SWEDD

AUTONOMISATION DES FEMMES ET DIVIDENDE DÉMOGRAPHIQUE AU SAHEL

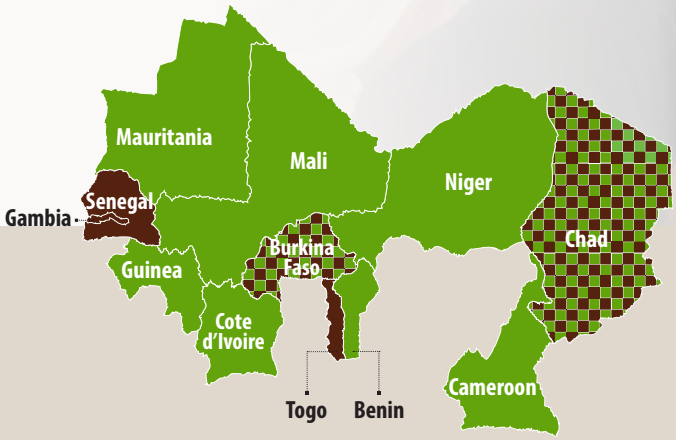
SAHEL WOMEN'S EMPOWERMENT AND DEMOGRAPHIC DIVIDEND

10

SWEDD SERIES: BEST PRACTICE GUIDE

A CLINICAL MENTORING APPROACH FOR MIDWIVES TO REDUCE MATERNAL DEATHS AND IMPROVE REPRODUCTIVE HEALTH

The research informing this Guide was led by the Centre Humanitaire des Métiers de la Pharmacie (CHMP) and focused on the SWEDD project. The information will guide the implementation of SWEDD+



SWEDD (2015–2024) SWEDD+ (2024–2028) SWEDD & SWEDD+

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The project covers countries in West and Central Africa

The International Confederation of Midwives (ICM) has defined clinical mentoring as *"A reciprocal learning relationship in which a mentor and mentee agree to a partnership where they work together to achieve mutually defined goals that will develop a mentee's skills, abilities, knowledge and/or thinking"* (ICF 2020). This is a specific approach to professional support in which the mentor and mentee enter into a mutually agreed, equitable and reciprocal learning relationship.

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In the more specific context of clinical mentoring for midwives, the following definition is the most widely accepted: *"it is an interpersonal, peer-to-peer relationship of support, sharing and learning in which a midwife experienced in clinical practice in reproductive health (Mentor), voluntarily transfers her experience and expertise to other midwives who have skills to learn (Mentees) and who freely and mutually agree to be guided at a clinical site for a set period of time"* (UNFPA-WCARO, 2019).

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Mentoring needs in West and Central Africa

The Independent Expert Group on Women's and Children's Health (iERG) stated in its 2015 final report that *"global health actors have largely failed to mobilise the action required to improve emergency obstetric care"* (Brun et al. 2020). In the West and Central Africa region, this gap is evident in the worrying maternal health indicators, which still show a high maternal and neonatal mortality ratio (679/100.000 live births), despite the progress made over the last ten years (UNFPA World Population Dashboard). A review carried out by UNFPA-WCARO on maternal mortality (Dougrou, Undated) shows that in West and Central Africa, countries with a high rate of births attended by qualified personnel are not necessarily those with the lowest maternal mortality. For example, six countries in the region (Cameroon, Côte d'Ivoire, Gambia, Liberia, Mali and Sierra Leone), where more than 60 percent of all births in 2020 were attended by qualified personnel, are among those where maternal mortality in 2020 is still above 400 maternal deaths per 100.000 live births. This undoubtedly raises the question of the quality of the services provided, but above all it calls into question the skills of the supposedly qualified staff. A mentoring approach is planned to address the gaps.

Sources: https://www.unfpa.org/data/world-population-dashboard; https://data.worldbank.org/indicator/SH.STA.MMRT?locations=ZG; Dougrou, Working Paper undated, using data from Population Data Portal, https://pdp.unfpa.org/; Brun et al., 2020.

Since 2010, mentoring has been implemented in most West African countries, including those covered by the SWEDD project, as an innovative and promising strategy for improving reproductive health and reducing maternal and neonatal mortality by improving contraceptive uptake and the quality of maternal and neonatal care.

The aim of this document is to provide information on the processes involved in the clinical mentoring of midwives, initiated in the three SWEDD project countries studied for this Guide (Mali, Burkina Faso and Niger). It analyses the specific features of each country, draws out lessons learned and good practice, and also reports on the difficulties encountered in training midwives in the region. These processes were rolled out in four phases.

Methodology and sampling:

Sample: Experts from 3 SWEDD countries: Burkina Faso, Mali, and Niger

Main data sources: Review of documents and summaries of interviews with key respondents.

Collection methodology: Qualitative, using a conversation guide drawn up with input from a group of experts

Analysis methodology: Transcripts, audio recordings and notes, analysed manually.

Dates: November 2022 - January 2023

See the annexes for more details on methodology and sampling.

PHASE 1 ADOPTION AND PREPARATION OF MENTORING

The mentoring initiative was launched with a series of advocacy meetings for stakeholders, led by UNFPA and the World Bank's SWEDD team, with the participation of professional networks such as the African Society of Gynaecology and Obstetrics (SAGO), the Society of Gynaecologists and Obstetricians of Burkina Faso (SOGOB), the African Federation of Francophone African Midwives (FASFAF), midwifery associations and orders, the Association of Midwives of Mali, and others. These meetings helped to raise the awareness of the stakeholders and to develop teaching tools in order to initiate the training of trainers, given the urgency of the issue of building the capacity of human resources to reduce maternal, infant and neonatal mortality. The interviews also revealed that the engagement of all stakeholders is a promising practice, as it guarantees the transparency of the process and the support of the partners.

Before the mentoring programme was launched in 2012, the UNFPA regional office, in collaboration with SAGO and the Association of Midwives, lobbied Burkina Faso's National School of Public Health (ENSP) to improve the quality of teaching in reproductive health. In addition, midwifery associations have played a leading role in lobbying the Burkina Faso government and partners to introduce clinical mentoring as part of efforts to build the capacity of trainees. A midwifewho is a member of the Midwifery Association said: *"We won't stop advocating. Awareness-raising and advocacy are key activities of the socio-professional health associations that serve to achieve the vision of the International Confederation of Midwives of the World, which wants every woman and every baby to have their own midwives. To achieve this, staff must be available everywhere."*

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Subsequently, each country followed a slightly different process. In Burkina Faso, mentoring was adopted following the emergency obstetric and neonatal care (EmONC) needs assessments carried out in 2010 and 2014, which revealed a lack of skills among maternity care providers (midwives, state midwives and auxiliary birth attendants) and unsatisfactory maternal and neonatal health indicators compared to national targets. The mentoring guide was developed with the support of the Society of Gynaecologists and Obstetricians of Burkina Faso (SOGOB), UNFPA, the the Burkinabè Association of Midwives and Birth Assistants (ABSFM) and Développement sans frontières (DSF). The country's various Regional Health Departments were provided with anatomical models for skills' practice before the mentors were recruited. In this respect, Burkina Faso drew inspiration from the mentoring models implemented in Madagascar and Ghana.

In Mali and Niger, the roll-out of mentoring benefited from experience already gained in Burkina Faso and from regional initiatives. It should be noted that in these two countries, the roll-out of the Centres of Excellence[1] has played a catalytic role in getting mentoring off the ground.

In Mali, the SWEDD project participated in developing the clinical mentoring programme in collaboration with the stakeholders (UNFPA, Ministries of Health and the Association of Malian Midwives). To this end, SWEDD contributed to the validation of the national clinical mentoring guide, which documents the operational objectives of mentoring, the approaches to implementation, the criteria for selecting mentors (the midwives providing mentoring), the tasks of the mentors, the monitoring and evaluation system, etc. Mentoring was adopted following various meetings organised by the UNFPA Regional Office under the auspices of the SWEDD project, which was supporting the development of a Centre of Excellence for clinical mentoring of midwives based at the ENSSP (National School of Public Health) in Nouakchott, Mauritania.[1] A consultant was recruited to develop the various mentoring tools for Mali, with the support of the UNFPA Mali country office.

Mentoring in practice: Example of Burkina Faso

The video entitled "Sauver des Vies Grâce au Mentorat" (Saving Lives through Mentoring), produced by UNFPA Burkina Faso, offers observations from mentors, mentees and the country's health system authorities on mentoring. The following is a selection of quotes:

- Not everything can be perfect. It is normal to be corrected until you improve. If I do something wrong, the mentor shows me how to do it (a mentee).
- When I arrived, most of my knowledge was theoretical. I had problems training for breech births, for example. But I managed to learn how (a mentee).
- Since the midwifery mentoring programme was rolled out, we've seen... a lot of improvement in the indicators, even if we haven't yet reached the expected levels. For example, prenatal consultations have risen from 25 to 50 per cent (Director of Reproductive Health in a participating district).
- Scaling up this type of programme requires the strategy to be integrated into annual planning (Family Health Director).

Watch the video: https://www.youtube.com/watch?v=nioFMUgIjTo

[1] See Best practice guide 11 for further details on the Centres of Excellence.

In Niger, mentoring was adopted as part of the midwifery training programme under the SWEDD project and addressed the same concerns as in Burkina Faso, i.e. improving the quality of maternal care in order to reduce maternal and child mortality rates.

In all three countries, discussions with key actors in the roll-out of mentoring show that both mentees and non-mentees are interested in incorporating evidence in developing and using strategies to combat maternal and neonatal mortality.

Lesson 1: The mentoring initiative is more relevant and coherent when evidence and health indicators are taken into account in assessing needs for improved maternal and newborn health and reproductive health.

Lesson 2: Stakeholder engagement is an important step in establishing mentoring programmes.

PHASE 2 RECRUITMENT OF MENTORS

The process of recruitment and final selection of mentors involved the lead ministries and technical and financial partners (World Bank, UNFPA, WHO, UNICEF) as well as professional networks, which contributed to the development of the selection criteria. In all countries, mentors were recruited based on criteria established and accepted by regional bodies (UNFPA, the International Confederation of Midwives (ICM), the Federation of Midwifery Associations of Francophone Africa (FASFAF) and the African Federation of Obstetrics and Gynaecology (SAGO)), with some differences between countries.

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The Mali Association of Midwives identified and selected the mentor midwives based on the following criteria: (i) professional experience of more than 5 years; (ii) experience providing maternal, neonatal and child health care; (iii) knowledge of reproductive health; (iv) effective communication skills; (v) open-mindedness; (vi) sensitivity to the needs of the mentee, friendly manner, motivation, empathy, perseverance, good listening and sharing skills, willingness to volunteer, availability and dynamism; as well as knowledge of the problems in the health area; (vii) competence in EmONC; (viii) retired or working; and (ix) registered with the Order of Midwives. Mentors were identified under the leadership of the National Mentoring Committee, with the participation of all its branches and regional offices, including the Association of Midwives. In Burkina Faso, according to interviews with respondents, some schools such as Magnificat attach greater importance to experience and seniority. The process of recruitment and final selection of mentors involved a public call for recruitment and the participation of stakeholders, namely the lead ministries (Health and Higher Education), technical and financial partners (World Bank, UNFPA, WHO, UNICEF) and professional networks.

In Niger, the mentors were recruited by means of a test organised by the Ministry of Public Health, Population and Social Affairs in collaboration with the Niger Association of Midwives. To ensure that the process was transparent, a call for applications was widely circulated, and the applications were selected on the basis of established criteria.

LESSON 3: The adoption of consensual criteria for the selection of mentors, based on the guidelines of the UNFPA regional office and the professional networks, enables mentoring training practices to be harmonised across the countries.

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PHASE 3 MENTOR TRAINING AND MENTORING ROLL-OUT

The development of training tools was overseen by the lead Ministries (Health and Higher Education). Teaching tools were developed and validated, initially at regional level. A budgeted 2020-2023 action plan for training trainers was produced. Mentor training generally lasts two weeks.

Training in the three countries covered all the topics relevant to midwifery practice and helped midwives to gain thorough knowledge and take ownership of the topics through simulation and role-playing. In particular, it addressed the main causes of maternal mortality. *"Mentoring provides personal support for midwives and birth assistants to develop their skills to ensure better care for the women and newborns for whom they are responsible"*, said a midwife in Burkina Faso.

Mentoring sessions take place over a period of at least two days in the mentees' health facilities, once every two months or as required by the mentee. These sessions encourage the development of an interpersonal relationship with the mentee, based on mutual respect and trust, discussions on the skills the mentee needs to acquire, the drafting of a problem-solving plan (action plan) with the mentee, and planning the next steps. Guided by the needs of the staff being mentored, clinical mentoring takes place face-to-face on site and can continue with remote support (by telephone, SMS, email and various other applications).

The key informant interviews indicate that mentoring can reduce the baseline frequency of miscarriages due to complications and contribute to improving the quality of care, change in the behaviour of staff, improvements in the quality of work organisation, the implementation of good practices, such as the use of partograms and medicines, a different attitude towards mothers, and better active management of pregnancy. As a midwife and mentor from Burkina Faso explained: *"The mentor's role involves close coaching of the mentee. The mentor must work with the mentee to identify her shortcomings. She must share her experience and help her mentee to improve her work in order to help reduce maternal and neonatal mortality."* The interviews also showed that the

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trainers are competent, have a good grasp of the subjects and are very open-minded. For women in the community, there was a reduction in waiting times (on average, 20-30 minutes at the Community Health Centre (CSCom)), satisfaction with assisted childbirth, listening and support, and with consultations; ability to differentiate between midwives who have benefited from mentoring and other midwives in terms of their ability to listen to and empathise with women.

However, although improvements in the quality of maternity care following the introduction of mentoring were noted, they were not documented. This was the case in Burkina Faso, where clinical mentoring was tested in the Centre, Hauts Bassins and Boucle du Mouhoun regions.

Compared with training supervision, clinical mentoring focuses on enhancing the skills and abilities of the mentee. The interviews reveal the following: *"Mentees are coached by more experienced midwives based on a pre-established practice-oriented capacity-building programme. The mentor also visits the mentee's workplace to gain first-hand experience of the context in which she works, and take the opportunity to offer advice on managing maternity care. For the mentees, traditional training has a much more theoretical focus, whereas mentoring includes follow-up, supervision and constant communication between mentors and mentees"* (Mentee midwife, Mali).

Mentoring also addresses the health issues and needs of the areas in which mentees are based. With the technical support of their mentors, the mentees quickly make their presence felt and develop the ability to monitor and manage pathologies related to childbirth, as expressed by a mentee midwife in Mali: *"Our mentors gave us a lot of support in inducing childbirth when necessary, which was a challenge for us. They are available for us to talk to at any time. Since our arrival, women in labour have stopped being referred to other health centres; we think we are sufficiently equipped to deal with everyday cases".*

Interviews with key respondents in Mali identified a number of promising and innovative practices. The mentees are supported on site, where the mentor stays for some time (on average three days) to work with the mentee in a real-life context, making the learning process more dynamic and effective. In particular, the training focuses more on practice than theory, with a specific emphasis on bedside skills. Mentors also provide support through a range of interactive channels - telephone, WhatsApp, video sharing, and supervision.

LESSON 4: Mentoring is a feasible way of filling the gaps in basic training and thus encouraging midwives to update their skills in line with developments in the practice.

LESSON 5: Thorough coverage of the essential topics during mentor training, supported by role-playing, quality teaching and the participation of national stakeholders and technical and financial partners is crucial for effective mentoring.

LESSON 6: The implementation of a mentoring scheme enables mentored midwives to increase their self-confidence, thereby contributing to enhanced productivity and improved quality of maternal healthcare provision.

LESSON 7: The existence of an institution dedicated to mentoring to (such as a national mentoring committee with branches and/or offices in all the areas covered by the project in Mali, and a mentoring technical working group in Burkina Faso and Niger) is a fundamental element in the successful roll-out of mentoring.

PHASE 4 MENTORING EVALUATION AND IMPLEMENTATION CHALLENGES

Different countries follow different processes. In Mali, for example, the mentoring approach is integrated into traditional supervision, monitoring and evaluation activities, led by the Mali Association of Midwives (ASFM). With the support of technical and financial partners, the ASFM has introduced the mentoring approach in Mali and participates in the selection of mentor and mentee midwives, as well as in monitoring and supervising mentoring activities. The ASFM provides supervision at training sites and host organisations through its mentor midwives, and has a contact point at each training site. For this approach, which is based on the transfer of skills *in situ*, to be sustainable, it needs to be incorporated into regular programming, particularly as concerns traditional supervision, monitoring and evaluation activities.

Despite promising practices and lessons learned, some difficulties were encountered. The first relates to the lack of financial and logistical resources, in particular lack of financial resources for mentoring visits. In some cases, there was also a lack of anatomical models (mannequins) for mentee practice at the training sites.


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Remote coaching, requested by some midwives, was difficult to provide. There were leadership conflicts in the mentoring schemes between mentors and head nurses; this raised another challenge. Securing mentors for the mentees was also difficult, and failure to replace mentors who had been posted to other locations or had retired was a challenge. There was a lack of effective post-mentoring follow-up. These challenges were exacerbated in Mali and Burkina Faso because of the security issues in these two countries.

LESSON 8: The roll-out of mentoring should be accompanied by a programmatic document such as a national strategic plan or a mentoring implementation plan in countries wishing to embark on it.

The absence of an institutional and programmatic framework means that the practice cannot be sustained or effectively monitored in some countries.

SUMMARY OF KEY LESSONS

Phase 1: Adoption and preparation of mentoring	1	The mentoring initiative is more relevant and coherent when evidence and health indicators are taken into account in assessing needs for improved maternal and newborn health and reproductive health.
	2	Stakeholder engagement is an important step in establishing mentoring.
Phase 2: Recruitment of mentors	3	The adoption of consensual criteria for the selection of mentors, based on the guidelines of the UNFPA regional office and professional networks, facilitates the harmonisation of mentoring training practices.
Phase 3: Mentor training and mentoring roll-out	4	Mentoring is a feasible way of filling the gaps in basic training and thus encouraging midwives to update their skills in line with developments in the practice.
	5	Thorough coverage of the essential topics during mentor training, supported by role-playing, quality teaching and the participation of national stakeholders and technical and financial partners is crucial for effective mentoring.
	6	The roll-out of a mentoring scheme enables mentored midwives to increase their self-confidence, thereby contributing to enhanced productivity and improved quality of maternal healthcare provision.
	7	The existence of an institution dedicated to mentoring is a fundamental element in the successful implementation of mentoring.
Phase 4: The mentoring evaluation process	8	The roll-out of mentoring should be accompanied by a programmatic document such as a national strategic plan or a mentoring implementation plan in countries wishing to embark on it.

ANNEX 1: Methodology and sampling

I. Data collection methodology

The information in this Guide was gathered during interviews organised by the Centre Hospitalier des Métiers de la Pharmacie (CHMP), with respondents selected to undertake the retrospective documentation of the conceptualisation and implementation of the experience of the clinical mentoring approach to midwives as a contextualised model to reduce maternal deaths. The SWEDD countries that opted to take part in the interviews on this theme were Burkina Faso, Mali and Niger. The respondents from each country were proposed by the IPs and the consultants, liaising with the PMUs. Conversations were organised face-to-face, or virtually in circumstances where face-to-face was not possible. The facilitators were provided with a conversation guide - developed by the technical partner - which included questions on the experience of the approach to clinical monitoring of midwives. During the conversations, the facilitators used personal recording devices (phones, tablets, etc.) to record the conversations and then transcribed them later before consolidating them into a summary.

II. Data sources

The information was gathered through key informant interviews on the experience of the approach to the clinical mentoring of midwives in the three SWEDD countries listed above. These informants do not represent a systematic sample, *"but, rather, a convenience sample of those with experience in the theme of this Guide across these countries"* that makes it possible to leverage existing SWEDD capacity. The country informants are listed in Annex 2. Some of the data is taken from a review of project documents.

ANNEX 2: Table of people consulted

Informants interviewed	Country
10 individuals: 1 PMU expert, 1 UNFPA expert, 1 local authority, 4 CBD agents and 3 community members	**Burkina Faso**
10 individuals: 1 PMU expert, 1 UNFPA expert, 1 local authority, 4 CBD agents and 3 community members	**Mali**
10 individuals: 1 PMU expert, 1 UNFPA expert, 1 local authority, 4 CBD agents and 3 community members	**Niger**

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This Guide is one of a series that retrospectively documents the process of implementing the interventions of the SWEDD project, and documents good practices, challenges and lessons learned. The "Sahel Women's Empowerment and Demographic Dividend" (SWEDD) project was launched in November 2015 with financial support from the World Bank, and technical support from the United Nations Population Fund (UNFPA) and the West African Health Organisation (WAHO). SWEDD aims to accelerate the demographic transition, trigger the demographic dividend and reduce gender inequalities in the Sahel. The motivation for this series is the fact that SWEDD has become a strategic framework for political decision-makers, opinion leaders (traditional and religious chiefs, and other community leaders), and the community to work together on issues considered sensitive in the region. This is why it was considered important to share the processes through which the project was developed. This includes descriptions of experiences, lessons learned and recommendations. This evidence could be used to enrich interventions in SWEDD+ and other initiatives on gender equality and the empowerment of teenage girls and young women. A total of four Guides in this series, including this one, aim to document the experiences of implementation under SWEDD component 2 interventions with the objective of improving the provision of reproductive health services. These include Community-Based Distribution (CBD) interventions to bring services and products closer to communities (Guide number 9), experience in building the capacity of healthcare staff, particularly midwives through mentoring programmes (Guide number 10) and Centres of Excellence (Guide number 11) and the deployment of these midwives to make up for the shortage of staff on the ground, particularly in rural areas (Guide number 12) However, the lessons learned from this documentation do not imply that all four interventions need always be simultaneously implemented.

For more information on the documentation of the processes involved in this intervention and on the SWEDD project, visit the SWEDD project's virtual resource platform: www.sweddknowledge.org