Case Study

LESS BACK AND FORTH, MORE DATA DRIVEN ACTION

By Tatenda Gonye, former Health Manager, Zimbabwe

The Good & Great Standards are IRC's approach to program quality. These Standards help guide us to make our programs better, and ensure that everyone has a shared understanding of what program quality looks like in practice. It also helps us build shared accountability for high quality programs. This case study – one in a series on learning from G&G experience -- shows that when we combine IRC best practice with critical thinking, creativity, and ambition, we can improve the quality and impact of our programs".

Strategy Learning & Innovation Unit

INTRODUCTION

Working for the IRC, we all know the importance of tracking how our projects are progressing and making timely decisions to ensure they are implemented effectively. For some time in IRC Zimbabwe, we've held project review meetings. These have been helpful in bringing people together, but they were time-consuming, not always informed by monitoring data, and often resulted in a lot of back and forth between departments before agreeing on next steps.

In Zimbabwe, we piloted an exciting new approach called the Project Implementation Meeting (PIM)[1]. The approach requires more time spent on preparation, but overall reduces the time in meetings and bilateral exchanges. The PIM has helped IRC Zimbabwe to be much more data-driven and focused on addressing the most pressing issues. This approach has helped us to make significant improvements in our Country Program.

BACKGROUND

Our Maternal and Newborn Care health project was the first to use this approach. This project serves clients in Mutare District, where maternal and infant mortality ratios are high at 641/100,000 and 55/1,000 respectively. Women, girls and infants too often die from preventable causes, and health care facilities are often ill-equipped and experience acute drug and medical supply shortages. The health team used the PIM to analyze project data, brainstorm on possible solutions and then choose actions to address implementation gaps and challenges.

APPROACH

To use the PIM approach, the Health Project Team brought together existing data (monitoring data, client responsiveness data, context data, and operational data) to reflect on progress.

The Health Manager[2] led the way to populating the Project Dashboard, a tool to collect and visualize project data, in advance of the meeting. This meant bringing together data from the following sources:

- Monitoring data retrieved from COMET
- Client feedback from client exit interviews
- Updates from Finance, supply chain, Grants, and HR on spending, status of procurements, and recruitment.

Having all of this data in one place meant that we were able to make decisions informed by a full picture the project. We used the Project Dashboard to present a high-level summary of project status based on spending, timely delivery and achievements of project targets and we celebrated the indicators that were progressing well.

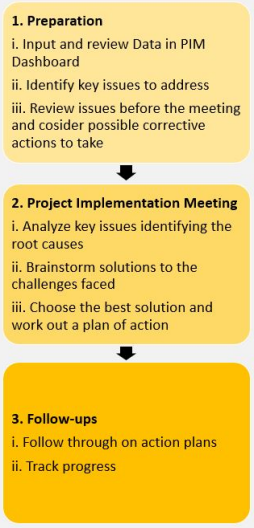

Figure 1: The Project Implementation Meeting (PIM) approach

[1] *This approach is part of the broader Project Cycle Meetings, to be rolled out in FY20.*

[2] *While the PIM guidance suggests that Technical Coordinators have this responsibility, Zimbabwe country program have no Coordinators, so the Managers lead on these tasks.*

However, the dashboard also showed the status of one of the key indicators as “at risk" that we did not expect: **% of women referred for a hospital-based delivery.**

We knew we needed to dig in on this, and identify root causes. Our project monitoring showed that more than 46% of women that were provided with antenatal care (ANC) in IRC supported facilities were referred for a hospital based delivery at Sakubva District Hospital, located in Mutare City (about 150km away), rather than at rural health centers. This was problematic, as the client feedback data collected through client exit interviews showed that pregnant women feared being referred for a hospital-based delivery, because they might then need to pay high accommodation, transport and other expenses in the city.

During the PIM, we discussed this issue. Why were women being referred to far away hospitals, when that was not their preference?

One theory was that the Ministry of Health and Child Care (MoHCC) had instructed rural health centers (RHCs) to increase referrals for hospital-based delivery, in order to improve the quality of care. But this did not take into perspective the access barriers that will be created by this change:

- Most rural women could not afford a hospital based-delivery with estimated costs of $200 USD.
- Referrals for hospital-based deliveries would likely lead women to opt for home deliveries (despite being associated with high rates of maternal and newborn mortality).
- This could even lead to fewer women would attending ANC for fear of being referred to a hospital.

We reached consensus on potential solutions and the next steps, including meeting with the District Health Officials to share IRC’s concerns. Additionally, we decided that the team would continue to work with the MoHCC to make sure that more women delivered at rural health centers, rather than being referred to hospitals.

RESULTS AND IMPACT

Following the PIM, we held a meeting with MoHCC, and agreed that in the short term:

- All women referred for hospital-based delivery during ANC could stay in maternity waiting homes at rural health facilities until the onset of labor. This cut accommodation expenses and allowed women to stay nearer to their families during pregnancy.
- Once labor started, an ambulance could be called from the District Hospital to transport pregnant women from rural health centers to the District hospital, which cut transport expenses significantly.

Women in IRC supported communities welcomed these changes, and we saw an increase in satisfaction from women receiving IRC care.

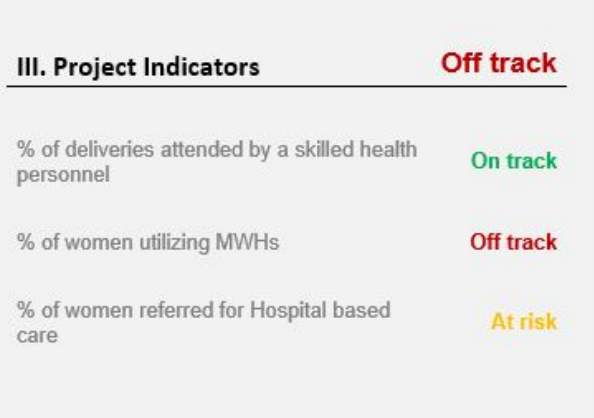

Figure 2: IRC Zimbabwe Health project snapshot from Project dashboard

Energized by the experience with the PIM, the Health Team conducted a Project Learning Meeting several months later and included MoHCC Health Officials, health care workers, and community representatives. We built on our previous discussions and made further improvements to the project, this time focusing on training health staff on basic emergency obstetric and newborn care.

LEARNING AND RECOMMENDATIONS

The PIM process in Zimbabwe helped us to focus more on high level project analysis and decision making. We were able to course correct one indicator that was at risk and made concrete changes to the project.

IRC Zimbabwe has seen the benefits of regularly using monitoring data to reflect on the progress of our programs. Using the PIM approach, teams are now more able to review every project in detail for at least 45 minutes to an hour, a process that previously took up to 3 hours. By updating the Project Dashboard prior to the meeting, we are able to have more meaningful, action-oriented discussions. As shown by the Maternal and Newborn Care project example, what may just seem like just another meeting, can have a huge impact on the lives of our clients

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*Explore **Decision-Making and Learning** and learn about the **Project Implementation Meeting (PIM)***

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