MLP Follow Up and Enhancement Program
Bajhang 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. This was considered the pilot FEP and based on that experience, the MLP FEP tools were modified and a second FEP of 21 participants was conducted in Bajhang in May 2011. A team of 6 FEP coaches spent approximately 6 days in the various health facilities in Bajhang conducting the assessment of previous MLP participants.

Location and Participants Demographic Data

The demographic data is as follows:

- 22 MLHCWs trained in MLP
- 22 MLHCWs still working in Dolakha District
- 20 MLHCWs assessed in FEP
  - 2 sites were not assessed due to logistics of time and cost effectiveness
- HA (3), SAHW (6), AHW (11)
- Average of 15 months post training (Range: 2 – 24 months)
- 12/20 in SHP, 5/20 in HP, 1/20 PHC, 2/20 DH
- TEAM Dadeldhura (6), Seti Zonal (5), Lamjung (6), Tansen (3)

Findings

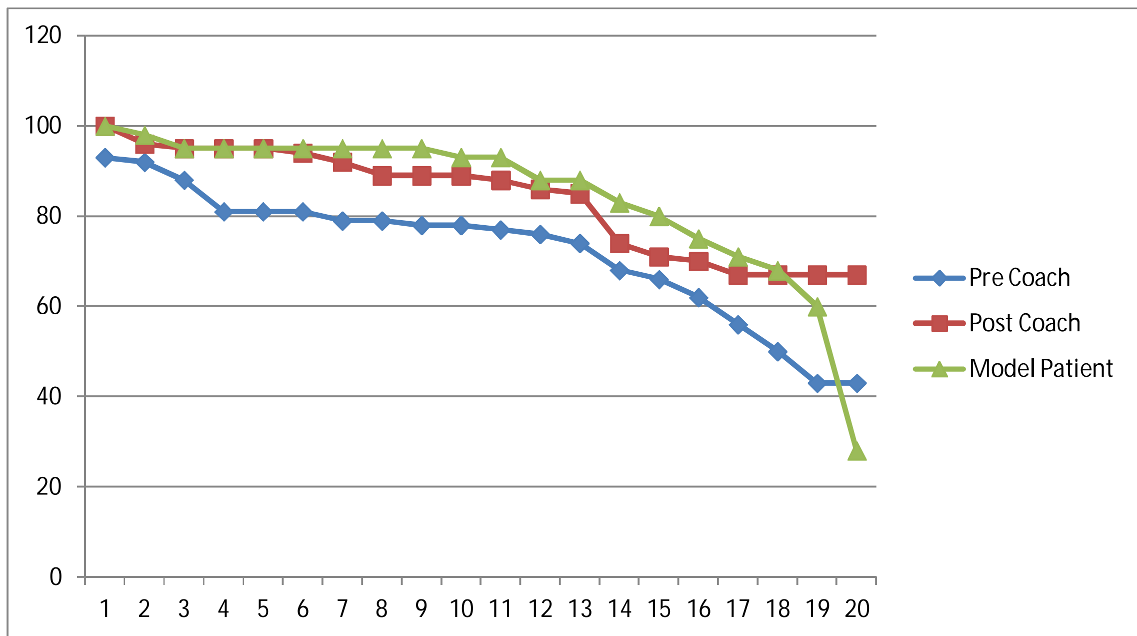
Clinical Skills

Post MLP OSCE	Pre Coach Pt. Encounter	Post Coach Pt. Encounter	Model Pt. Encounter	Appropriate Diagnosis	Clinical Procedures
93%	**73%**	**86%**	**87%**	**98%**	**86%**
	(43-93)	**(67-100)**	**(28-100)**	**(80-100)**	**(38-100)**

The various health posts were visited in May. Some health posts did not have the maximum of 10 patients needed in conducting this FEP. However, all participants except one was evaluated in real patient interactions. In the next FEP reducing the number of pre-coaching and post-coaching encounters with an expansion of model patient scenarios will be considered.

Many of the health facilities did not have any procedure cases for observation (7/20) and many of the procedures were simple such as dressing changes or injections. Likewise, the addition in future FEPs to include simulated procedures will be considered.

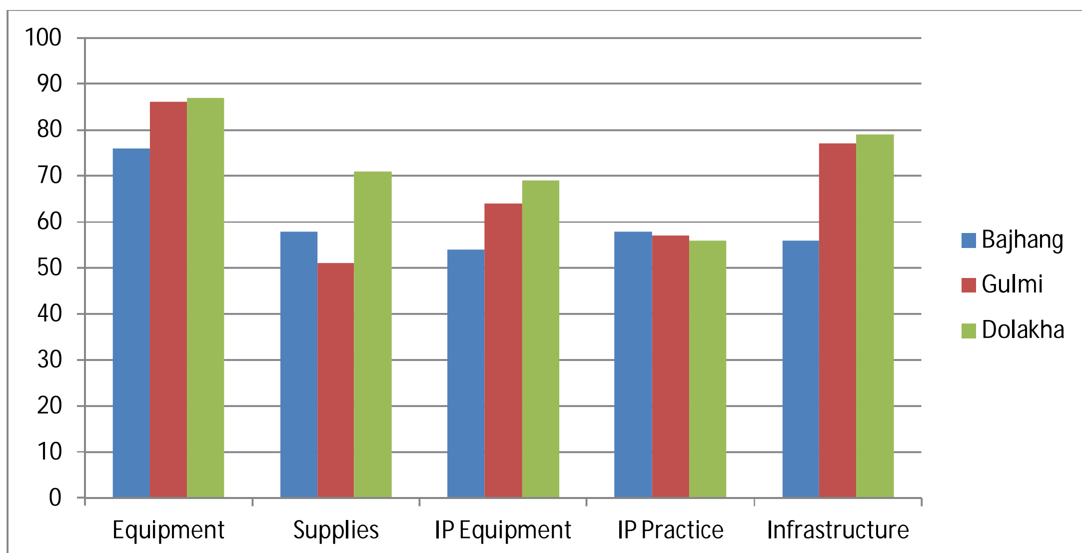
Distribution of Clinical Skills from Highest to Lowest



Working Environment

Clinical Equipment	Clinical Supplies	Infrastructure	IP Equipment	IP Practice
76%	**58%**	**54%**	**58%**	**56%**

In comparison to other districts in which the MLP FEP was conducted, the working environment was the least developed. The general infrastructure was adequate in most areas, but clinical equipment and especially IP equipment was not readily available and this translated into little IP standards practice.



Attitude & Perception

Use of the Algorithm	Percentage Answering
HCW using the algorithm all the time	**10%**
HCW using the algorithm some of the time	**40%**
HCW using the algorithm only when confused	**50%**
HCW not using the algorithm (lost)	**10%**

It appeared that the Bajhang MLP participants used their algorithms more than in other districts that were tested. They were observed at most of the health facilities at the working station of the health care worker.

Challenges of Working at MLP Standards	Score (0-2)
Equipment and supplies	**1.5**
Lack of man power	**1.3**
Lack of supervision	**1.1**
Lack of infrastructure	**1.1**
Lack of community support	**0.8**
Lack of trained co-workers	**0.8**

The biggest challenge listed among the MLP participants was equipment and supplies. Much of this was due to their geographical isolation and time for accessing Chainpur, the district center. Those that were on the road could access Chainpur in about 4-5 hours, but those off the road took a full day. The supply system at the district hospital and DHO office was also not adequate to meet the demands. Other challenges listed were lack of man power and supervision. This also was blamed on the remoteness of many of the health post locations.

Feedback to the DHO

The MLP FEP team met with personnel of the DHO office. The DHO received the FEP teams assessment summary sheets from each of the participants that were visited. There were some exceptional MLP participants who had really incorporated many of the MLP teachings including management in the daily operations of their health post. The DHO was encouraged to try and address the main challenge of equipment and supplies with a particular attention to IP equipment and practice.

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 13% increase after coaching was given. They scored (87%) on two model patient cases that were designed to determine if they could identify surgical cases and medical cases that needed referral.
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 and showed motivation for continued improvement. There were however about 20% 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 recommend that the DHO's office do better supervision and follow up of their SHP and HPs in regards to clinical quality.
5. We recommend putting together a better system for supplying clinical equipment and especially IP materials to the various health posts.

Recommendations

1. More support and supervision is needed of the more remote health facilities in regards to clinical quality and IP quality.
2. At the district level after the supply chain issue needs to be improved.