

IMCC



**Mid-term Review of the
IMCC Primary Health Care Project
in Sissala District, Upper West Region,
Ghana – Report**

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For:
IMCC (International Medical Cooperation Committee)

By:
Andreas Bjerrum, IMCC Denmark
Rofina Asura, GHS Ghana
Tom Barton, CRC Uganda

With:
Mette Bøge Larsen
Pernille Aurelius Jensen
Thomas Aagard Rasmussen

Executive Summary

Background

Setting

The UWR has historically been one of the most health-deprived parts of Ghana with very bad access to health facilities. Sissala District (sometimes called Tumu District), which is one of the five districts making up the Upper West Region, has a population of approximately 85,000 people living in 110 communities. The population density is low, only about 11-15/ km², which contributes to the problems of providing adequate access to health care, as well as affecting the provision of other social services. The roads are all dirt roads and most are in a bad condition. About two-thirds (68%) of the population are poor subsistence farmers, and about 85% of the adult population are illiterate (women are worse off than men in this regard). The formal health system in the district consists of one district hospital and 9 Health Centres represent the formal health system in the district. There are around 125 employed, and the district has only one permanently employed Ghanaian doctor. The non-formal health sector remains very strong in the villages and the co-operation between the two sectors is quite limited or poor.

IMCC

The International Medical Cooperation Committee (IMCC) is a humanitarian organisation comprised of Danish Medical Students, with the aim of supporting them to participate in projects that address common medical and sociomedical problems. IMCC runs three primary health care projects: one in Ghana and two in Bolivia. About 35 volunteers are preparing to work, are working, or are still in school after working at the projects.

Participants in the project from Denmark are medical or public health students in their final years of training. They are selected approximately one year before coming and then receive special training in tropical medicine and cross-cultural work, adult teaching methods and the use of visual aids, plus a series of meetings and seminars on Ghana and its health system. It is possible for the students to bring their partner who then works in the programme on equal terms with the medical and public health students. The duration of the working period is 14 months and there are at all times a minimum of three volunteers at the project site.

During their stay in Ghana, the students work with the District Health Management Team (DHMT) and Sub-district Health Team (SDHT) on Primary Health Care issues. Although the medical students are capable of curative work, their project document emphasises that their role is to focus on primary health care and supporting the DHMT.

Project focus and objectives

The present project is in the middle of a second five-year phase, based on the initial project that was started in 1997. The principal focus of the first phase of the project was supporting Primary Health Care in the district, mostly at the sub-district (SD) level.

The project objectives for the second phase

The development objective: The health status of people living in Sissala District improved.

The intermediate objective: by 1st of March 2006, the health services of Sissala District are strengthened.

Immediate objectives:

- The geographical and financial access to all basic health services for people living in Sissala District increased.
- Better quality of care in all health facilities and outreach points provided.
- Efficiency at all levels of the district health services improved.

- Lessons from Sissala District to the rest of UWR, other parts of Ghanaian health system and Denmark disseminated.

[for a detailed listing of the planned outputs, see the ToRs, Annex 1]

Internal monitoring and evaluation

A yearly M&E is carried out by the staff working on the project. Fifteen indicators have been selected to form the basis of the evaluation. These indicators are believed to monitor and evaluate not only a number of project outputs, but also in part intermediate and immediate objectives stated in the Project Document. The M&E report, written in the fourth quarter of every year, presents the data collected on basis of the indicators. The M&E report performs an analysis of any development seen in the status of the indicators and therefore project outputs and objectives and seeks possible explanations for this development. Furthermore, recommendations for future project activities or adjustment of strategies are given.

Mid-term review

Objectives for the midterm review of DHMT/IMCC project

The objectives for the midterm review of the joint DHMT/IMCC primary health care project are as follows:

1. Evaluate project performance as regards preparation and implementation of plans and achievement of targets and objectives
2. Make recommendations on possible improvements in project design and organization and on modification of targets, objectives and plans for further implementation
3. Make recommendation as to whether the project should be prolonged.

The evaluation shall comprise but not necessarily be limited to the following aspects (see Annex 1 for more details):

- The setting of the project
- Project implementation and performance
- Achievements of objectives and assessment of project design and strategies
- Project management
- Future operation and development of the project

Recommendations are expected to be guidance for the future project implementation. Therefore, the recommendations are expected in a form of adjustments of strategies, rather than a list of possible new activities.

Methods of the review

The review team met with stakeholders and beneficiaries to the project at multiple levels: national (MoH, HSSO [Health Sector Support Office, the former HSSP], Danish Embassy), regional (UWR), district (Sissala), sub-districts (Jeffisi, Wellembelle, Nabulo), and communities. Meetings were also held with various representatives of other health partners: the DA, TDH, SHEP co-ordinator, NGOs and CBOs. Data was collected with documents review, key informant interviews, focus groups, community meetings, and observations. Some meetings used PRA methods for greater participation. The main topics of discussion included:

- Context of project: past, current, anticipated
- History of IMCC in Ghana, including management
- Project outcomes, including indicators
- Recommendations, for current phase and future

Findings

Setting and context

Sissala continues to be one of the poorest and more health deprived districts in the country. IMCC is well informed on these issues and has been directly participating in the efforts of the health sector to address them. They have participated in bi-annual health sector summits and, at the district level, they are involved with efforts to focus disease targeting as well as attention to deprived areas, and to promote health insurance.

IMCC has been active in collaborating with their district partners to bring medical students up to the district with a view to helping the long term staffing problems. They are in frequent communication with the DHMT, the District Hospital and the District Assembly regarding human resource and service planning issues, largely through their very active partnership in the annual MTEF planning process, and their uniquely interwoven participation with the DHMT.

IMCC seems to be well informed about the policies and overall programmes of their stakeholders at all levels, from community to national. The working relationships are generally good, but there are additional opportunities for interaction and collaboration to the mutual benefit of the groups and the people of Sissala.

The isolated and remote conditions of Sissala district have not changed drastically during the time that IMCC has been active there, and they remain significant challenges to the work. It would be beneficial for the IMCC as an organisation and for its member students to have more linkages with other areas of the country – e.g., research and academic institutions, participation in short courses and trainings in other regions, site visits to best practice settings together with DHMT members, etc. But this remains a difficult balance making choices about such activities when the effort involved has such big time and cost implications for the work of IMCC in Sissala.

Interactions and information sharing

IMCC initially worked primarily in sub-districts, but during the second phase they were advised by counterparts to work at district level, and it has been a good idea. The IMCC has interactions with all of the key stakeholders at district level, both in one-to-one organisational encounters, and through participation in various district-wide fora, e.g., on health insurance, HIV/AIDS, and annual planning. Now the IMCC is doing more work on capacity building, not as much on training. IMCC is trying to work only in a supporting role, not filling gaps. The IMCC has an MoU with the DHMT and a very close relationship at this level. It has been 2 ½ years now, and IMCC is very well consolidated into the partnership.

Overall, the impression is that there are good quality linkages at all levels within the public health (DHMT/SDHMT/community) chain of operation. Outreaches are happening, and there is attention to the quality of the support supervision. Community clients are generally happy with the services at community and sub-district level. The SDHMT has been supportive of the community volunteers. Some SDs are now getting feedback from district level on their reports, and are finding this very helpful in their work.

The IMCC has been supporting improvement or maintenance of the health system linkages in several ways, including donation of used vehicles, contribution to the design of support supervision tools, participation in support supervision visits (and contributing transport on those occasions). The IMCC is actively participating in sub-district planning and local data analysis where they are the sub-district 'parent'. IMCC is also very active within the DHMT in promoting review of the support supervision visits, and in looking for solutions to address problems at all levels. These efforts are highly commendable.

The IMCC is well known to the various members of the Regional Health Directorate, much better, in fact, than it was four years ago. It is respected for its contributions to the quality of district reporting (Sissala reports are highly esteemed at regional level for their analysis), and for their active participation in the semi-annual manager's meetings.

Information sharing - According to discussions during the evaluation, the district newsletter is praised for its usefulness, and appears to be a feasible undertaking of the DHMT/IMCC partnership. Work is already underway, with considerable support from IMCC, toward setting up a district health library, with both hard copy documents and electronic materials.

Volunteer issues and performance

All persons consulted in the review, from community to regional level and including other NGO partners, felt that the IMCC has been doing a good job in training TBAs. The IMCC and DHMT have trained many of them; and they are doing good trainings. Significantly, they are also doing them inexpensively, and doing them together with the SD, involving the SD in the planning and training. The region believes that there are good lessons in this work to be shared with other districts in the UWR.

Sub-district issues

All of the sub-districts visited expressed appreciation for the system of monitoring and support visits. The SD in-charges liked the encouragement of the visits, and the assistance in solving various problems. The feedback aspect was praised, particularly the written feedback that is showing the SD team how to build up the quality of their work. The DDHS also highlighted the positive aspects of the new system of written feedback, to which IMCC has contributed heavily, not only in the design of the tool but also in collaborating with the DHMT to analyse the incoming results of the visits and the SD data for deciding what content to put into the feedback notes.

There is still some confusion at various levels, from district to national level about CHPS, and there is no clear agenda, or unified national strategy or policy document (though there is one in the pipeline according to the GHS). Sissala is working on CHPS, but at its own pace. Some members of the district leadership have heard of it and know what it is, but others will need more advocacy on the topic. Advocacy on CHPS is also needed at community level, since the same services are the ones that will or can be provided through health insurance. The IMCC is interested in supporting Sissala DHA in CHPS implementation, but the IMCC also argues that a clearer strategy is needed; it is not feasible for this district to operate 30 CHPS zones.

District and cross-cutting issues

The DHMT/IMCC relationship at district level is now very transparent, with easy collaboration. Weekly meetings have increased, and the monitoring and support visits have also increased. Monitoring and support has increased to all areas of the district, not just the parent/child areas of IMCC responsibility. Agenda for the meetings is better, and reporting on the meetings is better than before – all of which suggests positive changes of DHMT behaviour.

While IMCC has been active and contributing on health insurance and HIV issues at the district level, there is much more work needed by/with the district in these areas. Considering the very real limitations of capacity for IMCC, this will probably need to take the form of a more coherent advocacy strategy rather than any more extensive implementation efforts.

IMCC performance

The DHMT sincerely appreciates that the IMCC has developed their own office at the DHMT quarters. Members of the DHMT said that the collaboration with IMCC is very good; there is support on both sides concerning the work. The IMCC group do not take their own decisions; instead, they reach consensus decisions with the DHMT/DHA. The IMCC has a good approach to planning – before acting on anything, they first draw up a programme, and then circulate it to the DHMT. They put their activities in such a way that the DHMT is involved. The DHMT and IMCC recognise certain risks in the partnership, but both sides are able to articulate their ideas and discuss them openly.

One of the thornier issues for the DHMT is that IMCC expects the DHMT to fuel the IMCC car when they borrow it. There is a perception that the IMCC is very rigid on this issue, despite their flexibility on loaning the car, and despite their knowledge of the DHMT cash flow problems. In addition, at times the IMCC group get wrapped up in writing reports, and it becomes hard to get them to do other things. They used to call all the CHNs for in-service training on the motorcycle maintenance days, but then it stopped.

The DA praised IMCC's work as 'excellent'. They are an important participant in health insurance committee – health care, primary health care, and they have taught around the whole district. They attend meetings, go out to the communities, and help with immunisations, including vehicle support. Their biggest drawback from the DA perspective was not working more closely with the DA.

IMCC has been doing a very good job with the Ghanaian medical students – receiving praise from all students who have been through the programme with them, and strong expressions of interest from more students to participate. Meanwhile, there are various difficulties in this initiative, largely with developing a clear vision of where the programme is going and secondly, tying it in more firmly to advocacy efforts for the long term recruiting needs of the district.

The direct DHMT/IMCC relationship has really flowered during the past 2-3 years, much to the mutual benefit of both partners. As described above, this has been linked to many improvements in the organisation and management of district health services for Sissala. One of the emerging challenges for the rest of this phase in the programme and potentially for the next phase is how to support mutually beneficial improvements in the relationships of the DHMT with other key health partners, including the DA and the district hospital.

Conclusion

Overall, the IMCC-Ghana organisation has become an impressively successful example of an alternative model of health NGO (non-governmental organisation) working directly with the health system as an equal or supporting (rather than guiding or demanding) “health partner”. It is expected that the present phase will be completed in a highly successful way. The evaluation team strongly recommends that there should be another phase, and that part of IMCC’s efforts during the next two years should be directed toward the preparation and development of plans for that phase.

Key recommendations of this report

Each of the following recommendations is accompanied by a small note about what chapter it comes from; this is done to enable the reader to more easily track information about the justification of the recommendation, and about resources and opportunities available for implementing it.

Modifications of on-going activities

These are high priority issues for the current phase, if possible.

Monitoring and information systems

- **M&S form** - The monitoring and support form should be thinner/smaller with some greater attention to open-ended discussion time; possibly by have two different forms: a) one for technical/clinical supervision and b) one for administrative/management supervision. [chap 2 & 4]
- **Document visually as well as with words** - Use the digital camera (either the one owned by the DHMT or the one for IMCC) for taking pictures of service and maintenance issues at the time of the M&S visit, and bring these back to the DHMT for review and problem solving [chap 4]
- **Tracking problem resolution** - Consider using an incident/issue tracking form to follow whether issues are being resolved (see example from Somalia given to IMCC during the evaluation) [chap 4]
- **Activity support during M&S visits** – arrange some of the monthly visits so that they occur while SD activities are happening, and the visiting M&S team can assist; but not all of them, e.g., once per quarter a visit with clinical assistance, once per quarter a visit with outreach assistance, and once per quarter just a facility based discussion. [chap 4]
- **Info sharing** - Continue the newsletter, and explore options for expanding the audience, e.g., to secondary and possibly upper primary schools in the district. Look into partnerships for funding this activity, e.g., with the school health project, with the DA, and with other NGO partners in the district. If such partnerships and co-funding can be established, consider how to include at least a portion of the newsletter in vernacular. [chap 2]
- **Research agenda** - Establish a district health research agenda; based on suggestions from the field, the best group to do this would be a combination of the Research Interest Group – persons from the DHMT, hospital and IMCC. [chap 5]

Training and capacity building

- **In-service training on motorcycle days** - DHMT with IMCC (and possibly other partners) to explore how to restart the in-service training for SD staff on the motorcycle maintenance days. This

would be an ideal opportunity to progressively deal with all of the high priority agenda issues of the SDs, of the DHMT and ones that IMCC has identified to which it can contribute [i.e., improving the skills of all SDs in planning, prioritising and organisation of their work; refining the M&S system; improving analytical and reflective report writing; and enhancing the health reporting system.] [chap 4]

- **HIV counselling skills** - all sub-districts to have at least one person with HIV counselling skills. Use this as a topic within the motorcycle maintenance day in-service trainings. [chap 5]
- **TBA training** - Develop (or refine) and implement post-training assessment methods and tools for TBAs with support of midwives in the district. [chap 3]
- **Documentation of decisions** - Be more thorough in documenting changes to standard training curricula. Changes can be justifiable, but should be more carefully documented for future reference and follow-up monitoring of results with the altered training. [chap 3]
- **Clinical skills support** - IMCC and the DHMT should urgently explore further about how clinical skills supervision and support for SD clinic staff can be done, including more attention to reviewing and supporting technical quality of care. [chap 2 & 4]
- **Maintaining RHMT training links** – copy of all training reports, curricula and training plans to the Regional training co-ordinator. Will help in securing professional training credits for staff that participate. [chap 6]

Advocacy issues

The emphasis with these issues is that IMCC could at a minimum incorporate more messages related to these topics in the relevant interactions that they already have. Further enhancement of the advocacy by thinking out an advocacy plan would be desirable, but less feasible in the current phase.

- **CHPS initiative** - Within Sissala, IMCC could be of help in mobilising the communities to understand and support the CHPS initiative. Also with the DA. [chap 4]
- **Maternity exemptions** - Explore how SDs can claim for and secure the release of maternity care funds from the local government/DA. [chap 5]
- **Health insurance** - Speak more about health insurance to TBAs who will be able to mobilize women's groups since these groups already exist and TBAs are meeting them to share health information. [chap 5]
- **Volunteer support** - Pursue advocacy for volunteer support with the SDHMT and other partners; particularly exploring about gloves for TBAs and health care packages for volunteers at SD level. [chap 3]

Medical student issues

- **Involve medical students in preparations** – Christian and Simpson at Kumasi were already offering to do this. Content could include teaching the students what to expect, thereby minimising undue expectations, frustration and need for extended negotiations at arrival. Process - It could even have the former/experienced student bring new students up and facilitating their introduction to various individuals and agencies (where these have not changed in the interim), saving IMCC energy. [chap 5]
- **Enhance interaction between Ghanaian and Danish medical students** – Could share some photos of the Tumu region and health issues here with the Kumasi programme (e.g., with the point person) so that it would be easier to upload the pictures and documents onto their intranet at the medical school. Could send one or two IMCC staff down to Kumasi to participate in a preparation seminar for selected students who will be coming to Tumu – going with photos and perhaps a power point presentation – which might be able to be used for an even larger group of students who are considering applying in the future. [chap 5]
- **Facilitate more meaningful recruitment interactions during the visit** - Ensure the student has some time to discuss with various members of the DA, including the social welfare committee. Try to get some of the discussion to include what the district is prepared to do to support a doctor who comes to work in their district – up to even consideration for paying their school fees [chap 5]

Exploratory or development issues

Some of these issues may be able to be accommodated within the current phase, but all of them are relevant in pointing the direction for issues to be considered and explored as part of the preparation for another phase.

Training issues

- **DSV training** - Provide training on how to manage and how to treat mentally disturbed ('mad') people. Would be a good topic for update/refresher training; are resource persons available. [chap 3]
- **Herbalist training** - herbalists need some training to handle their herbs with good sanitation and hygiene. Male herbalists can also be a good group to promote male reproductive/sexual health and condom usage in the villages. Can be integrated if proposed training does take place. [chap 3]
- **SHEP programme** - Consider ways to link the SHEP programme with other ongoing public health initiatives of the IMCC and the DHMT. E.g., bring in HIV education, perhaps based on the work done by the Ghanaian medical students. Could also look at how to link the health newsletter of the DHMT with SHEP - using it for training material, circulating it to participating schools (and others), and appealing for articles from the teachers, health committees and students being affected by the programme. [chap 5]
- **CSO training** - Collaboration in some training to strengthen CSO skills in planning and research. [chap 6]
- **Regional sharing** – collaborate in sharing of IMCC's lessons learnt about training with key people from other districts, e.g., a small group of DDHSs and a few others, different from the big managers' conference. It would help if all of the districts (including Sissala) were mobilised to bring information showing: best practices, biggest questions, and teaching needs and resources assessment. [chap 6]

Concept issues

- **Partnerships** - Keep the issue of 'partnering' as an open conceptual issue for on-going literature review and dialogue with all stakeholders and 'partners'; but also include periodic reassessment of mutual aims, rights and responsibilities, benefits and risks for existing partnerships. [chap 2]
- **CHPS** - IMCC and the DHMT of Sissala could do a study visit to Nadowli for learning about CHPS implementation. [chap 4]
- **Exemptions** - Obtain copies of the relevant exemption analysis documents for review by the DHMT and IMCC; reconsider at district level the implications of the findings regarding the priorities of the district for whom to exempt within the available funds. [chap 5]
- **Discretionary funding for selected activities** – earmarked and flexible support to some DHMT activities. Could be feasible if there was careful negotiation ahead of time and clarification of what the ground rules would be – so that the DHMT did not become co-opted or the IMCC become a replacement agency. [chap 6]

Researchable issues

Note – these are some of the highest priority issues. There is a more extensive set of researchable topics included in the Annex section of this report.

- **Volunteer roles and responsibilities** – small-scale study to obtain job descriptions, lines of reporting and supervision, forms of support, training curricula, etc. for ALL the different kinds of volunteers currently working in the district on health-related issues. This could be done by members of the DHMT, together with SD staff, or by medical students, or by the District Assembly NGO co-ordinator, or by IMCC staff – or some combination of the above. It would be of considerable benefit to the DHMT in co-ordinating training activities and volunteer support. Appropriate point person on this might be Francis, the training officer, who is also part of the Research Interest Group. [chap 3]
- **Referral process** - Consider a small operational and action research on how to improve the referral process for better clinical care and management. Might include correspondence with other districts, possibly some other regional directorates, and with the MoH and GHS headquarters. There may also be ideas already available at Navrongo or with the schools of public health at the universities. Would include not only issues of the forms, but also information flow, and what kinds of advocacy and monitoring will help the system to be most functional for the various users and stakeholders. Funding might be available with the quality of care focus of the HSSO. [chap 4]
- **Exemption utilisation and pro-poor care** - Consider doing a comparative analysis of exemption use against the picture of exemption need (for paupers) as demonstrated by the district poverty mapping exercise and integrate this analysis into planning for prioritisation of district activities (addressing diseases of poverty, CHPS, etc.) and advocacy (with the DA and other health partners). [chap 5]

- **Identification of the poor** - Explore the options and assess capacity for small operational research on identifying the poor (building on the poverty mapping exercise done with the NDPC and DA, see map in chapter 1) and cost of care issues for SD and community level care in preparation for health insurance. [chap 5]
- **Medical students and long-term recruitment** – It would help to have research and real information on desires of Sissala district sons/daughters in medical school. What are their desires that would influence any of them coming to stay for at least two years or more? There should also be a system to maintain contact to medical students who have been in Tumu for follow-up. [chap 5]