

Expert Group Meeting
IMNCI in Pre-Service Education of Physicians:
Scaling up IMNCI Introduction in Undergraduate Curriculum

5th - 6th November 2005, AIIMS

In order to share experiences gained in the pre service IMNCI project and to envision nation-wide scaling up of IMNCI in MBBS curriculum, this Expert Group Meeting was organized at AIIMS in collaboration WHO India Office.

The objectives of the workshop were:

- i) Share pilot experience of introducing IMNCI in the MBBS curriculum with other medical colleges and representatives of Government of India, national and international organizations and professional bodies.
- ii) Identify steps to scale up IMNCI in the MBBS curriculum
- iii) Develop guidelines to help government authorities to introduce, support and sustain IMNCI teaching in medical schools.

Recommendations:

- I. The participants recommended that the implementation should be the **joint responsibility** of the Pediatrics and Community Medicine departments. For ensuring smooth implementation, there should be an **IMNCI Working Group** with alternating leadership from the two departments with involvement of the Dean/ Principal. The working groups should ensure quality of training, coordination, and monitoring.
- II. The participants had no concerns about the dilution of the current training of Pediatrics with the introduction of IMNCI training. In addition, it was suggested that regular feedback from the students and the faculty be used to refine the training.
- III. There was a consensus on the time of introduction of the package: Package should be introduced **early in the clinical training** and definitely by the end of 6th Semester. However, colleges may decide on specifics of the posting. The importance of **continuity** in the training package across different phases of MBBS curriculum was emphasized.
- IV. It was agreed upon that the training be delivered in sessions lasting **30- 36 hours**.
- V. For any new training program to be introduced, it is important to also evaluate the students. The participants agreed that **Assessment** on IMNCI should be carried out in both Pediatrics and PSM and both in the internal as well as final evaluations. The weight age, in terms of allocation of marks, should be between 10% and 20% of the total marks allocated to Pediatrics and Community Medicine.
- VI. The Community Medicine posting could be utilized for **home based training in IMNCI**.

- VII. There was a consensus on the utilization of the **internship** for practice of IMNCI. This should apply both the postings in Community Medicine and in Pediatrics: In particular it was strongly felt that rural posting in internship must be used effectively for IMNCI practice. There should be re-orientation at the beginning of internship. A log book should be used to ensure that certain minimum number of cases are managed using the IMNCI approach.
- VIII. Regarding the **learning resources**, the experts suggested the use of separate booklet/ module for the training. The importance of providing a **photograph booklet** was emphasized by all. Alternate resources such as website/ CD-ROM were also suggested. Adequate supplies of these materials should be ensured.
- IX. For implementation of the training, the groups suggested that the government provides the hardware- computer, LCD projector for projection of CDs, under joint ownership of Community Medicine and Pediatrics departments. The day to day use could be coordinated by the joint working group. In addition wall charts could be provided to the colleges for easy reference. Good quality video films could also be used as an adjunct.
- X. To ensure adequate exposure to various clinical settings, creation and use of a checklist was recommended. Coordination between Pediatrics and Community Medicine departments is essential to ensure adequate exposure. The clinical training should be carried out in the Pediatric OPD/ ward; Neonatology and also the Outreach clinics of the Community Medicine department.
- XI. Training of the faculty to ensure early introduction of the package was emphasized upon. It was suggested that for a state, there could be centralized training at one nodal center. 30- 50% faculty of a department could attend the course at a time.
- XII. The implementation of IMNCI should be refined with feedback from students and teachers.
- XIII. Finally it was emphasized that the use of IMNCI in day to day practice by the faculty and the residents would go a long way in training the MBBS students in IMNCI.

Policy, capacity & resource need for nationwide implementation

Recommendations:

- I. The group suggested the replacement of the term 'pre-service training of physicians' **with Undergraduate Medical Education**'. The experts viewed IMNCI introduction as a forerunner of inclusion of other programmatically crucial packages / skills (e.g. skilled birth attendance) in MBBS curriculum. Involvement of disciplines like microbiology / pharmacology in addition to Pediatrics and Community Medicine was suggested.
- II. The group reviewed the MCI guidelines for Pediatrics and Community Medicine and concluded that IMNCI introduction in UG medical curriculum upholds and promotes the

goals and objectives of the MCI guidelines (1997). Therefore, no new policy decision / direction from the MCI is required. The experts emphasized the involvement of the MCI in the implementation of the program as a partner with whom the recommendations of this meeting should be shared.

- III. The group suggested that the Government of India writes to the state governments and universities recommending IMNCI introduction in UG medical education. In continuation, the state governments should further write to their universities and medical colleges recommending IMNCI introduction in UG medical education [Action taken: Secretary Health, Government of India has already written a letter to state health secretaries in this regard].
- IV. Capacity building: The group recommended that at least 2-4 senior teachers from each medical college should receive training of first level (preferably, at national training centers). The rest of the faculty should also receive high quality training at regional / state levels; training could be arranged for college clusters. Lessons of the capacity-building experience at IGNOU should be built on.
- V. The importance of providing adequate and good quality resources for the introduction of the IMNCI package was highlighted. The group recommended provision of teaching aids / tools (video films, wall charts) to medical colleges, provision of audio-visual hardware (PC/LCD projector/TV/EMPC) to low resource colleges, especially in NRHM states. Provision of student learning materials (handbooks & chart books) free for 3-5 years was suggested. Thereafter, inclusion of IMNCI contents in popular text-books should be ensured. Over a period of time, resource materials could be made available on-line.
- VI. It is very important to learn from each other in early stages of scaling up of the IMNCI training. Opportunities to achieve this could be provided at various professional fora and through annual / bi-annual conclaves. Establishment of a Medical College Network on IMNCI was recommended.
- VII. The group also debated on innovative approaches such as distance learning, where the IGNOU experience would be helpful and also development of interactive e-modules. Satellite-based rapid sensitization of stakeholders could be implemented using Edusat and the ISRO nodes at AIIMS and in states.
- VIII. Assessment of the impact of the introduction of IMNCI in MBBS curriculum needs to be accomplished by operational research. The group recommended 10% of implementation budget for operational research. Various aspects needing evaluation were identified: impact on post-graduate learning; time series analysis of U5 child mortality; utility of alternate training approaches (modular/shorter courses; e-learning and standard learning); and prescription practices

Implementations and recommendations of the meeting

1. The government will support introduction and implementation of IMNCI in all the medical colleges and the physicians from Pediatrics and Community Medicine will have to take the lead. A letter to all the state health secretaries could be sent by the Ministry of Health asking them to start the process of introducing IMNCI in their state medical colleges [Action taken: Secretary Health, Government of India has already written a letter to state health secretaries in this regard].

India needs to take lead in preparing an 'army' IMNCI of trained people at all levels including undergraduate and postgraduate medical students. Survival and health of under five children was a national priority and IMNCI was an important strategy to achieve this. The academia will have to take the initiative to scale up IMNCI in routine UG teaching.

2. Representatives of WHO, UNICEF, IAP, NNF, IAPSM express wholehearted readiness to support IMNCI implementation in UG education in the country.
3. Medical Council of India should be seen as a partner and facilitator in implementing IMNCI in the MBBS Curriculum.
4. Urgent steps to develop capacity in IMNCI at medical colleges need to be undertaken without delay.
5. First hand exposure to IMNCI is extremely important to sensitize medical teachers to IMNCI and to allay their concerns about its relevance to UG education.
6. Academic and professional leadership in child health have the responsibility to not only promote IMNCI in pre service education of physicians but also that of the nurses, ANMs and other health professionals and workers.