



USAID
FROM THE AMERICAN PEOPLE

Maternal and Child
Survival Program

Institutionalizing IMNCI at the Health Facility Level in Liberia

MCSP/RHS Liberia Case Study

March 2018

www.mcspprogram.org

Summary

To improve child health service delivery, the USAID Maternal and Child Survival Program’s Restoration of Health Services Project (MCSP/RHS) in Liberia coordinated with the Ministry of Health (MOH) to build the capacity of health workers in the integrated management of newborn and childhood illnesses (IMNCI) and improve health facility readiness for service provision. MCSP provided technical assistance to the MOH to develop the Guide to Institutionalize IMNCI at the Health Facility Level, which establishes a framework for embedding IMNCI knowledge and skills in health facility staff to ensure sustainability, effectiveness, and efficiency in implementing IMNCI. The Guide has been successfully piloted in 17 health facilities across three counties. Results from the pilot show that Officers in Charge (OICs) at facilities are able to effectively fill IMNCI gaps identified at different service delivery points through internal supportive supervision and mentoring. MCSP is confident that implementation of the approach described here results in a higher quality of IMNCI care in health facilities. Thus, the MOH should incorporate the Guide and this approach into the standard IMNCI training package so that it can be scaled up and rolled out nationwide.



An OIC assesses a child using IMNCI job aids provided by MCSP and the MOH. (Photo credit: MCSP)

Background

MCSP/RHS worked with the Liberia MOH to improve the delivery of quality maternal, newborn, and child health services and restore confidence in the health system following the Ebola outbreak. One of MCSP’s areas of focus was child health service delivery. A baseline assessment conducted December 2015-January 2016 in MCSP’s 77 supported health facilities in three counties (Nimba, Lofa, and Grand Bassa) showed that health workers were not adhering to the Liberia IMNCI protocols, meaning that children were not adequately assessed and treated in health facilities.

To address this issue, MCSP first coordinated with the MOH to organize a six-day training using the Liberia IMNCI training package. This training was provided to only one clinician for each MCSP-

MCSP/RHS Key Facts

- Project start date: August 2015
- Project end date: June 2018
- Geographic focus: Grand Bassa, Lofa, & Nimba Counties
- Scope: 54 public & 23 private health facilities
- Technical areas: Essential primary health services & infection prevention and control

supported health facility making the service dependent on one person. This limitation, along with high attrition rates among trained clinical staff, made significant and sustainable change difficult to achieve.

To build IMNCI capacity among more health facility staff and reduce Liberia’s dependence on large-scale IMNCI trainings, MCSP provided technical assistance to the MOH to develop the Guide to Institutionalize IMNCI at the Health Facility Level (called “the Guide” throughout the rest of this document). The Guide establishes a framework for embedding IMNCI knowledge and skills at the health facility level to ensure sustainability, effectiveness, and efficiency in implementing IMNCI.

Methodology

Guide Development

Starting in May 2016, MCSP worked closely with the MOH IMNCI master trainers to develop the simple, clear Guide that provides guidance for delegating certain aspects of IMNCI care to staff working at nine service delivery points in health facilities: the triage area, the registration area, the growth monitoring area, the waiting area, the under-five consultation area, the laboratory area, the dispensary area, the oral rehydration therapy (ORT) corner area, and the immunization area. Delegated tasks include correctly administering ORT, identifying general danger signs, selecting and properly filling out the appropriate IMNCI record, accurately dispensing drugs and giving correct information to caregivers, and educating caregivers on general danger signs and appropriate feeding practices. Task delegation is tailored to the staffing, layout, and patient flow of each health facility. The Guide also includes job aids and training resources selected from the IMNCI training package and other approved MOH training manuals to support delegated tasks.

One of the key innovations of the Guide was the introduction of a structured internal supportive supervision and mentoring system. This system requires the facility’s OIC (or screener, if the OIC does not serve in that role) to provide ongoing supervision and mentoring to health facility staff on delegated IMNCI tasks. It builds the management capacity of the OIC and empowers health facilities to make changes and improve internally without depending entirely on costly external supervision from the district and county level. Before the Guide’s development, OICs were tasked with general supervision and mentoring, but the practice was not routinely and systematically carried out, and there were no clearly-defined standards or checklists to guide OICs in performing these responsibilities. MCSP and the MOH developed and included in the Guide simple internal supportive supervision instructions and checklists for use by the OIC to conduct supportive supervision at IMNCI service delivery points.

Sections of the Guide

- Training Staff at the Health Facility after an IMNCI Training
- Supportive Supervision, Mentorship, and Coaching
- Delegation of IMNCI Tasks to HF Service Delivery Points
- Under-5 Referral Process
- Linkages with Communities
- Supply Chain and Logistics for IMNCI Commodities
- Monitoring, Review, and Reporting
- Annexes (Tools and Job Aids for IMNCI)

Validation and Pilot Training

MCSP, in close coordination with the MOH, validated the Guide and its accompanying tools in May 2017 by testing their usefulness and accuracy through a series of field visits at different types of health facilities. MCSP then held a one-day validation workshop with the MOH master trainers to get their review, feedback, and approval of the document.

MCSP and the MOH conducted orientation workshops for supervisors at the district and county levels and OICs from each of the Program’s three supported counties: for 19 staff in Lofa in May 2017, for 30 staff in Grand Bassa in July 2017, and for 15 staff in Nimba in September 2017. After each training, MCSP updated the training materials using findings from the previous workshop and eventually shortened the workshops from two days to one day. The training included presentations on rationale for the Guide, use of the Guide, overviews of the job aids, and the importance of supportive supervision and mentoring to ensure a system of

ongoing support for delegated tasks. It also included a practical component that allowed participants to practice delegating and supervising tasks.

Pilot Implementation

Pilot implementation took place in selected health facilities (four facilities in Lofa, six facilities in Grand Bassa, and seven facilities in Nimba) from October-December 2017. At the health facility level, the OICs conducted one-hour personalized orientations for service providers at the various service delivery points to their newly-delegated tasks using a simple step-by-step package designed by the MOH and MCSP that included the Guide and relevant job aids. The OICs also provided on-the-job trainings to other facility clinicians that were unable to attend the six-day IMNCI training or another related training to ensure that they had the relevant IMNCI skills and could delegate tasks to service delivery points as appropriate.

After the orientations were complete, OICs made supportive supervision visits to each service delivery point at least once a week, using a checklist to determine whether staff there were performing the delegated IMNCI tasks correctly. If the OIC saw any gaps, he or she would mentor staff to help them fill the gap by understanding what they were doing wrong and how to perform the task correctly. Once a month, supervisors and MCSP staff embedded in the counties (county health program officers [CHPOs]) went to each facility to backstop the OIC in supervising and mentoring non-clinical staff.

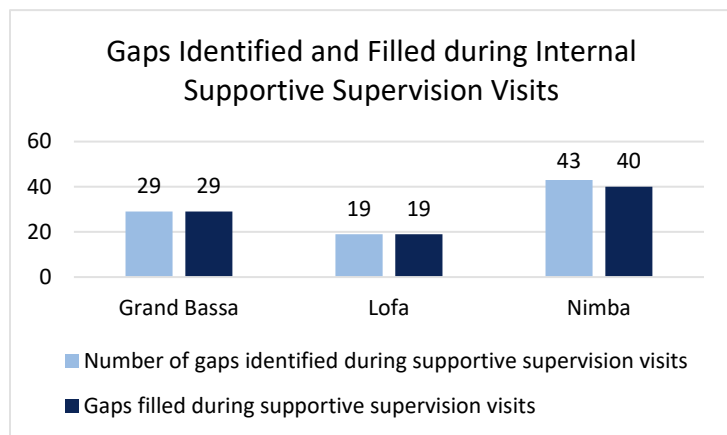
Data Collection

After the three-month pilot, MCSP developed simple questionnaires to assess the effectiveness of the Guide, trainings, and implementation approach and identify lessons learned during the pilot phase. MCSP's CHPOs used the questionnaire to collect data to assist the MOH in incorporating the Guide into standard IMNCI trainings and rolling out its use nationwide.

Results

Analysis of the data collected from the pilot sites in the three counties revealed that 100% of OICs did an orientation for facility staff when they returned to the facilities after training and 100% of the OICs initiated supportive supervision visits. The average number of visits conducted in each facility was 23, and OICs supervised 100% of service delivery points at least once in Lofa, while they supervised 98% in Grand Bassa and Nimba. In addition, 100% of staff in Lofa, 90% of staff in Grand Bassa, and 95% of staff in Nimba used job aids to provide services at the various IMNCI service delivery areas. This data indicates the MCSP has successfully integrated IMNCI services into routine activities within facilities.

The graph shown here indicates that of the 91 gaps identified by OICs during supportive supervision visits and reported during the data collection process, 88 (97%) were filled without the need for external support. An average of five gaps were filled per facility. Gaps were filled when OICs provided mentoring to staff after identifying a gap and then found that the gap was no longer an issue on a second supportive supervision visit. Gaps found and filled included staff having problems in counseling the mother or caregiver, not asking checking questions, not asking the mother to repeat instructions, not introducing themselves, being unable to identify danger signs, not washing hands between patients, and not using job aids. Gaps found but not yet filled were related to stock-outs, which are a nationwide issue, and to inadequate growth monitoring.



Based on the success of the pilot, MCSP is confident that implementation of the Guide and approach described here will result in a higher quality of IMNCI care in health facilities. This institutionalization of IMNCI in health facilities should lead to sustainability of services, continuing at least the 85% compliance with IMNCI standards that MCSP found in its endline assessment conducted in December 2017.

Lessons Learned and Recommendations

Delegating appropriate IMNCI tasks into various service delivery areas of a health facility while providing training, appropriate job aids, and supervision and mentoring for staff helped to institutionalize and promote sustainability for IMNCI at the health facility level. The pilot experience showed that the approach described in this brief enabled clinicians and non-clinicians who had not been through formal IMNCI training to effectively provide IMNCI services based on standards and provide better care for child patients. OICs expressed appreciation for the Guide, job aids, and checklists that enabled them to better supervise and manage their staff and address service delivery gaps. This approach could be adapted to allow clinical staff to delegate tasks related to maternal and newborn health, family planning, nutrition, and other technical areas to staff working in other parts of the health facility, thereby institutionalizing services in those areas as well.

Through the pilot implementation, MCSP learned that there are a few critical factors required to ensure that the approach described in this case study works. First, at least one person from the health facility needs to go through formalized IMNCI training. District- and county-level supervisors should also be trained so that they can effectively backstop the OICs in their training, supportive supervision, and mentoring. Second, regular visits from the supervisors were key to ensuring effective internal supportive supervision and mentoring, since this system was a new innovation for health facilities. Third, collaboration with the MOH is essential not only to ensure that interventions are effectively implemented and meet MOH standards but also to encourage incorporation of the Guide and approach into the standard IMNCI training package. Finally, these interventions would have been more effective had they been implemented earlier in the MCSP project. Interventions like these should be built into project design from the beginning, so that they can be effectively tested, implemented, and rolled out.

Future projects implementing an approach like this one should consider a few potential challenges. During data collection, OICs complained of increased workloads, limited print-outs of supervision tools, and stockouts of drugs and supplies. The supportive supervision and mentoring role should be established as a clear part of an OIC's scope of work, and incentives or recognition should be provided to encourage OICs to fulfill this role. Plans should be established early for regular re-printing and delivery of supervision tools, including checklists and job aids. In addition, stockouts should be addressed at a national level.

To ensure that the progress MCSP made on IMNCI in pilot health facilities continues, materials should be re-printed and delivered regularly to facilities, and visits from supervisors should continue to ensure that internal supportive supervision and mentoring continues in the hospitals. Most importantly, the MOH should incorporate the Guide and approach described here into the standard IMNCI training package so that it can be scaled up and rolled out nationwide.

This brief is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program and do not necessarily reflect the views of USAID or the United States Government.