

### Overview

IMPACT is a participatory methodology for health facility appraisal, planning and monitoring. Originally developed by a group of African health managers from Health Partners International and Health Partners Ghana, it has been developed and adapted through use in public and private health facilities in Ghana, Tanzania and Nigeria. The methodology borrows from several tools, such as Participatory Rapid Appraisal, change management, and several models for assessment and accreditation.

Health Partners' consultants work with local health managers and local consultants to use IMPACT. Over time the local consultants and health managers come to own and adapt the IMPACT process for their own use with minimal involvement of external consultants. IMPACT is thus an evolving tool, which is still being developed and improved by those who use it.

### Why is IMPACT needed in Africa?

Two of the major barriers to effective health service delivery in Africa are the poor management and weak systems that exist in health facilities. As well as direct health care services, hospitals are often responsible for managing beds, catering and laundry services, producing and selling drugs, and maintaining vehicles and buildings. Primary health care facilities also require a range of services to support them.

Health facilities are usually managed by health professionals who have little or no training in managing these other aspects of their services. Traditional monitoring systems for health facilities either do not address key issues of managing services, or are complex, expensive, and require specialised skills.

IMPACT has been developed to help address some of these issues.

### How does IMPACT work?

IMPACT consists of four components:

- 1. Appraisal and planning** (including PPRHAA – Peer and Participatory Rapid Health Appraisal for Action, and quality assessment)
- 2. Building systems and capacity in Health Management Information Systems (HMIS)**
- 3. Implementation, support and follow-up**

### 4. Quality assessment and recognition

A sample plan and timescale of components 1 to 3 is provided on page 3.

#### **Component 1: PPRHAA – Peer and Participatory Rapid Health Appraisal for Action**

The appraisal and planning process, conducted annually, brings together health managers from each participating health facility for around two weeks. The team uses pre-determined but flexible guides to assess each facility or service.

The assessment covers the following areas:

1. Patient care management
2. Internal facility management and external linkages
3. Finance, accounting, equipment and infrastructure
4. Client and community views
5. Facility output and coverage

#### **Key features that make PPRHAA successful**

- Simplicity enables health managers with limited management, planning or appraisal skills to participate
- Comprehensive in its assessment
- Affordable and quick, therefore sustainable
- Constructive and non-threatening, with emphasis on moving forward
- Develops achievable plans and identifies practical solutions
- Uses peer assessment, ensuring objectivity
- Increases communication and sharing of best practice within and across facilities.

Focusing on areas appropriate to their skills, team members assess the management and standards of service delivery as well as other performance indicators. They conduct client interviews and community focus group discussions to find out people's views of services. The involvement of communities in health service delivery is thus acknowledged by staff as integral to strengthening systems. In some contexts, PPRHAA has enabled clients and communities to have a voice on health service delivery issues for the first time.

As well as the visiting team's assessment, all middle and senior managers of the facility being appraised also

identify the most important issues in their own institutions and suggest how the facility itself can address them. The PPRHAA team facilitates workshops for managers to analyse management issues, prioritise needs and create simple, achievable action plans.

### **Component 2: Systems strengthening – initiatives and management**

**Initiatives:** Replicable systems strengthening initiatives or models have been developed for 12 priority areas:

1. Financial management
2. Health management information
3. Internal general management
4. Management of drug and medical supplies (including drug revolving funds and deferral and exemption schemes)
5. Patient-focused quality assurance
6. Community accountability
7. Human resource management
8. Management of infrastructure and equipment
9. Emergency obstetric care and safe motherhood programmes
10. Integrated management of childhood infections (IMCI)
11. Malaria
12. HIV/AIDS/STD/TB programmes (HAST)

Models 1–8 are for institutional management systems; models 9–12 are for managing priority health conditions.

Choosing which system is to be strengthened depends on what is identified at the annual appraisal and which system participants feel is most appropriate. Mainly local consultants and contractors implement the system through development of appropriate tools and materials, provision of necessary resources and staff training. Follow-up support is critical in ensuring sustainability of the initiative. This support is initially provided by external mechanisms but it is gradually phased into the integrated support and supervision system.

**Management:** Programmes to strengthen the management of these initiatives might include capacity building in general management, programme management or transformational leadership. The focus is on coaching or mentoring management teams to tackle practical problems, implement achievable plans, to monitor and review, and then repeat the cycle.

### **Component 3: Implementation, support and follow-up**

Regular supportive supervision is a key thread and runs through the other three components. The focus has been on building an integrated supervision system that ensures that managers are in the field supervising on a regular basis (monthly to quarterly). In some contexts community

members participate in the supportive supervision teams. This introduces another mechanism for strengthening accountability between health providers and the people who use their services.

### **Component 4: Quality assessment and recognition**

This component is currently in development. The approach is to assess facilities that are deemed ready against benchmarked criteria. In Ekiti State, Nigeria, the first facilities were assessed in April 2006 as part of activities under the PATHS Programme, to pre-test tools that had been developed. In Kaduna, Nigeria, the first facilities will be formally assessed in late 2007. Various levels of recognition are being developed, depending on the outcome of the assessment. As in PPRHAA, clients and communities will play an important role in the quality recognition process.

### **What changes has IMPACT already made?**

A recent review in Upper West Region, **Ghana**, showed the following changes that had taken place as a result of carrying out PPRHAA:

- Standards in medical and nursing care had risen significantly.
- Most essential drugs and medical supplies were now available at all hospitals.
- Wards, operating theatres, laboratories, X-ray departments and out-patient departments had most of the basic equipment and supplies required to do work effectively, while their services had been re-organised to make them better for clients.
- The numbers of patients and coverage rates had increased significantly, despite continuing severe shortages of qualified staff.
- Standards of hygiene and cleanliness had improved noticeably and were now good in most wards and departments.
- Hospitals were raising much more funding themselves and their accounting systems were much better at controlling the revenue so it was spent well.
- Team spirit had increased significantly, communication was working well and hospital management team meetings were better organised.
- Middle-level managers were beginning to make important contributions to running their hospitals.

In **Nigeria** a recent evaluation highlighted positive impacts on financial aspects in all states in which PPRHAA had been implemented. For instance, in Jigawa State, Dutse General Hospital now has standing orders, established by the state Ministry of Finance, to pay non-salary running costs straight to the facility (without the money physically passing through the State Ministry of Health). This money seems so far to be proving sufficient to keep the hospital running. In addition,

a drug revolving fund has just started functioning there – so drugs are also available. The PPRHAA work had helped the facilities – in putting forward credible estimates of running costs, and also the Ministry of Finance – in being able to see that the proposed estimates had been derived via a substantive process.

### Sample plan and timescale of components 1 to 3

