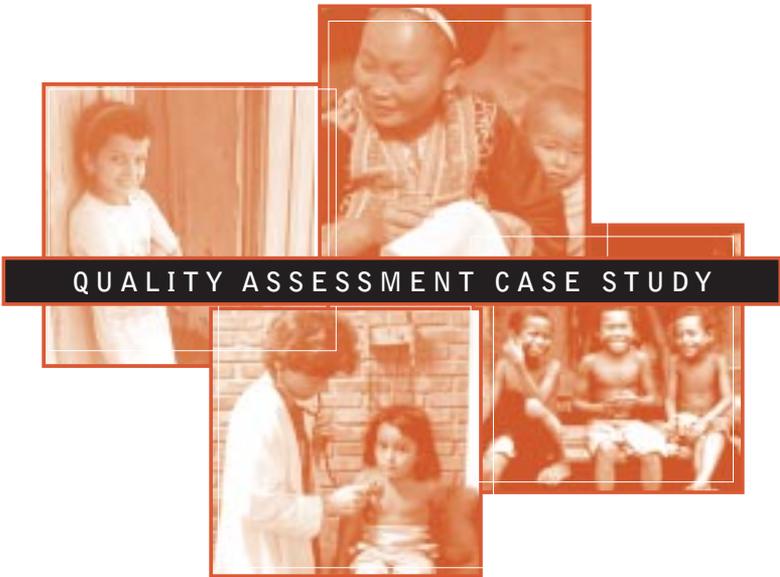


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Assessing Health Worker Performance of IMCI in Kenya





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The Quality Assurance Project (QAP) is funded by the U.S. Agency for International Development (USAID), under Contract Number HRN-C-00-96-90013. QAP serves countries eligible for USAID assistance, on USAID Missions and Bureaus, and other agencies and nongovernmental organizations that cooperate with USAID. The QAP team consists of the Center for Human Services (CHS), the prime contractor; Joint Commission International (JCI); Johns Hopkins University School of Hygiene and Public Health (JHSPH), Johns Hopkins University Center for Communication Programs (JHU/CCP); and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO). Together, they provide comprehensive, leading-edge technical expertise in the design, management, and implementation of quality assurance programs in developing countries. The Center for Human Services, the nonprofit affiliate of University Research Co., LLC, provides technical assistance in the research, design, management, improvement, and monitoring of healthcare systems and service delivery in over 30 countries.



About this series

The Case Study Series presents real applications of Quality Assurance (QA) techniques in developing countries at various health system levels, from national to community. The series focuses on QA applications in maternal and reproductive health, child survival, and infectious diseases. Each case study focuses on a major QA activity area, such as quality design, quality improvement, communication and development of standards, and quality assessment. In some cases, more than one QA activity is presented.

Quality assessment is the measurement of the quality of healthcare services. A quality assessment measures the difference between expected and actual performance to identify opportunities for improvement. Performance standards can be established for most dimensions of quality, such as technical competence, effectiveness, efficiency, safety, and coverage. Where standards are established, a quality assessment measures the level of compliance with standards. For dimensions of quality where standards are more difficult to identify, such as continuity of care or accessibility, a quality assessment describes the current level of performance with the objective of improving it.

A quality assessment frequently combines various data collection methods to overcome the intrinsic biases of each method alone. These methods include direct observation of patient-provider encounters, staff interview, patient focus group, record review, and facility inspection, among others. The assessment is often the initial step in a larger process, which may include providing feedback to health workers on performance, training and motivating staff to undertake quality improvements, and designing solutions to bridge the quality gap.

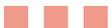
This case study describes how five Integrated Management of Childhood Illness (IMCI) trainers and supervisors conducted an assessment of provider knowledge and skill, to carry out IMCI at 38 facilities in two districts in Kenya.

Acknowledgments

The Kenyan Ministry of Health implemented the work described in this case study. This case study was written by Ya-Shin Lin and Paula Tavrow, with contributions from Dina Towbin. Editorial and technical review was provided by Lani Marquez and Diana Silimperi.

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Assessing Health Worker

Performance of IMCI in Kenya

Background

Approximately two-thirds of Kenyans are exposed to endemic malaria transmission, including 3.5 million children under five years of age. Since the 1980s, epidemic malaria has been increasing in frequency and severity among densely populated and economically important areas of Kenya's Western Highlands, such as Bungoma District. Malaria is the most common presenting complaint at health facilities in endemic areas and accounts for nearly 30 percent of outpatient visits and 20 percent of inpatient admissions nationally.¹ Some 26,000 children in Kenya die each year from the direct consequences of malarial infection: about 70 children each day.² It is estimated that 20-25 percent of childhood deaths in Bungoma district are due to malaria.³



In January 1998, the Government of Kenya and USAID initiated the Bungoma District Malaria Initiative (BDMI), managed by the African Medical Research and Education Foundation (AMREF), a nongovernmental organization with headquarters in Nairobi. The goal of BDMI is to reduce malaria morbidity and mortality through a multi-faceted approach that includes the improved case management of children, using

the Integrated Management of Childhood Illness (IMCI) guidelines, developed by the World Health Organization (WHO) and UNICEF. IMCI provides a structure for the comprehensive assessment, symptom classification, the treatment of children, and counseling of parents or caretakers for multiple diseases, including malaria.

Though the IMCI algorithm had not been officially launched in Kenya on a national scale, training of health workers in the IMCI protocol had been carried out in Bungoma and the neighboring district of Vihiga in 1996, with technical assistance from the U. S. Centers for Disease Control and Prevention (CDC). A CDC-sponsored evaluation in 1997 indicated, however, that many trained health workers in these two largely rural districts of western Kenya were still not performing IMCI effectively. Focus groups revealed that many providers had in fact stopped performing IMCI regularly. Under the BDMI, training in IMCI in Bungoma District resumed in 1998.

To support the BDMI, the Quality Assurance Project (QAP) developed an operations research study in the same two districts to test the impact of systematic team problem solving on providers' IMCI performance. The study entailed setting up facility-level problem-solving teams who would be coached on how to develop, implement, and evaluate solutions to the problem of poor compliance with IMCI standards. Depending on each facility's needs, these solutions could consist of supporting IMCI-trained providers through improvements to patient flow, reorganization of responsibilities, on-the-job training, or job aids. To better understand health workers' knowledge and attitudes about IMCI and identify the main constraints to improved performance, QAP proposed a baseline quality assessment of health provider performance during sick child consultations.

Designing and Preparing for the Assessment

Definition of performance standards and instrument design. To guide the original health worker training in 1996, WHO standards for IMCI had been adapted to conditions in western Kenya by the CDC. In preparing for the baseline assessment, QAP reviewed the tools CDC had developed for health worker assessment during supervision. QAP staff drafted three assessment instruments:

- An observation checklist (Appendix 1)
- A provider knowledge and competence questionnaire (Appendix 2)
- A facility inventory checklist

After incorporating some suggestions from AMREF staff, the instruments were pre-tested in Bungoma district hospital with the assistance of an IMCI trainer. Questions that were misinterpreted during the pre-test were clarified, and observation procedures were standardized.

Selection of facilities and quality assessors. All government facilities in the two districts where at least one health worker was trained in IMCI were selected to participate in the assessment. To explain the goals of the assessment and the operations research intervention, QAP gave a half-day quality assurance awareness seminar for selected members of the two District Health Management Teams (DHMTs) and the heads of all 38 facilities that would be assessed. After this workshop, the DHMTs nominated four people who had been trained in IMCI in 1996 to conduct the assessment.

Training of data collectors. In May 1998, the four nominees were trained to use the assessment instruments, but not all had sufficient skills in IMCI to conduct the assessment. QAP requested that the DHMTs nominate new assessors who were either IMCI trainers or supervisors. Three clinical officers and the two district nurse supervisors were selected. They then participated in an intensive, two-day training session. The training included discussion of questions,

role-playing, standardization of response recording from mock interviews, and a final pre-testing of the instruments at two facilities. To ensure interobserver reliability, the five assessors completed observation forms for the same provider-client interaction. They then discussed their differences and reached agreement on them. They repeated this exercise until nearly 90 percent interobserver reliability was achieved.

Collecting Quality Data

In June 1998, immediately after the training session, the assessment was launched. The data collectors spent 14 days in Bungoma and 10 days in Vihiga. For the first two days at each site, they worked in two-person teams to improve interobserver reliability. The assessors observed 74 health workers' IMCI performance in clinical sessions with 739 children at 38 facilities (21 in Bungoma and 17 in Vihiga).

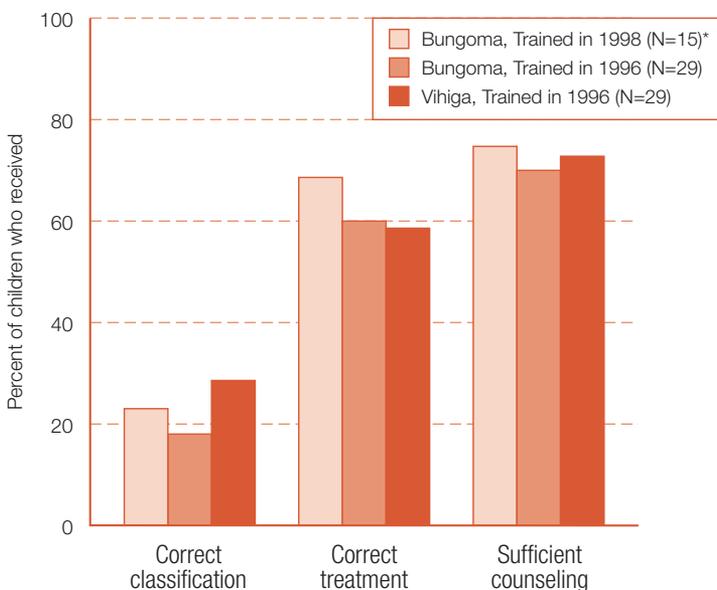
Each health worker was observed handling 10 sick children between the ages of two months and five years. Because of heavy patient utilization due to the malaria season, data collection in each facility was accomplished in a single day in most cases. On average, the five assessors observed four providers at two or three facilities each day. After the 10 observations, the assessors interviewed each provider using a questionnaire on IMCI knowledge and attitude, and then conducted a rapid inventory of the availability of necessary drugs and supplies for IMCI. Both the questionnaire and the inventory each took about 10 minutes to complete, while observations took two to three minutes longer than the duration of the consultations.

Results: Analyzing and Using Assessment Findings

Compilation of the quality of care data. Once the assessment was completed, AMREF personnel entered the data and a joint AMREF and QAP team cleaned and analyzed them.

Findings on compliance with IMCI standards. The observation checklist data revealed serious deficiencies in health workers' compliance with IMCI. For example, providers did not check for all danger signs in over one-third of the children observed, and they did not check for all major symptoms in two-thirds of the children. Less than 10 percent of the children received a complete assessment, in which all the assessment steps in the IMCI guidelines were followed accurately. Less than one-fifth were correctly "classified" (IMCI terminology meaning diagnosed). In addition, only 60 percent of sick children received correct treatment (Figure 1).

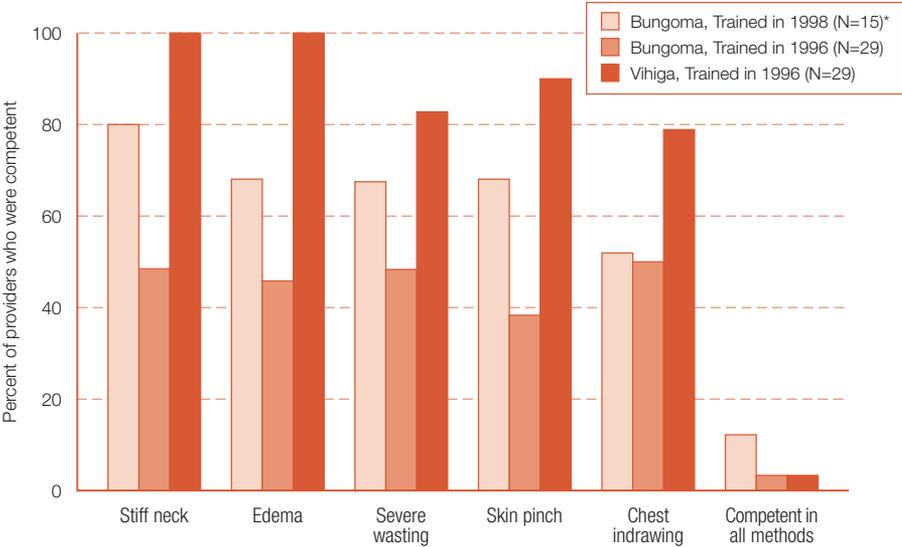
Figure 1. Providers' Performance of IMCI in 1998, by District and Year of Health Worker Training



* Dates indicate when providers were trained; N refers to the number of providers

Findings on health worker IMCI knowledge. The provider questionnaire data indicated that providers' knowledge of IMCI differed considerably by district (see Figure 2), regardless of whether they had received training in 1996 or 1998.

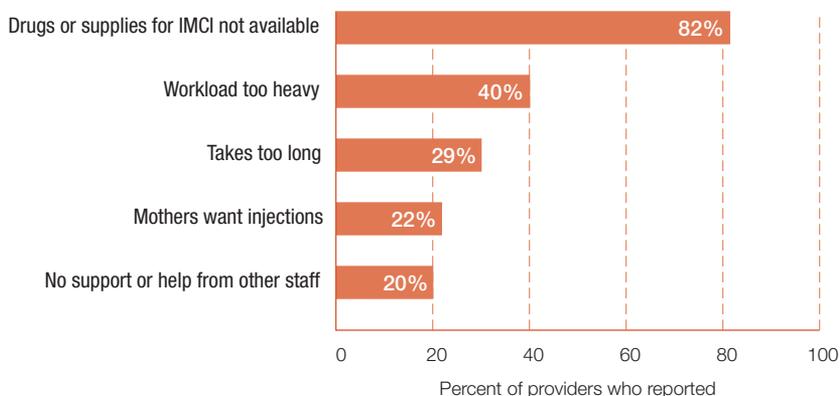
Figure 2. Health Worker's Competence in IMCI Assessment Methods, by District and Year of Training



* Dates indicate when providers were trained; N refers to the number of providers (These results are from Appendix 2, Question 5.)

In addition, providers expressed high frustration performing IMCI, which they found to be very complex and time-consuming. More than half said that IMCI took too long or made their workload too heavy. In addition, more than four out of five providers said that drugs and supplies were often unavailable (see Figure 3).

Figure 3. Top Five Difficulties Performing IMCI Reported by Health Workers*



* These results are from Appendix 2, Question 6 (open-ended).

Presentation of findings. In August 1998, QAP and AMREF conducted a one-day workshop to present the findings to the entire DHMT from each district, some 25 participants in all. Data were aggregated by district and not presented by facility, in order to focus participants' attention on district-level opportunities for improvement. The findings generated considerable discussion among the DHMT members.

Identification of opportunities for problem solving.

After the presentation of findings, the DHMT members divided into two groups by district to discuss district-level strategies and write brief action plans to address issues raised. When both groups reconvened, the top three strategies put forward were:

- Intensify supervision of health workers
- Redirect some of the cost-sharing monies to IMCI supplies and equipment
- Ensure that all facilities have oral rehydration therapy (ORT) corners[†]

[†] An ORT corner is an area set aside in a facility where caretakers can administer ORT to their dehydrated children over several hours.

Supplemental data collection. To gain additional insight into the assessment findings, QAP and AMREF convened a focus group with 11 IMCI-trained providers in Bungoma district. Providers were asked to detail the problems they faced in trying to perform IMCI. Half acknowledged that they could not perform IMCI regularly. They also cited numerous IMCI steps often skipped by providers, such as assessing the child's nutritional status. Providers also suggested strategies to save time in order to make the IMCI guidelines more feasible.

Follow-up with systematic team problem solving. In October 1998, 20 DHMT members, including IMCI supervisors and trainers, attended a three-week quality assurance coach training course. During the training, DHMT members were presented with the baseline assessment results for each facility for use in setting up problem-solving teams. Over the next six months, the DHMT coaches created teams at 23 facilities and began coaching them in problem solving. As part of the week-long onsite training for each problem-solving team, the coaches helped facility staff understand the assessment findings.

All teams initially concentrated on the problem of health worker implementation of the IMCI algorithm: specifically, that all children were not receiving a full IMCI assessment and appropriate treatment. Ensuring that health workers regularly use the IMCI algorithm was the first step in improving the quality of health worker performance. For the next year, AMREF monitored the teams and gave guidance to the coaches.

In March 2000, a follow-up assessment was conducted to measure the impact of the systematic team problem-solving work on IMCI performance. The facilities with teams were compared to those without teams. The assessment results showed that facilities with teams had significant improvement in IMCI case management when compared to facilities without teams. The difference was greatest among the teams with high problem-solving ability.

Quality Assessment Insights

This case study illustrates how quality assessments can provide the impetus for district and facility-level problem-solving. Providers had received training in IMCI guidelines, but they were not implementing them consistently or accurately, for reasons that were not well understood. Systematic team problem solving was the intervention chosen to increase compliance with IMCI guidelines, since it had been successful in other contexts. Quality assessment provided a baseline, against which the effect of the teams' interventions could be measured. In the process, the following lessons were learned:

Participation of the DHMT in the assessment process ensures local commitment to improving IMCI performance. The DHMTs participated from start to finish in every step—from the planning and pre-testing stage, through training as assessors, launching and conducting the assessment, discussing and analyzing the assessment data, addressing issues raised, setting priorities, and using problem-solving techniques to find appropriate solutions.

Quality assessment focuses providers' attention on their skills and makes them feel that their work is important, especially at small, remote facilities. The assessment was the first time that health facilities in the two districts had received feedback on their performance. Several providers mentioned that they appreciated having their performance assessed and hoped assessments would occur regularly.

The methodology of quality assessment needs to be continually adapted and refined. For the follow-up assessment in Kenya, changes were made to streamline the assessment, including reducing the number of cases observed to five per provider and simplifying the observation form so assessors could more easily observe

and record their observations. Another improvement was to initiate data entry during the same period as data collection, so that results were obtained in no more than two days after collection was completed. As with the first assessment, skilled IMCI trainers were used as assessors to ensure data quality.



End Notes

1. Bungoma District Malaria Initiative Annual Report, 1999.
2. Wellcome News, <http://www.wellcome.ac.uk/en/1/biosfginttrpinfbig.html>, 1999.
3. Mid-term Review of Bungoma District Malaria Initiative (BDMI), June 2000.

APPENDIX 1

IMCI Performance Process Assessment (Pages 1 and 2 of 4)

IMCI PERFORMANCE PROCESS ASSESSMENT v.0400 Date ___/___/___

Quest. no.: ___ Data Entry Clerk: ___ Supervisor: ___ Case No.: ___

District: ___ Facility: ___ Hosp. H.C. Disp.

Observer: ___ Consultation Number: ___ Start time: ___

OBSERVER: Tell HW to repeat child's name, age, weight & type of visit

Health Worker's Name: ___ Child's Name: ___

Type of visit: Initial Follow-up Age: ___ yrs ___ mos (Total mos. = ___) Weight: ___ kg

OBSERVER: Write assessing complaints and check appropriate "Pres." boxes below:

WAS THE CHILD CORRECTLY ASSESSED BY HW?

(Observer's perceptions in Italics)

| | | |
|---|---|---|
| 1 Checked all 4 danger signs? | Asked? | Did child have danger sign? |
| •Unable to drink or breastfeed | a. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | e. <input type="checkbox"/> Y <input type="checkbox"/> N |
| •Vomiting everything | b. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | f. <input type="checkbox"/> Y <input type="checkbox"/> N |
| •Convulsions | c. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | g. <input type="checkbox"/> Y <input type="checkbox"/> N |
| •Lethargic/Unconscious | d. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N <input type="checkbox"/> N/A | h. <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2 Checked cough/Difficult Breathing? | Checked? | Caretaker Response |
| •Asked | a. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | e. <input type="checkbox"/> Y <input type="checkbox"/> N |
| If Y/P, counted respiratory rate | b. <input type="checkbox"/> Y <input type="checkbox"/> N | Respiratory Rate (if counted) |
| If Y/P, checked chest indrawing | c. <input type="checkbox"/> Y <input type="checkbox"/> N | i. (HW) ___ p. / (Obs.) ___ |
| If Y/P, listened for stridor/wheeze | d. <input type="checkbox"/> Y <input type="checkbox"/> N | h. Obvious indrawing? <input type="checkbox"/> Y <input type="checkbox"/> N (Obs. stridor/wheeze)? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3 Checked for diarrhea? | Checked? | Caretaker Response |
| •Asked | a. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | g. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK |
| If Y/P, asked duration | b. <input type="checkbox"/> Y <input type="checkbox"/> N | h. ___ days <input type="checkbox"/> DK |
| If Y/P, asked about blood in stool | c. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | i. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK |
| If Y/P, checked for sunken eyes | d. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | j. Obviously sick? <input type="checkbox"/> Y <input type="checkbox"/> N |
| If Y/P, offered fluid to child | e. <input type="checkbox"/> Y <input type="checkbox"/> N | k. Drinks: <input type="checkbox"/> eagerly <input type="checkbox"/> normally <input type="checkbox"/> poorly |
| If Y/P, checked skin turgor | l. <input type="checkbox"/> Y <input type="checkbox"/> N | l. Goes back slowly? <input type="checkbox"/> Y <input type="checkbox"/> N |

APPENDIX 1

IMCI Performance Process Assessment

(Pages 1 and 2 of 4)

Facility _____ Child's Name _____ Date ____/____/____

WAS THE CHILD CORRECTLY ASSESSED BY HW (cont'd)?

| 4. Checked fever? | Checked? | Carer/Response |
|---|---|--|
| • Asked | a. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | g. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK |
| • Felt and/or measured | b. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | h. Temperature: _____ |
| • If Y/P, asked duration | c. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | i. _____ days <input type="checkbox"/> DK |
| • If Y/P, asked if measles in last 3 months | d. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | j. <input type="checkbox"/> Y <input type="checkbox"/> N |
| • If Y/P, checked for measles signs | e. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N <input type="checkbox"/> N/A | k. Obvious signs? <input type="checkbox"/> Y <input type="checkbox"/> N |
| • If Y/P, checked for stiff neck | f. <input type="checkbox"/> Y <input type="checkbox"/> N, looks flexible <input type="checkbox"/> N | l. Obviously stiff? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 5. Checked for ear problems: | Checked? | Carer/Response |
| • Asked if ear problem | a. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | 1. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK |
| • If Y/P, asked if pain | b. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | g. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK |
| • If Y/P, checked for discharge | c. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | h. Obvious discharge? <input type="checkbox"/> Y <input type="checkbox"/> N |
| • If discharge, asked duration | d. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | i. _____ days <input type="checkbox"/> DK |
| • If Y/P, checked swelling behind ear | e. <input type="checkbox"/> Y <input type="checkbox"/> Pres. <input type="checkbox"/> N | j. Obvious swelling? <input type="checkbox"/> Y <input type="checkbox"/> N |

| 6. Checked for malnutrition: | Checked? | Observer/Parent/Carer |
|--|---|---|
| • Checked for wasting (stripped child) | a. <input type="checkbox"/> Y <input type="checkbox"/> N | e. Obvious wasting? <input type="checkbox"/> Y <input type="checkbox"/> N |
| • Checked palmar pector | b. <input type="checkbox"/> Y <input type="checkbox"/> N | f. Obvious pector? <input type="checkbox"/> Y <input type="checkbox"/> N |
| • Checked <u>post</u> feet for oedema | c. <input type="checkbox"/> Y <input type="checkbox"/> N | g. Obvious oedema? <input type="checkbox"/> Y <input type="checkbox"/> N |
| • Determined weight-for-age | d. <input type="checkbox"/> Y <input type="checkbox"/> N | |
| 7. Checked immunization status: | Checked? | |
| • Checked for immunizations | a. <input type="checkbox"/> Y <input type="checkbox"/> N | |
| • If Y, did provider determine that any immunizations were needed? | b. <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N (completed) | |
| Recommended vaccinations today? | 8. Which recommended? | 9. Observer: Which should be given? |
| | a. <input type="checkbox"/> BCG | a. <input type="checkbox"/> BCG |
| | b. <input type="checkbox"/> OPV 0 | b. <input type="checkbox"/> OPV 0 |
| | c. <input type="checkbox"/> OPV 1 | c. <input type="checkbox"/> OPV 1 |
| | d. <input type="checkbox"/> OPV 2 | d. <input type="checkbox"/> OPV 2 |
| | e. <input type="checkbox"/> OPV 3 | e. <input type="checkbox"/> OPV 3 |
| | f. <input type="checkbox"/> DPT 1 | f. <input type="checkbox"/> DPT 1 |
| | g. <input type="checkbox"/> DPT 2 | g. <input type="checkbox"/> DPT 2 |
| | h. <input type="checkbox"/> DPT 3 | h. <input type="checkbox"/> DPT 3 |
| | i. <input type="checkbox"/> Measles | i. <input type="checkbox"/> Measles |
| | j. <input type="checkbox"/> None | j. <input type="checkbox"/> None |
| | k. <input type="checkbox"/> Unspecified | k. <input type="checkbox"/> Couldn't determine |

10. WAS ASSESSMENT DONE IN IMCI ORDER? Y N

APPENDIX 2

Rapid Provider Competence Assessment

RAPID PROVIDER COMPETENCE ASSESSMENT v0309 Date ___/___/___

| | | | |
|--------------------------|----------------------|--|---|
| Questionnaire no.: _____ | | Data Entry Clerk: _____ | Supervisor: _____ |
| District: _____ | | Facility | <input type="checkbox"/> Hosp. <input type="checkbox"/> H.C. <input type="checkbox"/> Disp. |
| Observer: _____ | Health Worker: _____ | AGE: <input type="checkbox"/> M <input type="checkbox"/> F | |

1. How long have you worked at this facility? _____ years (If 1.5 years or more, round to 2 years)

2. When were you trained in IMCI? (Mo/Yr) ___/___ No formal training

3. What are the IMCI danger signs? (Observer: Note all mentioned.)

| | | |
|---|---|------------------------------------|
| a. <input type="checkbox"/> Unable to drink or breastfeed | e. <input type="checkbox"/> Convulsions | g. <input type="checkbox"/> Other: |
| b. <input type="checkbox"/> Vomiting everything | d. <input type="checkbox"/> Lethargic/unconscious | f. <input type="checkbox"/> Other: |

4. What are the signs of some dehydration? (Observer: Note all mentioned.)

| | | |
|---|---|------------------------------------|
| a. <input type="checkbox"/> Restless, irritable | c. <input type="checkbox"/> Drinks eagerly, thirstily | e. <input type="checkbox"/> Other: |
| b. <input type="checkbox"/> Sunken eyes | d. <input type="checkbox"/> Skin pinch goes back slowly | f. <input type="checkbox"/> Other: |

5. Please describe or demonstrate for me how you would check this and what you are looking for (Observer: For each item, rate whether HM performed and explained it fully, correctly or not.)

| | | |
|---------------------|--|--|
| a. Chest indrawing | <input type="checkbox"/> fully correct | <input type="checkbox"/> incorrect |
| b. Skin pinch | <input type="checkbox"/> fully correct | <input type="checkbox"/> incorrect |
| c. Oedema | <input type="checkbox"/> fully correct | <input type="checkbox"/> incorrect |
| d. Stiff neck | <input type="checkbox"/> fully correct | <input type="checkbox"/> incorrect |
| e. Severe wasting | <input type="checkbox"/> fully correct | <input type="checkbox"/> incorrect |
| f. Respiration rate | <input type="checkbox"/> fully correct | <input type="checkbox"/> incorrect (doesn't know thresholds) |

6. What are the main difficulties you encounter in implementing the IMCI approach? (Probe once.)

| | |
|--|---|
| a. <input type="checkbox"/> Takes too long, workload too heavy, staff few | j. <input type="checkbox"/> Mothers don't give complete history |
| b. <input type="checkbox"/> Have too many other responsibilities | k. <input type="checkbox"/> Mothers don't want to be referred |
| c. <input type="checkbox"/> No OHT corner or room for IMCI | l. <input type="checkbox"/> Mothers don't like not receiving drug |
| d. <input type="checkbox"/> Don't like using chart book in front of mother | m. <input type="checkbox"/> Not allowed to do IMCI |
| e. <input type="checkbox"/> In-charge over-ruled decisions of provider | n. <input type="checkbox"/> Other (describe) : |
| f. <input type="checkbox"/> No support or help from other staff | |
| g. <input type="checkbox"/> Others have treated the child incorrectly | |
| h. <input type="checkbox"/> IMCI recommended treatments are not effective | |
| i. <input type="checkbox"/> Drugs or supplies for IMCI not available | |

7. Have you been trained in the new malaria guidelines? Yes: (Mo/Yr) ___/___ No

8. How many IMCI-trained providers are there at this facility? _____ (give best estimate)

9. Many providers do not regularly do the entire IMCI assessment and counselling, for various reasons. Would you say that you do the full IMCI: always sometimes rarely almost never

Assessing Health Worker Performance of IMCI in Kenya: Summary

In mid-1998, five district-level clinical trainers/supervisors conducted a baseline assessment of 74 providers' performance of the Integrated Management of Childhood Illness (IMCI) algorithm. The assessors observed the providers in clinical consultations with 739 children at 38 facilities in two districts of Kenya (21 facilities in Bungoma district and 17 in Vihiga district), with technical guidance from the Quality Assurance Project (QAP). Local District Health Management Teams (DHMTs) were involved throughout the process—from selecting the assessors, participating in the initial training, and collecting data, to interpreting and using results for district planning. This participatory approach built local commitment to improve IMCI compliance. It also marked the first time that health workers saw how their facilities performed in comparison with others.