of the Project indicators for monitoring climate change resilience in the health sector developed and climate risk screening tool operational	• Two studies have been conducted: - Development Of Indicators For Measuring Climate Change Resilience In The Health Sector (May 2012); and - Gender Sensitive Climate Resilience Screening Tool for the Health Sector (Oct2014) The screening tool has been tested in the three districts and is operational. The MOH is to take action to generalise CC screening of the health sector in the country		
Outcome 3 Lessons learned collected and knowledge management components established	• Number of stakeholders served by improved climate change related risks data from updated information management systems • Number of lessons learned from Project activities synthesized and captured in a	• No lessons learned exist yet for integration of climate change risks into the management of priority health issues	• By the end of the Project, at least 3 relevant departments regularly accessing climate change related risks information • By the end of the Project, at least five information, education, and communication	• There is no indication of such wide information management system being operational systematized in Ghana. • The Project has produced in 2015 a document called *Identification of best practices under the*	The Project is rather weak on this outcome. A lot of work remains to build on the Project outputs and ensure that knowledge management is effective.	MU

	specific KM Facility (e.g. ALM)	documents, describing lessons learned and best practices, developed and disseminated	*climate change and health Project and development of methods for their implementation, dissemination and incorporation into the health sector central database.* This is the only document referring to lessons learned, and stakeholders met regret the absence scientific study to demonstrate the health results of the Project and inform lessons learned.

All other ratings will be on the GEF six point scale.

GEF Performance Description		Alternative description on the same scale
HS	= Highly Satisfactory	Excellent
S	= Satisfactory	Well above average
MS	= Moderately Satisfactory	Average
MU	= Moderately Unsatisfactory	Below Average
U	= Unsatisfactory	Poor
HU	= Highly Unsatisfactory	Very poor (Appalling)

Annex 10. Analysis of the implementation of MTR recommendations

Table 12. State of implementation of the 16 MTR recommendations

Recommendation	Responsible institution	State of implementation at TE
1. Within one week[40], complete the GEF/SCCF Tracking tool and submit to MOH/UNDP for approval and processing	PMU	There is no indication that the GEF/SCCF Tracking tool has been completed, submitted or used.
2. Within two weeks: meet to endorse this Evaluation report and all the recommendations contained therein, and to firmly and solemnly commit in writing to ensuring the Project will achieve success and to making any necessary concessions. For any of the report's recommendations not endorsed at this time, a clear and measurable alternative must be formally set out.	UNDP (lead), MOH and GHS	No meeting minutes or document endorsing the MTR available. The UNDP Management response document mentions that the PSC reviewed and sent feedback on the MTR recommendations, but there is no written evidence this has actually happened.
3. Within two weeks: • clarify, in the form of a detailed jointly signed document, all costs that are eligible to be covered by the SCCF/UNDP funds, including: level of hotel for meetings, use of DSA for travel, etc. • clarify the format for a weekly progress report to be prepared by PMU (see 7 below).	UNDP (to lead) and MOH	• No jointly signed document made available to the TE. The UNDP Management response document mentions "the UN has established new DSA and T&T guidance for UN implementing partners. The government coordinating agency has requested to review it with IPs before implementation. • No weekly progress reports from PMU produced (nor any template prepared)
4. Within two weeks: commit to not making any further changes to eligible costs and procedures. Commit to supporting the Project substantively as necessary, and to understanding and appreciating the contributions made by MOH and PMU.	UNDP	No indication of such commitment. Probably done in oral form.

[40] All deadlines are from the submission of the final report (on 17th January) by the Evaluation Team

5. Within two weeks: make a full commitment to providing government contribution, this will include (i) preparing a monetized record of the contributions made so far, and (ii) providing fuel for transport of government vehicles.	MOH	No indication that this has been done
6. Within two weeks: • commit, in writing with details, to seeking cost efficiency in all procurement and all activities, and to preparing a clear explanation and justification for all planned expenditures; • commit, in writing with details, to ensuring all project plans and reports are prepared to quality and on time; • ensure that all terms of reference and plans justify and clarify how the concerned activities lie within the overall Project strategic framework.	PMU	No evidence of such commitmennts made in writing provided to the TE. Clarification of how the activities lie within overall Project strategic framework does not seem to have been done in writing.
7. Within three weeks, *and weekly thereafter*: prepare a progress report – less than one page (see 3 above for format) - to be submitted transparently to all stakeholders.		No indication that such weekly progress reports have been produced over the duration of the Project, starting from January 2014.
8. Within three weeks: meet to endorse this Evaluation report and all the recommendations.	MOH (to lead), UNDP and GHS	No meeting minutes or document endorsing the MTR available
9. Within four weeks, and *every two weeks* thereafter, meet to discuss progress, to resolve problems, and to plan activities for the coming two-week period. Minutes of these meetings shall be prepared by the Project Manager and be submitted to UNDP/MOH/GHS (Operational level) within 3 days of the meeting.	UNDP (to lead), MOH, GHS and PMU	TAC meeting have done this to some extent, but (i) frequency of meetings has been far less than every two weeks (rather quarterly), and (ii) no meeting minutes are available. UNDP management response mentions that "the PSC met on March 18 and agreed to meet on quarterly basis". However, (i) this decision is not reported in this PSC meeting minutes; and (ii) the PSC has met only twice between the MTR and project end.
10. Within six weeks, with support from one national expert and one international expert[41] in the health sector:	UNDP and MOH	(i) No indication of such paper produced

[41] The combination of national and international is essential to ensure (i) maximum learning of best practices from other countries (ii) optimal credibility (iii) outputs are high quality and matched to Ghanaian conditions. WHO should be invited to propose candidates for both positions.

(i) Oversee preparation of a paper elucidating the strategic approach of the project to identifying, testing and learning adaptation measures, and how the past and future activities of the Project fit into this strategic approach. This should clarify how Project activities are to be: anchored in MOH's long term plan and MOH institutions at multiple levels, (ii) coordinated and mutually supporting, (iii) part of a clear chain of events leading to innovative results; (iv) covering the climate change – health nexus, and (v) generating required visibility; (ii) Based on the findings in this report, prepare detailed workplan and targets for 2014 and for all remaining budget; (iii) As a part of the above exercise, verify the Project theory of change, taking the steps set out in Section II.2.4; (iv) Launch a process for the project to prepare a comprehensive document on the climate change – health nexus in Ghana. This should be based largely on the existing reports prepared by the project, but additional sections (such as economic costs analysis, assessment of indigenous adaptation measures) may need additional data collection or research, This document should be prepared quickly, and, once ready, be used for lobbying and gaining visibility; (v) Prepare a paper explaining how the Project will be mainstreamed into and across MOH activities, including into training, communications, policy development and implementation of the forthcoming HSMTDP; and, (vi) Ensure that the above provide a concrete basis to the project, strengthening the Project's sense of direction, and starting to generate a 'feel-good' factor around the project.	(ii) Annual work plans have been prepared but there is no evident link with the above. (iii) No indication of use of theory of change (iv) Comprehensive document on the climate change – health nexus in Ghana including economic costs analysis and assessment of indigenous adaptation measures has not been produced. (v) The document *Identification of best practices under the climate change and health Project and development of methods for their implementation, dissemination and incorporation into the health sector central database* somehow responds to that recommendation, but has been delivered in 2015 only. (vi) – UNDP management response was 1/ conduct a strategic review and revision of the project document and work plan, with assistance from GEF regional technical specialist. PSC meeting minutes refers to a slight modification of the project document. However, it is not clear how this responds to the recommendations made.no 2014 work plan has been made available to the TE. 2/ establish a TAC: this was not expressly recommended in the MTR but has revealed a good addition to project management. 3/ preparation of a paper on climate change-health nexus and a paper explaining how the project will be mainstreamed into and across MOH activities. This was to be implemented by the PMU and TAC. The document in (v) above is the only one that seems to somehow respond to this

		recommendation, and came very late in the process.
11. Within six weeks: Hold a one day retreat, within Accra, for operational staff, to (i) resolve all outstanding issues (ii) prepare strategic elements of the 2014 annual workplan.	MOH (to lead), UNDP, GHS (Project implementation level), Project management, District Representatives	No indication of such retreat organized. No report or minutes available.
12. Within six weeks: with technical support from national level or from international experts (see Recommendation no. 10), clarify the framework for ensuring that the 'pilot' activities at district level: lead to increased understanding of the climate change – health nexus; lead to better knowledge on the efficiency of adaptation measures, and; feed into national policy/strategy.	District Health Directorates	No indication of such technical support provided. According to UNDP management response, the setting-up of the TAC was the response provided to this recommendation.
13. Within eight weeks: visit all project sites to exchange with district officials and observe local activities.	UNDP	No indication of such mission organized (no mission report made available). According to UNDP management response, this this was supposed to be organized in Q2 2014.
14. Within eight weeks: prepare and finalize the 2014 workplan. The eight week period is allowed because of the need to complete many of the recommendations above (notably Recommendation 10, which will define activities for 2014). However, if, for administrative reasons, it is necessary to approve a 2014 workplan earlier, an interim plan should be approved as soon as possible, and then amended within eight weeks.	MOH (to lead), UNDP, GHS and Project management	No annual workplan made available for 2014.
15. Within twelve weeks: • meet to review all achievements in the preceding 12 weeks; • meet to validate whether or not the Project is firmly on track, subject to tangible evidence. If there is no evidence that the Project is firmly on track, recommend that the project be closed early. In all events, the discussion and recommendations must be justified and recorded and formally circulated to Project stakeholders.	UNDP (to lead), MOH and GHS	No evidence of such meeting. A PSC meeting was held on 12th March 2014 but minutes do not detail any review of MTR recommendations.
16. Implementing the above Recommendations will sharply increase the workload for project management and technical support, at least for the initial months. At the	UNDP (to lead) and MOH (immediately)	No such consultant for technical support has been hired. No trace of this in PSC meeting minutes.

September 2013 high level meeting between MOH and UNDP, "*hiring a consultant to facilitate project activities was proposed by UNDP. However, the Hon. Minister decided not to proceed with the recruitment until the next meeting where the project progress and needs for a consultant will be reviewed again*."[42] Given that this Evaluation finds that progress has not been strong since that meeting, and given the increase in workload associated with Recommendations 1- 15, the hiring of this consultant should be re-considered as a matter of urgency. The ToR for the new consultant should clearly distinguish between the tasks for the new consultant and existing members of the PMU. The ToR for the new consultant should include making substantive contribution to Recommendation 10. MOH, GHS and PMU should each, formally, and in writing, indicate their active agreement to these ToR.	

[42] Meeting minutes.

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