CTB

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

ANNUAL REPORT 2011

PROJECT "CAPACITY BUILDING IN THE DEPARTMENT OF HEALTH: PHASE II "

Before Capacity Building Intervention

After Capacity Building Intervention

Acronyms

<List all acronyms used in the Annual Report (alphabetically; see examples below)>

BTC	Belgian Technical Cooperation
NDoH	National Department of Health
JLCB	Joint Local Consultative Body
M&E	Monitoring and Evaluation
TFF	Technical and Financial File
NDoH – HRD	National Department of Health – Human Resource Development
IHL – DCU	International Health Liaison – Development Coordination Unit
DIRCO	Department for International Relations and Cooperation
NT – IDC	National Treasury – International Development Cooperation
NSDA	Negotiated Service Delivery Agreement
DG	Director-General Health
NHI	National Health Insurance
HSS	Health System Strengthening
CSHF	Core Standards for Health Facilities
HOD	Head of Department
SDF	Skills Development Facilitator

1 Project form

PROJECT NAME	CAPACITY BUILDING IN THE DEPARTMENT OF HEALTH OF THE REPUBLIC OF SOUTH AFRICA – PHASE II
PROJECT CODE	SAF0901811
LOCATION	National Office – NDOH PRETORIA Selected Districts And Health Facilities
BUDGET	2.000.000 EURO
KEY PERSONS	Carol Nuga Deliwe (Project Manager who resigned) Dr. B. Mogale (Transferred to another assignment)
PARTNER INSTITUTION	NATIONAL DEPARTMENT OF HEALTH
DATE OF IMPLEMENTATION AGREEMENT	14 JANUARY 2011
DURATION (MONTHS)	36
TARGET GROUPS	• Hospital management teams in selected health facilities • District management teams in selected districts • Skills development facilitators in selected districts and provincial offices
GLOBAL OBJECTIVE	Increase the efficiency, effectiveness and quality of care in the republic of South Africa's health sector
SPECIFIC OBJECTIVE	Improve the management capacity of government hospitals
RESULTS	1. Building the capacity of hospital management teams 2. Building the capacity of the skills development facilitators in the department of health 3. The programme is implemented in a well coordinated, fully integrated, sustainable process

Summary

1.1 Analysis of the intervention

A number of changes to the project logical framework were proposed by the partner during 2011. The revised project logical framework was approved in June 2011, by the first project JLCB. Once the project implementation was initiated, another major change was officially requested by the DG on 7 November 2011 setting back the project implementation to its initial design. The change was requested since the approved plan was confirmed as duplication with another initiative conducted by the Department. The project logical framework was not yet revised as at end of December 2011. There are therefore no outputs to be evaluated during 2011.

The description provided in the table below is in accordance with the framework approved by the first JLCB on 21 June 2011.

Intervention logic	Efficiency	Effectiveness	Sustainability
Specific objective: *Improve the management capacity of Government hospitals*	The evaluation of the efficiency criterion under the project objective cannot be done at this stage since there is no progress on implementation	The evaluation of the effectiveness criterion under the project objective cannot be done at this stage since there is no progress on implementation	The evaluation of the sustainability criterion under the project objective cannot be done at this stage since there is no progress on implementation
Result 1: *Capacity of facilities built in respect of functionality and performance*	The evaluation of the efficiency criterion under the project result 1 cannot be done at this stage since there is no progress on implementation	The evaluation of the effectiveness criterion under the project result 1 cannot be done at this stage since there is no progress on implementation	The evaluation of the sustainability criterion under the project result 1 cannot be done at this stage since there is no progress on implementation
Result 2: *Capacity of Skills Development Facilitators in the Department of Health is built at national and provincial level*	Result 2 was merged with Result 1	Result 2 was merged with Result 1	Result 2 was merged with Result 1
Result 3: *The programme is implemented in a well-coordinated, fully integrated and sustainable process*	A	B	C

Budget	Expenditure per year	Total expenditure year N (31/12/2011)	Balance of the budget	Execution rate
€ 2.000.000	**€ 0**	**€ 25.406,39**	**€1.974.593,61**	**1 %**

1.2 Key elements

The first year of the implementation was extremely challenging. The first approved proposal brought a significant aspect to the implementation ensuring sustainability through involving key participants from all levels of health delivery (national, provincial, district and facility), hereby ensuring sustainability of the implementation. The proposal focused on an integrated coordination that would have benefited the entire delivery chain. An additional benefit was that the plan would have consolidated the results of the first phase. Unfortunately, this approach was discontinued by the partner and a new proposal was put forward for implementation, in June 2011, looking at improving performance through an incentive and award system. This proposal was discontinued at the end of the year by the Director-General, being identified as duplication with current departmental activities. Consequently, a new proposal was put forward on 19 December 2011. The project implementation and budget plan are still not defined.

This continuous change impacted on the consolidation of the results of the first phase of Capacity Building project. The momentum and provincial buy-in achieved in the beginning of the year will need to be regained due to all these changes.

1.3 Key Risks

- Lack of commitment from partner on the approved plans and continuous changes proposed to the implementation is a high risk in achieving any progress. The project lost over one year in implementation without achieving any progress. This time loss will put great pressure on the planned activities over the next two years of the project implementation, which could have a major impact on the quality of the implementation.

- There is a risk of request for a no-cost extension considering the delays experienced to date.

- There is a risk of accurately planning the financial commitments for the next year of implementation and therefore achieve the minimum required compliance on disbursements, since there is no concrete project and budget plan proposed by the partner.

- There is a risk of regaining commitment and buy-into the process from all key external stakeholders (provincial, district and facility) due to the extent of the changes.

1.4 Key lessons learned and recommendations

Despite all measures taken to align the project interventions to the partner's new plans of action, the project implementation was still confronted with several cancellations and revisions of the implementation plan. This makes it very difficult to ensure commitment from different stakeholders since they have been involved in discussions regarding strategizing the plan which needed to be revised several times.

The project team tried several times to engage all those partners active in the same area however this seem not to have been enough. There is a high need of a focal point in the department, committed to coordinate all activities with all different partners to ensure consistency in decisions.

2 Analysis of the intervention

2.1 Context and evolution

"Capacity Building in the Department of Health of the Republic of South Africa – Phase II" was approved as a consolidation of the "Capacity Building in the Department of Health of the Republic of South Africa" (Capacity Building Phase I) project implemented between March 2004 and March 2010.

The Capacity Building Phase I project had a number of external reviews and evaluations. The evaluations concluded that the project in overall had a high degree of relevance and potential, through an approach which is innovative in RSA, to impact on working environment and to improve the functionalities of health services. The project evaluations brought reflection on challenges and significant input regarding modalities to overcome them. Consequent, a proposal for consolidation of gains and results was approved with a total budget of **2M EURO.**

The identification file was approved during the Partner Committee held in October 2008. This process was followed by a formulation, started in January 2010, conducted by external consultants through extensive consultations with NDoH. The findings of the formulation were presented and approved in the final Joint Local Consultative Body (JLCB) of the Phase 1 project, held on 9 March 2010. Consequently, the Technical and Financial File (TFF) of the second phase was produced by external consultants, with input from the NDoH representatives and other stakeholders, and approved on 9 June 2010.

The TFF was circulated together with the Specific Agreement to different departments (IHL – DCU and NDoH – HRD, Legal Services, DIRCO, and NT – IDC) for corrections/ amendments/ comments. After receipt and consolidation of all comments and inputs from the Departments consulted, the documents were finally reviewed by the NDoH Director-General's office to ensure alignment with the priorities of the Department, the NSDA and the Aid Effectiveness Framework.

The final approval was granted by the Minister of Health on 3 December 2010.

The process was finalized on 14 January 2011 when the Minister of Health and the Ambassador of Belgium signed the Specific Agreement for the project.

After to the signature of the agreement, NDoH – HRD engaged different NDoH stakeholders through consultation meetings to introduce the project. The purpose of

these consultations was to get their inputs regarding the implementation, and to see how the project activities would complement the department's activities in order to avoid duplication. The consultations were held with representatives of the Hospital Management Unit, Office of Standard Compliance, District Health Services, and IHL – DCU as well as Provincial representatives.

Consequent to this engagement and coordination process, a project framework and implementation plan was approved by the Director-General on 30 March 2011. The plan elaborated, aimed in capitalising on the gains and consolidating the results of the first phase of the project. The focus of the proposal was to empower the hospital staff with skills and methods to proactively solve problems and ensure efficiency in utilization of available resources. The plan served to strengthen capacity at different levels in the selected hospitals as well as bringing in a sustainability element through creation of a support, follow up and monitoring system throughout the delivery chain.

On 14 April 2011, a new management team was appointed by the DG to represent the Department in all strategic and operational meetings required for the implementation of the project. A number of meetings took place to discuss the operationalization of the project plan approved by the DG on 30 March 2011. The newly appointed team suggested changes to the proposed plan since the original plan was considered weak and unclear. A new proposal was put forward by representatives of NDOH for approval by the JLCB. The proposal focused on enhancing the facility performance through an incentive system (financial and non-financial) and/or award programme. The incentive programme would be informed by the results of a study of all existent information related to facility functionality and staff performance. An assessment tool for facility functionality and staff performance was proposed to be developed to be utilised as a monitoring tool of the programme. The plan was conditionally approved by the JLCB on 21 June 2011.

A number of internal consultation meetings took place from June to September 2011 to operationalize the proposed plan and identify areas of overlap with other programmes and interventions conducted or proposed to be conducted by other partners or internally in the department. The project plan was redefined in accordance with the discussions and inputs of the consultation meetings.

The project implementation was put on hold on 30 September 2011 when an informal notification was received by BTC on the resignation of the project manager.

Consequent to the BTC request for clarification of the proposed plan as well as the appointment of the new project manager, DG confirmed on 12 October 2011 that

the activity approved at the first JLCB was not relevant for the Department and needed to be discontinued. An official letter confirming the decision was sent to BTC on 7 November 2011. It was concluded that the Capacity Building Phase II project needed to return to its original design and the activities needed to be redirected in addressing the capacity gaps identified by the audit.

An official proposal was sent to BTC on 19 December 2011. However no implementation and budget plan was attached. This is still not yet confirmed.

2.1.1 Institutional Anchoring

The project is correctly anchored to the National Department of Health and is driven by the Director-General's office. Furthermore, there are a number of contributors, such as: Strategic Planning Directorate, Project Management Directorate, Office of Standard Compliance and Quality Improvement Directorate. Under NHI and Health System Strengthening, existing interventions such as the facility profiling and baseline quality audits have been conducted by the Department. At institutional level the project is anchored with the Department plans and policies in strengthening the Health System. The assessment of functionality, efficiency and appropriateness of the organizational structure has already been initiated. The results will be utilised to finalise the competency frameworks for managers as well as design of specific training, support and performance management measures to address identified challenges.

Since April 2011, NDOH embarked on a baseline audit of all health facilities, after having developed a standard tool consisting of 500 indicators that inform the performance of health facilities. To date 2300 facilities have already been audited. The NDOH is committed to address the audit findings to improve the conditions and performance of all health facilities. The current request for utilization of the funding, put forward by the partner, is to address the capacity gaps identified by the audits to prepare the health facilities for compliance. This gives a **Score A** to institutional anchoring.

2.1.2 Execution Modalities

Considering the extensive partner approval processes, the execution modalities set in the project framework are appropriate for the implementation of the project. However, it is important to note and consider that the Department is going through an organization transformation which impacts severely on resources. This process created already quite a few vacancies which impacted on the availability of a

dedicated team assigned to this project. In this case the project team needs to consider a stricter approval process when changes to the project framework are suggested, to ensure the message reaches the decision maker in the Department.

2.1.3 Harmo-dynamics

The Government of South Africa has taken practical measures to ensure that by 2014 the Department of Health has contributed positively to improving the status of all South Africans. In the Government programme of action, health and education are given particular importance.

For the health sector, the priority is improving the health status of the entire population and to contribute to Government's vision of "A Long and Healthy Life for All South Africans". To this end the Government has identified four strategic outputs which the health sector must achieve. These are:

Output 1: Increasing life expectancy

Output 2: Decreasing maternal and child mortality

Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis

Output 4: Strengthening Health System Effectiveness

The above listed outputs are well defined and explained in the Negotiated Service Delivery Agreement (NSDA) signed between the Minister of Health and the President.

The current proposed plan requires a very high level of coordination and harmonisation of activities since many development partners are contributing to the Departmental plan of action. The proposed plan by NDoH is not yet fully defined and the role of development partners is not yet confirmed. However it is confirmed that DIFD, EU and Belgium will be the main partners in the implementation. Many actions are also taken internally in the department through different units as well as through provincial health structures to ensure that the facilities are prepared for the roll out of the NHI.

2.2 Specific objective

2.2.1 Indicators

Specific objective: To improve the management capacity of Government hospitals						
Indicators	**Baseline value**	**Progress year N-1**	**Progress year N**	**Target year N**	**End Target**	**Comments**
Total number of facilities enrolled in the programme	50	Not applicable	0	20	50	No progress could be achieved due to the requested changes by the partner.
% of continuous implementation of improvement programmes in respect of functionality and performance	0	Not applicable	0	0%	100%	It is important that all facilities in the programme will continue their improvement programmes to ensure compliance with standards
% of realization of Core Standards for Health Facilities	Not established	Not applicable	0	0%	100%	The realization of the Core Standards can only be visible once the programme is implemented in the facility
Project coordinating working group operational	Working group formed	Not applicable	17 meetings took place	4	12	Only quarterly meetings were envisaged, however due to the extent of request for change of the project plan, the number of meetings increased substantially
Number of facilities with Quality Improvement strategies in respect of functionality and performance	0	Not applicable	0	0	50	The improvement plans can only be visible once the programme is implemented in the facility. All facilities are expected to produce and implement improvement plans

2.2.2 Analysis of progress made

The progress made on implementation of the project is very limited. Many coordination meetings and revisions of the implementation plan took place but there was no actual implementation and no output. A new project plan is foreseen to be prepared in January 2012 and implementation should be started in February 2012, if no further delays are experienced.

These changes and lack of progress in the implementation were clearly unexpected since a lot of effort was put in place to ensure the project's kicks-off. The project team took all measures possible at the time of implementation to ensure progress was made, and sufficient flexibility was provided to achieve full alignment with the

departmental priorities.

Another factor that influenced the progress was the lack of appointment of project manager. This project had officially a project manager for 5 months, making progress very difficult. Consequently, temporary arrangements were made by the Department which were clearly unsustainable.

2.2.3 Risks and Assumptions

Risk (describe)	Probability (score)	Potential implications		Risk Level (score)
		Describe	Score	
External and internal brain drain due to high staff turn-over & mobility	Medium	The new policy on NHI can influence availability of health professionals	Medium	B
Impact of factors such as AIDS on HR Workforce	Low	Working conditions	Low	A
Internal staff turn-over – caused by the internal departmental organizational transformation	High	Job insecurity resulted in frustration and ultimately resignation	High	D
Lack of buy-in of stakeholders from all levels (national, provincial, district and facility) due to the top-down approach in solving problems proposed by NDoH	High	High impact on project implementation resulting in difficulty on achieving the objective	High	D
Lack of sharing exiting baseline data to measure against (due to the confidentiality of the report/s)	Medium	Could result in allocating extra resources to establish the baseline (duplication)	High	C

2.2.4 Quality criteria

Criteria	Score	Comments
Effectiveness	-	This cannot be evaluated at this stage since there is no progress to date in the implementation of the project
Efficiency	-	This cannot be evaluated at this stage since there is no progress to date in the implementation of the project
Sustainability	-	This cannot be evaluated at this stage since there is no progress to date in the implementation of the project
Relevance	A	Many measures were taken to ensure relevance of the proposals.

2.2.5 Potential Impact

The specific objective remains relevant to the project. All changes proposed to the

project plan were in line all along with the specific objective. However the interventions proposed in achieving the objective made use of different approaches, some more, some less feasible. The indicators, as proposed in the TFF, could change once the capacity gaps, that require to be addressed through the project, are identified. The Department is committed in improving the health status of the entire population and improving the condition of health facilities and capacity of the hospital management is key.

2.2.6 Recommendations

Recommendations	Source	Actor	Deadline
Project implementation and budget plan defined; Project logical framework, revised where necessary	3.2.2.	BTC in collaboration with NDoH	January 2012
Project manager to be appointed	3.2.2.	DG – NdoH	January 2012
Steering committee members representing the department and the chairperson – to be appointed	3.2.2.	DG – NdoH	January 2012
Redefine the approval process of the project framework		BTC	January 2012

2.3 Result 1 and Result 2 (merged)

Note: **Result Area 1 and Result Area 2 were merged** and activities were integrated.

Result 2: "Capacity building of Skills Development Facilitators in the Department of Health is built" was specifically looking at building capacity of provincial SDF's through training. The project team identified more stakeholders that would be required to be on board to ensure sustainability (e.g. provincial coordinators of hospital management, quality assurance, district services etc.), which will all require capacity. The project team suggested forming a coordination team made of all relevant stakeholders and capacitate them as required to provide the adequate support. Consequently, having one result area only for one of the targeted group of required coordinators was not seen feasible. In the context of the approved proposal, in June 2011, Skills Development Facilitators (SDFs) will be required to be part of the working group at provincial/district/facility level, and contribute to the programme. They will be required to participate in the implementation of the programme to ensure continuity of it. However, no training curriculum is foreseen to be designed specifically for them, outside the scope of the interventions.

2.3.1 Indicators

Result 1: Capacity of facilities built in respect of functionality and performance

Indicators	Baseline value	Progress year N-1	Progress year N	Target year N	End Target	Comments
Number of facilities in the delivery chain enrolled in the programme	50	Not applicable	0	20	50	There was no progress this year due to the changes in the project implementation plan.
Number of incentive and awards systems and processes set up	0	Not applicable	0	0	To be determined	This activity was part of the study that needed to take place before the end of December 2011 and inform the required systems to be set up. In the context of the new proposal this indicator requires to be changed.
% of trained staff in post at project completion	0	Not applicable	0	0	80%	This was a measuring indicator for end of the project.
% of continuous implementation of improvement programmes in respect of functionality and performance, at the end of the project	0	Not applicable	0	0	100%	This was a measuring indicator for end of the project.
% of realization of Core Standards for Health Facilities	0	Not applicable	0	0	100%	The progress on this indicator can only be measured once the improvement programme is implemented.
Incentive and awards granted	0	Not applicable	0	0	50	The awards are set to be granted at the end of the project once achievements are seen. It was expected that the follow up programme would support all facilities to achieve improvements and therefore qualify for an award. In the context of the new proposal this indicator may require to be changed.

Number of SDFs and HRDs involved in the incentive system implementation	0	Not applicable	0	0	Not confirmed	The end target is not confirmed since the facilities and the corresponding district and provincial offices were not yet selected. The selection will be guided by the political decision especially in relation to NHI piloting option and criteria.

2.3.2 Evaluation of activities

Activities	**Progress:**				**Comments** (only if the value is C or D)
	A	B	C	D	
Develop a standardised tool for assessing the health system performance				X	This activity was prepared during the course on August and September 2011. A tender process was expected to be initiated in September, tender specifications was prepared and ready to be launched. However the project manager resigned in September before the launch of the tender and the process was put on hold, pending confirmation from the DG. An official confirmation was received from the DG on 7 November 2011, cancelling the activity.
Preparatory workshops with identified facilities to be strengthened using identified incentives				X	The incentive system would have been informed by the study foreseen as part of the terms of reference of the tender. This could not take place since the tender was cancelled.
Workshops/trainings of all relevant staff to address identified gaps that affect the functionality and performance of the facility				X	This activity is still relevant; however the new project proposal needs to be defined.
Follow up, monitor and assess the performance in selected districts				X	This activity may still be relevant however the new project proposal needs to define the expected contribution of this project.
Incentives and awards for facilities performance				X	This activity may no longer be relevant. This will be redefined by the new project plan.

2.3.3 Analysis of progress made

There is limited progress under this result area due to the changes proposed by the partner. Below is a summary of the changes proposed.

On 30 March 2011 a project plan was approved by BTC and DG in view of capitalising on the gains and results obtained during Phase I of the project. The consolidation would, complementary to Phase I, contribute towards improved leadership and management in health services, with sustained effect, through offering the possibility of exchanges between hospitals in-country with support from district and provincial offices. Improving patients care and satisfaction is a top priority of the Department of Health. The Negotiated Service Delivery Agreement (NSDA) makes clear mention to the lack of cleanliness and tidiness of health facilities as well as to the long waiting times that patients experience during their visit. Often the hospital systems are faced with many problems emanating from broken processes. As a consequence hospital staff works long hours, morale

declines and the level of satisfaction and confidence that patients have in public hospitals decreases.

The scope of the proposal was to address the above matters through empowering the caregivers and hospital managers to proactively solve problems. The main objective was to introduce the relevant hospital staff to a methodology that addresses elimination of wastes in processes and supports system function more efficiently. The capacity would be provided in view of improving work flow and efficiency in delivery healthcare services to reduce the current long waiting times. Targeted areas will be reviewed and agreed with the hospital management teams in order to ensure the focus is on the most critical and challenging area in the hospital.

In addition, provincial and district coordinators would have been selected to participate in the trainings, and further modules will be provided to them specifically to assist them with further follow up and measurement tools. Follow ups and further quality reviews will be made with the assistance of the selected provincial and district coordinators.

The new appointed project team representing the department requested changes to the project plan in April 2011. Different consultation meetings took place to define the plan, despite the strong request from BTC on ensuring the proposed changes are within the approved framework. A new plan was proposed to the first JLCB for approval. The plan focused on improving the performance of health facilities through creation of an incentive and award system. This system would be informed through a study on current systems and processes as well as required activities for which an open tender was necessary. After the development of the tender specifications, this process was also discontinued and a new proposal was put forward for approval.

The new proposal focused on taking forward the outcome of the baseline facility audits through addressing all of the identified gaps to prepare the facilities for compliance with the core standards. The identified approach by DG NDOH is to select 40 senior managers from the national office to conduct exploratory work to define in detail the issues flagged by the baseline audits. They will be taken through a training programme and be orientated to have a shared understanding of the required work. The outcome of the exploratory work is to produce observations and recommendations that will fully inform the implementation plan (health facility improvement plan). The project and budget plan still need to be defined and agreed on.

2.3.4 Risks and Assumptions

Risk (describe)	Probability (score)	Potential implications		Risk Level (score)
		Describe	Score	
Overall loss of acquired skills at facility level	High	Capacity can be lost if not institutionalised resulting in fruitless expenditure	High	D
High staff turn-over	Medium	Potential loss of skills if not transferred resulting in waste of opportunity	Medium	B
Lack of programme follow up	Medium	Programme discontinued after implementation resulting in fruitless expenditure	High	C
Limited buy-in from the major stakeholders at targeted levels	Medium	Programme can fail if buy-in is not achieved	High	C

2.3.5 Quality criteria

Criteria	Score	Comments
Effectiveness		Can't be evaluated at this stage due to lack progress
Efficiency		Can't be evaluated at this stage due to lack progress
Sustainability		Can't be evaluated at this stage due to lack progress

2.3.6 Budget execution

Refer to Annexure 7.3 below.

2.3.7 Recommendations

Recommendations	Source	Actor	Deadline
Capacity should be provided in teams and not only for individuals but to ensure that the transferred skills have remained in the facility even though one of the trainees resigns.		Project Team with support and instruction from the DG	Q1 2012
A system for follow up and support is highly required to ensure institutionalization of the skills.		Project Team with support and instruction from the DG	Quarterly
Follow up of the implemented programme should be continuous, driven by the national and provincial office. Reporting structures must be created and utilised.		DG and HODs	Q1 2012
Follow up and reporting activities must form part of the performance agreements internally signed in the department.		DG and HODs	Q1 2012

2.4 Result 3

2.4.1 Indicators

Result 3: The programme is implemented in a well-coordinated, fully integrated and sustainable process.

Indicators	Baseline value	Progress year N-1	Progress year N	Target year N	End Target	Comments
Project coordinating working group operational – [With co-opted representatives from other relevant departments from National and Provincial Departments of Health, hospitals & development partners]	0	0	17 meetings	4	12	Only quarterly meetings were envisaged, however due to the extent of request for change of the project plan the number of meetings increased substantially.
Strengthened capacity & skills at the National Department of Health specific to this Project	0	0	-	-	-	The indicator requires more quantification. The project did not have a permanent resource dedicated to the project by NDoH. Only temporary resources have been assigned, who have all either resigned or been reassigned, therefore transfer of skills was difficult.
Degree of programme integration into National Department of Health	0	0	High	High	High	The project is highly aligned with the department policies and plans on Health System Strengthening

2.4.2 Evaluation of activities

Activities	Progress:				Comments (only if the value is C or D)
	A	B	C	D	
Hosting working group meetings (National Department of Health, Provincial Departments of Health and other donors)	B				
Update capacity building strategic frameworks, guidelines, modules and assessment tools	B				

2.4.3 Analysis of progress made

This result area looks specifically at coordination and involvement of all different stakeholders at all levels to ensure a good support throughout the implementation. The project is looking at achieving a high degree of coordination making the project self-sustainable.

The project team made all possible that stakeholders at all levels are informed and involved from the beginning to ensure their buy-into the process. Since the project

plan has been already changed three times, coordination needed to be ensured each time a change was proposed; thus the substantial increase in the foreseen number of meetings.

The challenge that could be faced in this area is lack of commitment from the stakeholders involved should changes be proposed again. The implementation targets the same group of coordinators and consistency in implementation is very important.

2.4.4 Risks and Assumptions

Risk (describe)	Probability (score)	Potential implications		Risk Level (score)
		Describe	Score	
Non-functional Steering Committees at some levels of the health structure	Medium	Delays in making prompt decisions to support the implementation	Medium	B
Poor or lack of effective communication with relevant stakeholders	High	Lack of effective communication could lead to duplication, overlap and ultimately project failure since there are many other partners involved in the implementation	High	D
Overlooking complimentarity of actions of National Department of Health, BTC and other partners/donors implementing similar Projects such as CDC, EC etc	Medium	Coordination gaps that could lead to duplication of interventions	Medium	B
Lack of an appropriate & sustainable exit strategy as it relates to the end of BTC funding for the Project	Low	Gaps in skills transfer that could lead to a non-sustainable project – this is only applicable at the end of the project	Low	A

2.4.5 Quality criteria

Criteria	Score	Comments
Effectiveness	A	Effectiveness is high on this result area since the project team ensured at all times that activities are not done in isolation. Coordination and communication involved all major stakeholders and inputs were always requested
Efficiency	B	The communication was done directly with implementers (at national and provincial levels). This can be an element of risk since the message may not always be carried to higher levels for decision making
Sustainability	C	NDoH resources allocated to this project were all on a temporary basis. The Project Manager was only appointed for 5 months and no official appointment has yet been confirmed. This leads to a non-sustainable process since changes to the implementation plan are being brought to the project every time a new project leader is appointed

2.4.6 Budget execution

Refer to Annexure 7.3 below.

2.4.7 Recommendations

Recommendations	Source	Actor	Deadline
A working group must be formed as a permanent structure to this project. Alternatively, current structure must be suggested to be used for a good coordination of this project		DG-Health	Q1 – 2012
Members and chairperson of the JLCB must be appointed. The JLCB should include all those contributing to the implementation of the project (e.g. other donors, head of other units involved in the implementation)		DG-Health	Q1 – 2012
Coordination forum must be created to ensure effective communication		DG-Health and donors	Q1 – 2012
Efficient and effective communication must be ensured at all times, involving the highest levels of decision making		BTC	Ongoing

3 Transversal Themes

3.1 Gender

There are no aspects regarding gender, to be reported as yet, since the project implementation was challenged throughout the year. No progress was yet achieved.

3.2 Environment

No environmental aspects, either positive or negative, are expected as a result of the project.

5 Decisions taken by the JLCB and follow-up

Decisions	Source	Actor	Time of decision	Status
A letter of appointment of the Chairperson for the JLCB will be signed by the DG and officially sent to BTC.	Minutes of JLCB meeting	Dr. Funani / Ms. Nuga Deliwe	21 June 2011	Not done
It was agreed that the project proposal will be edited to reflect the development of a tool to assess the health system performance along with the design of specific interventions, such as incentive and awards, to address the performance gaps. It was agreed that the tool will not be limited to the incentive and awards system only.	Minutes of JLCB meeting	Dr. Funani / Ms. Nuga Deliwe	21 June 2011	Activity cancelled by the partner 3 months later
The Project Logical framework – Indicators was approved with the following requested changes: Result Area 1 – Risks: "Implementation of facility level incentive and awards programme not approved" – removed since this is in contradiction with the intention of the project Result Area 2 – Risks: "Unavailability of targeted SDF's" – removed since this is already addressed under the administrative constrains related to unavailability of adequate staffing	Minutes of JLCB meeting	Ms. Nuga Deliwe	21 June 2011	Changes were reflected as decided, however the project logical framework will need to revised
The proposed Project Business Plan for the next six months, annual financial planning and reallocation of budgets were approved with no objections.	Minutes of JLCB meeting		21 June 2011	Needs to be revised
It was agreed that the project file will be reviewed considering the requested changes and the final version will be produced within 2 weeks and made available to all members for perusal.	Minutes of JLCB meeting	Ms. Nuga Deliwe	21 June 2011	Done with delays, however it now requires to be revised
The need to elaborate detailed key sub-activities was noted.	Minutes of JLCB meeting	Ms. Nuga Deliwe	21 June 2011	Not done
The implementation plan was approved provided that the activities will be edited, subject to finalisation of sub activities. This will be developed in detail with input from relevant colleagues, particularly the NHI Colleagues responsible for ensuring the facility performance speaks to requirements for NHI piloting.	Minutes of JLCB meeting	Ms. Nuga Deliwe	21 June 2011	Cancelled before finalised

6 Lessons Learned

Lessons learned	Target audience
There are no lessons learned from interventions since there is no progress achieved during 2011.	-

7 Annexes

7.1 Logical framework

Overall Objective			
To increase the efficiency, effectiveness and quality of care in South Africa's health sector			
Specific Objective			
To improve the management capacity of Government hospitals			
Indicators	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
• Total number of hospitals that has completed capacity building interventions. • Number of participating hospitals accredited by achieving Core Standards for Health Facilities. • % completion of District Managers training per district. • % completion of SDF's training per province. • Project coordinating working group operational. • Agreed Memorandum of Understanding and guidelines for implementation of HRD strategy /plan by SDF's. • Number of hospitals with sound strategic plans • Number of hospitals with good monitoring and evaluation of clinical outcomes • Number of hospitals with Quality Improvement strategies	• National & Provincial skills training statistics & reports. • Core Standards for Health Facilities Appraisal reports[1] and accreditation. • Random Interviews / Questionnaires with local service beneficiaries. • Frequency of meetings, quorum & minutes of meetings. • Report on implementation of the National Department of Health HRD strategy at National & Provincial levels.	• External and internal brain drain due to high staff turn-over & mobility. • Impact of factors such as AIDS on HR Workforce	• External and internal brain drain due to various reasons controlled. • Impact of other factors such as AIDS on HR Workforce controlled. • Local high staff turn-over & mobility reduced. • Acquired skills are retained within the sector.

APPROVED CHANGE

Overall Objective			
To increase the efficiency, effectiveness and quality of care in South Africa's health sector			
Specific Objective			
To improve the management capacity of Government hospitals			
Indicators (specific objective)	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
• Total number of facilities enrolled in the programme • % of continuous implementation of improvement programmes in respect of functionality and performance • % of realization of Core Standards for Health Facilities • Project coordinating working group operational • Number of facilities with Quality Improvement strategies in respect of functionality and performance	• National & Provincial skills training statistics & reports • Core Standards for Health Facilities Appraisal reports[2] and accreditation • Random Interviews / Questionnaires with local service beneficiaries • Frequency of meetings, quorum & minutes of meetings • Report on implementation of the NDoH incentive and awards programme	• External and internal brain drain due to high staff turn-over & mobility • Impact of factors such as AIDS on HR Workforce	• Availability of data (e.g. reports on the skills audit, reports on the CEO assessments) • Buy-in of all key stakeholders • External and internal brain drain due to various reasons controlled • Impact of other factors such as AIDS on HR Workforce controlled • Local high staff turn-over & mobility reduced • Acquired skills are retained within the sector

AS DEFINED IN THE TECHNICAL AND FINANCIAL FILE

RESULT AREA 1: Capacity of Hospital management teams built at all levels			
Indicators	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
• % of high, middle and low-level management teams trained within a facility. • % of trained staff in post at Project conclusion. • % realisation of Core Standards for Health Facilities. • % individual completion of District Managers training. • % completion of District Managers training per district. • Service Excellence Awards granted[3].	• Hospital, Provincial & National skills training statistics & reports. • Activity reports. • EQi & Psychometric evaluations • Random Interviews / Questionnaires with service beneficiaries. • Staff perception of institutional management (by structured Interviews & questionnaires). • Core Standards for Health Facilities Appraisal report & accreditation. • PMDS[4] reports.	• External and internal brain drains due to due to high staff turn-over & mobility. • Impact of other factors such as AIDS on HR Workforce. • Overall loss of acquired skills from the beneficiary Institutions • Unavailability of whole teams during training intervention.	• External and internal brain drain due to various reasons controlled. • Impact of other factors such as AIDS on HR Workforce controlled. • Local high staff turn-over & mobility reduced. • Acquired skills are retained within hospitals & in the sector • Consistent availability of whole teams during training intervention.

APPROVED CHANGE

Result Area 1: Capacity of facilities built in respect of functionality and performance			
Indicators	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
• Number of facilities in the delivery chain enrolled in the programme • Number of incentive and awards systems and processes set up • % of trained staff in post at project completion • % of continuous implementation of improvement programmes in respect of functionality and performance, at the end of the project • % of realization of Core Standards for Health Facilities[5] • Incentive and awards granted	• Facility readiness assessment report • Incentive and awards programme approval • Tools, guideline, criteria and procedures developed and agreed • Attendance registers and progress reports • Registers submitted by health facility • Facility improvement plans; M&E reports; • Core standards for health facilities appraisal report and accreditation • M&E reports	• Overall loss of acquired skills at facility level • High staff turn-over • Lack of programme follow up • Limited buy-in from the major stakeholders at targeted levels	• External and internal brain drain due to various reasons controlled. • Impact of other factors such as AIDS on HR Workforce controlled. • Local high staff turn-over & mobility reduced. • Acquired skills are retained within hospitals & in the sector • Consistent availability of all targeted beneficiaries during training intervention.

AS DEFINED IN THE TECHNICAL AND FINANCIAL FILE

Result Area 2: Capacity of Skills Development Facilitators in the Department of Health is built at national and provincial level			
Indicators	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
• Number of SDF's trained. • Level of individual completion of SDF's training. • % completion of SDF's training per province. • Level of implementation of national and provincial HRD plans by mid term review and final evaluation. • Level of aligning institutional skills development to Provincial/National skills development strategy by mid term review and final evaluation.	• National & Provincial SDF's training statistics & reports. • Activity reports. • Evaluation reports. • Random Interviews / Questionnaires with training beneficiaries. • Report on implementation of National Department of Health HRD strategy at national & provincial levels.	• Unavailability of targeted SDF's during training interventions. • Financial constraints such as lack of or insufficient National & Provincial budgets to allow the implementation of the HRD plans. • Administrative constraints such as the unavailability of adequate staffing at all levels to monitor & ensure development & implementation of HRD plans.	• Consistent availability of targeted SDF's during training interventions. • Availability of national & provincial budgets to allow implementation of the HRD plans. • Staff availability at all levels to monitor & ensure development & implementation of HRD plans.

APPROVED CHANGE

Result Area 2: Capacity of Skills Development Facilitators in the Department of Health is built at national and provincial level			
Indicators	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
• Number of SDFs and HRDs involved in the incentive system implementation	• Report on implementation of NDoH incentive and awards programme at national & provincial levels	• Financial constraints such as lack of or insufficient National & Provincial budgets to allow the active participation in the incentive and awards programme • Administrative constraints such as the unavailability of adequate staffing at the required levels to monitor & ensure development & implementation of the incentive and awards programme	• Consistent availability of targeted SDF's during the programme • Availability of national & provincial budgets • Staff availability at all levels to monitor & ensure development & implementation of the programme
• **Explanatory Note:**	• In the context of the current project proposal, SDFs will be required to be part of the working group at provincial/district/facility level, and contribute to the programme. They will be required to participate and provide support in the implementation of the project to ensure continuation of it. However, no training curriculum is foreseen to be designed specifically for them.		

AS DEFINED IN THE TECHNICAL AND FINANCIAL FILE

Result Area 3: The programme is implemented in a well coordinated, fully integrated and sustainable process			
Indicators	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
• Project coordinating working group operational – [With co-opted representatives from other relevant departments from National and Provincial Departments of Health, hospitals & development partners]. • Strengthened capacity & skills at the National Department of Health specific to this Project. • Agreed Memorandum of Understanding and guidelines for the implementation of HRD strategy /plan by SDF's. • Degree of programme integration into National Department of Health. • Participation & Inputs into relevant development partners consultative meetings.	• List of co-opted members of the working group. • Frequency of meetings, quorum & minutes of meetings. • Technical assistance from BTC deployed at the National Department of Health to strengthen capacity & transfer skills in the management of this Project. • Fully integrated programme into National Department of Health HRD frameworks at end of BTC Project • Developed implementation plans for HRD strategy & their execution. • Recognition of programme within the National Department of Health & Provincial MTEF. • Relevant development partners meetings reports. • Monitoring & Evaluation reports.	• Non-functional Steering Committees at some levels of the health structure. • Poor or lack of effective communication with relevant stakeholders. • Over looking complimentarity of actions of National Department of Health, BTC and other partners/donors implementing similar Projects such as CDC, EC etc • Lack of an appropriate & sustainable exit strategy as it relates to the end of BTC funding for the Project.	• Functional Steering Committees at all levels primarily providing strategic leadership, guidance, oversight, and coordination on Project operation. • Improved & sustained communication networking all relevant stakeholders. • Actions of National Department of Health and BTC are complementary with a firm handle on embodiment & a premium on ownership. • Partnerships with other donors implementing similar Projects such as CDC, EC are pursued & harmonized. • National Department of Health in collaboration with BTC & relevant stakeholders develop an appropriate & sustainable exit strategy as it relates to the end of BTC funding for the Project

APPROVED CHANGE

Result Area 3: The programme is implemented in a well coordinated, fully integrated and sustainable process			
Indicators	**Means of Verification**	**Risks**	**Assumptions (Hypothesis)**
• Project coordinating working group operational – [With co-opted representatives from other relevant departments from National and Provincial Departments of Health, hospitals & development partners]	• List of co-opted members of the working group • Frequency of meetings, quorum & minutes of meetings	• Non-functional Steering Committees at some levels of the health structure • Poor or lack of effective communication with relevant stakeholders	• Functional Steering Committees at all levels primarily providing strategic leadership, guidance, oversight, and coordination on Project operation • Improved & sustained communication networking all relevant stakeholders
• Strengthened capacity & skills at the National Department of Health specific to this Project	• Technical assistance from BTC deployed at the National Department of Health to strengthen capacity & transfer skills in the management of this Project • Capacitate an internal DOH resource	• Over looking complimentarity of actions of National Department of Health, BTC and other partners/donors implementing similar Projects such as CDC, EC etc	• Actions of National Department of Health and BTC are complementary with a firm handle on embodiment & a premium on ownership • Partnerships with other donors implementing similar Projects such as CDC, EC are pursued & harmonized
• Degree of programme integration into National Department of Health	• Fully integrated programme into National Department of Health HRD frameworks at end of BTC Project • Recognition of programme within the National Department of Health & Provincial MTEF	• Lack of an appropriate & sustainable exit strategy as it relates to the end of BTC funding for the Project	• National Department of Health in collaboration with BTC & relevant stakeholders develop an appropriate & sustainable exit strategy as it relates to the end of BTC funding for the Project
• Participation & Inputs into relevant development partners consultative meetings	• Relevant development partners meetings reports • Monitoring & Evaluation reports		

7.2 M&E activities

First project JLCB – 21 June 2011

7.3 "Budget versus current (y – m)" Report

Budget vs Actuals (Year to Month, Last 5 Years) of SAF0901811

Project Title : **Capacity Building in the Department of Health of South Africa - Consolidation Phase**

Budget Version : **D2**
Currency : EUR
Year to month : 31/12/2011
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2007	2008	2009	2010	Expenses	Total	Balance	% Exec
A SPECIFIC OBJECTIVE (PART) 1			1.615.000,00					**45,46**	45,46	1.614.954,54	**0%**
01 result 1 : capacity of Hospital Management			1.570.000,00					**45,46**	45,46	1.569.954,54	**0%**
01 need analysis of selected districts and		REGIE	0,00					**0,00**	0,00	0,00	?%
02 capacity building interventions in 50 hospitals		REGIE	0,00					**0,00**	0,00	0,00	?%
03 capacity building interventions in 10 districts		REGIE	0,00					**0,00**	0,00	0,00	?%
04 impact assesment and evaluations		REGIE	0,00					**0,00**	0,00	0,00	?%
05 service excellence award for hospital and		REGIE	0,00					**0,00**	0,00	0,00	?%
06 Develop an incentive and awards system for		REGIE	350.000,00					**45,46**	45,46	349.954,54	0%
07 Preparatory workshops with identified		COGES	95.000,00					**0,00**	0,00	95.000,00	0%
08 Workshops/trainings of all relevant staff to		REGIE	915.000,00					**0,00**	0,00	915.000,00	0%
09 Follow up on the programme		REGIE	200.000,00					**0,00**	0,00	200.000,00	0%
10 Incentives and awards for facilities		REGIE	10.000,00					**0,00**	0,00	10.000,00	0%
02 Result 2 : capacity of Skills Development			0,00					**0,00**	0,00	0,00	**?%**
01 Agree and harmonize the training modules		COGES	0,00					**0,00**	0,00	0,00	?%
02 Agree and harmonize the training modules		COGES	0,00					**0,00**	0,00	0,00	?%
03 Conduct evaluations & impact assessment.		COGES	0,00					**0,00**	0,00	0,00	?%
03 Result 3: The programme is implemented in			45.000,00					**0,00**	0,00	45.000,00	**0%**
01 Hosting working group meetings (NDOH,		COGES	15.000,00					**0,00**	0,00	15.000,00	0%
02 Update capacity building strategic		COGES	30.000,00					**0,00**	0,00	30.000,00	0%
03 Develop a memorandum of understanding		COGES	0,00					**0,00**	0,00	0,00	?%
		REGIE	1.852.000,00					**25.406,39**	25.406,39	1.826.593,61	1%
		COGEST	148.000,00					**0,00**	0,00	148.000,00	0%
		TOTAL	2.000.000,00					**25.406,39**	25.406,39	1.974.593,61	1%

Budget vs Actuals (Year to Month, Last 5 Years) of SAF0901811 Printed on maandag 23 januari 2012 page: 1

Budget vs Actuals (Year to Month, Last 5 Years) of SAF0901811

Project Title : **Capacity Building in the Department of Health of South Africa - Consolidation Phase**

Budget Version : **D2**
Currency : EUR
Year to month : 31/12/2011
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2007	2008	2009	2010	Expenses	Total	Balance	% Exec
X BUDGETARY RESERVE			40.600,00					**0,00**	0,00	40.600,00	**0%**
01 Budgetary reserve			40.600,00					**0,00**	0,00	40.600,00	**0%**
01 Budgetary reserve CO-manangement		COGES	8.000,00					**0,00**	0,00	8.000,00	0%
02 Budgetary reserve STATE manangement		REGIE	32.600,00					**0,00**	0,00	32.600,00	0%
Z GENERAL MEANS			344.400,00					**25.360,93**	25.360,93	319.039,07	**7%**
01 Staff expenses			126.000,00					**19.391,54**	19.391,54	106.608,46	**15%**
01 National manager		REGIE	126.000,00					**19.391,54**	19.391,54	106.608,46	15%
02 Finance and administration team		REGIE	0,00					**0,00**	0,00	0,00	?%
02 Investments			15.000,00					**3.759,84**	3.759,84	11.240,16	**25%**
01 Office equipment		REGIE	8.000,00					**1.973,49**	1.973,49	6.026,51	25%
02 IT equipment		REGIE	7.000,00					**1.786,35**	1.786,35	5.213,65	26%
03 Operational expenses			108.400,00					**1.892,83**	1.892,83	106.507,17	**2%**
01 Office rent		REGIE	0,00					**0,00**	0,00	0,00	?%
02 Services and maintenance costs		REGIE	6.000,00					**0,00**	0,00	6.000,00	0%
03 Vehicle running costs		REGIE	12.000,00					**0,00**	0,00	12.000,00	0%
04 Telecommunications		REGIE	3.600,00					**0,00**	0,00	3.600,00	0%
05 Office supplies		REGIE	1.800,00					**680,81**	680,81	1.119,19	38%
06 Missions		REGIE	82.500,00					**0,00**	0,00	82.500,00	0%
07 Representation and external communication		REGIE	2.500,00					**623,87**	623,87	1.876,13	25%
08 Training		REGIE	0,00					**0,00**	0,00	0,00	?%
		REGIE	1.852.000,00					**25.406,39**	25.406,39	1.826.593,61	1%
		COGEST	148.000,00					**0,00**	0,00	148.000,00	0%
		TOTAL	2.000.000,00					**25.406,39**	25.406,39	1.974.593,61	1%

Budget vs Actuals (Year to Month, Last 5 Years) of SAF0901811

Project Title : **Capacity Building in the Department of Health of South Africa - Consolidation Phase**

Budget Version : **D2**
Currency : EUR
Year to month : 31/12/2011
YtM : **Report includes all closed transactions until the end date of the chosen closing**

	Status	Fin Mode	Amount	Start to 2007	2008	2009	2010	Expenses	Total	Balance	% Exec
09 Consultancy costs		REGIE	0,00					**0,00**	0,00	0,00	?%
10 Financial costs		REGIE	0,00					**94,38**	94,38	-94,38	?%
11 VAT costs		REGIE	0,00					**493,77**	493,77	-493,77	?%
12 Other operational expenses		REGIE	0,00					**0,00**	0,00	0,00	?%
04 Audit and Monitoring and Evaluation			95.000,00					**316,72**	316,72	94.683,28	**0%**
01 mid term review		REGIE	25.000,00					**0,00**	0,00	25.000,00	0%
02 final evaluation		REGIE	25.000,00					**0,00**	0,00	25.000,00	0%
03 external audit		REGIE	30.000,00					**0,00**	0,00	30.000,00	0%
04 Backstopping		REGIE	15.000,00					**316,72**	316,72	14.683,28	2%
		REGIE	1.852.000,00					**25.406,39**	25.406,39	1.826.593,61	1%
		COGEST	148.000,00					**0,00**	0,00	148.000,00	0%
		TOTAL	2.000.000,00					**25.406,39**	25.406,39	1.974.593,61	1%

7.4 Beneficiaries

Since there were no interventions as part of the project implementation, the effects on beneficiaries cannot be assessed at this stage.

7.5 Operational planning Q1-2011

I.1. ANNUAL PLANNING OF THE ACTIVITIES – Update Q1 2011

To be updated in Q1 2011: 20 January 2011 / Q2 2011: 20 April / Q3 2011: 20 July / Q4 2011: 20 October)

Project: (Capacity Building in the Department of Health + SAF0901801)

R1: Capacity of Hospital Management teams built

Activities	Sub activities	State of execution	Person in charge	Remarks - Difficulties – Points of attention
A.1.1 : Needs analysis of selected districts and hospitals in 3 provinces		The project plan is currently being developed and is to be approved before the end of April by the 1st JLCB		
A.1.2 : Capacity building interventions in 50 hospitals				
A.1.3 : Capacity Building interventions in 10 districts				
A.1.4: Impact Assessment and evaluations				
A.1.5: Service excellence award for hospital and district management teams				

R2: Capacity of Skills Development Facilitators in the Department of Health is built

Activities	Sub activities	State of execution	Person in charge	Remarks - Difficulties – Points of attention
A.2.1 : Agree and harmonise the training modules based on needs analysis		The project plan is currently being developed and is to be approved before the end of April by the 1st JLCB		

A.2.2 : Conduct Capacity Building interventions by training in the standardised modules				
A.2.3: Conduct Evaluations and impact assessments				

R3: The programme is implemented in a well coordinated, fully integrated and sustainable process

Activities	Sub activities	State of execution	Person in charge	Remarks - Difficulties – Points of attention
A.3.1 : Hosting working group meetings (NDOH, PDOH and other donors)		The project plan is currently being developed and is to be approved before the end of April by the 1st JLCB		
A.3.2 : Update capacity building strategic frameworks, guidelines, modules and assessment tools				
A.3.3: Develop a memorandum of understanding for mplementation of HRD strategy by SDF's				

Z. General management activities

Personnel:

Activities	Sub activities	State of execution	Person in charge	Remarks - Difficulties – Points of attention
Recruitment (started up or in case of resignation)				
	Recruitment of the long term Assistant Project Manager in accordance with the TFF.	The recruitment process was initiated in March 2011 and the contract is to be signed in April 2011.	Mr. Tom Smis	None
Training of project staff				

Prior notice (in closing phase)				

Investment:

Activities	Sub activities	State of execution	Person in charge	Remarks - Difficulties – Points of attention
IT equipment	Procurement of IT equipment.	The project plan is currently being developed and is to be approved before the end of April by the 1st JLCB		
Office supplies and equipment				

Operational expenses:

Activities	Sub activities	State of execution	Person in charge	Remarks - Difficulties – Points of attention
Office rent		The project plan is currently being developed and is to be approved before the end of April by the 1st JLCB		
Services and maintenance costs				
Vehicle running costs				
Telecommunications				
Office supplies				
Missions				
Representation and external communication costs				
Training				
Consultancy costs				
Financial costs				
VAT costs				
Other operational expenses				

Audit and Monitoring and Evaluation:

Activities	Sub activities	State of execution	Person in charge	Remarks - Difficulties – Points of attention
Mid Term Review		The project plan is currently being developed and is to be approved before the end of April by the 1st JLCB		
Final Evaluation				
External Audit				
Backstopping				