កម្មវិធីរួមគ្នាដើម្បីជួយជីវិតមាតា និងទារក
Partnering to Save Lives

Learning Update – July 2017
Theme 1: Technical Harmonisation

What is PSL?

Partnering to Save Lives (PSL) is a partnership between CARE, Marie Stopes International Cambodia, Save the Children, the Australian Government and the Cambodian Ministry of Health (MoH). PSL aims 'to save the lives of women and neonates in Cambodia through improved quality, access and utilisation of reproductive, maternal and neonatal health (RMNH) services through a partnership approach' in line with the objectives of the MoH's Fast Track Initiative Roadmap for Reducing Maternal and Neonatal Mortality.

PSL Learning agenda

One outcome of PSL is focused on documenting learning and evidence that can contribute to improved policy and practices. The four PSL Learning Agenda themes are technical harmonisation, community referrals, garment factories and reaching vulnerable groups.

What are the issues?

PSL partnership aims at identifying technical approaches that are effective in improving RMNH, particularly among vulnerable groups[1] with significant unmet needs in terms of information and services.

Coaching and Midwifery Coordination Alliance Teams (MCATs) are promoted as key interventions to build capacities of midwives to provide quality RMNH services. In 2016, the MoH finalised and disseminated a National MCAT Protocol and is introducing a new quality enhancement monitoring system including two coaching sessions per facility per quarter. The recently updated Safe Motherhood Clinical Management Protocol is also a key reference document for improving midwives' clinical skills and practices.

In the meantime, progress across components of RMNH is uneven and some key services continue to face challenges.

1 For more information on gender equity and disability inclusion, refer to the learning update "Theme 4: reaching vulnerable groups"

We observed that attendance to postnatal care (PNC) remains low and the quality of this service scored poorly during the Level II Quality of Care Assessment. Provision of comprehensive abortion care (CAC) remains very limited in public health facilities despite training of providers.
With this in mind, the PSL annual review aimed to inform a better understanding of key quality improvement mechanisms (MCATs and coaching) and provider confidence with clinical skills specific to postnatal care with attention to newborns and mothers, and abortion.

Learning questions in year 4 were as follows:

1. Do health workers and health department/district representatives find MCATs and coaching an effective means to transfer skills and increase confidence and motivation to deliver appropriate life-saving services to women and newborns?
2. Do health workers, particularly midwives, demonstrate the appropriate skill sets to deliver appropriate newborn services including PNC for newborns and mothers, and CAC?

What learning approaches have we used?

PSL used a mix of quantitative and qualitative methods to learn more about these issues:

- Consultation with PSL's Technical Reference Group to share experience and lessons learnt on coaching, in October 2016;
- Monthly meetings of PSL's Quality Team comprising technical representatives from the three NGOs;
- Learning and testimony from PSL field managers and implementing staff and members of the Quality Team, during the Annual Review Workshop in March 2017;
- Fieldwork in Kratie, Mondul Kiri and Kampong Cham as part of PSL's Annual Review process in February 2017, which involved key informant interviews, focus group discussions, observations and simulation exercises.

What have we learned?

Are MCATs and coaching an effective means to transfer skills and increase confidence and motivation?

MCATs

During **PSL year 4 annual field review,** 30 midwives and five provincial health department (PHD) staff were interviewed and shared their views on successes and challenges with MCAT meetings. **Midwives found that MCATs function well to improve their knowledge on clinical skills especially when participatory approaches and simulation are used.** MCATs also help improve relationships between midwives and between health centers, hospitals, and Operational District (OD)/PHD teams. It has helped solve problems and promote team work. PHD/OD teams demonstrate good ownership and found that the new National MCAT Protocol provides good guidance to MCAT facilitators. They found that the large number of participants during meetings is not an efficient means to promote active participation. Challenges remain in the absence of midwives and sometimes facilitators due to per diem issues. **Providers from referral hospitals do not participate regularly** due to conflicting agenda or lack of interest, which limits the possibility to discuss and solve issues around referrals. Time is also too limited to practice skills as the capacity building session is limited to the afternoon only. Some midwives do not have the chance to practice new skills after MCATs, due to limited cases. MCAT meetings are mostly supported by development partners budget and **should be included in annual operation plan (AOP) budgets.** The continuous education requirements for health professional licensing may be an incentive for PHDs and ODs to invest budget in MCATs.

Coaching

Midwives interviewed during the **annual field review** were also asked if they found coaching effective to build their clinical skills. **Midwives found coaching to be very useful. It provides hands on experience and helps to gain self-confidence.** Midwives appreciated to be praised by their supervisors when they do well and to receive advice to further improve their practices. The coaches expressed the **need to receive more training and guidance on how to do coaching.** They remain confused about what coaching is and some have difficulties to adopt a supportive attitude. They are also lacking materials such as mannequins to practice skills when patients are not present. Limitations observed were the insufficient involvement of referral hospital staff in coaching teams to share their clinical knowledge and practices and the limited real case opportunity at the time of coaching in some health centres. Also, midwives are sometime absent or not available due to other duties, even though the appointment for coaching was agreed in advance.

Common lessons learnt identified during the technical reference group meeting in October 2016 included the following:

- Coaching does not only improve skills but also **self-confidence** to practice and perform life-saving skills, **supportive relationship** between the staff and PHDs/ODs, and it **empowers** staff to make the right decision.
- **Having the right coaches** is of primary importance for successful coaching. Results of coaching are very dependent on coaching skills and supportiveness of the supervisors.
- Coaching skills cannot be acquired through theoretical training only. There is a need to **"Coach the coaches"**.
- Coaching must happen **on-site,** ideally with actual patients.
- Coaching should be **structured and competency based.**
- Follow up needs to be **supportive,** not "controlling/checking".
- Checklist use should be kept to a **minimum.**
- **Provision of feedback** can happen through the coaching session directly to the midwife/staff being coached and then during a feedback session involving facility chief to develop joint action plan.

Do health workers demonstrate the appropriate skill sets to deliver appropriate newborn services and comprehensive abortion care?

Postnatal care service:

During PSL Year 4 field review, simulations of PNC 1 visits including immediate newborn care were organized to measure the quality of service provided. Gaps were observed in the application of the national standards and steps such as in recording information, checking mother's breasts and newborn vital signs. **It was noted that very little attention was paid to the newborn.** PNC outreach visits remain limited especially during rainy season. It was also observed that some vaccines were out of stock.

The Level II Quality of Care Assessment completed by the MoH in 2015 among public health facilities in 15 provinces and Phnom Penh municipality identified that PNC was among the poorest quality services with scores of 36.4% for PNC2 and 47.6% for PNC1. This poor quality is reflected by the relatively low coverage of such services. Discussion with women at the community level during the PSL field review also confirmed the fact that women are not visiting health centers after delivery except in cases of emergency or for vaccinations. Despite awareness messages and community education on PNC, **women are not convinced of the usefulness of this essential check-up for them and their baby.** The practices of roasting and other traditional methods continue to be very high, especially among ethnic communities.

During the first six months of PSL Year 4, 18 newborns died across the four northeast provinces (four still birth and 14 neonatal deaths) both in community and in facility. Causes of death included mother's severe anemia, prematurity, low birth weight and congenital defects among others. Most could have been avoided with appropriate referral.

CAC

The fieldwork also looked specifically at factors influencing CAC with trained providers. It was found that some health centres do not receive CAC clients. As a result of their limited use of these skills, **providers do not feel confident in their skills to perform CAC.** Strong moral barriers are also reasons for midwives not to perform CAC, suggesting that values clarification needs to be strengthened. Additionally, sharing financial incentives for CAC with other staff is not well perceived by providers.

Simulation of CAC services during field work showed that providers did not follow CAC protocol. Issues were found with checking vital signs, hygiene and infection control (hand washing, wearing aprons, material preparation and waste management), history taking and recording information. There is a need to reinforce CAC supervision and to build the clinical skills of supervisors on CAC.

Women in the community also expressed that they prefer going to private clinics to receive this service due to privacy issues.

What are we doing about it?

PSL's technical harmonisation activities will focus particularly on health facility and PHD/OD staff:

Health Facility	Provincial/District/National
• Continue to provide MCAT with systematic use of participatory approach and simulation. • Encourage participants to MCAT to share their good experience with their absent colleagues to motivate them to join next round. • Continue to provide coaching support to midwives at health centre level. • Address clinical weaknesses in PNC and in CAC through quality assurance visit, coaching and MCATs. • Integrate attitude issues and CAC value clarification in MCATs and coaching. • Conduct values clarification for provider and health centre chief during recruitment for CAC training. • Conduct attitudes training to sensitise midwives to the needs of vulnerable groups such as ethnic minorities, young and unmarried women and people living with a disability.	• Support and build the capacities of coaches in both clinical and soft skills. • Identify and mobilize coaching teams that combine representatives from PHD/OD and from referral hospitals. • Include RMNH activities, especially MCATs and coaching in Annual Operation Plans and Commune Investment Plans. • Support PHDs/ODs to move away from 'checklist' supervision and towards more supportive supervision that encourages skills transfer, observation, simulations/practical exercises and continual feedback. • Support the understanding and use of new supervision/coaching tools by OD and PHD teams and ensure the PSL learning and good practices are integrated into new systems. • Coach MCAT facilitators in participatory methods.