Strengthening Health Provider Performance for Maternal Newborn Care in Lao PDR Through a Mentoring Approach

Implementation & Training Guide

USAID
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Photo by Adri Berger

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Acronyms and Abbreviations

EBF	Exclusive Breastfeeding
EmONC	Emergency Obstetric and Neonatal Care
ENAP	Every Newborn Action Plan
EPCMD	Ending Preventable Maternal and Child Deaths
EPMM	Ending Preventable Maternal Mortality
MCSP	Maternal and Child Survival Program
MH	Maternal Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MRN	Model Referral Network
NGO	Non-governmental Organization
PHO	Provincial Health Office
PMP	Performance Monitoring Plan
SOW	Scope of Work
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Acknowledgements

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INTRODUCTION

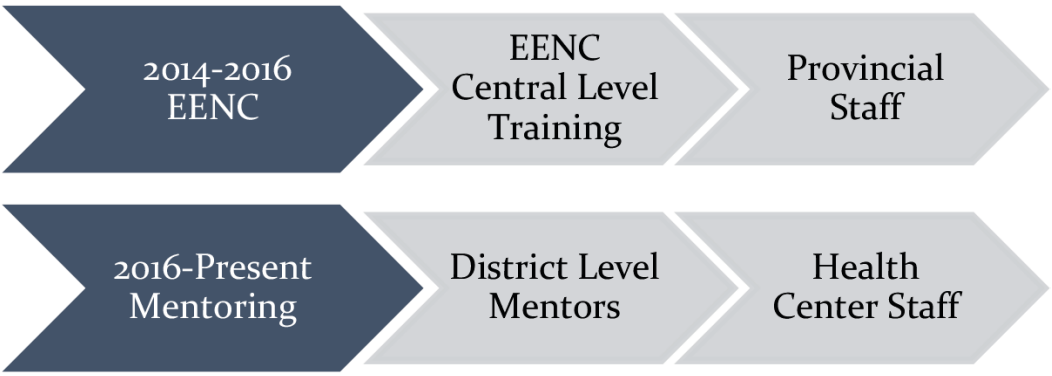
COUNTRY CONTEXT AND NEED FOR MENTORING

The Lao People's Democratic Republic (PDR) has a population of approximately seven million with 67% living in rural areas and 32% of the population below the age of 14 years. Nationally, about 30 % of the rural population still lack access to health care services. In 2012, the National Lao Demographic Health Survey reported the maternal mortality ratio as 357 deaths per 100,000 live births, and the neonatal mortality rate as 27 per 1,000 live births with more than half of these occurring during the first week of life. Over 70% of women birth at home (63% with a family member) and are at higher risk of complications without a skilled birth attendant. Lao also faces constraints to health service provision due to a lack of qualified, adequately distributed staff and inadequate infrastructure.

For 23 years there was no midwifery training in Lao. In 2009, there were only 100 midwives left in the country. In response, the government developed the Skilled Birth Attendant (SBA) Development Plan (2008-2012) to train more SBA and midwives across a variety of programs with the aim to have 1,500 midwives by 2015. However, the rapid, didactic training produced unskilled and inexperienced midwives deployed in hospitals and remote health centers unsupported and unsupervised.

An evaluation in 2014 of the SBA development plan confirmed there would be 1,784 new midwives by 2015. Numerical targets were surpassed, but as the SBA evaluation stated, there was no progress on the other key objectives of the SBA development plan namely the quality of education, the enabling workplace environments for new midwives and no progress on supportive supervision. A draft supportive supervision plan was developed in 2011 together with accompanying checklist and tools. However, the plan has never been endorsed and progress has halted. The review also identified the need to strengthen the quality of training and the lack of coaching skills among midwife trainers as an issue. There is clearly a need for a new approach to build skills and capacity among maternal and neonatal health (MNH) providers.

In 2014, the government launched the Essential Early Newborn Care (EENC) policy, with technical support from WHO and the Center of International Child Health (CICH) from Melbourne. This initiative began by developing a cadre of central level trainers, trained on the EENC module, who in turn trained provincial staff as trainers in a cascading TOT completed at the end of 2016. The provincial trainers began expanding the training in 2017 in one select district of the province.



Following the EENC trainings, the mentorship approach was developed to facilitate the transfer of skills and further improve the quality of care at the time of birth, focusing on mother and newborn. As part of the SCI Primary Health Program, mentoring leverages an integrated health systems strengthening approach. The mentorship and EENC approaches are similar and complementary with interactive learning and coaching. Mentorship differs, however, in the full integration of maternal and newborn care including Respectful Maternity Care (RMC) and Infection Control (IC). Additionally, mentorship includes the training of district level mentors to mentor their peers and colleagues as part of daily work in district facilities. The aim is to build capacity in the facility in order to contribute to sustainability in the long term. District level mentors initiated training of health center staff in September 2017, as will be outlined further below.

MENTORING APPROACH

Traditional in-service training and traditional supervision methodologies have not resulted in meaningful improvements in health care provider performance in low and middle-income countries (Leslie, et al. 2016). Mentoring approaches, however, have demonstrated improved competence among providers of HIV care and treatment in Sub-Saharan Africa (WHO 2006). In addition, MCSP global program learning from 23 country programs implementing mentoring indicate it is well suited for complex clinical skills (MCSP 2018). Because of these results, maternal, newborn and child health programs have utilized similar mentoring approaches to improve health provider performance both at the facility and community levels.

The definition of mentoring can vary in clinical practice. For the purpose of this guide, we use the MCSP definition: Mentoring is the process through which an experienced, empathetic person with proficiency in their content area (mentor), provides another individual (mentee) or group of individuals (mentees) with in-person on-site teaching and coaching focused on ensuring workplace performance and ongoing professional development. (MCSP 2018)

KEY ELEMENTS FOR OPERATIONALIZING THE MENTORING APPROACH

1. There should be approval of the mentoring approach by national and sub-national leaders. Leaders of facilities should be in full acceptance and support for the use of mentoring approach to build and retain skills of their staff.
2. Mentors should work with mentees both individually and in small teams at the facility to build and strengthen knowledge and skills, improve quality of care and ensure respectful provision of care. They should develop rapport and build relationships with mentees, based on mutual respect and positive feedback that empowers and motivates mentees to improve performance.
3. Mentors have to be clinically proficient in their content area. In addition, they should be proficient in conducting demonstrations, coaching, providing feedback, and facilitating facility action planning sessions. All mentors' clinical and mentoring skills should be assessed periodically to ensure quality and maintenance of skills.
4. Mentees should be keen to learn and apply new knowledge and skills. Once skills are acquired, they need continuous practice to ensure retention over time. This is relevant to all level of providers, whether mentor or mentee.
5. Mentoring should be complementary to existing government led supervisory systems and quality improvement efforts. External supervisors /mentors should provide periodic on-site visits to support the quality of clinical and mentoring skills. Ideally, mentoring should become part of regular supervisions with mentors included in supervision teams.
6. Mentorship uses review of quarterly data on health provider skills, and facility indicators to develop QI action plans.

PURPOSE OF IMPLEMENTATION AND TRAINING GUIDE

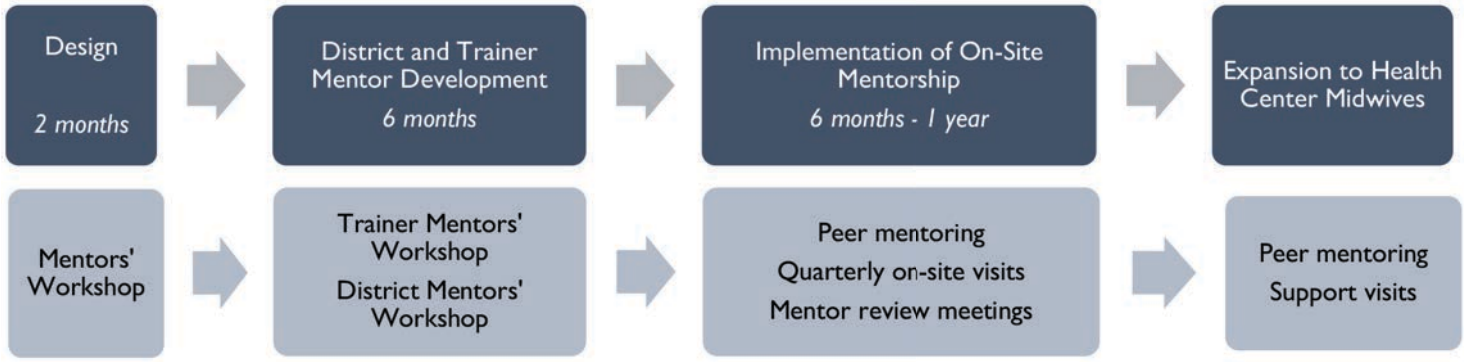
The purpose of this implementation guide is to provide a flexible process that can be adapted to guide, design, implement and measure mentoring efforts to improve health service delivery. This guide synthesizes the learning from processes and tools utilized to implement mentoring in Luang Prabang and Sayabury provinces in Lao. The guide focuses on day of birth and skills of normal delivery and when the baby is not breathing. It is assumed that once these skills are consolidated, other skills can be introduced incrementally according to mentor/mentee ability. For example, management of complications like PPH, pre-eclampsia, or low birth weight baby. Introduction of complications should be tailored to the needs and progress of mentor and mentees and their ability to assimilate new skills. Although the processes and tools compiled in this implementation guide focus on quality of MNH care on the day of birth, they can be adapted for use in other technical areas or disciplines to mentor health care providers for performance improvement.

AUDIENCE

The intended audience for this implementation guide are those interested in developing a mentoring capacity building approach. This could be a project manager, non-profit organization or government entity. Although the examples shared are from one MNH program in Lao PDR, the process and tools are adaptable to various contexts and can be applied to capacity building across professions.

PHASES OF IMPLEMENTING THE MENTORING APPROACH

The mentoring approach is divided into four phases of implementation. This guide includes detailed descriptions of each phase with additional tools in the appendices. A mentoring training film complements this guide and visually captures each step of the mentoring approach.

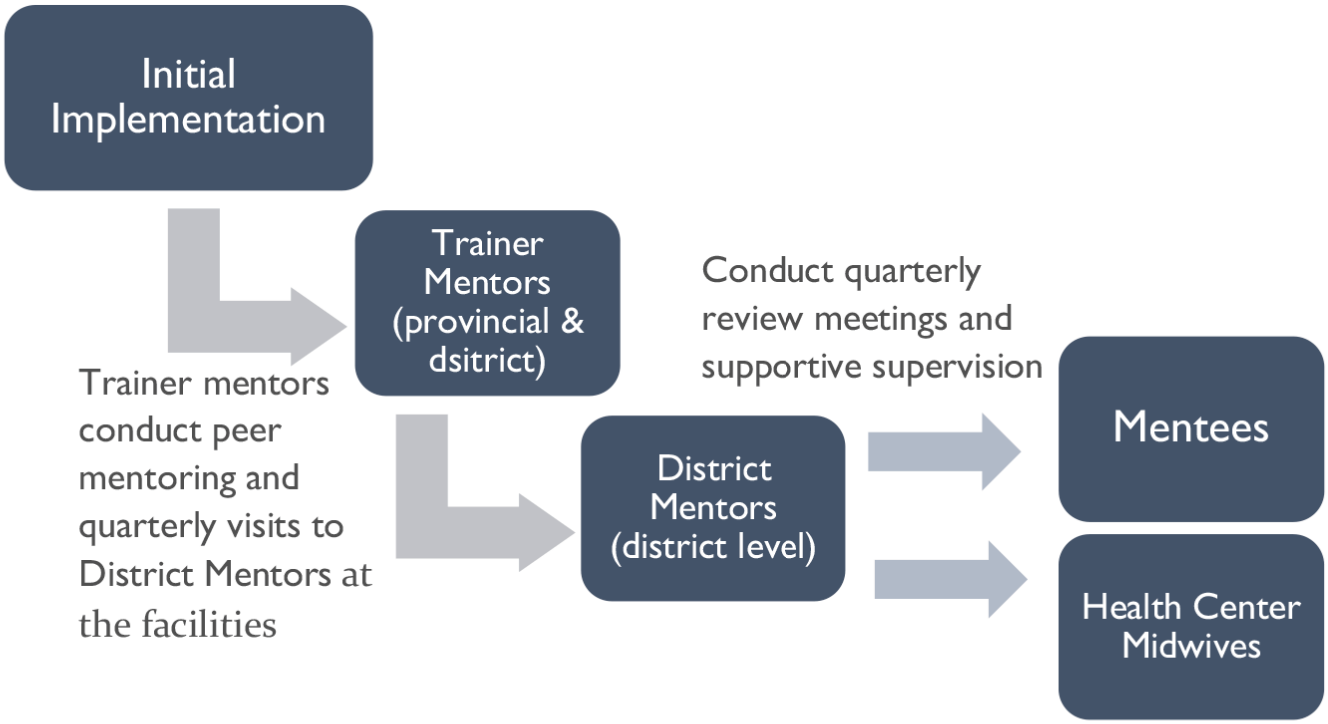


MENTORING ROLES

Actor	Role	Selection	Key Activities
Mentor Cohort of 15	Design the mentoring activity and mentor at the provincial and district level	Provincial and district midwives, nurses and doctors	1. Participate in the Mentors' Workshop
Trainer Mentor Cohort of 8	Trainer mentors mentor their own colleagues /peers in daily practice and provide on-site support visits to districts during early implementation of mentoring (1 year). They should be included in the GoL supervision teams to provide supportive supervision	Select subset of mentors	1. Participate in the Trainer Mentors' Workshop 2. Train district mentors in District Mentors' Workshop 3. Conduct two-day facility visits and participate in mentor review meetings 4. Inclusion in supervision team for on-site supportive supervision
District Mentor Team of 4 mentors in each district facility	Mentor their peers/colleagues in daily practice, monitor mentee skills and track health service data. District mentors lead mentoring for health center staff. One mentor out of the team of 4 is selected as team lead to coordinate	In-facility peer mentors	1. Participate in District Mentors' Workshop 2. Mentor their own staff in the facility and health center midwives. Provide inter-district support visits to other districts 3. Inclusion in supervision team for on-site supportive supervision

	activities in their own facilities and provide leadership to the district mentor team They should be included in the GoL supervision teams to provide supportive supervision		
Mentee	Provincial/District MNH provider (midwife, nurse or doctor) 1:3 mentor to mentee ratio	District/provincial level MNH provider who is working in delivery room or MCH regularly assisting deliveries	Supported by mentors (Five mentees are selected to be tracked over time for project implementation, but all MNH providers and staff can be mentored in the facility by on-site mentors)
	Health Center Midwife One HC midwife from each district	Health Center	Supported by mentors

MENTORSHIP IMPLEMENTATION FLOWCHART



PHASE 1: DESIGN

PHASE	KEY ACTIVITIES	OUTPUTS
Design: (adapting for country context, building ownership & expertise) Time required: 2 months	1. Meet with provincial leadership and stakeholders to define the scope and process of mentoring 2. Select mentors 3. Conduct mentors' workshop 4. Design a monitoring system for quality improvement	➢ Tools for mentoring ➢ Indicators to track progress ➢ Mentors with standardized clinical skills along with mentoring capacity ➢ Plan for mentoring visits

ACTIVITY 1: MEET WITH PROVINCIAL LEADERSHIP AND RELEVANT STAKEHOLDERS

The first activity of the design phase should be preliminary consultations with provincial leaders and partners to introduce the idea of mentoring and receive permission to implement in the province. When possible, identify existing systems that the program can be built upon. Identifying current national structures and systems to strengthen and support is preferable to a short-term solution. Once the necessary approvals and MOUs have been acquired, the Provincial Health Office (PHO) should create a committee to determine the appropriate MNH providers to be trained as mentors, including developing draft selection criteria. Ideally, this committee will include a diverse set of representatives from MoH, medical schools and health facilities.

ACTIVITY 2: SELECT PARTICIPANTS FOR MENTORS' WORKSHOP

The program team should facilitate a meeting with this committee to select the first cohort of mentors. Participants of the MNH mentoring workshop should have maternal and neonatal clinical experience, the desire to share knowledge and teach others, and the commitment to make district visits. A committee of senior provincial leaders should lead the process, including agreeing on selection criteria.

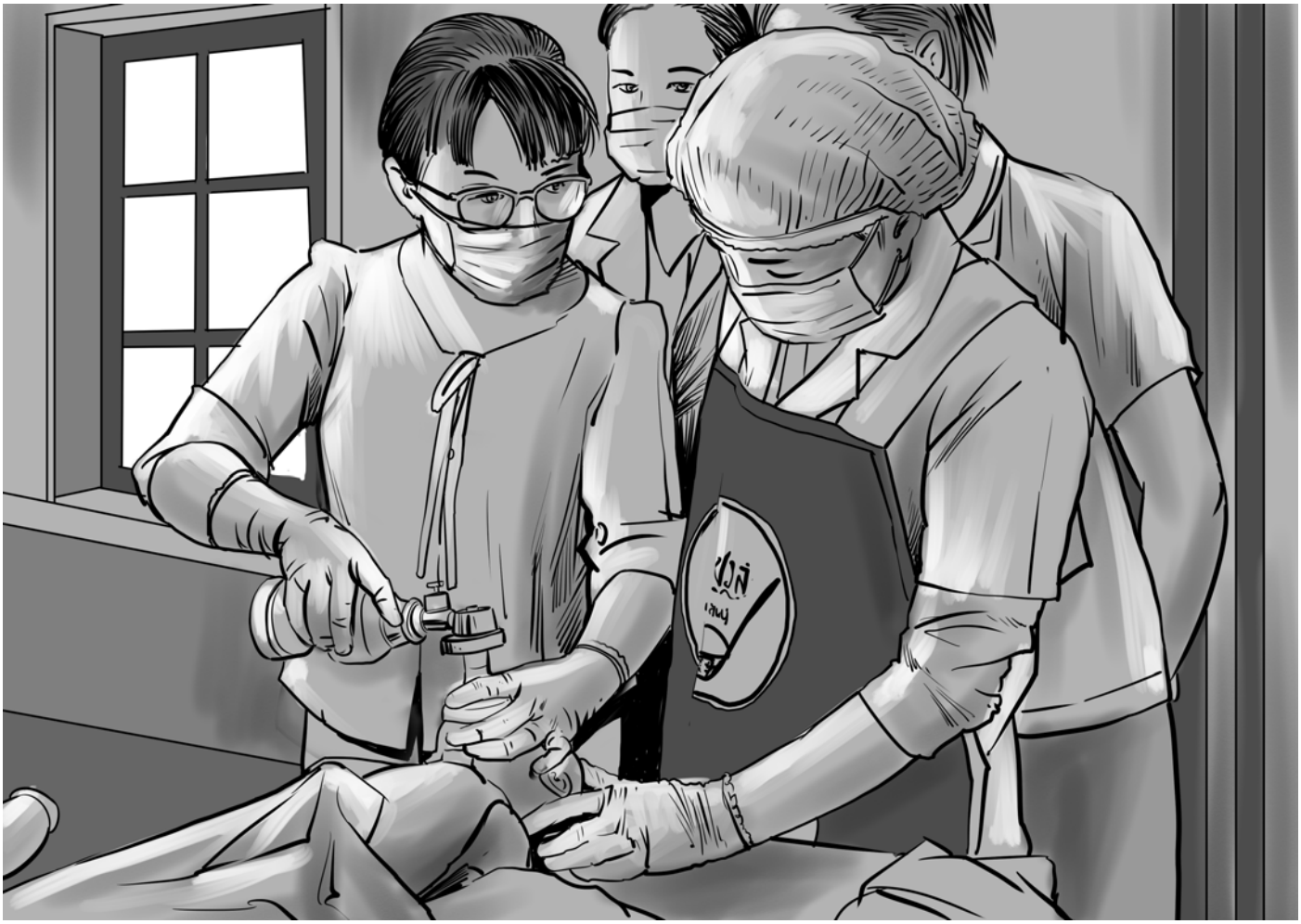
Resources: Annex 1: Mentor Selection Criteria

ACTIVITY 3: CONDUCT THE MENTORS' WORKSHOP

The mentors' workshop is an 8-day training, with the aim to design the mentoring activity, build mentoring skills and develop ownership of the program. It is key to successful initiation and a critical time to create tools, standardize clinical skills, and develop mentoring skills, M&E plans, and mentoring plans. The workshop requires thorough preparations and must be well-designed, well-facilitated and well-supported.

Though participants come with existing clinical MNH experience, it is important to standardize their clinical skills according to the guidelines they jointly finalize. Facilitators will promote peer skill practice through role-plays, conduct peer mentoring sessions with feedback on technique, and include interactive group work. All along, the principles of mentoring should guide the practice and workshop activities. Once clinical skills are standardized, the sessions should focus on participants practicing mentoring with each other. The accompanying film highlights this through a session on making a simple box from A4 paper (see Sample Session Plans).

Resources: Annex 2: Sample Mentors' Workshop Goals and Learning Objectives, Annex 3: Sample Mentors' Workshop Agenda, Annex 4: Mentors' Workshop Materials List, Annex 5: Mentors' Workshop Teaching Topics, Mentorship Approach Film: https://vimeo.com/257073720



ACTIVITY 4: DESIGN A MONITORING SYSTEM FOR QUALITY IMPROVEMENT

To document skills and monitor progress, program implementers should conduct regular skills assessments of both mentors and mentees. To do this, a monitoring system should be designed to capture participant's skills assessments and areas for improvement. It is important to ensure the system is user-friendly and pragmatic based on the resources available.

Over the course of the program, implementers should track the mentoring skills of mentors and the clinical skills of mentors and mentees. When developing the monitoring system, use a minimum number of indicators to track initial mentoring program progress. Starting with relevant indicators included in DHIS2, program implementers should work with facility leadership teams to determine if there are any additional indicators that the facility would like to monitor over the course of the program (ex: service delivery readiness, use of partograph and early initiation of breastfeeding). Capturing facility specific indicators will help participants identify gaps within their own facilities and develop possible solutions. After the first year of the program, review the plan and consider if any indicators should be adjusted or are no longer necessary, and review the frequency of data collection. Ideally, these indicators should be incorporated into regular supervision monitoring or in DHSI2 data system. Targets can be set in consultation with the facility, current standards and long-term goal, and should be phased over time.

SAMPLE INDICATORS:

#	Indicator	Target	Program Year 1				Program Year 2			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	% **mentors** who demonstrate at least 7/9 key skills for normal delivery if the baby is not breathing according to OSCE standards.									
2	% **district mentees** who demonstrate at least 7/9 key skills for normal delivery if the baby is not breathing according to OSCE standards.									
3	% **health center mentees** who demonstrate at least 7/9 key skills for normal delivery if the baby is not breathing according to OSCE standards.									
4	**Percentage of mentors** correctly demonstrating 5/7 key mentoring skills according to mentoring standards									
5	% women from randomly selected clinical records that received a uterotonic (oxytocin IM) in the third stage of labor in MCSP-supported areas									
6	% newborns from randomly selected clinical records placed "skin to skin" immediately after birth for at least 90 minutes in targeted facilities									
7	% deliveries of randomly selected partographs filled in as per protocol at target health facilities									
8	% newborns from randomly selected clinical records that achieve early initiation of breastfeeding within 90 min at targeted health facilities									
9	% target health facilities with appropriate handwashing supplies in the delivery room in MCSP-supported areas									
10	# MCSP supported health facilities with facility QI Action Plans									
11	# joint supervision visits with the provincial or district health office supervision team, trainer mentors and/or mentors conducted within the life of project									
12	# meetings held at provincial/district level to disseminate learning									

On a quarterly basis, mentors and mentees should have their skills assessed using the monitoring system. Mentors should assess each other's skills and provide immediate and positively stated feedback. They should also track the skills of their mentees. The monitoring system will look different for each program based on the location and skill-level of the mentors and mentees, but below is a list of key activities to consider when implementing the system:

KEY ACTIVITIES WHEN IMPLEMENTING THE MONITORING SYSTEM:

- ✓ Select key MNH indicators to track project progress. For example, clinical skills, mentoring skills, chart review, mother exit interview, and service delivery readiness.
- ✓ Use DHSI2 as the main source of data.
- ✓ Include data recording and reporting in regular mentoring visits, thereby improving the quality of data collected.
- ✓ Utilize mentoring visits to review the data with health facility staff, discuss the trends seen, implications, issues with recording.
- ✓ Initiate quality improvement discussions with hospital staff using the action plan. Review the action plan and update at every quarterly visit.
- ✓ Utilize quarterly mentor review meetings to present both skills and health service data. Discuss issues and seek joint solutions using small group sessions and feedback.

Resources: Annex 6: Sample Documentation System (clinical skills guideline, mentoring skills guideline, exit interview, partograph survey, chart review, and service delivery readiness)

PHASE 2: TRAINER AND DISTRICT MENTOR DEVELOPMENT:

PHASE	KEY ACTIVITIES	OUTPUTS
Trainer and District Mentor Development (district hospitals) Timeframe: 6 months	1. Initial introduction of mentoring in the districts (6 months) 2. Select trainer mentors conduct trainer mentors' workshop 3. Select district mentors and conduct district mentors' workshop	➢ First cadre of mentors provide on-site visits to mentor district staff ➢ Subset of mentors selected to be trainers ➢ ToT of trainer mentors. Trainer mentors train district MNH providers as mentors ➢ District mentors implement mentoring in their facility as part of daily practice

ACTIVITY 1: INITIAL INTRODUCTION OF MENTORING IN THE DISTRICTS

The first cadre of mentors introduce mentoring to the district facilities and begin mentoring within four weeks of the initial mentors' workshop. There is regular assessment and recording of mentor and mentee skills. After approximately six months of mentoring, and once the mentors are confident in their mentoring capabilities, Activity 2 can begin.

ACTIVITY 2: SELECT TRAINER MENTORS AND CONDUCT TRAINER MENTORS' WORKSHOP

A set of trainer mentors will be selected to train new cohorts of mentors to initiate peer mentoring in district facilities. Capable and motivated trainer mentors are strategically selected from the first cadre of mentors in close consultation with provincial leadership. They should have demonstrated robust clinical and mentoring skills, availability and commitment to the program, an eagerness to develop others as mentors and support their continued progress.

The trainer mentors' workshop should be a minimum of 5 days, with 7 days recommended to allow time for planning and practice of teaching sessions. The first 2 days should be devoted to standardizing skills and building confidence in the clinical and mentoring capacity of the trainer mentors, and the remaining days include time to for them prepare their lesson plans, practice teaching sessions and prepare logistics for the subsequent workshop.

Resources: Annex 7: Trainer Mentor Roles and Responsibilities, Annex 8: Teaching Topics for Trainer Mentors' Workshop, Annex 9: Trainer Mentors' Workshop Sample Agenda, Annex 10: Trainer Mentors' Workshop Materials List

ACTIVITY 3: SELECT DISTRICT MENTORS AND CONDUCT DISTRICT MENTORS' WORKSHOP

The role of the district mentor is primarily to coach and support their peers in clinical skills using the Mama-Natalie. They should also help with monitoring of mentee skills and tracking of health service data to assess outcomes of improved skills of their peers. In addition, the district mentors will lead on mentoring for health center staff. The district hospital director and authorities will select key MNH providers from their facility to develop as mentors using similar criteria to those outlined above.

The workshop for the new district mentors should directly follow the trainer mentors' workshop. This provides the opportunity for newly traine d trainer mentors to lead a workshop entirely on their own under supervision of the facilitators that trained them. The aim of this activity is to train a cadre of district mentors by developing their clinical and mentoring skills in an interactive participatory workshop led by the newly trained trainer mentors.

Resources: Annex 11: District Mentor Selection Criteria and Roles and Responsibilities, Annex 12: District Mentors' Workshop Sample Agenda, Workshop Film: https://vimeo.com/232945738

PHASE 3: IMPLEMENTATION OF ON-SITE MENTORSHIP

PHASE	KEY ACTIVITIES	OUTPUTS
Implement on-site peer mentoring Timeframe: Ongoing	1. Mentors lead peer mentoring in the district facilities 2. Conduct quarterly on-site visits and maintain support from provincial and district mentors, 3. Conduct mentor review meetings	➢ Assess skills of mentors and mentees ➢ Action plans based on gaps identified (skills assessment, monitoring data)

ACTIVITY 1: DISTRICT MENTORS LEAD PEER MENTORING IN THE DISTRICT FACILITIES

The aim of developing district level mentors is to institutionalize peer mentoring in the facility. This facility-based approach brings the focus more on 1:1 coaching, with regular skills building and practice. District mentors keep the OSCE skills checklist of the mentees they mentor and use them to track progress. The facility based action plan is a tool for the mentor and mentee team to collaboratively plan facility based improvements.

ACTIVITY 2: CONDUCT QUARTERLY ON-SITE VISITS WITH SUPPORT FROM PROVINCIAL MENTOR OR DISTRICT MENTOR (INTER-DISTRICT VISITS)

Quarterly on-site visits will commence within one month of the district mentors' workshop to ensure support to the new district mentors in their new roles and to provide continuous capacity building for mentoring skills. This 2-day facility visit is also a time for collection of program data, which is done collaboratively with district level staff, trainer mentors, and project team. As district mentors gain experience and confidence, they should

begin conducting inter-district support visits to other districts. Five district-level MNH providers are selected as mentees for the purpose of initial tracking of program progress. These MNH providers are tracked consistently during quarterly on-site visits. It is important to note, however, that with four mentors in the facility, mentoring can happen in daily practice with all MNH providers.

Resources: Annex 13: Sample Agenda for Facility Visit, Sample Session Plans: Evaluation Forms and Partograph Case Study

ACTIVITY 3: CONDUCT MENTOR REVIEW MEETINGS TO SHARE RESULTS AND ENGAGE PROVINCIAL AND DISTRICT HOSPITAL DIRECTORS AND LEADERSHIP

Mentor review meetings at the provincial level should continue every quarter after the quarterly on-site visits and data collection. The purpose of these meetings is to share results and to plan improvements with district hospital directors and provincial leaders. Mentors will have time to share their experiences and implementation challenges, with an opportunity to review their original action plans and adjust as needed. Facility teams of mentors and hospital directors will develop their new action plans and present to meeting participants. This meeting is also an open forum to discuss the next stages of the program.

Innovation: A WhatsApp network of mentors is a useful tool to share information between mentors and to highlight activities mentors are doing in their facilities by posting photographs. This initiative is led by mentors themselves. Mentors post photos of real deliveries, skills building sessions with their staff on-site in the facility, and health center follow up visits. Other mentors comment and praise the activity. This is a good method to encourage peer support and motivation to share their mentoring activities. It helps mentors build relationships and is an open forum in which they feel comfortable asking questions.

Resources: Annex 14: Sample Agenda for Mentor Review Meetings

PHASE 4: EXPANSION TO HEALTH CENTER MIDWIVES

PHASE	KEY ACTIVITIES	OUTPUTS
Initiate **expansion to health centers** Timeframe: Ongoing	1. District mentors introduce mentoring to health center midwives at the district facility 2. Invite health center midwives for two-day mentoring in the district hospital 3. Continue peer mentoring in the district facilities 4. Continue supportive supervision and ongoing professional development	➢ One district mentor acts as a team lead to provide leadership to the district mentor team ➢ Health center midwives build their skills and confidence ➢ Opportunities to perform a real delivery in the district supported by a mentor

ACTIVITY 1: INTRODUCE MENTORING TO HEALTH CENTER MIDWIVES

Each district will select five health center midwives to mentor based on their own criteria (for example, including health centers with a high number of deliveries or known capacity building needs). The five health center midwives will be invited to join mentoring in the district hospital every quarter. Ultimately, health center midwives are able to learn together and perform real deliveries with mentor support. Inclusion of one midwife from each health center in the district can occur after initiation and consolidation with the initial five health center mentees.

ACTIVITY 2: CONTINUE PEER MENTORING IN THE DISTRICT FACILITY

District mentors continue mentoring district mentees as part of daily practice and follow their facility action plans. For example, mentoring practice with staff can be conducted every two weeks. They will also initiate

self-monitoring such that the district mentors will assess the five district mentees and complete the checklist before the quarterly on-site visit. In addition, the team leader district mentor will assess the clinical and mentoring skills of the other three district mentors and five district mentees with the OSCE skills test before the on-site visit. During the on-site visit, the visiting district mentor will assess the clinical and mentor skills of the team leader district mentor.

ACTIVITY 3: CONDUCT TWO-DAY SUPPORT VISITS FOR MENTORING HC MIDWIVES

The plan for the HC midwives' two-day visit to the district will be the same as the two-day visit plan in Phase 3, but with the focus of this visit on mentoring health center midwives. During the onsite visit, the OSCE skills test data from district level mentors and mentees will be collected. To ensure validity and reliability, a random repeat test will be performed and compared to the district-collected data during the two-day visit.
Either the provincial mentor or district mentor from another district will check mentoring skills during the 2-day visit. In the case of real deliveries, encourage health center midwife to perform the delivery with a mentor standing by for support and feedback.

Resources: Annex 13: Sample Agenda for Facility Visit

ACTIVITY 4: CONTINUE SUPPORTIVE SUPERVISION AND ONGOING PROFESSIONAL DEVELOPMENT

Mentors should become a part of the regular supervision team and lead supervision from the province to the district and from the district to the health center. The long-term aim is for regular supervision to become less surveillance and monitoring with checklists, and more skills practice and capacity building. This will take time to institutionalize, but is the optimal way for mentoring to be integrated into the system and ensure long-term sustainability.

SAMPLE SESSION PLANS

These session plans can be used during the mentoring workshops to teach new mentors initial mentoring skills. The educational film complements these lessons and shows how they are then implemented with mentees.

1. SESSION PLAN: DEMONSTRATION SKILLS 1.

DATE	VENUE	SESSION NUMBER	DURATION
			60 minutes
Topic: Providing a good demonstration			
Session Objectives: By the end of session mentors will be able to conduct a participatory demonstration that involves the learners			
Methods and Activities			**Materials / Resources**
Introduction / Activity (5 minutes) • State objective of session **Demonstration – "non-participatory way of making paper box"**: (15 minutes) • Provide each learner with a blank sheet of A4 paper • Ask learners to make paper boxes by following him / her • Facilitator goes through the steps of making a paper box at the front of the classroom assuming all students understand • After facilitator makes the box, ask learners if they have been able to complete the box • Ask what was difficult to understand? • Obtain feedback from learners. How did they feel? What would have been better? • Summarize on flip chart **Demonstration – "participatory way of making paper box"**: (20 minutes) • Distribute short guideline for making a box and new A4 sheet (see below). • Ask learners to read aloud the short guideline in turns • Facilitator then goes through the steps of making a box • This time, facilitator goes slowly making sure all understand and are following each step. Facilitator also goes individually to those struggling to understand and helps them to follow the step **Plenary:** (10 mins) • Ask learners if they have been able to complete the box • Ask what helped this time round			• Flip chart with objective of session • Blank Flip chart papers Marker pens • A4 paper • Short guideline on making a box (see below) • Checklist for Clinical Demonstration Skills (see Sample Checklists section)

• Summarize on flip chart. Highlight the key steps of providing a good demonstration. • Distribute checklist on demonstration (below) and ask learners to read through in turns • Allow time for learners to ask questions **Summary**: Re-cap the key steps of demonstration and how it is different to didactic teaching. (10 minutes)	
Following the theory then the skills is practiced during role-plays in small groups. **Hint**: If it is easier, demonstration skills can be practiced on one of the steps of the guideline initially for example checking the placenta or neonatal resuscitation. This gives the opportunity to focus and improve on the mentoring skill of demonstration rather than the clinical skill. This can be practiced until the mentor feels confident to provide a demonstration of the whole 9 steps of the guideline	

PAPER BOX GUIDELINE

S. No	✓	Steps
1		Begin with a piece of square paper.
2		Fold the paper in half. Crease the fold with your finger. Then open the paper.
3		Fold the paper in half again, but on the other side. Again, use your finger to crease the fold. Then open the paper. By now you should have two creases that intersect at the center of the square.
4		Open the paper completely and bring each corner to the center, so that the points are all touching. Crease the folds with your finger. Don't unfold it this time.
5		Fold the top and bottom edges to the center of the square. Crease the edges of the both folds to secure them.
6		Unfold the square along one side. Unfold completely – the halfway folds and the triangles beneath those folds. Leave the side triangles folded in.
7		Fold the long edges to the center. Fold over the bottom of the still folded triangles. Crease the bottom edge. You should have what looks like a necktie with two points.
8		Match and bring one tip of the diamond shape to the other end. Repeat with the opposite end in similar way. Crease along the long sides to solidify the folds.
9		Create the side walls of the box by pulling up the flaps along the long side to create the side walls of the box.
10		With the side walls assembled, construct the head wall. As you lift the head wall flap, the creases from previous folds should form two triangle shaped flaps that you will want to fold inwards. Be sure these triangles are folded inwards before proceeding. The head wall will fold over these triangle corners and the top triangle of the head wall will fit neatly into the bottom of the box where you will want to crease it snugly against the sides of to keep the box together. After creasing, you should see a triangle on the bottom of the box.
11		Repeat the process for the other end

2. SESSION PLAN: MENTOR AS A COACH

DATE	VENUE	SESSION NUMBER	DURATION
			60 minutes

Topic: Mentor as a Coach

Session Objectives: By the end of session mentors will understand the role of coaching in clinical practice

Methods and Activities	Materials / Resources
Introduction / Activity (5 minutes) • State objective of session • Ask mentors example of coach in real life (can be sports coach for example) **Instructions to the group**: (5 minutes) Quiz: Play a game, whichever group answers the most wins. Among your group, select one person who will talk. Each group will take turns in stating one characteristic of good coach. Whichever team states the most characteristic wins the round Divide into 2 groups by calling out 1, 2. Ask groups to sit together. Plenary: (15 minutes) Summarize on flip chart (5 minutes) Distribute check list for coaching and ask to read in turns (20 minutes) Summary: Learners will be asked to prepare one question on mentor as a good coach. Ask each learner to ask the question and discuss answers (10 minutes)	Flip chart Marker pens Checklist for Clinical Coaching Skills (see Sample Checklists section)

Self-Review / Evaluation (key points from session, what worked / what did not, modifications for next session etc.)

Following the theory then the skills is practiced during role plays in small groups

3. SESSION PLAN: ELICITING FEEDBACK FROM MENTEES

DATE	VENUE	SESSION NUMBER	DURATION
			50 minutes
Topic: Eliciting feedback from mentees			
Session Objectives: To ensure mentors are able to elicit feedback from mentees and provide balanced and constructive feedback to mentees			
Methods and Activities			**Materials / Resources**
Plenary – Ask: **In Mentoring visit when do we do feedback?** (5 mins) Brainstorm – Answer: 1) after demonstration, 2) after role-play 3) final all group feedback **Why do we do feedback- what is the purpose?** - flip chart 2 groups (5 mins) Answers; tool for learning, guide for improving, opportunity to motivate and encourage mentee **Demonstration role-play 1** Mentor - mentee observer (10 mins) Mentor: Ok you did quite well you prepared yourself well for the delivery but you forgot to prepare for the newborn. You need to practice more about resuscitation and you need to understand about cleaning instruments. How do you think you did? Mentee SILENT **Demonstration role-play 2** Same actors Mentor: Well done. Tell me how did you do? Mentee: Ah, I forgot to give oxytocin and I think I tried to cut the cord too early…. Mentor; Anything else? Mentee: I forgot to explain to the mother about skin to skin Mentor: what did you do well? Mentee: I did Ok with checking for second baby Mentor to mentee observer: Do you have any other feedback to share? Mentee observer: I thought she prepared well Mentor: Thank you. Yes you did well. Try and remember to do skin to skin for 90 mins…why is this important?			Flip chart Marker pens Checklist for Clinical Coaching Skills (see Sample Checklists section)

Mentee: Because the baby can start to breastfeed within this time and it helps with bonding
Mentor: Well done. Are you happy with that feedback?
Mentee: Yes thank you

Ask the plenary what was the difference between the 2 role-plays? – put on flip chart (10 mins)

Show large photo of 2 ears and 1 mouth. Ask: **How many ears do we have? How many mouths?** Elicit 2 and 1. Ask **WHY?** Answer: we should listen twice as much as we speak!
Conclude **HOW** we do feedback is important

Have 2 Flip charts with Step 1 and step 2 on each chart and written. How, who and tools. Give meta cards (12) with the words 'eliciting', 'mentee', 'guided questions' etc. and get them to stick appropriately under step 1 or 2 and under 'how' 'who' or 'tools'. – (10 mins)

Process of feedback

Step 1:
HOW Eliciting-
WHO Mentee
TOOLS Guided questions,

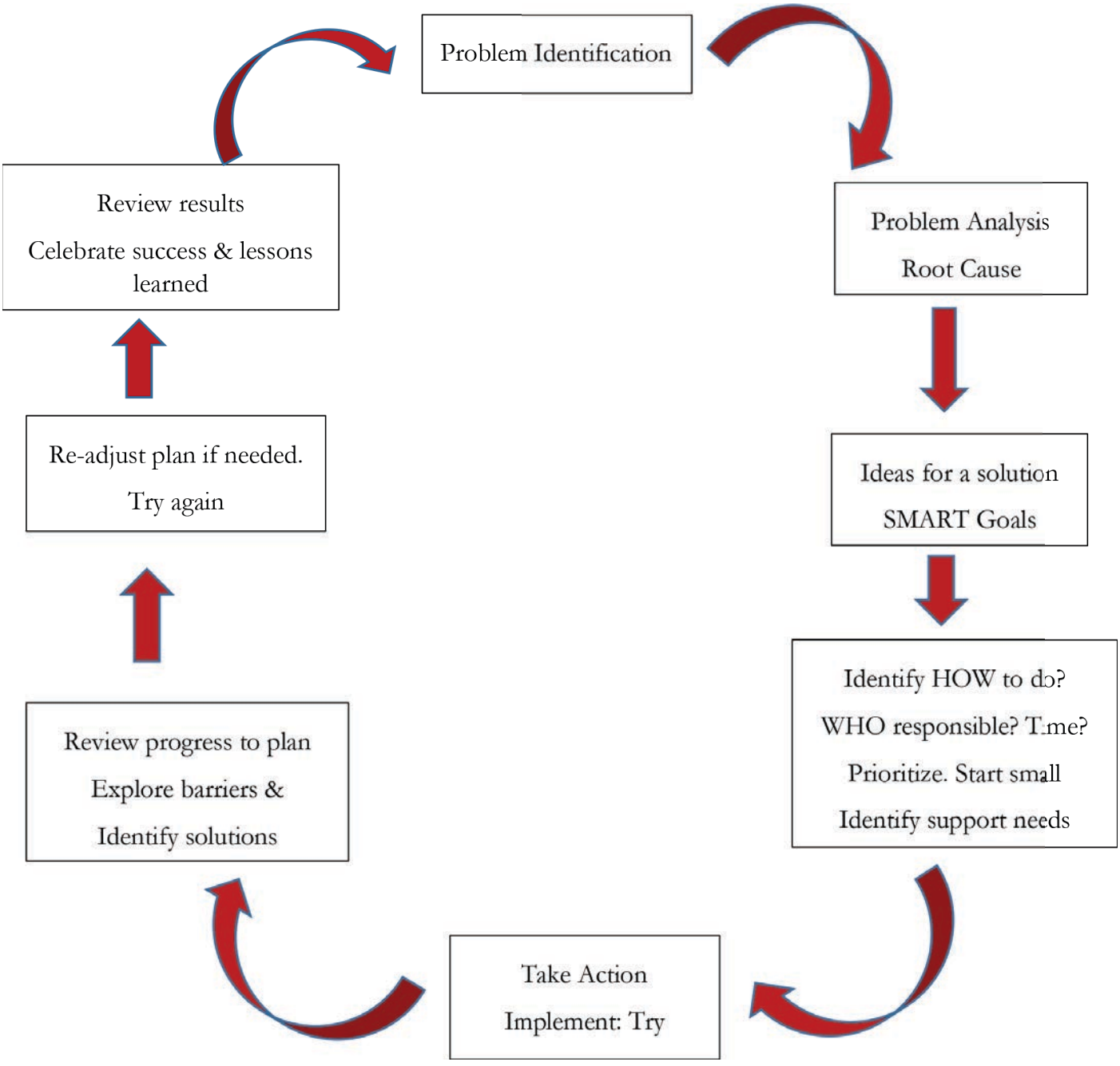
- Listen
- Silence
- Give time to answer

Step 2:
HOW Providing
WHO Mentee observer and mentor
TOOLS Be specific, Balance positive and things to improve, constructive/useful, Ensure agreement/ acceptance of feedback

4. SESSION PLAN: ACTION PLANNING SKILLS

DATE	VENUE	SESSION NUMBER	DURATION
			60 minutes
Topic: Problem identification & Action Planning			
Session Objectives: To ensure mentors are able to support mentees to identify problems, create a realistic action plan and steps to implement it			
Methods and Activities		**Materials / Resources**	
Plenary: Ask**: How do they plan in their daily life?** (5 mins) Brainstorm and write on flip chart. **Ask: What makes a good plan?** - flip chart whole group (5mins) Divide into 2 groups and give each group a set of cards of steps of action plan 8 cards. Give each group a flip chart paper and ask them to arrange the steps on the cards on the paper how they would do them. They can do however they like. Give 15 mins for them to discuss and arrange. Ask groups to pin up their charts side by side and then each group will feedback what they did and explain the steps in what order and the reason they did like that. Compare group 2. (15 mins) Make a 3rd flip chart together after agreement of steps made. Talk through steps in 3rd chart focus on some discussion of steps 1-3 (15 mins) 1) Problem identification – can come from feedback 2) Root cause- ask Why why why 3) SMART goals – start small 4) Action (needs motivation) **Summarize:** Ask someone to summarize key points of making an action plan.		Need cards and glue Action planning cycle (see below)	
Self-Review / Evaluation (key points from session, what worked / what did not, modifications for next session etc.)			

ACTION PLANNING CYCLE



5. PARTOGRAPH CASE STUDY

STEP 1

Ma Wai was admitted at 05.00 on 12.9.2014

Membranes ruptured 04.00

Gravida 3, Para 2+0

Hospital number 7886

On admission the fetal head was 4/5 palpable above the symphysis pubis and the cervix was 2 cm dilated

Q: What should be recorded on the partograph?

Note: Ma Wai is not in active labour. Record only the details of her history, i.e., first four bullets, not the descent and cervical dilation.

STEP 2

09.00:

The fetal head is 3/5 palpable above the symphysis pubis

The cervix is 5 cm dilated

Q: What should you now record on the partograph?

Note: Ma Wai is now in the active phase of labour. Plot this and the following information on the partograph:

3 contractions in 10 minutes, each lasting 20–40 seconds

Fetal heart rate (FHR) 120

Membranes ruptured, amniotic fluid clear

Sutures of the skull bones are apposed

Blood pressure 120/70 mmHg

Temperature 36.8°C

Pulse 80/minute

Urine output 200 mL; negative protein and acetone

Q: What steps should be taken?

Q: What advice should be given?

Q: What do you expect to find at 13.00?

STEP 3

Plot the following information on the partograph:

09.30 FHR 120, Contractions 3/10 each 30 seconds, Pulse 80/minute

10.00 FHR 136, Contractions 3/10 each 30 seconds, Pulse 80/minute

10.30 FHR 140, Contractions 3/10 each 35 seconds, Pulse 88/minute

11.00 FHR 130, Contractions 3/10 each 40 seconds, Pulse 88/minute, Temperature 37°C

11.30 FHR 136, Contractions 4/10 each 40 seconds, Pulse 84/minute, Head is 2/5 palpable

12.00 FHR 140, Contractions 4/10 each 40 seconds, Pulse 88/minute

12.30 FHR 130, Contractions 4/10 each 45 seconds, Pulse 88/minute

13.00 FHR 140, Contractions 4/10 each 45 seconds, Pulse 90/minute, Temperature 37°C

13.00:

The fetal head is 0/5 palpable above the symphysis pubis

The cervix is fully dilated

Amniotic fluid clear

Sutures apposed

Blood pressure 100/70 mmHg

Urine output 150 mL; negative protein and acetone

Q: What steps should be taken?

Q: What advice should be given?

Q: What do you expect to happen next?

STEP 4

Record the following information on the partograph:

13.20: Spontaneous birth of a live female infant weighing 2,850 g

Answer the following questions:

Q: How long was the active phase of the first stage of labour?

Q: How long was the second stage of labour?

6. SESSION EVALUATION FORMS

Mentor Evaluation Questions

1. Which part of the workshop did you enjoy most?

2. Which part of the workshop did you least enjoy?

3. Can you list 5 new things you learned during the workshop?

    1. ……..

    2. ……..

    3. ……..

    4. ……..

    5. ……..

4. What parts of the workshop could be improved for next time?

5. What was difficult to understand?

6. What do you feel you need more practice on?

7. What activities in the workshop most helped you understand the mentorship approach?

8. How caN you be a good mentor (list 3 key points)

    1. ……

    2. ……

    3. ……

Next steps:

9. What do you think will be challenging in your own practice setting?

10. What would help you feel more confident/ready to be a mentor?

Trainer Mentor Evaluation Questions

1. Which part of the workshop did you enjoy most?

2. Can you list 5 new things you learned during the workshop?

    1. ……..

    2. ……..

3. ……..

4. ……

5. ……

3. What parts of the workshop could be improved for next time?

4. What was difficult to understand?

5. What do you feel you need more practice on?

6. How can you be a good trainer mentor (list 3 key points)

1. ……..

2. ……..

3. ……

Next steps:

8. What do you think will be challenging in your own practice setting?

9. As a trainer mentor and leader of the mentor team in your hospital, what is your first goal that you would like to achieve?

Sample Checklists

To be used during sessions outlined above

CHECKLIST FOR COACHING SKILLS

Learner: _____ **Date Observed:** _____

CHECKLIST FOR CLINICAL COACHING SKILLS						
STEP/TASK	**OBSERVATIONS**					
BEFORE PRACTICE SESSION						
1. Greets learner and reviews previous performance when applicable.						
2. Works with the learner to set specific goals for the practice session.						
DURING PRACTICE SESSION						
1. Observes the learner, providing positive reinforcement or constructive feedback (when necessary for client comfort or safety) as s/he practices the procedure.						
2. Refers to the checklist or performance standards during observation.						
3. Records notes about learners' performance during the observation.						
4. Is sensitive to the client when providing feedback to the learner during a clinical session with clients.						
AFTER PRACTICE FEEDBACK SESSION						
1. Reviews notes taken during the practice session.						
2. Greets the learner and asks to share perception of the practice session.						
3. Asks the learner to identify those steps performed well.						
4. Asks the learner to identify those steps where performance could be improved.						
5. Provides positive reinforcement and corrective feedback.						
6. Works with the learner to establish goals for the next practice session.						
Skilled delivery of coaching						

CHECKLIST FOR DEMONSTRATION SKILLS

Learner:_____ **Date Observed:**_____

CHECKLIST FOR CLINICAL DEMONSTRATION SKILLS						
STEP/TASK	**OBSERVATIONS**					
1. States the objective(s) as part of the introduction.						
2. Presents an effective introduction.						
3. Arranges demonstration area so that learners are able to see each step in the procedure clearly.						
4. Communicates with the model or client during demonstration of the skill/activity.						
5. Asks questions and encourages learners to ask questions.						
6. Demonstrates or simulates appropriate infection prevention practices.						
7. When using model, positions model as an actual client.						
8. Maintains eye contact with learners as much as possible.						
9. Projects voice so that all learners can hear.						
10. Provides learners opportunities to practice the skill/activity under direct supervision.						
Skilled delivery of a clinical demonstration						

References

1. Lao PDR Social Indicator Survey 2011-2012. Vientiane, Lao PDR
2. The 4th Lao PDR Population and Housing Census 2015. Lao Statistics Bureau, Lao PDR
3. Leslie H et al. 2016. Training and supervision did not meaningfully improve quality of care for pregnant women or sick children in sub-Saharan Africa. Health Affairs 35(9): 1716–1724
4. Mentoring for Human Capacity Development Implementation Principles and Guidance, MCSP, January 2018

ANNEXES

ANNEX 1: MENTOR SELECTION CRITERIA

Selection of the core group mentors will be deliberate and consultative with the MoH to include skilled teachers and professionals who are embedded in key educational institutions including pre-service training sites and teaching hospitals. It will include clinicians that affect MNH service delivery from multiple entry points and across professions. The selection will be decided by a committee appointed by the PHO.

Criteria

1	Qualification as medical doctor, medical assistant, midwife or midwife trainer
2	Minimum 5 years of experience working with mother and newborn care
3	Current role provides opportunity for sharing/mentoring on new skills for maternal and newborn survival (working in clinical area, training school, provincial supervisor)
4	Previous training / mentoring experience for mother and newborn care
5	Participation in MCSP Mentoring activities will not be detrimental to workload of current workplace
6	Senior management is supportive and agrees to allow staff to participate as mentor for MCSP project
7	Can commit to participation in MCSP mentorship activities for the duration of the program (18 months minimum)
8	Interested and enthusiastic to learn and apply new skills in the workplace, enjoys facilitation and participatory learning, and is a collaborative team member respected by colleagues
9	Has the ability and willingness to travel to remote districts and stay overnight in district at regular frequency for an agreed period of time
10	Can commit to being a role model by consistently practicing the new competencies in own workplace
11	Can commit to actively participate and contribute in learning and evaluation of mentorship process through feedback, and participation in mentor meetings for sharing experience and learning

ANNEX 2: SAMPLE MENTORS' WORKSHOP GOALS AND LEARNING OBJECTIVES

Workshop Goals

1. To develop 15 MNH senior professionals as mentors, skilled and competent to mentor other MNH providers.
2. Collaboratively develop the tools to support mentorship in practice and field test the approach.
3. Prepare and equip mentors to begin mentor visits and to feedback process learning to develop the approach.

Learning Objectives

1. Develop skills in mentorship as a 'learning by doing together' approach for adult learning.
2. Collaboratively develop a clinical skills guideline for quality care for mother and newborn at the time of birth (Normal delivery and Neonatal resuscitation).
3. Ensure mentors are competent in their skills to perform a safe delivery following the clinical skills guideline.
4. Ensure mentors are competent in the use the anatomical models (MamaNatalie and Neo Natalie).
5. Field-test the clinical skills guideline during a mentor visit to a provincial and district hospital.
6. Outline the plan for a mentor visit including preparation, agenda and feedback.
7. Understand the three areas of focus for quality improvement (Skills/knowledge, Environment/opportunity and Motivation/attitude).
8. Ensure that mentors are prepared to respond appropriately to challenges in practice and collaboratively agree on a solution using the action-planning tool.
9. Mentors develop action plans for their own practice setting and have a sense of ownership for improving quality in practice in their facility.

ANNEX 3: SAMPLE MENTORS' WORKSHOP AGENDA

Strengthening Maternal and Newborn Service Delivery Mentors' Workshop

This 8-day workshop is held to develop an initial cadre of mentors (provincial and district). These mentors will subsequently provide support visits to districts and mentor staff. Facilitators are competent mentors and trainers with robust clinical skills and expertise.

Workshop Preparation:

- ✓ **Draft workshop goals** and learning objectives and have them ready for sharing during the launch. See Annex 2 for sample workshop goals and learning objectives
    - o Prepare draft tools ahead of the workshop – these will include clinical guidelines / checklists and mentoring standards that are updated for most recent WHO and other global guidance documents.
- ✓ Draft workshop agenda. Build in flexibility to review and update it on a daily basis based on feedback from workshop participants. Workshop should be a minimum of 8 days.
    - o Develop session plans and materials required to organize the session
    - o Identify games for ice-breakers and to re-energize the group when required
- ✓ Identify facilitators: Facilitators should be clinically experienced in technical areas, as well as experienced in mentoring and facilitating capacity-building workshops. An ideal facilitator to participant ratio is 1:6.
- ✓ Prepare workshop venue. Ensure adequate space for group work and other learning activities. A circle or U-shape is recommended for chairs, with a break out space with 4-5 stations behind where role-play practice can occur
- ✓ Organize workshop materials: Ready equipment, supplies, stationary, anatomical models, banners for the workshop. Develop full inventory of materials and include a mechanism to keep track of them, es pecially the equipment and anatomical models. Ensure completeness and functionality. See Annex 4 for list of recommended workshop materials.

Workshop Session Planning:

- ✓ Participants should have time to review draft tools (clinical guidelines / checklists and mentoring stan dards) and adapt them to comply with national policies and protocols and their own experience with clinical practice.
- ✓ The workshop should include a half-day session where mentors field test their newly finalized checklists / guidelines and skills in the nearest facilities in small groups. This is a critical component of the work shop that provides the opportunity for the participants to field-test the tools they develop and also allow the mentors to experience the opportunities and challenges they could potentially face once they move to the field sites.
- ✓ Sessions on Problem Solving skills development should also be built in for example, including non-clini cal challenges like motivating staff to receive and support mentoring
- ✓ A session led by an M&E expert should be an integral part of this first workshop to review M&E for the delivery of day of birth clinical services and for the delivery of mentoring services to support clinical services. Indicators, sources of data, frequency of data collection and regular use of data for program improvement should be included in the discussions. However, this needs to be realistic and as far as possible indicators and data should be sourced from the national DHSI2 system with only minimal additional indicators for initial program monitoring during the start-up phase. The long-term goal is for sustainability of mentoring within the government system and this should include sustainable M&E. A draft initial M&E plan should be a product of such a session.

MENTORS' WORKSHOP AGENDA

Time	Activity	Facilitators	Objectives of Session
DAY ONE			
Morning	Official Launch of the workshop		MOH, PHO and stakeholders including NGO's
11:00 – 12:00 pm	Ground rules, assignments Objectives for workshop Roles and responsibilities for mentors		Workshop atmosphere created
1:00 – 1:30 pm	Introductions: ice-breaker pair work, including expectations of participants		Workshop atmosphere created
1:30 – 3:45 pm	Identification of competencies and gaps in role-play activity in groups		Competencies prioritized and gaps identified
3:45– 4:00 pm	**Wrap up Activity Day One**		
4:00 – 4:30 pm	Facilitation team meeting		
4:30 – 6:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY TWO			
8:30 - 9:00 am	**Recap**		
9:00 – 10:30 am	Approach to mentoring: principles of demonstration		Increased understanding on correct method of demonstration
10:30 – 2:30 pm	Use of anatomical model Gain proficiency in equipment set up and preparation		Mentors introduced to using anatomical models: MamaNatalie and Neo Natalie?
3:00 – 3:45 pm	Gathering input to project monitoring plan What are anticipated challenges for the first mentoring visit?		Involving mentors in the design of M&E plan
3:45 – 4:00 pm	**Wrap Up Activity Day Two**		
4:00 – 5:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY THREE			
8:30 – 9:00 am	**Recap**		
9:00 – 2:45 pm	Develop clinical skills guideline for normal delivery and EENC		Mentors develop clinical skills guideline in line with existing national policies and protocols, including EENC
2:45 – 3:45 pm	Standardize skills and practice on normal delivery and EENC using the developed guideline		Mentors practice using the clinical skills guideline. Role plays in 4 groups
3:45 – 4:00	**Wrap Up Activity Day Three**		
4:00 – 5:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY FOUR			
8:30 – 9:00 am	**Recap**		
9:00 – 10:30 am	Develop clinical skills guideline: delivery where baby does not cry / breathe		Mentors developed clinical skills guideline in line with existing national policies and protocols, including EENC

10:45 – 12:00 pm	Mentoring use of partograph – case study (Sample Session Plans)		Mentors develop skills on use of partograph as a tool for decision making
1:00 – 2:30 pm	Improving Quality Services in health facilities through mentorship		Mentors understand how mentoring leads to improved quality of services in health facilities
2:45 – 3:45 pm	Planning and preparations for field testing of the developed clinical skills guideline and mentorship approach as a learning visit		Mentors generate preliminary understanding of steps involved for mentoring visit
3:45 – 4:00 pm	**Wrap Up Activity Day Four**		
4:00 – 5:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY FIVE			
8:00 – 12:00 pm	Mentoring practice in 5 groups in LPB health facilities (2 groups to the districts and 3 groups alternate to LP provincial hospital)		Field test of clinical skills guideline and mentoring approach
1:30 – 3:45 pm	Group discussion to reflect on mentoring visit: what went well, what needs improvement, challenges faced, anticipated and potential solutions, input in clinical skills guideline		Refinement of clinical skills guideline and mentoring approach
3:45 4:00 pm	**Wrap Up Activity Day Five**		
4:00 – 5:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY SIX			
8.30am -9am	What is Mentorship? What makes a good mentor? Differences between mentor and trainer.		Identify how the concept of mentorship has been understood
9:00 – 10:30 am	Standardize skills and practice: - Delivery where baby is not crying / breathing - Demonstration of newborn resus		Mentors practice using clinical skills guideline Competence in newborn resus
10:45 – 12:00 noon	Practice using MamaNatalie and NeoNatalie: assemble, disassemble, use, including preparation of list of parts		Mentors become competent in use of anatomical models
1:00 – 2:00 pm	Group work: Mentors develop challenging scenarios for mentoring, review of the scenario and complete for practice		Mentors involved in anticipating challenging mentoring scenarios; set of scenarios ready for practice
2:00 – 3:45 pm	Standardize competencies for: - Normal delivery and immediate ENC - Delivery where baby is not crying / breathing; Group work role-play -		Mentors become competent in skills for normal delivery and a delivery where baby is not crying / breathing

10:45 – 12:00 pm	Mentoring use of partograph – case study (Sample Session Plans)		Mentors develop skills on use of partograph as a tool for decision making
1:00 – 2:30 pm	Improving Quality Services in health facilities through mentorship		Mentors understand how mentoring leads to improved quality of services in health facilities
2:45 – 3:45 pm	Planning and preparations for field testing of the developed clinical skills guideline and mentorship approach as a learning visit		Mentors generate preliminary understanding of steps involved for mentoring visit
3:45 – 4:00 pm	**Wrap Up Activity Day Four**		
4:00 – 5:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY FIVE			
8:00 – 12:00 pm	Mentoring practice in 5 groups in LPB health facilities (2 groups to the districts and 3 groups alternate to LP provincial hospital)		Field test of clinical skills guideline and mentoring approach
1:30 – 3:45 pm	Group discussion to reflect on mentoring visit: what went well, what needs improvement, challenges faced, anticipated and potential solutions, input in clinical skills guideline		Refinement of clinical skills guideline and mentoring approach
3:45 4:00 pm	**Wrap Up Activity Day Five**		
4:00 – 5:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY SIX			
8.30am -9am	What is Mentorship? What makes a good mentor? Differences between mentor and trainer.		Identify how the concept of mentorship has been understood
9:00 – 10:30 am	Standardize skills and practice: - Delivery where baby is not crying / breathing - Demonstration of newborn resus		Mentors practice using clinical skills guideline Competence in newborn resus
10:45 – 12:00 noon	Practice using MamaNatalie and NeoNatalie: assemble, disassemble, use, including preparation of list of parts		Mentors become competent in use of anatomical models
1:00 – 2:00 pm	Group work: Mentors develop challenging scenarios for mentoring, review of the scenario and complete for practice		Mentors involved in anticipating challenging mentoring scenarios; set of scenarios ready for practice
2:00 – 3:45 pm	Standardize competencies for: - Normal delivery and immediate ENC - Delivery where baby is not crying / breathing; Group work role-play -		Mentors become competent in skills for normal delivery and a delivery where baby is not crying / breathing

3:45 - 4:00 pm	**Wrap Up Activity Day Six**		
4:00 – 5:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY SEVEN			
9:00 – 10:30 am	Developing competency in mentorship using various scenarios: including environment and motivation challenges: group work role-play		Mentors become competent in mentoring in challenging situations
10:45 – 12:00 noon	Follow up and mentoring at regular intervals: Use of action planning tool (Sample Session Plans section)		Mentors agree on regular follow up with health facility team they have mentored using action planning tool
1:00 – 3:30 pm	Mentors as role models: standardizing QOC through mentorship in own health facility / hospital Develop Action plan for their own facility and share in plenary		Mentors develop action plans to standardize QOC in their own practice areas
3:45 4:00 pm	**Wrap Up Activity Day Six**		
4:00 – 5:00 pm	In-house meeting of MCSP team to review day, prepare for next day etc.		
DAY EIGHT			
9:00 – 10:30 am	Mentors and MCSP team brain storm for the first round of mentoring in groups: - What needs to be considered when thinking of planning a schedule? - How do you prepare for a mentor visit? Develop generic agenda for mentorship visit - How do we align mentorship with existing regular supervision and other programs like EENC? - How will mentors feedback into the learning process and share experience and what support do they need?		Mentors involved in designing mentoring plans and planning next steps including alignment with current supervision schedules and programs and feedback into mentorship process learning
10:45 – 12:00 pm	Mentors share ideas for closing ceremony with invited guests		Mentors involved in disseminating achievements of workshop
2-4 pm	Debrief and closing with partners		Sharing process of workshop with partners
	Post-workshop debriefing and planning next steps In-house meeting of MCSP team to review workshop. Discussion on use of key mentors to work with technical expert/advisor to give input into planning and delivery of next workshop. Plans for guideline dissemination		Review of workshop and plan for modifications to approach for 2nd workshop. Learning from workshop. Planning next steps- 3 months visit and visit from technical expert / advisor

ANNEX 4: MENTORS' WORKSHOP MATERIALS LIST

NUMBERS NOTED BELOW FOR ONE GROUP 4-5 trainees

S. No	Description	Unit	Quantity
	Materials for Demonstration		
	Delivery set per group		1
1	Artery forceps	2 (6")	1
2	Sponge holding forceps	1 (8")	1
3	Cord cutting scissors	1	1
4	Bowl for placenta	1 (Big)	1
5	Gallipot	1 (small)	1
6	Drapes (1X1 meter)	4 pc	4
7	Gauze	3 pc	
8	cotton ball	few	
9	Pad	2	
10	Rubber sheet (Mackintosh)	1 (1/2 meter)	1
11	Set wrapper	1 (1X1 meter double)	1
12	Cord clamp (plastic)	1	1
13	Surgical gloves	(6.5)	1 box
	Models		
1	MamaNatalie		1
2	NeoNatalie		1
3	Mama Breast		1
	Short Guideline		
1	Normal Birth		20
2	Birth where is born not crying/breathing		20
	IP materials per group		
1	Bucket		2
2	Bucket with tap		1
3	Bowl		2
4	Mug (1 liter)		1
5	Plastic apron		1
6	Gumboots		1 pair
7	Visor		1
8	Tooth brush		2
9	Soap		1
10	Utility gloves		1
11	Virex		1

ANNEX 5: MENTORS' WORKSHOP TEACHING TOPICS

Key Topics to be covered	
1	Introduction, objectives, expectation, agenda
2	Standardizing mentor's own clinical skills (practical session)
3	Developing different types of competencies - partograph
4	Demonstration skills
5	Mentor as a coach/coaching skills
6	Eliciting feedback from mentees
7	Problem identification & action planning
8	Mentor's reflection and self-evaluation as mentors

ANNEX 6: SAMPLE DOCUMENTATION SYSTEM

M&E Tools

This list of tools was developed for the one-year start-up phase of the program. Any tools that are already in the DHSi2 system can be discarded from this list and sourced directly from DHSi2. The long-term goal is to refine the M&E tools so that they are integrated into the routine monitoring system.

1.	Clinical Skills Guideline	5 mentees and mentors	Mentors (checked by trainer mentor)
2.	Mentoring skills	All mentors	Trainer mentor
3	Exit interview	Mothers after delivery	Program staff
4.	Partograph survey	5 per month (15)	Program staff with MCH staff mentors and mentees
5.	Chart review	5 per month (15)	Program staff with MCH staff mentors and mentees
6.	Service delivery readiness	1 form	Program staff with MCH staff mentors and mentees

1. CLINICAL SKILLS GUIDELINE:

Mentor name……. Mentee name……..

Date……..…… Place……

Clinical Skills Guideline For Assisting Birth If Baby Does Not Cry / Breathe at Birth (*Some of the following steps/tasks should be performed simultaneously*)					
Step					
STEP 1. MONITOR PROGRESS OF WOMAN IN LABOR					
1. Use the partograph to monitor the woman in labor and use the information gained for clinical decision making.					
Score step 1					
STEP 2. PREPARATIONS JUST BEFORE BIRTH					
1. Introduce yourself to the woman. Let the woman identify a companion of choice (at the right time and occasion).					
2. Review partograph data, obtain pregnancy history and birth plan, check laboratory results including test for syphilis / HIV / Hepatitis B.					
3. Encourage the woman to empty her bladder (if she can walk) to avoid using a urine catheter. Let the woman adopt a comfortable position of her choice for the delivery.					
4. Adjust the temperature in the delivery room to be between 25-28 degrees, with no air drafts					
5. Ensure woman's privacy for the mother's comfort.					
6. Remove jewelry from hands of providers and from the woman in labor (prepare for skin to skin with baby) and give advice to the woman at the same time.					
7. Perform proper hand washing (7 steps): 1st time.					
8. Provide continual emotional support and reassurance. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
9. Examine the woman: take BP, pulse rate, respiratory rate, and temperature.					
10. Prepare the necessary materials for provider, mother and baby: -For the provider: 1. Boots, apron, cap, mask, glasses. 2. Prepare the delivery kit, oxytocin, syringes, Povidone, 8-10 cloths, 3 pairs of sterile surgical gloves. -For the mother: 1. One plastic sheet under the mother's body. 2. Two Lao skirts. -For the baby: 1. Two large baby blankets to cover the baby. 2. 4-6 cloths. 3. A bonnet/hat. 4. Vitamin K1, BCG, HepB, Tetracycline Eye ointment					

Clinical Skills Guideline For Assisting Birth If Baby Does Not Cry / Breathe at Birth (*Some of the following steps/tasks should be performed simultaneously*)					
1. Use both hands to gently support and deliver the baby onto the dry cloth draped over the mother's abdomen. Gently dry the baby with the cloth immediately within 5 seconds • Dry the baby's face, head, arms, legs and back in order to dry the baby (it will also help stimulate the baby). • Assess the newborn's breathing / cry while drying, and call out the time of birth and sex of the baby. Remove the wet cloth. Place the baby skin to skin on the mother's abdomen, cover the baby with a new, clean, dry cloth, cover the baby's head with hat / bonnet. **Do not do routine suctioning if not necessary**.					
2. ***If baby is not crying/breathing: immediately begin resuscitation.***					
Score step 4					
STEP 5. NEWBORN RESUSCITATION – AIRWAY AND STIMULATION					
1. Call for help. Explain to the mother that her baby needs help to breathe and ask an assistant to help with the mother. If attending the birth alone, prioritize newborn resuscitation and give mother the injection of Oxytocin only after resuscitation is complete (perform the following steps, after checking that there is no second baby).					
2. Turn baby on its side, continue skin-to-skin contact, and check if airway is clear. *Suction only if airway is full of secretions (**Do not suction mouth and nose routinely if not necessary**).					
3. In the side position and in skin to skin contact, stimulate breathing by rubbing the back 2-3 times					
4. If the baby cries or breathes normally, continue skin-to-skin contact with the mother's chest, covering the baby with a warm, dry cloth. Ensure head continues to be covered by hat / bonnet.					
5. **If the baby does not breathe** after rubbing the back, clamp and cut the cord long with sterile scissors					
6. Transfer the baby to a firm, clean, dry surface that was prepared and cover the baby and its head with a hat / bonnet, and body with warm clean cloth leaving the chest exposed. **The area and equipment for resuscitation should have been prepared before the birth.**					
7. Stand at the baby's head to control the head of the baby and to look at the movement of the chest.					
8. Proceed with ventilation using bag and mask **within one minute after the baby's birth.**					
Score step 5					
STEP 6. NEWBORN RESUSCITATION – BAG AND MASK VENTILATION					
1. Select size of mask which is appropriate for newborn babies.					
2. Position the baby's head in a slightly extended position to open the airway					

Clinical Skills Guideline For Assisting Birth If Baby Does Not Cry / Breathe at Birth (*Some of the following steps/tasks should be performed simultaneously*)					
3. Position the mask on the face so that it rests on the tip of the chin, then place the mask over the mouth and nose. Hold the mask firmly, forming a tight seal on the face.					
4. Hold the mask with the thumb and index finger on top of the mask. Use the middle finger to hold the chin up toward the mask. Use the fourth and fifth fingers along the jaw to lift it forward and help keep the airway open. Form a tight seal by pressing lightly on the top of the mask and gently holding the chin up towards the mask.					
5. Squeeze the bag attached to the mask with two fingers or the whole hand, according to bag size, 2-3 times. Observe the rise of the chest.					
6. Ventilate at a rate of 40 breaths/minute for 1 minute. Count aloud, "breathe...two…three…breathe….two….three." Squeeze the bag as you say "breathe" and release while you say "two…three".					
7. Evaluate the breathing of the baby while ventilating. Some babies improve quickly and begin breathing after brief ventilation. Some require continued ventilation with the bag and mask.					
8. Stop ventilation when the baby is breathing normally. Change to new sterile gloves. Clamp and cut the cord to the right size using sterile scissors. Take the baby back to the mother for skin to skin contact under close monitoring.					
9. If the baby is not breathing, take steps to improve ventilation: a. Reposition the head with the neck slightly extended. b. Reapply the mask to the face to form a better seal. c. Check the mouth and the nose for secretions and clear them as necessary. d. Open the baby's mouth slightly before reapplying the mask. e. Squeeze the bag harder to give a larger breath.					
10. If the baby does not breathe after one minute of ventilation with chest movement, evaluate the heart rate by feeling the umbilical cord pulse or listening to the heart beat.					
11. If the heart rate is normal, continue to ventilate until the baby is breathing well. Gradually reduce the rate of ventilation and look for the baby's breathing. If the heart rate stays normal as the baby begins to breathe, stop ventilation. Ventilation can stop when the baby is breathing and the heart rate stays normal (more than 100 beats per minute).					
12. If the baby has no heart rate and no breathing after giving ventilation for 10 minutes, the baby is dead. Stop ventilation.					
13. If after 20 minutes of effective ventilation, the baby does not start to breathe or gasp and the heart rate is less than 60 per minute, stop bag and mask ventilation. Explain to the mother and family (in a kind and gentle tone) that despite all attempts you are unable to help the baby to breathe. Provide comfort care, including warmth and psychological support. Record the event.					
14. Whatever the outcome, ensure that the mother and family are aware of the process of resuscitation and provide support as necessary.					
Score step 6					

Clinical Skills Guideline For Assisting Birth If Baby Does Not Cry / Breathe at Birth (*Some of the following steps/tasks should be performed simultaneously*)					
STEP 7. ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR					
1. If after completion of resuscitation and checking there is no additional baby, give oxytocin 10 units IM. However, if additional help is available, give oxytocin 10 units IM within 1 minute of birth.					
2. Palpate for uterine contraction.					
3. With one hand above the pubic bone, apply pressure in an upward direction (towards the woman's head) to apply counter traction and stabilize the uterus.					
4. At the same time, with the other hand, pull with a firm, steady tension on the cord in a downward direction (follow direction of the birth canal).					
5. Deliver the placenta slowly with both hands, gently turning the entire placenta and lifting it up and down until the membranes deliver.					
6. Immediately after the placenta delivers, check uterine tone and if necessary massage the uterus until firm. Note time of delivery of the placenta.					
7. Examine the placenta, membranes and cord.					
8. Inspect the vulva, perineum and vagina for lacerations/tears and carry out appropriate repairs as needed. In case of heavy bleeding, manage as necessary.					
9. Gently cleanse the vulva and perineum with clean water and apply a clean pad/cloth between the thighs.					
10. Assist the mother to a comfortable position for continued skin to skin contact for 90 minutes, and breastfeeding within one hour to stimulate bonding with her newborn.					
Score step 7					
STEP 8. POST-DELIVERY TASKS					
1. Dispose of contaminated items in a plastic bag or leak-proof, covered waste container.					
2. Decontaminate instruments (delivery kit, resuscitation devices) by placing them in a container filled with 0.5% chlorine solution for 10 minutes. When they are disinfected, set them aside for cleaning and sterilization					
3. Dispose of needles, syringes and broken glass vials in a puncture-resistant sharps container.					
4. Remove gloves by turning them inside out. Place gloves in a plastic bag or leak-proof, covered waste container.					
5. Perform proper hand washing.					
6. Record information on the mother and newborn in the partograph, patient chart and register book.					
Score Step 8					
STEP 9. ROUTINE PROCEDURES AFTER BIRTH					
1. Follow up closely with the mother in the first two hours: every 15 minutes in the first hour and every 30 minutes in the second hour (if necessary check more often).					

Clinical Skills Guideline For Assisting Birth If Baby Does Not Cry / Breathe at Birth (*Some of the following steps/tasks should be performed simultaneously*)					
2. Check mother's vital signs, uterine tone and bleeding.					
3. Follow up closely with newborn in the first two hours: every 15 minutes in the first hour and every 30 minutes in the second hour (if necessary check more often). Check newborn for breathing, temperature (by feeling baby's forehead or foot) and breastfeeding.					
4. After 90 minutes of birth, complete further care of the newborn that includes: a. Eye care. b. Cord care. c. Vitamin K. d. Hepatitis B treatment. e. Measurement of weight, length, and head circumference. f. Complete examination focusing on breathing, movement and tone, skin color, and cord appearance to rule out congenital anomalies.					
Score Step 9					

2. MENTORING SKILLS GUIDELINE

Standards for Mentoring

Name of mentor	
Location	
Date	
Name of observer	

Performance Standard	Verification Criteria	Yes / No	Comments
1. Mentor creates good learning environment	Mentor greets the mentees and prepares the appropriate learning environment to begin mentoring		
	States overall objective of mentoring session		
2. Mentor can provide clear demonstration	States objective of session as part of introduction		
	Arranges demonstration area so that learners are able to see clearly		
	Communicates with model during demonstration of the skill		
	Maintains eye contact with learners as much as possible		
	Projects voice so that learners can hear		
	Asks questions and encourages learners to ask questions		
	Demonstrates steps as per standard guideline		
	When using model, positions model as actual client		
3. Mentor coaches effectively	**Before:**		
	States objective of session as part of introduction		
	Reviews previous performance as applicable		
	Works with mentees to set specific goals		
	During:		
	Observes the mentee providing positive encouragement		
	Refers to the guideline during observation		
	Provides learners opportunities to practice skill / activity under direct supervision		
	Records notes about learners' performance		
	Considers the mother's feeling when providing comment/ feedback to mentee during real delivery.		

	After:		
	Reviews notes taken during practice session		
	Asks the mentee to share reflections of the practice session		
	Asks mentee to identify steps where performance could be improved		
	Provides positive and constructive feedback		
4. Mentor uses assessment effectively	Uses the Guideline (assessment tool) to assess mentee		
	Reviews client records to provide feedback on clinical decision making skills		
5. Mentor facilitates the development of a realistic action plan for the facility and follows up on progress towards achieving the plan	Works with mentees to identify problems and analyze root cause		
	Facilitates the mentees to create a realistic action plan with SMART goals		
	Follows up on facility action plans from previous visit and provides constructive feedback		
6. Mentor is able to reflect on own progress as mentor and demonstrates self-awareness	Mentor able to describe what they would like to improve as a mentor and where they need further support/practice		
	Mentor is able to share their own lessons learnt during the mentoring visit		
	Mentor is able to share their recommendations for next visit		
7. Mentor is able to ensure the safety of the mother and newborn at all times	Mentor can ensure the privacy of the mother and appropriate number of mentees		
	Ensures the safety of the mother and newborn		
	TOTAL SCORE		

3. EXIT INTERVIEW WITH POSTPARTUM MOTHERS

Facility name:	**Date:**
For the period:	**Data collector:**

Question	**Mother No.**				
	1	**2**	**3**	**4**	**5**
Interview section (Answer the questions with Y = yes; N = no)					
1. Informed consent obtained					
2. Age of the baby (Hours)					
3. Did the midwife introduce herself to the mother?					
4. Was the mother asked if she would like a companion of choice?					
5. During childbirth					
a. Was the mother encouraged to sit, stand or lay in the position she most wanted?					
b. If yes, what position?					
6. Was baby placed in immediate skin to skin contact with mother?					
7. Was baby kept skin to skin for at least 90 minutes?					
8. Was breastfeeding started within 90 minutes after birth?					
9. Are you breastfeeding your baby now?					
10. Since delivery was her baby fed anything other than breast-milk? If yes, ask what?					
a. Water or sugar water					
b. Infant formula or other powder milk/celeriac					
c. Other, specify					
11. Did the mother receive breastfeeding demonstration + support from the midwife?					
12. Does the mother feel confident to breastfeed and to continue to breastfeed at home?					
13. Was the mother satisfied/happy with the care provided overall?					
Ask Mother if she would like to make any comment…… (Please note what is said) ……					

Question	Mother No.				
	1	2	3	4	5
……					

Clinical Record Validation	1	2	3	4	5
Mother's hospital ID					
Baby placed in immediate skin to skin contact with mother (Y/N)					
Baby kept skin to skin for at least 90 minutes (Y/N)					
Breastfeeding started within 90 minutes after birth (Y/N)					

4. PARTOGRAPH SURVEY

Facility name:	Date:
For period:	Data collector:

		Month_____ Year_____					Month_____ Year_____					Month_____ Year_____				
Assessment items		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1	Pregnancy history															
2	Time record															
3	Fetal heart every 30 min															
4	Amniotic fluid															
5	Moulding															
6	Cervical dilatation															
7	Descent of head															
8	Contraction															
9	Vital sign															
10	Urine test															
11	Time of birth															
12	Sex of baby															
13	Baby weight															
14	Baby condition															
15	APGAR (for live birth)															
	Total Score															
Tick (✓) if properly filled																

5. CHART REVIEW OF POSTPARTUM MOTHERS

Facility name:	Date:
For the period:	Data collector:

Please review 5 charts per month

Question Answer the questions with Y = yes; N = no	Month_____ Year_____					Month_____ Year_____					Month_____ Year_____				
	1	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
1. Identifying information of mother and baby															
2. Was IM oxytocin given after delivery?															
3. Was the newborn placed skin to skin?															
4. Was the time skin to skin started and time skin to skin stopped noted accurately (Ie started at 9.20am-10.50am) and lasted for at least 90 minutes?															
5. Was breastfeeding started within 90 minutes?															
6. Was the newborn weighed and weight documented?															
7. Was the mother's ability to attach the baby correctly and breastfeed confidently before going home documented in the chart?															
8. Was any case PPH? If yes, was it documented?	☐ Yes ☐ No ☐ Yes ☐ No														

6. SERVICE DELIVERY READINESS

Facility name:	Date:
For period:	Data collector:

Tick (✓) the applicable box

1. Is water available in delivery room? (Check running water in delivery room):

   ☐ Yes ☐ No

2. Is soap available in delivery room?

   ☐ Yes ☐ No

3. Are clean towels available in delivery room?

   ☐ Yes ☐ No

4. Is a resuscitation bag available in delivery room?

   ☐ Yes ☐ No

5. Are two sizes of masks available in delivery room?

   ☐ Yes, both sizes

   ☐ No, only one size is available 0 1

6. Are bag and mask clean (no dust)?

   ☐ Yes ☐ No

7. Are bag and mask easily accessible for use? (kept in delivery room without lock, no special permission needed)

   ☐ Yes ☐ No

8. Is a UBT kit prepared and available in the facility?

   ☐ Yes ☐ No

9. Is a current facility quality improvement action plan in place?

   ☐ Yes ☐ No

10. When was the quality improvement plan last updated?

    In the last month ☐ In the last 3 months ☐ Not updated ☐

ANNEX 7: TRAINER MENTOR ROLES AND RESPONSIBILITIES

	Roles and Responsibilities of Trainer Mentors
1.	Trainers of mentors will develop MNH providers to become mentors, ensuring they have both clinical and mentoring skills
2.	Trainers of mentors will support the ongoing progress and development of mentors by providing supportive supervision, on-site visits to other districts and through regular contact
3.	Trainers of mentors will support mentors to implement mentoring sessions in their own facility and at health centers
4.	Trainers of mentors will assist in monitoring and evaluation using simple clinical and mentoring skills assessment tools and documentation of learning
5.	Trainers of mentors will continue to be mentors in their own place of work and will influence quality improvements
6.	Understands that fees/perdiem and other costs will follow the Save the Children policy and payment scale

ANNEX 8: TEACHING TOPICS FOR TRAINER MENTORS' WORKSHOP

Topics for Teaching		
	TOPICS	**FACILITATOR**
	Knowledge assessment	
	OSCE	
	CLINICAL SKILLS	
1.	Partograph - case study	
2.	Use of anatomical models	
3.	Demonstration - Normal delivery with baby breathing + breastfeeding session	
4.	Demonstration - Delivery with baby not breathing	
	MENTORING SKILLS	
5.	Coaching in a clinical setting: delivery with baby not breathing / crying	
6.	Providing feedback. Mentor reflection and self-evaluation	
7.	Action Planning, includes planning for mentoring session within district hospital	
8	Mentoring in challenging situations	

ANNEX 9: TRAINER MENTORS' WORKSHOP SAMPLE AGENDA

The trainer mentors' workshop should be a minimum of 5 days, with 7 days recommended to allow time for planning and practice of teaching sessions. The first 2 days should be devoted to standardizing skills and building confidence in the clinical and mentoring capacity of the trainer mentors.

Additional Pointers:

- ✓ Sessions should be facilitated interactively, using different teaching styles to provide trainer mentors with examples of how to develop their own sessions.
- ✓ Practice teaching should be included as often as possible, with teaching topics allocated to each trainer mentor.
- ✓ Trainer mentors should have the opportunity to practice teaching in pairs.
- ✓ Time should be included toward the end of the workshop for trainer mentors to work together with facilitators to develop their own session plans, including selecting training methodologies and gathering materials required to facilitate their sessions. Trainer mentors should have the opportunity to practice leading their developed sessions with feedback from the group.

Monday	Tuesday	Wednesday	Thursday	Friday
8:30 - 9:00 am Welcome, logistics for the week **9:00 - 9:45 am** Introductions, objectives, expectations, agenda **10:00 - 12:00 noon** Knowledge assessment and introduction to different types of competencies (partograph)	**8:30 - 8:45 am** Recap **8:45 - 10:15 am** Tips for facilitating learning activities - small group activities **10.30 - 11:15 am:** Providing feedback **11:15 - 12:00 noon** Problem Identification and Action Planning Reflection and self-evaluation	Old Mentors prepare their sessions	Old Mentors start presenting their sessions	Sharing details of next week's workshop, agenda, roles and responsibilities, prepare workshop: old mentors present sessions
1:00 - 2:00 pm Mentor as a coach **2:00 - 3:00 pm** OSCE on baby not crying **3:15 - 4:00 pm** Mentoring Standards	Distribution of topics Old Mentors prepare their sessions	Old Mentors start presenting their sessions	Old Mentors start presenting their sessions	Reflections of the week: role as trainers, expectations for next week, support required Old Mentors prepare training site for workshop next week

ANNEX 10: TRAINER MENTORS' WORKSHOP MATERIALS LIST

Training Equipment (numbers for one group):

S. No	Description		Unit	Quantity
	Materials for Demonstration			
	Delivery set per group			1
1	Artery forceps		2 (6")	1
2	Sponge holding forceps		1 (8")	1
3	Cord cutting scissors		1	1
4	Bowl for placenta		1 (Big)	1
5	Gallipot		1 (small)	1
6	Drapes (1X1 meter)		4 pc	4
7	Gauze		3 pc	
8	cotton ball		few	
9	Pad		2	
10	Rubber sheet (Mackintosh)		1 (1/2 meter)	1
11	Set wrapper		1 (1X1 meter double)	1
12	Cord clamp (plastic)		1	1
13	Surgical gloves		(6.5)	1 box
	Models			
1	MamaNatalie			1
2	NeoNatalie			1
3	Mama Breast			1
	Short Guideline			
1	Normal Birth			20
2	Birth where is born not crying/breathing			20
	IP materials per group			
1	Bucket			2
2	Bucket with tap			1
3	Bowl			2
4	Mug (1 liter)			1
5	Plastic apron			1
6	Gumboots			1 pair
7	Visor			1
8	Tooth brush			2
9	Soap			1
10	Utility gloves			1
11	Virex			1

Stationary Materials:

S. No	Description	Quantity
	TRAINING MATERIALS	
1.	Banner	
2.	Notebook	
3.	Pilot dot Pen-Black	
4.	Lid pencil	
5.	My clear bag	
6.	Meta cards	
7.	Flipchart paper	
8.	Masking tape	
9.	Scissors (medium)	
10.	paper cutter	
11.	Stapler with pin	
12.	Paper clips	
13.	Highlighter (different color)	
14.	Re-Stick notes-Flags	
15.	Glue stick	
16.	A4 size colourful papers	
17.	Permanent markers (flat tip)-Black	
18.	Permanent markers (flat tip)-Blue	
19.	Permanent markers (flat tip)-Red	
20.	Permanent markers (flat tip)-Green	
21.	Board marker (flat tip)-Black	
22.	Board marker (flat tip)-Blue	
23.	Board marker (flat tip)-Red	
24.	Board marker (flat tip)-Red	
25.	LCD	
26.	Laptop	
27.	Printer	
28.	A4 size paper for printing	
29.	Payment sheet	
30.	Resource materials/equipment/ instruments/models	
31.	Checklists	
32.	Attendance sheet	
33.	Scale	
34.	Tipex	
35.	Agenda	
36.	Power point presentation	
37.	Post-it notes	

ANNEX 11: DISTRICT MENTOR SELECTION CRITERIA AND ROLES AND RESPONSIBILITIES

Selection of District Mentors

Aim for four nominees from each district. Workshop should not be more than 20 participants total. Train an initial cohort and repeat workshop 6 months later if numbers exceed this.

	Criteria
1.	Qualification as midwife, midwife trainer, nurse, medical doctor, medical assistant.
2.	Minimum 5 years of experience working with mother and newborn care
3.	Current role provides opportunity for sharing/mentoring on new skills for maternal and newborn survival (working in clinical area, training school, provincial supervisor)
4.	Previous training / mentoring experience for mother and newborn care
5.	Participation in MCSP Mentoring activities will not be detrimental to workload of current workplace
6.	Senior management is supportive and agrees to allow staff to participate as mentor for MCSP project
7.	Can commit to participation in MCSP Mentoring activities
8.	Understands that fees/per diem and other costs will follow the Save the Children policy and payment scale
9.	Interested and enthusiastic to learn new skills, apply new skills in workplace, enjoys facilitation and participatory learning, and is a collaborative team member respected by colleagues
10.	Ability and willingness to travel to remote districts and stay overnight in district

Roles and Responsibilities of District Mentors

1.	District mentors will support and mentor their colleagues in daily practice to ensure quality of care for mothers and newborns
2.	Will demonstrate role-model clinical skills, knowledge, attitude and behavior in workplace
3.	Will mentor health center staff in the health centers and encourage learning and improvement in mentees
4.	District mentors will become members of the District supervision team and will join supervision visits to provide mentoring in the health center
5.	Commits to participation in mentorship activities for one year with a review after one year
6.	Understands that fees/perdiem and other costs will follow the Save the Children policy and payment scale

ANNEX 12: DISTRICT MENTORS' WORKSHOP SAMPLE AGENDA

This workshop is held directly after the trainer mentors' workshop. This provides the opportunity for newly trained trainer mentors to lead a workshop entirely on their own, with supervision of the expert facilitators who trained them. This workshop is recommended to take 5-8 days, with priority given to establishing clinical skills at the outset.

Additional Pointers:

- ✓ Ensure clinical skills through pre- and post-test OSCEs
- ✓ Build mentoring skills during the workshop to the extent possible

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Opening, objective, expectations etc. Knowledge Assessment	Feedback on Knowledge Assessment (if not completed Day 1) Partograph - case study Use of anatomical models	Demonstration in plenary - 4 groups Practice skills of normal delivery baby not crying at birth	Mentor as a coach Providing feedback Reflection and self-evaluation	OSCE
PM	OSCE Feedback on Knowledge Assessment	Buddy system, identify buddies Demonstration in plenary - 4 groups Practice skills of normal delivery baby crying at birth, Breastfeeding session	Developing demonstration skills Developing coaching skills	Action Planning Knowledge Assessment	Mentoring in challenging situations

After the workshop, trainer mentors will conduct mentoring visits to districts to further develop per mentors' mentoring skills. After they establish their role in the facility and are competent mentors, the district mentors will expand their role to mentor health center midwives.

ANNEX 13: SAMPLE AGENDA FOR FACILITY VISIT

Outline of two-day mentoring visit

The purpose of spending two days is to ensure time for practice and skills building, and a greater opportunity to see a real delivery. If a birth occurs at any time, the mentorship session will be focused on a real delivery with limited number of mentees.

Recommended 2-day visit plan

- ✓ Conduct courtesy introduction to hospital director.
- ✓ Assess district mentors' clinical skills using OSCEs - provide feedback and repeat if needed.
- ✓ Invite mentees and observe district mentors mentoring their mentees. After the session is over, provide feedback separately. Include positive feedback and identify areas for improvement
- ✓ Review data with district mentors – include OSCEs of mentees, health service data, partograph records etc. Discuss gaps, issues they have faced and jointly find solutions that they can implement as action plans. Include hospital director in these feedback sessions where possible.
- ✓ Whenever possible, observe real deliveries and encourage a mentee to perform the delivery with a mentor standing by. After the completion, provide positive and supportive feedback for areas needing improvement.
- ✓ Conduct interviews with post-natal mothers in the facility to gather information on perception of care.

Additional Pointers:

- ✓ Mentors should take 2-3 sets of MamaNatalie for one mentor to work with groups of 5-9 mentees
- ✓ Focus the first 1.5 days on identifying gaps in skills and providing hands on mentoring to standardize the MNH clinical skills of the mentees.
- ✓ During the afternoon of the second day, mentors should assist mentees in developing a facility action plan and would also provide feedback to the mentees on their performance.
- ✓ The exact mentor numbers should be determined in close consultation with the district hospital director.

[1] MamaNatalie is a birthing simulator designed for training both normal delivery and postpartum complications, including severe bleeding, uterine atony, and retained placenta. With realistic bleeding, MamaNatalie is a useful complement in postpartum hemorrhage trainings programs, such as Helping Mothers Survive Bleeding After Birth Complete. MamaNatalie gives birth to NeoNatalie, a highly realistic newborn simulator. (https://laerdalglobalhealth.com/products/mamanatalie/)

Day One	Activities	Objectives
Morning	1. Join hospital meeting and discuss objectives with hospital director. 2. Visit MCH center and do quick check of equipment and bag/ mask. 3. Obtain list of mentees names & roles. 4. Ask facility midwife to demonstrate normal delivery with MamaNatalie. 5. Mentor demonstrate normal delivery. 6. Ask mentees what was different. 7. Divide into 3 small groups and practice the steps of a normal delivery. 8. Rotate role's and keep practicing in small groups and ensure feedback. Highlight respectful maternal care/ infection control. 9. Do equipment list full check in MCH.	• Ensure support of hospital director & clear understanding. • Quick check if emergency equipment is in the delivery room. • Understand strengths and areas to improve. • Demonstrate steps of normal delivery and have mentee's practice. • Identify missing equipment and supplies and discuss with director of the facility
Afternoon	1. Continue to practice normal delivery in small groups and ensure that mistakes are corrected fully 2. Give Mentees guideline for baby not breathing to read at home	• Build skills, competence and confidence in steps of normal delivery.
Day Two		
Morning	1. Facility midwife demonstrates normal delivery where baby not breathing. 2. Mentor demonstrates normal delivery baby not breathing. 3. Ask Mentees what they notice was different. 4. Focused skills practice on resus technique using bag and mask. 5. Divide into 3 groups and practice normal delivery baby not breathing.	• Assess strengths and knowledge/ skills gaps. • Show steps of guideline to standard practice. • Ensure resus competency in all staff individually.
Afternoon	1. Continue role play practice if needed. 2. Follow up on Action plan tool developed during first visit with engagement from hospital director. 3. Check the status of the facility's free MCH policy and ask the mothers about what happens in practice. 4. Guided feedback session for mentees on 2-day visit with facilitation questions (M&E). 5. Reflection on 2 days mentor visit by mentors and feedback on their own progress and development as mentors (M&E).	• Ensure steps of delivery and baby not breathing are adequately performed. • Capture lessons learnt from mentees/ mentors. • Support mentors with their progress as mentors. • Ensure M&E requirements fulfilled. Document lessons learnt.

ANNEX 14: SAMPLE AGENDA FOR MENTOR REVIEW MEETINGS

The purpose of this meeting is to gather mentors, facility leaders and pro
vincial leaders to review quarterly progress and plan together for the next steps of the program. The meeting is held at the provincial level but districts could also host on a rotating basis. All districts and mentors are invited.

Mentor Review Meeting: (Insert date)

Location: (Insert location)

Time	Activity	Facilitators
8.30 am 8.45am	Welcome and objective of meeting Opening speech by provincial leadership	
9.00am- 9.30am 9.30-10.15am	Mentoring visits, indicators and results Presentation and questions/discussion Mentoring visits – Districts present on their activities in each facility	
10.15-10.30am	Coffee Break	
10.30- 11.15 11.15- 12.00	Mentors who performed inter-district visits to share their experience Review experience of supervision – mentors to feedback on their follow up to HC midwives as part of supervision team View mentors' own photos posted on WhatsApp from last three months and vote on photo that best shows mentoring activity	
12-1.30 pm	Lunch	
1.30-2.15pm 2.15-3pm	Small group work and discussions Each district reviews their own data results and makes a plan Each district presents their plans to the meeting participants	
3- 3.15 pm	Coffee break	
3.15-4pm	Open discussion on next steps of mentoring program Present results of WhatsApp photo competition Distribute bi-monthly newsletter Meeting closing by provincial leadership	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