MLP Follow Up and Enhancement Program
Dolakha District Dissemination Report

Background

The MLP Follow Up and Enhancement Program (FEP) was began in late 2010 to address the need for follow up after training. The purpose of the FEP is not only to assess the clinical skills that had been taught during the MLP training, but is to be seen as an extension of the original training. MLP trainers, referred to as coaches, visit past MLP participants at their place of work. During their visit, they will assess the clinical skills of the participants through observed real patient encounters, observe clinical procedures, assess the environment, interview both the participant and supervisor and finally, introduce and encourage the use of the Quality Improvement (QI) tools.lmi

The first FEP was conducted in the RSSP district of Gulmi in 2010 on 13 MLP participants. A second FEP of 21 participants was conducted in Bajhang in May 2011. In November, NSI conducted another FEP in Dolakha District from 8-15 November, 2011

Location and Participants Demographic Data

The demographic data is as follows:

- 26 MLHCWs trained in MLP
- 25 MLHCWs still working in Dolakha District
- 21 MLHCWs assessed in FEP
    - 1 was out of District (Jiri Hospital)
    - 1 was unable to be contacted (Lamidanda)
    - 2 sites were not assessed due to logistics of time and cost effectiveness (Kopachangu HP, Suri PHC)
- HA (2), SAHW (14), AHW (5)
- Average of 15 months post training (Range: 2 – 24 months)
- 14/21 in SHP, 5/21 in HP, 1/21 PHC, 1/21 DH
- AMDA-Damak (20), Bharatpur (1)

Findings

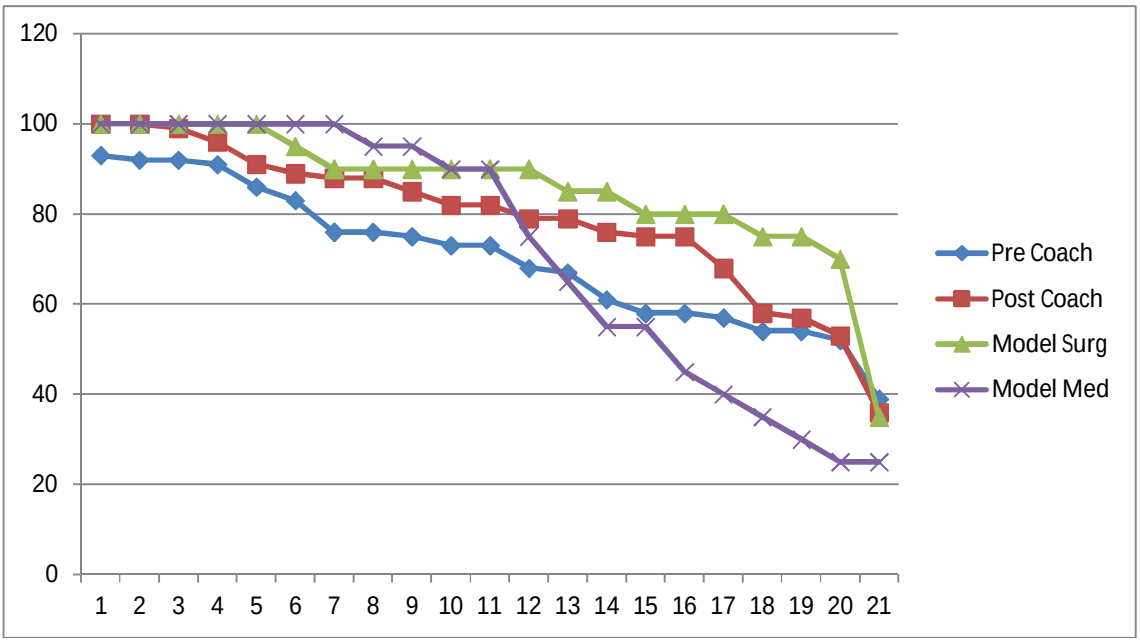
Clinical Skills

Post MLP OSCE	Pre Coach Pt. Encounter	Post Coach Pt. Encounter	Model Pt. Encounter	Appropriate Diagnosis	Clinical Procedures
93%	**72%**	**81%**	**79%**	**93%**	**82%**
(Range)	**(39-93)**	**(36-100)**	**(25-100)**	**(50-100)**	**(44-100)**

Unfortunately, this FEP was during the harvest time as well as some local festivals. This resulted in low patient numbers on most of the days we visited. Two sites had no patients at all. This resulted in less patient encounters than the FEP standards call for. Despite this problem, I believe that an accurate assessment of their clinical practice skills were gathered. Likewise, there were very few procedures that we were able to assess. Only 7/21 sites had any procedures that we were able to observe.

The participants scored (79%) on two model patient cases that were designed to determine if they could identify surgical cases and medical cases that needed referral. They were better at identifying the surgical case of appendicitis (86%) vs. the medical case of congestive heart failure (72%).

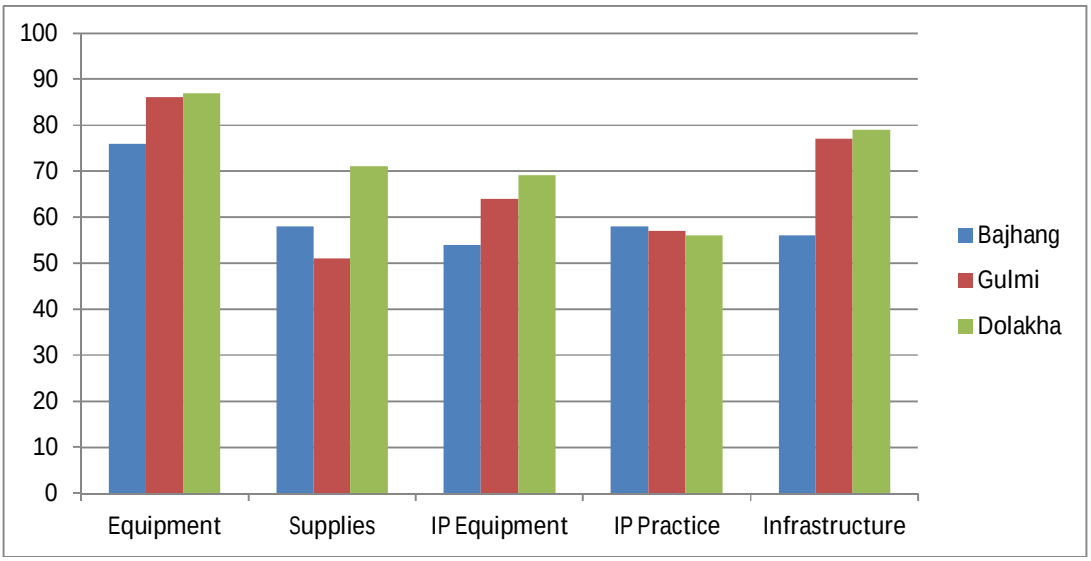
Distribution of Clinical Skills from Highest to Lowest



Working Environment

Clinical Equipment	Clinical Supplies	Infrastructure	IP Equipment	IP Practice
87%	71%	79%	69%	56%

In comparison to other districts, the working environment was better. The general infrastructure was better and they had more equipment available. This included the IP equipment, unfortunately, the challenge of having them actually use it in accordance to IP protocols was lacking in some sites. It seemed the lower scores were directly related to the remoteness from the district center and the amount of supervision they had from the DHO office.



Attitude & Perception

Use of the Algorithm	Percentage Answering
HCW using the algorithm all the time	**10%**
HCW using the algorithm some of the time	**10%**
HCW using the algorithm only when confused	**60%**
HCW not using the algorithm (lost)	**20%**

It appeared that the Dolakha participants were not as comfortable using the algorithms as other MLP trainees. As most came from the AMDA-Damak training site, this may indicate a lack of algorithm use at the training site. This will need to be followed up with the trainers there. Much of the coaching that I did related to helping them work through the algorithms based on the chief complaints that they identified.

Challenges of Working at MLP Standards	Score (0-2)
Equipment and supplies	**1.1**
Lack of trained co-workers	**1.0**
Lack of man power	**0.9**
Lack of community support	**0.7**
Lack of supervision	**0.6**
Lack of infrastructure	**0.4**

Although the biggest challenge listed among the MLP participants was equipment and supplies, in reality, their district was easily far above other districts assessed in regards to equipment and supply. Most health posts were accessible to Charikot within 3-4 hours and most of that was by road. A main issue raised was that many of the other MCHWs upgraded to ANMs and VHWs upgraded to AHWs and thus were not competent in basic medical care. The MLP participant generally had to do all the clinical work themselves due to this problem. Thus, this issue rated higher on their challenge scale.

Feedback to the DHO

The MLP FEP team met with personnel of the DHO office. The DHO was unable to be there and the plan was to brief him when he was in Kathmandu. The overview of the FEP was done as well as the specific data regarding Dolakha District. Interest was expressed in developing a better supervision mechanism at the district level for the monitoring of quality clinical care. Some ideas were discussed including a 1-2 day workshop that would give supervisors an orientation of what the MLP participants have learned as well as how to implement the QI tools for the SHP, HP and PHCs though out the district.

Summary Findings

1. The MLP trained participants have retained most of their clinical skills that they learned. There was about a 20% decrease in the initial assessment with a 9% increase after coaching was given. They scored (79%) on two model patient cases that were designed to determine if they could identify surgical cases and medical cases that needed referral. They were better at identifying the surgical case (86%) vs. the medical case (72%).
2. Clinical procedures were assessed but the number observed was quite low and were repetitions of procedures rather than a wide variety. The areas were most of the point deductions occurred was due to lack of maintaining sterile procedure. The cause for this was usually lack following IP protocols

3. Overall, the participants felt that the MLP training had improved their clinical skills and diagnostic abilities. We encountered some very strong HCWs who managed well their health facilities, had all the supplies they needed, had the communities confidence. There were however about 25% of the MLP participants who for whatever reason were not able to practice at the level of MLP standards either in clinical decision making or in procedures or IP practice.
4. We commend the DHO's office willingness to do better supervision and follow up of their SHP and HPs in regards to clinical quality. NSI will work a long side them to develop such a mechanism.

Recommendations

1. More support and supervision is needed of the more remote health facilities in regards to clinical quality and IP quality.
2. Recommendation of clinical refresher training (CME) at the DHO office every month when the various workers come in for their monthly meeting. at a district level after the supply chain issue has been addressed. Topics that need to be addressed are both clinical and infection prevention.
3. NSI considers how to best implement QI tools at the PHC level and below through the RSSP program. NSI will work with the RSSP team to develop a package that may include MLP and QI tool orientation for supervisors at the DHO level in Charikot.