CLINICAL COACHING/MENTORING PROGRAMME FACILITATION GUIDE

for

MNH SERVICE PROVIDERS AT BC, BEONC, AND CEONC SITES

2079

GOVERNMENT OF NEPAL
MINISTRY OF HEALTH AND POPULATION
FAMILY WELFARE DIVISION
Teku, Kathmandu
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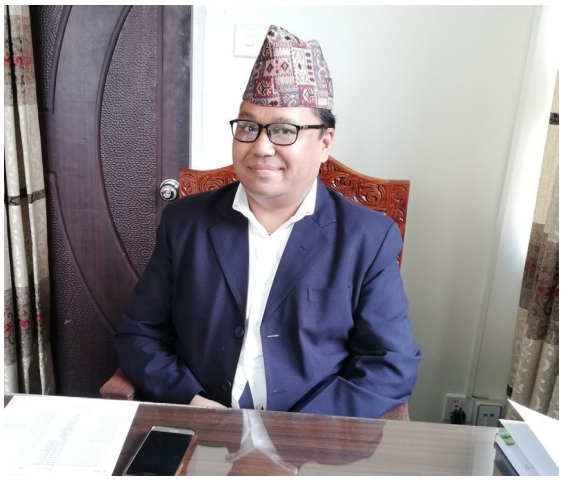

Preface

As enshrined in the Constitution of Nepal, Government of Nepal is committed to providing the highest possible quality of health care to all citizens. Ministry of Health and Population is also obligated to deliver high quality safe motherhood and reproductive health services to its population as per the *Right to Safe Motherhood and Reproductive Health Act, 2075*.

Maternal and newborn health has received good attention and support from the government and Nepal has made significant progress in reduction on maternal mortality ratio over the last few decades. However, improving quality is an on-going process and is everyone's responsibility. Family Welfare Division (FWD) has adopted the coaching/mentoring approach for improving the quality of care provided at health facilities. I am pleased to know that Department of Health Services, Family Welfare Division has led the development of *'Clinical coaching/mentoring programme facilitation guide for MNH service providers at BC, BEONC, and CEONC sites 2079'* with the support of various stakeholders.

I believe, this guidance to federal, provincial and local government policy makers, health managers and health workers will help further improvements in maternal and newborn health in Nepal.
I would like to congratulate Family Welfare Division for taking the lead role and all involved in developing this guide.

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Foreword

Maternal and newborn service has been established as rights for the citizens as per *Rights to Safe motherhood and Reproductive Health Act, 2075.* Nepal has made significant progress in Maternal and Newborn Health in the past two decades by reducing maternal and newborn deaths, but more efforts are needed to achieve target set by Sustainable Development Goals. Evidence has shown that maximizing coverage of essential interventions is insufficient to reduce maternal mortality and morbidity as poor quality of care contributes to morbidity and mortality. Quality of healthcare services should not be compromised and for this, standard of health care must be maintained at every step of service delivery.

It has been shown that training of health workers alone without follow up support and continuous capacity enhancement is not adequate to provide quality health services. Family Welfare Division (FWD) has adopted the coaching/mentoring approach for improving the quality of care provided at Birthing centres, Basic Emergency Obstetric Care centres and Comprehensive Emergency Obstetric Care centres. In this context, FWD has led the development of 'Clinical coaching/ mentoring programme facilitation guide for MNH service providers at BC, BEONC, and CEONC sites 2079'. The objective of this guide is to improve the quality of care and outcomes for mothers and newborns through clinical coaching/mentoring and MNH readiness quality improvement programme at health facilities.

I believe, this guide will be very useful for health managers, clinical mentors and health workers of levels to provide quality maternal and newborn health services. I would like to thank the whole team of Family Welfare Division along with all the partners who have contributed to the development of this guide.

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Acknowledgment

The Family Welfare Division is pleased to introduce the 'Clinical coaching/mentoring programme facilitation guide for MNH service providers at BC, BEONC, and CEONC sites 2079' that aims to improve the quality of care through increasing knowledge and competency and changing behavior, practice, and skills of health workers in the provision of MNH services. This guide is built on the citizen's rights to the accessible and affordable quality of healthcare services conferred in the Constitution of Nepal 2072. This guide will ultimately contribute to the reduction in Maternal Mortality Ratio, Perinatal mortality rate, and Neonatal Mortality Rate.

First of all, I would like to extend sincere gratitude towards all participatory dignitaries from the national level- PMWH, NHTC, NSSD, NHEICC, CSD, MD, and all partner organizations working in MNH sector for the guidance and inputs in this facilitation guide. I must greatly extend our acknowledgment to Dr. Dipendra Raman Singh, Director General, Department of Health Services for his continuous support and encouragement in developing this facilitation guide. We are very much thankful to Ukaid/Nepal Health Sector Support Programme for the technical and financial support throughout the process of development of this guide.

Last but not the least, I would like to thank all my colleagues at Family Welfare Division for their continuous effort and cooperation in developing this guide. I hope this document will be widely used by all levels of health managers, clinical mentors, and health workers to improve the quality of care and outcomes for mothers and newborns.

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List of Abbreviation

AA	:	Anesthesia Assistant
APH	:	Antepartum Hemorrhage
ANC	:	Antenatal Care
ANM	:	Axillary Nurse Midwife
ASBA	:	Advance Skilled Birth Attendance
AWPB	:	Annual Working Program Budget
BC	:	Birthing Center
BEONC	:	Basic Emergency Obstetric and New-born Care
CEONC	:	Comprehensive Emergency Obstetric and New-born Care
CSD	:	Curative Service Division
CS	:	Cesarean Section
DGO	:	Diploma in Gynecology and Obstetrics
EOC	:	Emergency Obstetrics Care
FWD	:	Family Welfare Division
HDC	:	Hospital Development Committee
HFOMC	:	Health Facility Operation and Management Committees
HLD	:	High Level Disinfection
HMIS	:	Health Management Information System
HQIP	:	Hospital Quality Improvement Process
HF	:	Health Facility
IM	:	Intramuscular
IP	:	Infection Prevention
KMC	:	Kangaroo Mother Care
KMC	:	Kangaroo Mother Care
LSCS	:	Lower Segment Cesarian Section
MD	:	Management Division
MDGP	:	Doctor of Medicine in General Practice
MMR	:	Maternal Mortality Ratio
MNH	:	Maternal and Neonatal Health
MOHP	:	Ministry of Health and Population
MRP	:	Manual Removal of Placenta
MVA	:	Manual Vacuum Aspiration
MSS	:	Minimum Service Standard
MPDSR	:	Maternal and Perinatal Death Surveillance and Response
NBR	:	Newborn Resuscitation
NHSS-IP	:	Nepal Health Sector Strategy-Implementation Plan
NHTC	:	National Health Training Center
NMR	:	Neonatal Mortality Rate
NSSD	:	Nursing and Social Security Division
NHSS	:	Nepal Health Sector Strategy
ODK	:	Open Data Kit
OT	:	Operation Theater
PNC	:	Postnatal Care
PPH	:	Post-Partum Hemorrhage
QIP	:	Quality Improvement Process
RMC	:	Respectful Maternity Care
SBA	:	Skilled Birth Attendance
SHP	:	Skilled Health Personnel

TABLE OF CONTENTS

Introduction 9

Objectives 10

Section 1: General coaching/mentoring guideline 11
1.1 introduction 12
1.2 Coaching/mentoring Principles and Skills 12

Section 2: Programme Implementation process for coaching/mentoring to BC/ BEONC service providers 15
2.1 Selection of participant for clinical coach/mentor training from CEONC/BEONC sites 16
2.2 Training and skill development of BC/BEONC coaches/mentors 16
2.3 Selection of BC/BEONC sites for clinical coaching/mentoring 16
2.4 Pre-coaching/mentoring orientation at Provincial or Local level 16
2.5 Pre-coaching planning and coordination between BC/BEONC coach/mentor and Palika focal person 18
2.6 Clinical coaching/mentoring process 18
2.6.1 Coaching/mentoring to BC/BEONC service providers 18
2.6.2 IP demonstration (Equipment Processing) 19
2.6.3 MNH readiness quality improvement process 19

Section 3: Programme Implementation process for coaching/mentoring to CEONC service providers 21
3.1 Selection of CEONC coaches/mentors at referral hospitals 22
3.2 Training and skill development of CEONC coaches/mentors 22
3.3 Selection of CEONC sites for clinical coaching/mentoring 22
3.4 Pre-coaching/mentoring orientation at Provincial or at hospital level 23
3.5 Onsite support and coaching/mentoring to CEONC service providers at CEONC sites 23

Section 4: Supportive areas for programme Implementation process for coaching/ mentoring to BC/BEONC/CEONC service providers 25
4.1 Establishment of Skill Lab for clinical coaching/mentoring for BC/BEONC/CEONC service Providers 26
4.2 Follow up coaching/mentoring visit to BC/BEONC/CEONC sites 26
4.3 Reporting and monitoring of clinical coaching/mentoring programme 26
4.4 Rotation practice to BC/BEONC and CEONC service providers 27
4.4.1 Rotation Practice of nurses working at BC/BEONC sites 27
4.4.2 Rotation practice of CEONC service providers (ASBA, AA, OT nurse) working at CEONC sites in remote district 27
4.5 BC/BEONC and CEONC coach/mentor refresher and review meeting schedule 27
4.6 Monitoring of Key MNH competencies focused on SBA clinical coaching/mentoring 28

Annexes 29
Annex-1: Clinical Coach/Mentor development training course-outline 30
Annex-2: Skill Lab materials list for onsite coaching/mentoring to BC/BEONC service providers 37
Annex-3: Clinical coaching/mentoring guide for clinical mentors at BC, BEONC, and CEONC sites 39
Annex 4: Clinical Simulation for Surgery in OT when there is no case of surgery. 39
Annex 5: Skill Standardization orientation schedule for CEONC coach/mentor 41
Annex 6: Knowledge assessment questionnaires for CEONC service providers 42
Annex 7: BC/ BEONC coach/mentor refresher and review meeting schedule 45
Annex 8: PPT - Presentation on overall MMR and NMR of Nepal 46

LIST OF CONTRIBUTORS FOR DEVELOPING CLINICAL COACHING/MENTORING PROGRAMME FACILITATION GUIDE FOR MNH SERVICE PROVIDERS AT BC, BEONC, AND CEONC SITES, 2079 47

INTRODUCTION

The Ministry of Health and Population (MOHP), Family Welfare Division (FWD) has given priority to expansion of CEONC, BEONC and birthing centers in order to reduce maternal and newborn deaths. National Health Training Center (NHTC) provides Skilled Birth Attendant (SBA) and Advanced Skilled Birth Attendant (ASBA) trainings. It has been shown that training of health workers alone without follow up support and continuous capacity ehnacnement is not adequate to provide quality health services. Moreover, availability of enabling environment is paramount for service providers to be able to exercise their skills and provide quality services. Family Welfare Division (FWD) has adopted the coaching/mentoring approach for improving the quality of care provided at Birthing Centres (BC), Basic Emergency Obstetric Care (BEONC) centres and Comprehensive Emergency Obstetric Care (CEONC) centres.

FWD is the implementing division of the clinical coaching/mentoring programme and National Health Training Centre (NHTC) will train the clinical coaches/mentors at selected SBA training sites and CEONC sites. This guide covers clinical mentoring process and tools for SHP/SBA, ASBA, AA and OT nurses, and quality improvement process and tool for maternity care.

Improving quality is an on-going process and is everyone's responsibility. This includes all staffs working at the health facilities as they all play an important role in ensuring mothers, babies and their families receive the safest and best quality of care possible. Therefore, SBA clinical coaching/ mentoring will be implemented together with MNH service readiness process and Infection Prevention (IP) demonstration to all staffs at the health facility/hospital and management committee members.

The guide is intended for health managers and coordinators at central, provincial and local levels, clinical coaches/mentors of above-mentioned cadres and supporting partners. This guideline includes:

- Part One - General coaching/mentoring guideline
- Part Two - Programme Implementation process for coaching/mentoring to BC/ BEONC service providers
- Part Three - Programme Implementation process for coaching/mentoring to CEONC service Providers
- Part Four - Supportive areas for programme implementation process for coaching/mentoring to BC/BEONC/CEONC service Providers
- Annexes

OBJECTIVES

Overall objective:

The overall goal of the clinical coaching/mentoring is to improve quality of care through increasing knowledge and competency and changing behaviour, practice, and skills of health workers in provision of MNH services. This in turn will contribute to the reduction in Maternal Mortality Ratio, Perinatal mortality rate and Neonatal Mortality Rate. The overall objective for achieving this goal is to improve the quality of care and outcomes for mothers and newborns through clinical coaching/ mentoring and MNH readiness quality improvement programme at BC/ BEONC/CEONC centres.

The specific **objectives** of this programme are:

- To improve knowledge, skills, and practices of service providers
- To become a competent, confident, and motivated provider – and
- To improve enabling environment for service providers including service readiness and management of the health facilities/hospitals.

1

PART ONE

General coaching/mentoring guide

1.1 Introduction:

Effective coaching/mentoring improves the skills, competency, confidence, and motivation of mentees and helps them to develop a supportive professional network to enhance their professional development, growth, and future leadership potential. It should be seen as part of the continuum of education required to create competent health care providers. Coaching/mentoring strengthens the understanding, links, and relationships between the health facilities at all levels to facilitate and improve referrals because mentees know someone they can trust to call at the next level when a complication or emergency occurs.

> "Mentoring is a two-way street. The coach gets wiser while coaching/mentoring and the mentee gains knowledge through his/her coach."
>
> Marisol Gonzalez

Coaching/mentoring is a "joint venture" or partnership between two people- the mentor and the mentee. Both are equally responsible for the success of the relationship. Coaching/mentoring should be seen as part of a continuous process to improve the competency, skills, and attitudes of health care providers.

1.2 Coaching/mentoring Principles and Skills

Almost every person can learn and adopt new knowledge, attitudes, behaviors, and skills given sufficient time and the appropriate learning methods are used. Some adults acquire new skills and knowledge quickly; others require more time and a variety of teaching methods.

The learning process should be participatory, relevant, practical, and competency-based; use behavior modeling; incorporate humanistic learning techniques:[1] build on what the mentee already knows or has experienced; and provide opportunities for practicing skills. Learning skills usually takes place in three stages, highlighted in the chart below:

The 3 Stages of Learning Skills[2]

Acquisition	Competency	Proficiency
• Mentee sees others perform skill and acquires mental picture of required steps. • Mentee attempts to perform skill under supervision. • Mentee knows steps and sequence to perform skill but needs assistance	• Mentee practices until competency achieved, knows steps and sequence, and feels confident performing procedure. • Can perform the required Skill.	• Occurs with repeated practice over time. • Mentee knows steps and sequence and can perform skill effectively.

[1] Reduce stress for the mentee by initially working with models in a simulated setting rather than on patients; the patient's safety, needs, well-being, dignity and modesty always comes first and the patient is treated with the utmost respect.

[2] Adapted from ACCESS Project materials, Jhpiego 2003

Definition of Coach

"A coach is a more experienced individual, willing and ready to share his/her knowledge and skills with someone less experienced in a relationship of mutual trust", (Clutter buck 1992). A coach is a coach, sponsor, guide, advocate, and role model, who is there to point to the mentee the right direction, advise on his/her career and personal matters and help him/her to achieve his/her goals and overcome problems during service delivery.

Role of the Coach

The role of a coach is to teach, encourage, instruct, influence, guide and inspire health care workers to provide the highest quality care possible to mothers and newborns. Coaching/ mentoring can be demanding and requires proficiency, patience, and dedication.

The role of the coach in this guide is to "coach." Coaching/ mentoring motivates and encourages others by giving respectful and constructive feedback to improve the behavior and performance of health workers.

During the coach/mentor relationship, the coach/mentor will:

- Orient mentee(s) on the purpose and develop a list of objectives to be met over the course of the coaching/ mentoring. The objectives can be a mix of areas of interest of the mentees based upon gaps identified in the quick-assessment findings using the tools provided.
- Engage in a one-on-one continuous professional development session in areas relevant to the objectives of the session and the needs of the mentee.
- Provide mentee with tools to continue self-learning between sessions, such as reading materials, logbooks to record complicated/difficult cases that can be discussed in the following sessions.
- Discuss difficult cases that have arisen since the previous visit.
- Give feedback at the end of the session, regarding strengths, gaps to the mentees and specific suggestion for improvement; together with the mentees develop an action plan on how the mentees will strengthen the gaps identified for follow-up on the next coaching/mentoring visit.

The Qualities of an Effective Coach/Coach

- Respectful
- Patient
- Kind
- Empathetic
- Builds relationships based on trust
- Demonstrates genuine interest
- Models best practices and humane care
- Listens actively
- Observes systematically
- Committed to helping others improve
- Communicates clearly and simply

The Qualities of a Model Mentee

- Positive attitude
- Willingness to learn
- Courtesy and respect
- Patience
- Listens actively
- Asks good questions
- Open to constructive criticism
- Asks for guidance and assistance when needed
- Expresses appreciation for support and feedback
- Keeps accurate records of learning, cases, calls and support

Service Provider (Mentee)

Mentee is a service provider at a point of care (e.g., hospital, health post) who is willing and ready to be supported to learn, develop skills, improve performance, change behavior to maximize their potential.

- Through coaching/mentoring and peer-to-peer support sessions, they actively participate in strengthening the knowledge, attitudes, skills, and behaviors of themselves and their peers.
- As they grow more familiar with the performance standards and their use, they assume increasing responsibility for learning and performance improvement activities at their point of care.
- They track their progress in a logbook.

Expectations from Mentees

- **Understand himself/herself:** Mentee should take some time to think honestly about their strengths and weaknesses. They are expected to share their thinking around their goals, needs and wants with the coach. She/he should be clear on the areas he/she will need support in.
- Prepare before coming for coaching/mentoring.
- Coaching/mentoring time is limited so mentee should make full use of this time.
- Develop key listening skills, be flexible and open to constructive feedback.
- Be committed to the agreed upon activities, schedules, responsibilities, and roles.
- **Initiate professional communication:** Use “gentle” language, such as, “That is a good suggestion, but it doesn’t fit me.” Use “I” versus “You” statements, such as “I understood that we are receiving handouts “rather than “You didn’t give me a handout”.
- **Internalize his/her coach/mentor’s input:** Reviews what the coach/mentor is talking about in his/her mind. Forgetting is natural; so, records the outcome of each coaching/mentoring session to reinforce his/her learning. Discusses the learning with others.
- Set realistic timelines and stay flexible in changing expectations and plans.

2

PART TWO

Programme implementation process for coaching/ mentoring to BC/ BEONC service providers

This section describes summary of process and implementation of SBA clinical coaching/ mentoring and MNH readiness quality improvement processes at both CEONC and BC/ BEONC for enhancing skill and knowledge of MNH service providers. The detailed guide has been developed for health managers, coordinators as well as supporting partners at central, provincial, and local levels for implementing clinical coaching and mentoring program.

2.1 Selection of participants for clinical coach/mentor training from CEONC/BEONC sites

SBA clinical coaches/mentors will be selected from the CEONC/BEONC site using the following criteria:

- Minimum level staff nurse (minimum PCL).
- Staff from a CEONC facility and referral hospitals .
- Staff from BEONC facility attending at least 15 births per month if staff is not available from CEONC.
- Willingness to travel regularly to coaching/mentoring sites of other local level within district and physically fit.
- SBA (Skilled Birth Attendant) trained and currently providing clinical services proficiently.
- Providing regular clinical services for at least 2 years.

2.2 Training and skill development of BC/BEONC coach/mentor

Coach/Mentor:

The training of clinical coaches/mentors is blended learning competency-based training. For this training, the clinical coaching/mentoring learning resource package (or SBA manual with topics of clinical coach training) will be sent to the selected candidates 4 weeks before the training. At the beginning of the coach training, knowledge assessment of the candidates will be conducted by the SBA training site. The candidate who does not achieve required marks (minimum 85%) and not fulfill required criteria will not be allowed to participate in the training. The clinical coach/mentor development training is of 7 days duration and the schedule is attached in Annex 1.

2.3 Selection of BC/BEONC sites for clinical coaching/mentoring

For starting coaching/mentoring program at BC/BEONC to MNH service providers, at first coaching/mentoring and QI need to be started from the health facility/hospital where they are currently working. For selection of BC/BEONC sites for clinical coaching/mentoring and MNH readiness quality improvement process, health sections of local level will coordinate with clinical mentors and select the BC/BEONC sites as per performance of MNH service providers who need to be mentored. Selection of health facilities for mentoring should be aligned with annual budgeting and planning for the program. The following points should be considered during mentoring site selection:

- Clinical mentoring sites should be BC/BEONC
- Mentoring sites should be prioritized based on remoteness and whether service providers need to update their skill and knowledge.
- Birthing centers should be atleast half an hour travel from CEONC sites in terai and more than 2 hours travel in hills and mountains.
- Sites should be prioritized where most of the non-SBA staffs are providing delivery services.
- Clinical mentoring should be onsites. Clinical mentor should visit BC/BEONC sites, stay alteast 2 -3 days (as per need) for clinical mentoring.

2.4 Pre-coaching/mentoring orientation at Provincial or Local level

Once the clinical coaches/mentors training is completed, provincial/local level programme focal person will coordinate with clinical mentors and conduct half day orientation meeting before starting clinical mentoring at BC/BEONC sites. Programme focal persons and clinical mentors will explain briefly about the process of clinical mentoring during orientation.

The objectives of this meeting are:

- To make aware the team about importance of clinical mentoring, processes of coaching/ mentoring and MNH service readiness quality improvement to all stakeholders and elected bodies at local level.
- To make commitment local level for allowing SBA coaches/mentors for field visits to BC/BEONC for the coaching/mentoring purpose.
- To advocate local level support (financial) for the programme coverage especially for clinical mentoring beyond the conditional budget.
- Selection of BC/BEONC sites based on available allocated budget and local financial support.

Clinical mentoring programme focal person will organize and call the pre-coaching/mentoring orientation meeting.

Meeting participants at local level will be all staffs from health section, clinical mentors, a representative from supportive organization related to MNH programme, elected bodies, and chief administrative officer etc. Programme focal persons and clinical mentors will briefly explain the clinical mentoring process during orientation based on following points:

1. Hospital staff mentoring and coaching and QIP process (at hospoital)
2. Mentor mobilization based on program guideline
3. BC/BEONC/CEONC selection for clinical mentoring
4. Budget planning for mentoring
5. Establishment of skill lab at CEONC sites and its purpose
6. Program at mentoring site (BC/BEONC and CEONC sites):
    - Use self-assessment QI tool for enabling environment preparation.
    - After assessment and scoring, health workers and management team need to plan activities to fill gaps and improve quality services.
    - After assessment, QI tool will be at BC/BEONC/CEONC sites.
    - QI score card will be prepared and displayed at the health facility or at maternity department of the hospital.
    - Use SBA clinical coaching/mentoring tool for BC/BEONC and CEONC
    - Assess the knowledge and skill of each mentee and coach them as per identified gaps.
7. During the orientation, the participants will also be informed about the importance and need of Equipment and EOC management set up and readiness for coaching/mentoring which are as follows:
    - Severe pre/eclampsia management box
    - PPH management box
    - Condom temponade box
    - Placement of delivery bed-privacy
    - New-born corner set up
    - New-born resuscitation set
    - Standard delivery set
    - Episiotomy set
    - Cervical tear repair set
    - MVA set
    - Vacuum delivery set
8. Prepare equipment for IP demonstration:
    - Decontamination (0.5% chlorine solution
    - Steam sterilization (autoclaving)

9. Stationaries-material for coaching/mentoring
    - SBA clinical coaching guideline and tool for BC/BEONC coach/mentors
    - PNC checklist job aid
    - EOC complication management flow charts (9 sets)
    - HQIP self -assessment tool and score card flex at CEONC site
    - QIP self-assessment tool and score card flex at BC/BEONC
    - One set of clinical coaching/mentoring guideline for coach/mentor
    - clinical mentoring tool for each mentee at BC/BEONC/CEONC site
    - Partograph and other material

2.5 Pre-coaching planning and coordination between BC/BEONC coach/mentor and Local level focal person

After the completion of clinical coaching/mentoring training, clinical mentors will be mobilized at BC/BEONC for onsite clinical mentoring for MNH service providers incoordination with MNH focal person of health office and local level. BC/BEONC coaches/mentors and focal person of local level and Health Office will schedule coaching/mentoring visits in coordination with health facility in-charge and nursing staff at the birthing centers. They will be reminded and planned detailed planning for the visit one week before the scheduled date of coaching/mentoring visit.

2.6 Clinical coaching/mentoring process

The onsite clinical coaching/mentoring will focus and evolve around key competency areas to improve key health facility performance targeting major complications affecting maternal and perinatal mortality. This is one of the multipronged approaches to improving the quality of health care services in the NHSS.

2.6.1 Coaching/mentoring to BC/BEONC service providers

BC/BEONC coach/mentor needs to start coaching/mentoring to MNH service providers at the health facility/hospital where they are currently working at first and then go to BC and BEONC. The clinical coaching/mentoring to MNH service providers of BC/BEONC sites focuses on the following areas:

- Management of normal delivery
- Vacuum delivery
- Condom tamponade
- Use of partograph for tool of labour and identification of complication and timely referred as clinical decision making.
- Mannual Vacuum Aspiration (MVA)
- Management of severe Pre-eclampsia and Eclampsia
- Management of shock due to PPH including condom tamponade
- Newborn resuscitation
- Identification of danger signs and timely referral – mother and baby
- KMC (Kangaroo Mother Care)

Clinical coach/mentor will use process guide when mentoring at BC/BEONC and CEONC sites. The guide named **“Clinical coaching/mentoring guide for clinical mentors at BC, BEONC and CEONC sites 2079”.**

2.6.2 IP demonstration (Equipment Processing)

All HF staff and hospitals' nurses/cleaners will be involved in IP demonstration session. During this session, SBA clinical coach/mentor will provide updates on IP and demonstrate the followings:
Decontamination process including preparation of 0.5% chlorine solution

- Cleaning and drying the used equipment
- Proper wrapping (Packaging) the equipment
- Serilization of equipment
- Proper drying and storing sterilized equipment

Detailed process of IP demonstration has been included in Part 2 of clinical coaching/mentoring guide for clinical mentors.

2.6.3 MNH readiness quality improvement process

Along side clinical coaching/mentoring, BC/BEONC coaches/mentors and provincial health directorate/ local level will facilitate for improving quality of service by self-assessment and action plan using MNH service readiness QI tool at the health facilities/hospital. This process relates to systems-level changes at the service delivery sites with the involvement of all stakeholders for the improvement of clinical sites including infrastructure, equipment, supplies and management that can support the delivery of basic and comprehensive MNH services in line with gaps identified.

Clinical coaches/mentors, focal person from provincial health directorate/ local level will introduce MNH readiness quality improvement process to all staffs of the health facilities (BC/BEONC and CEONC sites).

2.6.3.1 MNH readiness hospital quality improvement process (HQIP) at CEONC

MNH readiness quality improvement program will be started at first by conducting brief orientation at CEONC sites (maternity department of hospitals) through the following processes:

- Hospital orientation and formation of health facility management strengthening committee for quality improvement as per MSS implementation guideline.
- Introduction of MNH readiness Hospital Quality Improvement Process (HQIP) tools, self-assessment and scoring through score card method and action planning process.

After the orientation, the BC/BEONC coach/mentor will initiate to do 6 monthly MNH readiness self assessment process in coordination with nursing incharge/clinical mentor in maternity department (or secretary HQI committee). Nursing incharge in maternity department and mentors (or secretory of HQI committee) can initiate MHN readiness HQI 6 monthly self-assessment process aligning with onsite clinical coaching/mentoring process. Aama institutional cost will be used for action plan implementation to improve quality delivery services. Detail process and MNH readiness QI tool for hospital is included in Clinical coaching/mentoring guide for ***clinical mentors at BC, BEONC and CEONC Sites*** in Annex 3.

2.6.3.2 MNH readiness quality improvement (QIP) at BC/BEONC

The clinical coaches/mentors, local level focal person and PHN will facilitate the following one-day programme on MNH service readiness quality improvement process. All HF/hospital's staff, HFOMC/HDC and elected bodies should be involved in this one-day programme.

The process will include:

- A presentation on overall MMR/PNMR/NMR of Nepal.
- MNH service utilization status of the HF/hospital, and whether the poor and marginalized are left behind.
- The HFI/mentees should prepare and present their status to the local stakeholders.
- Introduction of the MNH readiness quality improvement tool and facilitate/conduct the self-assessment.
- Sharing of the assessment findings (using traffic light scores) and identification of gaps by participants.
- Develop Action plan based on gaps identified.
- Display action plans and score card at the information board or information area/nursing station.

It is expected that, the local participants HF staff with the involvement of health facility operation and management committee/elected representatives will do self-assessment and development of action plan, and review and re-planning. Identified gaps can be managed by aama programme institutional cost. Institutional cost of Aama program has already mentioned in ***"Aamaa Tatha Nawajaat Sishu Surakshya Kaaryakram Nirdeshika 2078'*** to improve quality delivery services at BC/BEONC and CEONC sites. Therefore, institutional cost of Aama program can be used for 6 monthly self-assessment meeting. Detail process and MNH readiness QI tool for BC/BEONC is included in 'Clinical coaching/mentoring guide for clinical mentors at BC/BEONC and CEONC sites'.

3

PART THREE

Programme Implementation process for coaching/ mentoring to CEONC service providers

This section describes summary of implementation of clinical coaching/mentoring and MNH readiness quality improvement processes at CEONC sites for CEONC service providers. The detailed guideline has been developed for health managers and coordinators at central, provincial, and local levels, CEONC coaches/mentors and supporting partners.

3.1 Selection of CEONC coaches/mentors at referral hospitals

CEONC Clinical Coach/ Mentor include a team of Gynecologist, Anesthesiologist, Anesthesia Assistants, Paediatrician/ Neonatologist and OT Management Nurse. CEONC clinical coaches/ mentors will be selected from the CEONC hospitals under Federal, Provincial and Loal level gov. and Academia using the following criteria:

- For ASBA mentoring, Gynecologist /MDGP working in Maternity services or as ASBA trainer.
- For Anesthesia provider mentoring, Anesthesiologist working in hospitals providing anesthesia
- For OT nurses mentoring, nurses working in Operation Theatre of hospitals
- For Newborn care Mentoring, Paediatrician/ Neonatologist working in Newborn Hospital or Newborn Sections of Hospitals
- Willingness to travel regularly to coaching/mentoring sites in their district and physically fit
- Providing regular clinical services for at least 2 years

The Provincial health directorate will coordinate with CEONC coach/mentor team at the centre incoordination with FWD and Medical Superintendent (MESU) and Maternity Head of Department (HoD) for starting coaching/mentoring to CEONC team.

3.2 Training and skill development of CEONC coaches/mentors

CEONC mentors:

Gynecologists, Anesthesiologists and OT Nurse will be provided orientation of use of standard tools and skill standardisation for mentoring inorder to maintain uniformity of standards of service. They will be provided orientation/training on how to coach by respective Division or provincial health directorate. All CEONC providers including Gynecologists, Paediatrician/ Neonatologist, MDGP, DGO, ASBA, Anesthesia providers and OT nurses of CEONC hospitals will be assessed and mentored where necessary.

The selected and interested Gynecologist/MDGP and Anesthesiologist and OT management expert will be oriented on different topics and tools for mentoring, and will standardize skills based on NHTC ASBA quality Impovement Tools.They will be provided ASBA quality improvement tools and clinical coaching/mentoring guideline for CEONC coach/mentor which contain selected Knowledge assessment questionnaires and skill checklists and guides.They will have participatory discussion on how to use the tools and practice the tools on models and clinical simulation. Teaching aids (skill lab material for CEONC coaching/mentoring) like sponge foam uterus, Mama- U and equipment will be used for assessing and demonstration for clinical procedures. Instruction on clinical procedures is in **Annex 4:** *Clinical Simulation for Surgery in OT when there is no case of surgery.* Skill standardization orientation schedule for CEONC coach/mentor is in the **Annex 5.**

3.3 Selection of CEONC sites for clinical coaching/mentoring

CEONC site for clinical coaching/mentoring and quality improvement programme will be selected by Provincial/Central government based on performance of the CEONC sites and capacity of individual service provider or request from the Hospitals or linkage with MPDSR implemented hospitals and team of CEONC service providers.

3.4 Pre-coaching/mentoring orientation at Provincial or at hospital level

Once the CEONC clinical coaches/mentors visited at hospital he/she will do brief orientation to the hospital management team to achieve following:

The objectives of this meeting are:

- To make aware about the processes of coaching/mentoring and MNH service readiness quality improvement to all stakeholders, elected bodies medical superintendent from CEONC (where coach/mentor are working) with coordination with clinical coach/mentor and PHN at Provincial health directorate and local level.
- To make commitment from the hospital medical superintendent, Provincial health directorate / Provincial health office and local level for allowing clinical coaches/mentors for field visits to BC/ BEONC for the coaching/mentoring purpose.
- To advocate for Povincial and local level support for the programme especially for expansion beyond conditional budget, and
- Selection of CEONC sites based on available allocated budget and local financial support.

Clinical mentoring programme focal person will organize and call the pre-coaching/mentoring orientation meeting. Meeting participants at province level (at health directorate) will be health director, MNH program focal persons, representative from supporting organization related to MNH programme, health division chief and section chief from MoSD at province. Meeting participants at hospital level will be medical superintendent, Matron, HOD and nursing incharge from maternity department, clinical mentors, health section chief from local level, PHN from HO.

3.5 Onsite support and coaching/mentoring to CEONC service providers at CEONC sites

Prior to the meeting with focal person of provincial health directorate, the programme focal person will have to meet the hospital incharges and the CEONC providers to discuss about the purpose of visit and programme, understand their routine clinical work, their available time for discussion. CEONC coach/ mentors in conjunction with CEONC unit incharges will assess CEONC service units (Maternity ward, labor room, Operation Theater, post operative ward) using Quality Improvement (QI) tools of ASBA. Coach/mentor refer section one to four for service availability and annex number 1-10 for equipment and supplies availability assessment. Team will discuss with maternity department incharge and clinical mentors to know the status of score card on MNH readiness QI at hospital. MNH readiness QI tool is available in ***clinical coaching/mentoring guide for clinical mentors at BC/BEONC and CEONC sites (Annex 3).*** The aim of the assessment is to find out gaps in readiness of CEONC services. They will discuss on the gaps of readiness with the incharges and head of institution and make action plan for the management of the gaps. CEONC coach/mentors will play a role of facilitator to initiate and re-inforce the process of regular self-assessment and management of gaps by the unit incharges using the tools. This initiation could be a good way for institutionalization of quality improvement process.

CEONC mentors provide knowledge assessment questionnaires (knowledge assessment questionnaire is in Annex 6 to individual doctors to work on them and to return with the answers. Here, mentors need to be very careful not to breach the self-esteem of doctors as they may not be willing to be assessed. The mentors need to assure them that this is just a self-assessment or self revision but not any kind of examination. The mentor will give positive feedback in the gaps individually and separately.

CEONC coach/mentors will observe the clinical procedures of CEONC providers in wards, labor room and in operation theatre and identify any gaps using ***Maternal and Newborn Care QI tools for ASBA.***The QI tools includes Infection Prevention, Blood transfusion, Operative Procedures like caesarean section, laparotomy for Ectopic Pregnancy, Subtotal Hysterectomy, Condom Tamponade), obstetric anesthesia, Operation Theater Techniques and Management). Mentor also observe OT table setting up and assisting the surgeon during operation). Using the checklist, they will identify the gaps in clinical procedures and give positive feedback individually separately and update if necessary. Assessment and mentoring to senior doctors may be a little tricky as they may be very busy and difficult to get their time so the mentor should be very humble, respecful and flexible to get time from them. The mentor must make sure that this is the revision of knowledge and skill as per National standard for CEONC service.

When there is no clinical case, the mentor will work with the mentee observe the procedures in model and provide feedback in the gaps. If necessary, the mentor will demonstrate in the model or in clinical simulation role play in OT *(Annex 4)*. Use of foam uterus for suture of tear and B-Lynch suture and use of Mama U for condom tamponade.

4

PART FOUR

Supportive areas for programme Implementation process for coaching/mentoring to BC/BEONC/ CEONC service providers

4.1 Establishment of Skill Lab for clinical coaching/mentoring for BC/BEONC/CEONC service Providers

Skill lab material are necessary to demonstrate the procedures based on developed tool and guideline for coaching and mentoring to BC/BEONC/CEONC service providers as per identified gaps during assessment. Skill lab needed to be established in CEONC sites hospital and Local level so that clinical coach/mentor for BC/BEONC and CEONC sites can practice on it for their skill retention as well as material need to use during BC/BEONC coaching/mentoring process. Provincial and Local government will be responsible to establish skill lab at local level and CEONC hospitals in coordination with respective Division. Clinical coach/mentor will take the role to establish skill lab in their hospitals in coordination with maternity department head and nursing incharge.

In referral hospitals, where the CEONC coach/mentors are working, a skill lab[3] will be established with the support of Federal/Province/supporting partners. Additional material needs to be added for CEONC coaching/mentoring if skill lab has already established for BC/BEONC coaching/mentoring or skill lab material available in SBA training site/hospital.

The list of skill lab materials for BC/BEONC coaching/mentoring is aviailable in ***Annex 2*** and the necessary items of skill lab material for CEONC coaching/mentoring will be added and used gradually.

4.2 Follow up coaching/mentoring visit to BC/BEONC/CEONC sites

The BC/BEONC clinical coaches/mentors and CEONC coach/mentors will follow up in the visited sites via phone at least once a month. The staff at BC/BEONC and CEONC will contact the clinical coach/mentor of BC/BEONC and CEONC on a regular basis and when they encounter difficult case or need referral for off-site consultation and support. Onsite follow-up coaching/mentoring visit need to be conducted every 6 months. The budget needs to be allocated by center/province or local level.

4.3 Reporting and monitoring of clinical coaching/mentoring programme

To track the regularity and effectiveness of the clinical coaching/mentoring for BC/BEONC and CEONC service providers and MNH readiness quality improvement programme implementation, federal, provincial and local level health section will monitor and show the data (performance) in the QI dashboard[4]. Clinical coach/mentor for BC/BEONC and CEONC is responsible to submit program report to the division/unit at local, province and federal level. The reporting format for BC/BEONC coaching/mentoring and MNH readiness QIP is included in this guideline.

After completing the clinical mentoring, clinical mentors will report coaching/mentoring and QI score via **ODK mobile app to respective division**. Clinical mentors are trained on ODK mobile reporting app if not respective division will provide orientation to new clinical mentors for reporting. The reporting format for CEONC coaching/mentoring will be based on Q**I Tool for ASBA (NHTC 2009)**.

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[3] Skill lab has exist in SBA training sites already, however necessary materials needed for field visits will be provided by local level(palika).

[4] QI dashboard will be developed and informed later by FWD/Province.

4.4 Rotation practice to BC/BEONC and CEONC service providers

Service providers' skill need to be retained and updated regularly to provide quality services. Therefore, coach/mentor need to visit the service sites and coach the service providers as per their knowledge and skill gaps through demonstration and simulation practices. However, if the service providers do not have opportunity to take care of sufficient number of normal delivery and emergency obstetric cases then they lose their skills easily. Therefore, service providers need to be sent to the functional CEONC sites where at least 2 weeks for rotation practice in addition of having onsite coaching mentoring program mentioned above in Part One to Three. Federal, Province and Local government can plan rotation practice activities.

4.4.1 Rotation Practice of service providers working at BC/BEONC sites

Two weeks rotation practice program should be conducted every two years at CEONC/Training sites for all nursing staffs to refresh their knowledge and skills working at BC/BEONC. Priority should be given to staff had no SBA training and completed their training more than two years ago, currently working in remote locations, and currently providing delivery care services.

During this rotation practice, SBA trainers or clinical coaches/mentors for BC/BEONC will provide knowledge and skill assessment and provide update and coaching/mentoring sessions as in onsite coaching/mentoring session and supervise their practices. Their Rotation will be made by the SBA trainers, coaches/mentors, and maternity ward in-charge/department head.

Their travel and daily allowance will be provided by their own local government for BC/BEONC service providers. Local government will allocate some budget and provide to the placement hospital where their staffs sent for rotation practice.

4.4.2 Rotation practice of CEONC service providers (ASBA, AA, OT nurse) working at CEONC sites and clinical mentors from remote district

Two weeks rotation practice should be conducted every two years at selected CEONC/ASBA Training sites where CEONC coach/mentor are working. The doctors who are providing CEONC services, Anaesthesia providers and OT nurse and clinical mentors will be placed at tertiary level hospital/ASBA training sites to refresh their knowledge and skills. Priority should be given to the staffs who are working at CEONC sites where case load is less, currently working in remote locations, and currently providing CEONC services.

During this placement CEONC coach/mentor or ASBA trainers will provide knowledge and skill assessment and provide update and coaching/mentoring sessions as in onsite visit coaching/mentoring session and supervise their practices. Their Rotation will be made by the maternity ward in-charge/department head. Their travel and daily allowance will be provided by their own Provincial government for CEONC service providers (doctor, AA, OT nurse). Their services at placement site will be considered as their payment for placement coaching/mentoring by CEONC clinical coaches/mentors or ASBA trainirs. (Fees to CEONC/ASBA training sites will be paid by their concerned Provincial government.

4.5 BC/BEONC and CEONC coach/mentor refresher and review meeting schedule

BC/BEONC and CEONC coach/mentors' refresher and review meeting will be organized by federal and provincial health directorate every year. BC/BEONC coach/mentor refresher and review meeting schedule is in ***Annex 7*** and CEONC coach/mentor refresher and review meeting schedules will be developed and used when it is necessary based on QI tool for ASBA.

4.6. Monitoring of Key MNH competencies focused on SBA clinical coaching/mentoring

i. Input level indicators (To be monitored by program managers)

1) Proportion of health workers who have been mentored
2) Proportion of health facilities where mentoring sessions have been completed
3) Proportion of health facility who received the follow up mentoring
4) Proportion of health facilities where the quarterly QIP self-assessment conducted
5) Proportion of health facilities developing an action plan
6) Proportion of health facilities who have followed up with the agreed action plan
7) Proportion of health facilities who have performed relevant/appropriate signal functions in the past 4 months.

ii. Process/ Output (Mentor)

1. Mentees knowledge and skills scores
2. QIP scores – quality domains (8/13) and signal functions
   1) Proportion of health facilities who submit their complete HMIS data in a timely manner.
   2) Proportion of health facilities received mentoring/coaching have appropriate infection prevention (IP) measures in place

iii. Outcome level indicators: (Mentor and mentee)

1. Service utilization rate:
   a. ANC 4 and 8 visits
   b. Institutional delivery
   c. PNC 3 and 4 visit as per protocol
2. Improved quality of care:
   1) Proportion of birth asphyxia (Apgar <=6) (Maternal Register)
   2) Proportion of still births (HMIS)
   3) Proportion of pregnant women with their blood pressure checked during ANC (Survey during immunization/ DHS/ similar survey)
   4) Proportion of women who had their urine checked during ANC (Survey during immunization/ DHS/ similar survey)
   5) Proportion of babies who were applied chlorhexidine (HMIS)
   6) Proportion of MWRA who had received counseling on family planning during the post-partum period (Survey during immunization/ DHS/ similar survey)
   7) Proportion of referred cases where pre-referral treatment was initiated
   8) Proportion of referred cases where referral slip was used
   9) Proportion of babies in whom breast feeding was initiated within the first hour of birth.
   10) The proportion of obstetric complications referred from lower health facilities to CEONC {tertiary facilities}

ANNEXES

Annex-1:
Clinical Coach/Mentor development training course-outline

Participants: All selected SBAs staff (at least SN) from CEONC sites
Objective: To train SBA service provider for coaching in basic EmONC skill
Duration: 7 days

Time	Session	Methodology	Learning Materials
	1st day		
10:00-11:30am	• Arrival/ Registration • Welcome • Goal/ Objectives • Welcome Remarks • Introduction –Mentor's experience sharing • Expectation of participant • Agenda • Ground Rules/Norms • Daily Activities	• Welcome / Welcome Remarks by Local Authority / representative. • Other Activities by trainers/ Facilitator.	• Slides/power point Laptop • Newsprints / Meta cards/ Marker
11:30 - 12:00pm	Knowledge Assessment	SBA mid-course Questionnaires	
12:00-12:15pm	Tea Break		
12:15- 1:00pm	sharing of Recent update (RMC)		slides/power point Laptop
1:00-2:00pm	• Introduction to coaching / Mentoring • Roles and responsibilities of Mentor/coach	Lecture /Discussion	• Power point/ Laptop • Newsprint/meta card/marker • Printed case scenario for Role Play. • Pre prepared Instruction for role play and other necessary set up.
2:00-2:30pm	Lunch		
2:30-3 :00 PM	Knowledge result sharing		Prepare matrix
3:00: -5:00	• Clinical Mentor and Mentoring process • Different between effective and ineffective coach/ mentor	• Role play by trainers • Feedback by participants	

Time	Session	Methodology	Learning Materials
2nd day			
10:00-10:15am	Recap and Agenda		
10:15- 11:15am	Gap Analysis on • Labor monitoring using partograph (Importance of partograph as decision making tool). • Vaginal Bleeding after childbirth (PPH) • Bimanual Compression • Aortic Compression • Newborn resuscitation • severe pre -eclampsia / Eclampsia management • Manual Vacuum aspiration (MVA) • Vacuum Delivery • Normal Delivery • KMC • Condom Tamponade	• Gap assessment on skill of individual participants using check lists. • Individual gaps identify on eclampsia and PPH management. • Constructive feedback based on gaps individual • Simulation by participants (shock and Eclampsia management)	• Case study no.1, 2 (Normal and abnormal case study for each individual participant. • Birthing model, Joe model, Neonatally, KMC set. • Scenario will provide by trainers.
11:15-11:30am	Tea break		
11:30am - 2:00pm	continue gap analysis on • Labor monitoring using partograph (Importance of partograph as decision making tool). • Vaginal Bleeding after childbirth (PPH) • Bimanual Compression • Aortic Compression • Newborn resuscitation • severe pre -eclampsia / Eclampsia management • Manual Vacuum aspiration (MVA) • Normal delivery • Vacuum Delivery • Condom Tamponade • KMC	• Gap assessment on skill of individual participants using check lists. • Feedback based on gaps individual • Simulation by participants	• Case study no.1, 2 (partograph normal and abnormal) • Birthing model, Joe model, Neonatally • Scenario will provide by trainers.
2:00-2:30pm	Lunch break		
2:30-5:00pm	• continue gap analysis • Feedback individual and group on identified gaps (Discussion session)	Case Study Group work, Divide in 3 groups	• Different skill station • Birthing model, Joe model, Neonatally

Time	Session	Methodology	Learning Materials
3rd day			
10:00-10::15 am	Recap/Agenda		
10:15- 12:00	• Demonstration skills by trainers • Condom Tamponade • Kangaroo mother Care (KMC) • MVA • Shock Management • Severe Eclampsia and Eclampsia management	• Demonstration by trainers • Emergency drill • Simulation by trainers	different skill Station (one trainer should be at each station. • Joe model with MVA set • Mama U • Condom temponade set • PPH management box • KMC set Scenario used from mentoring tools
12:00-12:15 Pm	tea break		
12:15- 2 :00Pm	Continue skill Demonstration • NBR • Nomal delivery • Vacuum delivery	skill demonstration by trainer	different skill Station • NBR baby with resuscitation set • Birthing model with delivery set • Vacuum set
2:00-2:30pm	Lunch break		
2:30- 5:00pm	• continue skill demonstration by trainers • summary of the day	skill practice by participants by using checklist under supervision of trainers.	

Time	Session	Methodology	Learning Materials
	4th day		
10:00-10:15am	Recap /Agenda		
10:15-12:00 pm	skill practice by participants • Labor monitoring using partograph (Importance of partograph as decision making tool). • Vaginal Bleeding after childbirth (PPH) • Bimanual Compression • Aortic Compression • Newborn resuscitation • severe pre -eclampsia / Eclampsia management • Manual Vacuum aspiration (MVA) • Vacuum Delivery • Normal Delivery	• Make pair of participants. • One trainer stays in each station during practice time	Checklist used during practice time.
12:00-12:15pm	Tea break		
12:15-2:00pm	continue skill practice by participants	skill practice by participants under supervision of trainer	
2:00-2:30pm	Lunch Break		
2:30-5:00pm	Continue Skill practice by participant • Normal Delivery • Vacuum Delivery • MVA • Condom Temponade • Shock Management • Eclampsia Management • NBR • KMC summary of the day	Continue Pair practice until confident developed.	prepared different skill station for practice

Time	Session	Methodology	Learning Materials
5th Day			
10:00-10:15am	Recap and Agenda		
10:15-12:15 Pm	Infection Prevention practice • Equipment Processing • Decontamination • Sterilization process (Autoclave) • Storage and packaging	• Discussion with participants • Real demonstration by trainers	prepared equipment for decontamination (chlorine,3 color bucket, protective attires, small Autoclave, drum.
12:15-12:30 PM	Tea Break		
12:30- 2:00Pm	Skill evaluation by trainer • Normal Delivery • Vacuum Delivery • MVA • Condom Tamponade • Shock Management • Severe Eclampsia Management • NBR • KMC • Partograph	• Evaluation by trainers using checklist until 100 percent achieved. • Simulation by participants on shock with PPH management and Eclampsia management)	• prepared different skill station for evaluation • Scenario (Mentoring/ coaching tool)
2:00-2:30 PM	Lunch Break		
2:30- 5:00PM (Including 30 min for preparation time)	• continue skills evaluation by trainers • Topic distribution to preparation for coaching/mentoring skill demonstration • summary of the day	checklist evaluation by trainers	

Time	Session	Methodology	Learning Materials
6th Day			
10:00-10:15 AM	Recap and Agenda		
10:15-12:15PM	Micro teaching on MNH skills presentation and demonstration by each individual participant. • Partograph (normal) • Partograph(abnormal) • MVA • Severe pre- eclampsia • Eclampsia • Shock Management • Kangaroo Mother Care • Condom Tamponade • Vacuum Delivery • Newborn resuscitation (NBR) Pair mentoring /coaching skills on given topic (30 min presentation and 10 min feedback for each individual)	• Simulation and demonstration of coaching/ mentoring skills in pair by participants followed by assessment and feedback • Simulation on Severe Pre-eclampsia and eclampsia) • Simulation on Shock management due to PPH • Practice to give constructive feedback (trainers and participants)	Power point/Laptop Newsprint/Metacard/ marker Printed case scenario for Role Play. Pre prepared Instruction for coaching role play and other necessary set up
12:15-12:30PM	Tea Break		
12:30-2:00PM	Continue demonstration of mentoring/coaching process by participants		Power point/Laptop Newsprint/metacard/ marker Pre prepared Instruction for role play and other Necessary set up/setup for Demonstration
2:00-2:30PM	Lunch Break		
2:30- 5:00PM	Continue presentation Feedback and Discussion summary of the day	Discussion on gaps	

Time	Session	Methodology	Learning Materials
7th Day			
10:00-10:15AM	Recap and Agenda		
10:15 – 10:30 AM	Tea Break		
10:15-1:00PM	Orientation of SBA clinical coaching/mentoring Tools and MNH Readiness Quality Improvement process.	Lecture and Discussion Demonstration (Hospital Visit) Prepare action plan	Use HQIP/QIP tool (CEONC/BEONC) Score flex color based on the gaps (Red, Green, and yellow marker)
1:00- 1:30PM	Lunch break		
1:30-4:00PM	Recording and Reporting and ODK apps orientation	Lecture and Discussion Practice on clinical mentoring and QIP reporting.	Individual mobile
4:00-5:00PM	Closing Ceremony		

Annex-2:
Skill Lab materials list for onsite coaching/ mentoring to BC/BEONC service providers

S.N.	Equipment & Material set	Name and description of Items needed	No. of set need
1	Birthing model with Baby and placenta	Product description: *Birthing Model* with Baby-1 set. Placenta– 1 set	1 set
2	New-born resuscitation baby and sets,	Product description: NeoNatalie Complete Kit with Ambu bag for Newborn resuscitation 1 Masks 0 and 1 Mask - number 2 Penguin suction or Dele suction)- 1 set	1 set
3	MAMA U	Product description: Mama U- condom temponade	1 set
4	Vacuum extractor set	Product Description: Handheld Vacuum Extractor complete set with Silicon cup – 2 size	1 set
5	Standard Delivery set	Product –Pakistani and its number and standard size: long Artery Forceps (Haemostatic, Rankin – Crile or Rochester – Pean) 24 cm -2 pc Cord Cutting Scissor (Umbilicus – Blunt – 1 pc) Sponge Holding Forceps (Forester; Straight; Serrated) 20cm -2 pcs. Small Gally Pot – 1 pc Big Bowl more than 750 ml. – 1 pc	1 set
6	MVA set	Product –Pakistani and its number: Double Valve Speculum (small, medium, large size)- 3 speculum in 1 set Velselum- 1 pc Sponge holder – 1 pc Small Gally pot – 1pc Kidney Tray (500 ml) – 1pc MVA syringe for post abortion care (Mva USA) with cannula in different size- 1 complete set	1 set
7	Plastic box	Large box for preparing eclampsia and shock management box (2 sets)	2 pcs

S.N.	Equipment & Material set	Name and description of Items needed	No. of set need
8	Emergency medicine and supplies	**Severe pre-eclampsia management Box** (critical items): 1. Inj. Magnesium sulfate 50% -16 gm. 2. Inj. Calcium Gluconate- 2 gm. 3. IV cannula 16 G and or 18 G - 2 4. IV set – 2 5. Inj. RL at least – 1 bottle 6. Foley's catheter – 1 pc 7. Urobag – 1 pc 8. Syringe 10 ml – 2 pcs 9. Syringe 20 ml – 1 pc 10. Inj. 2% Xylocaine – 1 vial 11. Cap Nifedipine 5 mg at least 5 caps 12. Gudal Air way for (Adult) – 1 pc **Shock (due to PPH) management box** (critical items): 1. Inj. RL - 3 litters 2. IV cannula 16 G or 18 G – 2 pcs 3. IV sets- 2 pcs 4. Inj. Oxytocin at least 20 unit. 5. Foley's catheter – 1 pc 6. Urobag – 1 pc 7. Gudal air way – 1 (Adult) 8. Inj. Ergometrine 0.2mg – 2 ampules if available 9. Syringe 2 or 5 ml – 3 pcs	1 set
9.	KMC set	Wrapper for baby- 2 pc Long wrapper for mother - At least 3 meters Gown for mother- 1pc socks for baby- 1 pair cap for baby- 1 set gloves for baby-1 pair Napkin for baby- 1 pc	1 set

Annex-3:
Clinical coaching/mentoring guide for clinical mentors at BC, BEONC, and CEONC sites

(Note: this guide is for clinical mentors for mentoring to nurses at BC/BEONC and CEONC sites. This is separate set, it has three parts: i, SBA coaching/mentoring guide for mentors (in Nepali and English mixed), ii, coaching/mentoring tool and iii, MNH readiness QI tool for CEONC and BC/BEONC. Clinical mentors need to print these materials before starting the clinical mentoring process for preparing themselves and for mentees.

Annex 4:
Clinical Simulation for Surgery in OT when there is no case of surgery.

- When there is no patient for surgery (CS), Doctor, nurse and other staffs play a role as patient, surgeon, and nurse assistant.
- Simulation made by sponge form for the abdominal wall and uterus (see the picture below) and rectus sheath by the Mackintosh rubber sheath. And peritoneum by disposable cap. Uterus is made of sponge form and a baby doll is kept inside the uterus.

Surgeons pretend to perform the operation on the woman. Mentor will observe the performance according to QI tools as follows:

- Examine the woman, assess her condition and examine the medical record for information and completeness.
- Catheterize the woman's bladder.
- Ensure that the anesthesia has taken full effect.
- Apply antiseptic solution to the abdomen, allow to dry and place a drape over the woman.
- Make a 2–3 cm midline vertical incision below the umbilicus to the pubic hair (or transverse incision if using Pfannenstiel's incision) through skin and fascia.
- Lengthen the incision and separate the rectus sheath.
- Place a bladder retractor (Doyen's retractor) over the pubic bone.
- Extend the incision by 3 cm on each side.
- Push the bladder downward off the lower uterine segment and replace the bladder retractor over the pubic bone to retract the bladder downward.
- Make a 3 cm transverse incision in the lower segment of the uterus.
- Widen the incision. Extend the incision, if necessary.
- Grasp and flex the head, and gently lift the fetal head through the incision.
- Gently press on the abdomen over the top of the uterus to help deliver the head. If necessary, ask an assistant to push the head up through the vagina from below.
- Clamp the cord at two points and cut it.
- Conduct an instrument and swab count.
- Repair the uterus and ensure hemostatsis.
- Ensure that there is no further bleeding.
- If there are no signs of infection, close the fat layer, if necessary, with an interrupted suture, using a round needle and plain catgut, and close the skin with interrupted mattress sutures about 2 cm apart, using a cutting needle and 3-0 nylon or silk.
- Ensure there is no bleeding, clean the wound with gauze moistened in antiseptic solution and apply a sterile dressing.
- Evacuate clots from vagina using forceps and swab and put on sterile pad.

B-Lynch suture

During the c-section if the uterus is flabby and it's bleeding continuously then the B-Lynch suture is performed with another smaller Uterus and do B-lynch suture there according to the checklist. Which is usually applied for the bleeding (PPH) during the c-section.

- Try bimanual compression to assess the potential chance of success of the B-Lynch suturing technique.
- If the bleeding is controlled by Bimanual compression, then the procedure will work as follows:
- Puncture uterine cavity 3cm from the lower uterine incision and 3cm away from the right lateral border with chromic catgut round body no 1.
- Emerge the needle 3cm above the upper incision margin and 4cm from the right lateral border.
- Pass the suture vertically over the fundus and enter the posterior wall into the uterine cavity at the same level as the upper anterior entry post.
- Emerge the needle back posteriorly through the same surface lying horizontally in the uterine cavity.
- Pass the chromic catgut through posteriorly and vertically over the fundus to lie anteriorly and vertically compressing the fundus on the left side as on the right side.
- Enter the needle into the uterine cavity on the left side and take out approximately 3cm anteriorly and below the lower incision margin on the left.
- Pull the two lengths of the suture by bi-manual compression to minimize trauma.
- Check the uterus that tension distribution is evenly spread before replacement into the abdominal cavity and abdomen closed.

Laparotomy for the Ectopic Pregnancy

Ectopic pregnancy also done with the simulation with Role play as mentioned in c-section.

Uterus made by form and the fallopian tube by the catheter and the end of the opening is made like fimbriae, Mesosalpinx by the disposable cap.

- Identify and bring to view the affected fallopian tube and its ovary.
- Clamp the mesosalpinx to stop bleeding, aspirate blood from the abdomen and remove any blood clots.
- Use moist gauze to pack away the bowel and omentum from the operative field.
- Divide the mesosalpinx using a series of clamps and tie the mesosalpinx with 2-0 chromic catgut (or polyglycolic) suture.
- Place a proximal suture around the tube at the isthmic end and excise the tube.
- Ensure that there is no bleeding.
- Check instruments and swabs.
- Rest continues closing the rectus sheath and skin as c-section.

The mentor will provide positive feedback if there is missing of any steps.
She also observes the OT table set up and how nurse assist the surgeon.
CEONC coach/mentor will use the "Maternal and newborn care Quality Improvement (QI) tools for Advancced Skilled Birth Attendents (ASBA) and Comprehensive Emergency Obstetrics and Newborn Care (CEONC) Sites".). This QI tool is a separate book published by NHTC in 2009.

Annex 5:
Skill Standardization orientation schedule for CEONC coach/mentor

Venue:

Date:

Date:		
Time	**1st day**	**2nd day**
8.30- 9 AM	**Arrival and Breakfast**	
9:00 – 11 :00	**Welcome / Introduction** • Goal and Objective of the Project • Agenda • Orientation of the Program • Review of content / Skills that need to be updated. • Review the knowledge questionnaire	**Discussion and Practice:** • Discussion and practice on tools • To agree upon ASBA QI tool - LSCS - Laparotomy for EP - Subtotal Hysterectomy - B-Lynch suture
11 AM	**TEA BREAK**	
11:15- 12:30	**Discussion and Practice:** • Newborn Bag and Mask ventilation • Condom Tamponade • Vacuum Extraction • MVA Procedure	• Discussion and Practice: • Anesthesia Skill:..... • OT management Skill....
12:30 – 1:30	**LUNCH BREAK**	
1:30 – 5:00	**Continues Practice in group** • All of the above • MRP	**Continues Practice in group** Discussion and practice on tools and skills -LSCS -Laparotomy for EP -Subtotal Hysterectomy - B-Lynch suture - Reporting format

Annex 6:
Knowledge assessment questionnaires for CEONC service providers

Infection Prevention

1. The aim of decontamination is to:

a) make surgical instruments and other items contaminated with blood or body fluids safer to handle by staff who clean them.

b) protect patients from infectious diseases

c) protect patients from unsafe practices

d) (b) and (c)

2. High-level disinfection (HLD) can be achieved by:

a) boiling in water for 20 minutes

b) boiling in water only

c) soaking in chemical disinfectants only

d) none of the above

Cesarean section

3. If there are signs of obstruction or the fetal heart rate is abnormal in an occiput posterior position

a) Delivery should be by caesarean section.

b) the membranes should be ruptured.

c) labor should be augmented using Oxytocin.

d) spontaneous maternal pushing should be encouraged.

4. Approximately what percentage of deliveries should be by CS to reduce maternal and neonatal morbidity and mortality?

a) 1-5%

b) 35%

c) 5-15%

d) At least 50%

5. Problems frequently encountered during cesarean section include:

a) Difficulty controlling bleeding.

b) Adhesions

c) Difficulty in delivering malpresentation.

d) All the above

6. The advantages of lower segment caesarian uterine incision are

a) ease of operation

b) less bladder dissection and less blood loss

c) less risk of scar rupture

d) All the above

7. Absolute indications for cesarean section include:

a) Complete placenta previa

b) Previous CS with vertical incision or extension

c) Breech presentation in a multiparous woman

d) A and B only

Blood Transfussion

8. Blood is essential for:

a) helping the body fight infections

b) carrying oxygen and nutrients to all of the organs throughout the body

c) carrying waste products away so that they can be excreted.

d) all the above

9. For each unit of blood transfused, the woman should be monitored

a) before starting the transfusion and for 4 hours following completion

b) before starting the transfusion, at the onset of the transfusion and at least every hour during the transfusion

c) every 15 minutes during the transfusion

d) during the transfusion but not after the transfusion

10. If a transfusion reaction occurs

a) the transfusion should be stopped, and the iv-line removed.

b) the transfusion should be stopped, and the iv-line kept open, and the patient should be managed.

c) the transfusion should be slowed, and the woman monitored more closely.

d) none of the above

Condom Tamponade

11. On average, women who die because of postpartum hemorrhage die within:

a) Two hours
b) Twelve hours
c) 24 hours
d) 2 days

12. Immediate postpartum hemorrhage can be due to

a) atonic uterus
b) trauma to the genital tract
c) retained placenta.
d) all of the above

13. When performing abdominal aortic compression to control postpartum hemorrhage, the point of compression is

a) just below and slightly to the right of the umbilicus
b) just below and slightly to the left of the umbilicus
c) just above and slightly to the right of the umbilicus
d) just above and slightly to the left of the umbilicus

14. Postpartum hemorrhage is defined quantitatively as

a) vaginal bleeding of any amount after childbirth
b) sudden bleeding after childbirth
c) vaginal bleeding more than 300 ml after childbirth
d) vaginal bleeding more than 500 ml after childbirth

15.Tears of the cervix, vagina or perineum should be suspected when there is immediate postpartum hemorrhage and

a) a complete placenta and a contracted uterus
b) an incomplete placenta and a contracted uterus
c) a complete placenta and an atonic uterus
d) an incomplete placenta and an atonic uterus

Ectopic pregnancy

16. The immediate management of ruptured ectopic pregnancy involves

a) Cross matching blood and arranging for laparotomy.
b) making sure that blood is available for transfusion before surgery is performed.
c) observing the woman for signs of improvement
d) all of the above

17. Exclusion of diagnosis of ectopic pregnancy is best supported by:

a) Negative pregnancy test and bleeding
b) Amenorrhea
c) One sided abdominal pain and positive pregnancy test
d) Tissue protruding from the cervical os

18. If a patient presents with acute abdominal pain, one episode of syncope and a low blood pressure, and she is known to be pregnant, the first step is to:

a) Perform a laparotomy.
b) Obtain an ultrasound.
c) Perform rapid assessment for shock, including IV fluid replacement.
d) Check her hemoglobin.

19. The most common site of tubal/ectopic pregnancy is:

a) ampulla of fallopiantube
b) isthmus
c) Infundibulum
d) Interstitial

20. Abdominal pain in early pregnancy may be symptomatic of

a) ovarian cyst
b) appendicitis
c) ectopic pregnancy
d) all of the above

Ruptured uterus Hysterectomy

21. During a subtotal hysterectomy for uterine rupture:

a) The ovaries and cervix are left behind.
b) The uterus is removed vaginally.
c) The rupture of the uterus is repaired, and the tubes are tied.
d) The cervix is removed but the uterus and tubes are left behind.

22. If contractions continue in obstructed labor:

a) the uterus will become tired, and contractions will stop.
b) the uterus will become thin and will likely rupture lower segment of uterus.
c) the baby will be born once the head is moulded to the shape of the pelvis.
d) the baby will always die.

23. A transverse uterine scar

a) may rupture during active labor or during the expulsive phase
b) is an indication for elective cesarean section
c) is an indication for trial of labor if the fetus is in a normal vertex presentation?
d) (a) and (c)

24. Absent fetal movements and fetal heart sounds, together with intra-abdominal and/or vaginal bleeding and severe abdominal pain, may be suggestive of:

a) abruptio placentae
b) ruptured uterus
c) obstructed labor
d) all of the above

25. Vertical scars from a previous cesarean section

a) never rupture
b) rarely rupture during labor
c) rarely rupture during labor and childbirth
d) may rupture before labor or during the latent phase.

26. The immediate management of ruptured ectopic pregnancy involves

a) Cross matching blood and arranging for laparotomy.
b) making sure that blood is available for transfusion before surgery is performed.
c) observing the woman for signs of improvement
d) all of the above

Spinal anesthesia

27. Which of the following can NOT be used for anesthesia for cesarean section:

a) Spinal anesthesia
b) General anesthesia with ketamine
c) Pudendal block
d) Local anesthesia

Ketamine anesthesia

28. Good options for postoperative pain relief after obstetric surgery include:

a) Paracetamol 500 mg by mouth as needed
b) Pethidine 1 mg/kg body weight IM
c) Diclofenac 75mg IM
d) All of the above

29. Methods of nonpharmacologic pain relief in labor include:

a) Support from birth companion, ambulation and change of position.
b) Encouragement, compassion and support from provider
c) Back massage and breathing techniques.
d) All the above

30. Good options for postoperative pain relief after obstetric surgery include:

a) Paracetamol 500 mg by mouth as needed.
b) Pethidine 1 mg/kg body weight IM
c) Diclofenac 75mg IM
d) All of the above

31. Immediate resuscitation using a bag and mask should be implemented if the baby's:

a) respiratory rate is between 30 and 60 breaths per minute
b) respiratory rate is less than 40 or greater than 30 breaths per minute
c) respiratory rate is between 20 and 30 breaths per minute
d) if baby does not cry after initial stimulation

Annex 7:
Clinical coach/mentor refresher and review meeting schedule

Time	Content	Facilitator
First Day		
10:00 -10:15 AM	Introduction and Welcome to all participants	
10:15 - 11:00 AM	Overview of National SMNH status of Nepal	
11:00 – 11:30 AM	AWPB SMNH program orientation	
11:30 – 12:30 PM	Recent update /Orientation on PPH management and Condom Balloon Tamponade (Video show)	
12:30 – 1:30 PM	Discussion of major issues/confusion raised by participants) Clarity on knowledge, Decision making skills and core skills.	
1:30 – 2:00 PM	Lunch Break	
2:00 – 4:00 PM	Planning and review clinical mentoring program /Experience sharing/ Learning and challenges during mentoring (Experience sharing by one by one)	
4:00 – 5:00 PM	Mobile Apps orientation (ODK presentation) Download apps in the mobile Practice reporting on mobile apps Data entry by each participant	
Second Day		
10:00 -10:15 AM	Review of the day	
10:15 – 1:30 PM	Skill assessment, Demonstration and Practice Make the different skill station • Normal Delivery and Vacuum Delivery-: Trainer • Newborn Resuscitation-: Trainer • Condom Tamponade-: Trainer • Manual Vacuum Aspiration (MVA)-: Trainer • Eclampsia Management/ PPH management-: Trainer • Kangaroo Mother care-: Trainer • PPH with shock Management-: Trainer	
1:30 – 2:00 PM	Lunch Break	
2:00 – 4:30 PM	Skill practice by participants	
4:30 - 5:00 PM	Closing Remarks	

Annex 8:
PPT - Presentation on overall MMR and NMR of Nepal

(Note: please contact to respective division, MNH section chief or MNH focal person for updated PPT slides for presentation. Need to link the presentation with quality of care for reducing the maternal and newborn mortality rate during presentation and discussion).

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