EMMS International
Health for Today, Hope for Tomorrow

Lessons Learned

This document records lessons which EMMS International staff have taken from evaluation reports commissioned by EMMS International of its projects.

1. Nkhoma Mission Hospital Health Coordination Unit, Malawi, 2012-13

Changing Ministry of Health policies have workload and cost implications for our partners. For example, free malaria drugs mean more patients, who pay consultation fees set by our partners, but these consultation fees may not cover the consultation costs. Similarly, Service Level Agreements (SLAs) which our partners sign with the MoH, e.g. for free deliveries of babies, and antenatal and postnatal services, result in more women coming for these free services, which is good, but if the SLA does not cover the cost of each treatment, then our partners have greater net costs as a result of participating in the policy. Also, there is a ceiling for how much the DHO can pay monthly to each hospital. Our value is to bring fresh thoughts to an old problem, and our incentive is to find solutions which will enable us to put our charitable resources to other issues. Would it be helpful for EMMS International finance staff to spend time talking through with hospital staff options for covering costs outof income?

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2. Hawthorn Brae, Scotland, 2012-14

Preamble: The Senior Management Team (SMT) agreed in early 2015 to implement all recommendations in the report. The Hawthorn Brae Committee reconvened from April 2015.
1. The SMT now receives the Committee's 6-monthly minutes.

2. It's valuable for EMMS to talk to the public about EMMS work in the U.K.

2. Quarterly reports now help staff to be aware of the project.

3. We shall articulate the scheme's objectives, using suggestions in the report.

4. Reports from sponsors will tell us if this scheme benefits the carers and has any impact on poverty.

5. This project helps us understand our projects overseas, as it helps us understand how people in these situations feel.

6. It's valuable for us to talk to the public about our work in the U.K.. We'll ask sponsoring organisations for reports after each grant is used, stating which bits we can share with the public. Each quarterly report from the UK Projects Officer to the Director of International Programmes could include an anonymised case study, if the sponsor agrees, containing information that we could publicise. We may give the scheme a different brand name in communications with the public.

3. Palliative Care in Mulanje District, Malawi, 2012-13

Preamble: Since this project, EMMS has started the following: using the expenses rates of institutional donors in Malawi, issuing Project Agreements before projects start, and asking partners to say in their quarterly reports to EMMS what difficulties and changes have arisen which affect the project.

1. A joint project with government and mission hospitals working side by side to improve each other worked well.

2. It is good to use recognised external standards to check the quality of a partner's service.

3. The most useful evaluation reports emphasise outcomes rather than implementation of activities.

4. Patients' quotes bring this report to life, and are useful stories.

7. If a donor reduces our funds in order to give them to a complementary partner, we should have a plan in case that partner does not do what they said they would do.

9. We must be clear that we are a partner of our implementing partners on the ground.

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4. EHA Palliative Care, India, 2012-17

1. The report benefits from being written by people who are internationally known in their field, and who will disseminate it and name EMMS International as co-implementer with its partners.

2. The report is clear about the scale of the service and its achievements, with numbers of patients and the service received.

3. Our partner works with everyone, of all castes, religions, genders and ages, and sets a positive example.

4. All projects are individual to their countries and cultures, but can benefit from common themes across countries. We can help our partners to meet each other, and can tell our partners each other's best practices in our Partners' Newsletter.

5. There is a lot of variety in India, including between EMMS's partner's hospitals. They could learn from each other.

6. People may volunteer informally, outside any formal service.

7. We must consider what scope of spiritual work we can support.

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5. PCST & QECH Palliative Care, Malawi, 2014-15

1. The project showed measurable success, in aiming for and achieving a set standard: APCA Level 3.

2. This partner could disseminate its best practice to our other partners, to the rest of the international palliative care community, and to government in Malawi, Africa and further.

3. PCST has very quickly achieved a high standard in Malawi.

4. PCST, an organisation in a hospital, is dedicated. They can attract doctors who are not attracted to higher-paying jobs.

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6. Karuna (Compassion) MCH in East Champaran, India, 2014-17

For future programme developing with Duncan Hospital, we need to discuss with staff there:

- What is the quickest way to improve primary healthcare systematically?

6. Let's do more outreach with older women, adolescent boys and adolescent girls, to build on their changing attitudes.

- Duncan Hospital has great staff, great female staff, as does EHA. How can we help EHA to replicate such great female staffing?

- Do our Indian Christian partners lack confidence in outreach and collaboration because as Christians and/or better off health providers they've experienced attacks?

- We need to discuss openly that there is expertise beyond doctors, and beyond EHA.

- Let's do more of the outreach with older women, adolescent boys and adolescent girls, to build on their changing attitudes. Duncan has done great work here.

- Ask our partners to prove that data collection skills are adequate at the start of a project.

- Before project start, ask our partners for proof of any ethics permission required if their baseline survey is to be published, and ask for a professional opinion of the robustness of the baseline survey design, before our partners start the survey.

7. MCH at and near Chhatarpur, India, 2014-17

Additional inputs such as buidlings are only worth putting into large, institutionally funded projects.

It is difficult to get skilled people to Chhatarpur, and to work outside the hospital there. What kind and scale of project can EMMS do in places where it is difficult to get staff?

As in this project, should EHA sometimes appoint as manager someone with community health experience who is not a doctor? They may be easier to find.

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8. Floods Response, Malawi, 2015

Bamboo rather than timber had to be used, and therefore we should check in late 2017 how many bamboo-built latrines are still standing, and whether the toilet block was built to withstand another flood.

EMMS learned from this project how to run emergency appeals, and went on to do another two.

EMMS's strength in this project was its partners, and so EMMS had a bigger impact than a bigger organisation. Our partners in this project were effective, knowledgeable, connected to the District Health Office

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and other essential stakeholders, good value, and with no additional costs such as flights or staff.

Our partners did not specifically ensure inclusion of vulnerable service-users, such as women and people with disabilities, and therefore for any future emergency response, we should give partners the relevant part of SPHERE standards to the project.

9. MMH Primary Healthcare, Malawi, 2013-15

Patience is a virtue, when waiting for adults to change behaviour and cultural beliefs.

Therefore where a project promotes cultural change, it is good that EMMS works with this partner for a long time, although we can also identify the routes to quick change.

We should consider working more with religious leaders, as hospitals may fear what they will say to patients – they may tell patients that this illness is their punishment. EMMS should consider giving religious leaders extra training in all projects, given how important religious leaders are in society.

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10. MZICHE, Malawi, 2015-16

Churches can be barriers to caring for People Living with HIV and AIDS (PLHA) and talking against stigma. Should they be looking after their congregation members? What are they saying to patients and their families?

EMMS could include a theological element to its projects, in working with churches - with all churches. This could be a niche for EMMS.

The project was very successful.

LISAP has since improved at involving chiefs, identifying the more active ones.

Should incentives be better targeted and constistent, e.g. to engage men?

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11. Training of Spiritual Leaders, Malawi, 2014-15

There is a great need for training in palliative care for spiritual leaders. Their comments show how useful they found it, and that the training changed their behaviour.

One-day training in palliative care for spiritual leaders should be followed by more training, and events to get trainees together.

EMMS' partners should train leaders from a variety of religions and denominations, appropriate to the religions and denominations present in the population.

EMMS could investigate whether its partners could offer palliative care training as part of theological colleges' curricula.

Spiritual leaders and patients, as members of the public, have misconceptions about palliative care and how it is delivered, and why spiritual leaders are coming to give items freely.

Pastoral care is holistic. Churches can help address a variety of needs of the most vulnerable, and spiritual leaders must speak appropriately to those with life-limiting conditions. Training in these areas is vital.

Working through churches makes an intervention sustainable.

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12. Poverty Reduction in India through Palliative Care, 2015

More and more palliative care is needed, to reduce the most desperate poverty. The Indian government has said that it will fund states to deliver palliative care.

All over the world, many people need palliative care, and numbers of those getting it are similar across countries. This research should be promoted to bodies interested in poverty reduction, to encourage them to do more palliative care to reduce poverty.

Early diagnosis and enrolment in a palliative care programme are vital to the poverty reduction impact of palliative care.

Palliative care may help hospitals, as they will have a less busy outpatient department, due to palliative care being home-based.

Palliative care is holistic, and in India can include helping people to get their government benefits and avoid corrupt gatekeepers.

What are the limits of EMMS's partners' skills, in which they perform better than others: spiritual services, social work, business development?

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13. Establishing courses for Registered Nurse Midwives and Clinical Officers at Ekwendeni College of Health Sciences, Malawi, 2013-16

This project had been needed for a long time, for Malawi and the college. Staff were incentivised to stay at the college, Malawi is gaining more trained healthcare staff, and people are keen to do the courses. EMMS staff could review later what progress the country made in the goal, to which the EMMS project contributed.

For how long will the college deliver both RNM and NMT courses?

The project was affected by political challenges outside EMMS and ECOHS control.

The Malawian government may not be able to honour its promises.

Families tend to invest in male students, and so EMMS can consider finding student fees for females.

Students said that their behaviour had changed due to the training, but the hospitals where they worked did not say that they had. EMMS should ensure the evaluator asks questions of relevant people.

Malawi's regulatory system assures the courses' quality.

EMMS needs an evaluation of fundraising for RNM students' fees.

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14. Chhatarpur Hospital Maternal and Child Health 2014-17

A lot of good results were achieved, perhaps because there was a strong staff team spirit in the community development team. Although some staff felt inadequately trained, they won trust in the villages. The project was unlike anything else in the area.

The report is written by a professor of community health, who does not attribute to this project the reductions in the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) which were evidenced in district reports after the evaluation report was issued. She also does not extrapolate from percentage results to absolute numbers. This is because of wariness of making claims which she cannot fully substantiate, although we can reasonably deduce that this project did contribute to reduced MMR and IMR. EMMS could commission evaluations after districts issue results, and ask evaluators which results are attributable to our project.

14. EMMS Programmes staff must meet project leadership (project manager, their line manager and partner's CEO) before EMMS agrees a project.

The partner, EHA, allowed hospital leadership to treat the project as two (equipment plus community outreach), and the hospital delayed buying the equipment. The hospital director was absent on all three visits by the EMMS Programmes Director. EMMS must treat each partner as one, withholding funds from one hospital or department if another implements late. EMMS Programmes staff must meet project leadership (project manager, their line manager and partner's CEO) before EMMS agrees a project.

15. Research report on training in METHOD, 2018

Social, spiritual and legal workers should be part of palliative care teams, so that they can apply their training and can coordinate with each other. While the MoH, PACAM and PCST mentor, monitor and supervise healthcare staff woking in palliative care, perhaps the staff of country-wide social, spiritual and legal bodies also be involved, to complement and reinforce successor project's Chifundo's work with such workers on the ground.

This report is about PCST's 2-day training of existing social, spiritual and legal workers. It would be good to work to include palliative care in colleges' pre-service curricula for training social, spiritual and legal workers.

The healthcare workers trained and interviewed did not mention that the training lacked training in measures to address lack of nutrition in palliative care families, but this is a major part of follow-on project Chifundo. Evaluators must ask the right questions, and encourage open discussion.

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16. Hawthorn Brae Trust – 3-yearly evaluation, to March 2018

Since this evaluation, we have moved to giving one annual grant to Waverley Care only, for them to disburse up to 40% to the other two partners. EMMS has therefore stopped implementing Hawthorn Brae directly. We had wanted to do this for some time, and this evaluation report was the final trigger to do so. Therefore EMMS will now update its website such that no one is invited to apply to EMMS for a Hawthorn Brae grant for a client, and to enable the public to donate to HBT on the EMMS website.

Our Terms of Reference should not have included whether we had implemented activities that we did not want to do, either at this time or later.

16. Publicising this UK programme widely will require thoughtful engagement between EMMS's Fundraising, Communications and Programmes departments.

Publicising this UK programme widely will require thoughtful engagement between EMMS's Fundraising, Communications and Programmes departments, to determine our communications about the differences between a Scotland project and an overseas project.

17. ISABEL Service Delivery Satisfaction Survey (mid-term evaluation, Improved Services for AIDS and Basic healthcare through Empowerment and Local democracy)

As a result of ISABEL, do we expect satisfaction to increase (due to improved services) or decrease (due to improved knowledge of rights)?

This has limitations as a mid-term evaluation report, as it does not include measurements of, for example, participation in the ISABEL project; for that, we need to look at the reports to the donor.

This is a satisfaction survey, and so perhaps the causes of problems and improvements do not belong in the Executive Summary. Similarly, the questions should be in an annex.

17. As a result of ISABEL, do we expect satisfaction to increase (due to improved services) or decrease (due to improved knowledge of rights)?

18. METHOD (Malawian Education and Training for HIV & Other Diseases) final evaluation

- Teamwork amongst EMMS and 4 partners was very useful, learning from and supporting each other, having quarterly meetings of largely the same staff at each meeting;

- Partners should start all tasks early, resolve problems early, and complete tasks early, in order not to delay each other;

- EMMS should chase up partners as soon as they are behind timetable, and always know its partners' financial situations, to assess how realistic partners' commitments are;

- Partners should early on help facilities recruit patients and keep accurate data;

- Parners should learn actively from each other's experience;

- Goals dependent on an external partner, or in times of turmoil, require persistence and judgement of whether to change plans;

- Partners should communicate with EMMS as soon as any questions arise, and not wait until we meet.

18. EMMS should always know its partners' financial situations, to assess how realistic partners' commitments are.