maniQC
Quality of Care

Learning brief

Strengthening health worker competencies through clinical mentorship for improved maternal and newborn quality of care

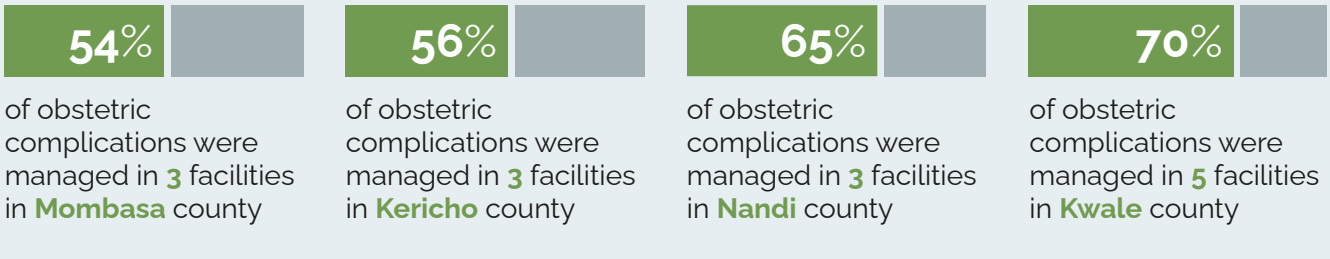
Background

Despite progress towards the Sustainable Development Goals, around 5,000 women and 28,000 newborns worldwide die each year from preventable causes[1,2]. In Kenya, sub-standard care has been identified as a key driver of 90% of maternal deaths[3].

Without ongoing practical training and support, including exposure to complicated cases, primary health facility health professionals can lose their skills and confidence to manage maternal and newborn complications before they become life-threatening, resulting in more referrals to tertiary facilities. This adds undue pressure to health workers who are already stretched by low staffing levels and frequent staff rotations; this affects the quality of care provided and contributes to poor health outcomes.

The Maternal and Newborn Improvement Quality of Care (MANI-QC) project, funded by UKaid, works with the Government of Kenya and other health partners to improve the quality of care for mothers and babies in four counties (Nandi, Kericho, Kwale, and Mombasa). Around 15% of all deliveries require critical care[4]. While we would expect to see tertiary facilities manage these, more than half of these deliveries occurred in tertiary facilities across these four counties in 2018. (see Figure 1).

Figure 1: Percentage of deliveries with obstetric complications that occurred in selected tertiary facilities



This brief describes an EmONC mentorship programme implemented under the MANI-QC project and how it has improved the quality of care for mothers and babies.

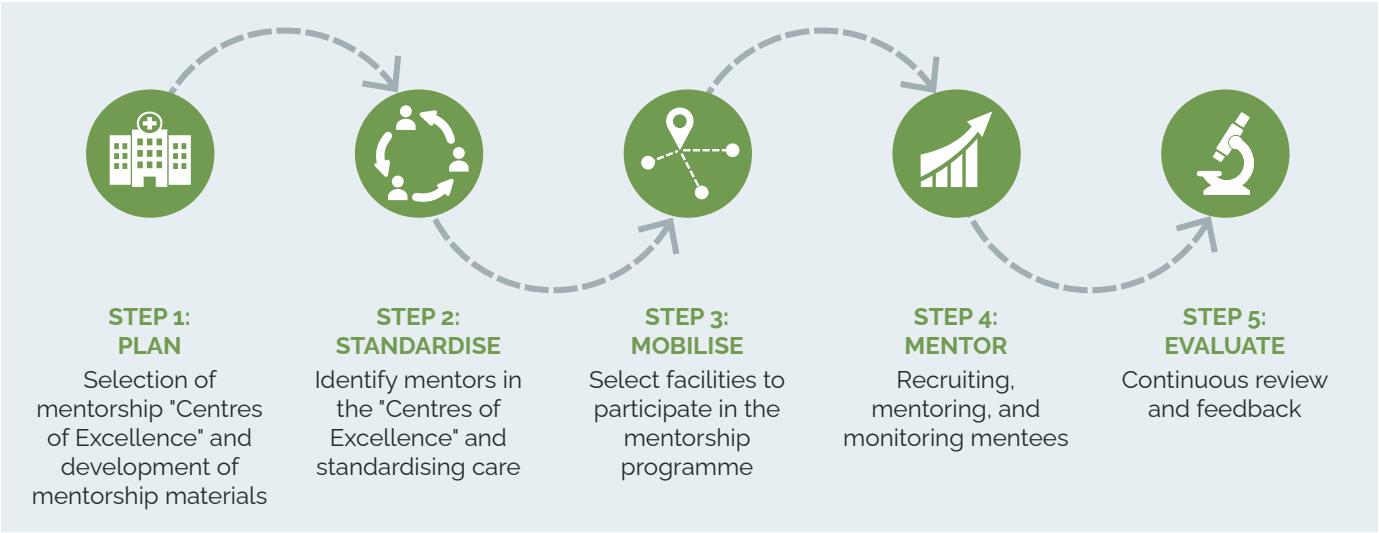
Mentorship approach

Building on the **mentorship model from our work in Bungoma county** from June 2020 to March 2021, the MANI-QC team worked with county and sub-county health management teams (CHMT and SCHMT) to implement the EmONC mentorship programme in the four counties. The programme aimed to address skill gaps among health workers for managing obstetric and newborn emergencies at the primary health care level, improve quality of care and reduce the need for referrals to tertiary care facilities. The model was tailored to each of the four counties' unique situations.

Process

Five key steps were followed during implementation of the mentorship programme (see Figure 2):

Figure 2: Mentorship roadmap



Results

A qualitative approach was used to assess the mentorship programme and its contribution to improving EmONC knowledge and skills among health providers. Semi-structured interviews were held with 65 individuals involved in the mentorship programme in August 2021 (see Table 1).

Table 1: Interviews conducted

Respondents (n)	Kericho	Nandi	Kwale	Mombasa
Supervisors (13)	3	2	4	4
Mentors (18)	4	5	2	7
Mentees (34)	8	9	8	9
Total (65)	**15**	**16**	**14**	**20**

Health care workers mentored

A **total of 303 health care workers** from **119 facilities** (51 from Kericho, 33 from Nandi, 18 from Kwale, and 17 from Mombasa) enrolled in the mentorship programme in the eight mentorship sites, two per county. Most (92%, n=279) of mentees came from government-owned facilities followed by faith-based facilities (5% n=14) and private facilities (3%, n=10). Of these, 62% were primary health facilities (131 health centres and 58 dispensaries) and 38% hospitals. A total of 285 (94%) mentees completed their respective rotations. (Kericho 145, Nandi 82, Mombasa 30, Kwale 28).

Overall, mentees had positive feedback on the mentorship programme and felt it was a valuable opportunity to refresh skills, knowledge and should be extended to all facility staff. They were motivated to complete it even though the mentorship sessions took place outside of their working hours. The hands-on practical structure of the programme was appreciated and seen as a helpful addition to previous classroom learning.

> "Usually there are some things we don't learn in colleges, so when you come on the ground, you find that there are some things you don't know completely or maybe you didn't perfect those skills while in college."
>
> **Mentee, Kwale County KWL008**

Improved existing and new clinical skills

Most mentees reported that they gained new skills or improved existing skills that they rarely had the opportunity to practice at their facilities before the programme. This led to increased competence and confidence in handling complications.

> "Before went for the mentorship, people used to fear on how to conduct a breech delivery. People used to say, I can't manage a PET [pregnancy induced hypertension] client, I can't manage a PPH [postpartum haemorrhage], and you start rushing. During our mentorship in our county referral hospital, you are not just taught what to do but also how to manage such patients."
>
> **Mentee, Kericho County KRC006**

Among the thirteen causes of maternal and newborn health emergencies, the top three skills prioritised by mentees were performing assisted vaginal delivery (AVD), managing eclampsia and performing manual vacuum aspiration (MVA).

Reduced and improved timeliness of referrals to higher-level facilities

Nearly all mentees reported that their increased skill set, confidence, and ability to manage complicated deliveries in their facilities resulted in reduced referrals to higher-level facilities and workload. Mentors confirmed this at referral sites.

> "Even the so-called manual vacuum aspiration, those we can, we can do them because we learned, so there is no need to refer them to higher facilities."
>
> **Mentee, Mombasa County MBA 001**

Improved clinical management practices

The mentorship programme motivated some health workers to pursue improvements in their facilities, such as working with them to improve management protocols, referral practices, and equipment availability and passing on their improved and new skills to colleagues.

> "The standard operating procedures that we saw [in the Centre of Excellence], it is best [to use] in our facility. I translated them to our facility, the PPH kit, the eclampsia kit, the emergency kit that we're using maternity we didn't have, but through that programme of mentorship, we saw this is the best thing. So, when we have a baby to resuscitate, everything is there; When we are managing a mother who is bleeding post-delivery, we are ready any time"
>
> **Mentee Kericho County KRC006**

Continued relationships and support post-mentorship

The mentorship programme has helped improve relationships, communication, and collaboration between the county, sub-county, and facility teams, which were sustained after the programme. Mentees can phone their mentors when they need clinical advice, which helped mentees to maintain confidence in their skills and ability to manage complications.

> "We had a WhatsApp platform for mentors within our facility and as a coast platform. And, we didn't have one for us with the mentees. But we can communicate. Every mentee had our numbers. So, we had some mentees in Tiwi who sometimes call us when they get a case and are unsure of it. "Sister, we have this question of this and this, what can I do?"
>
> **Mentee, Kwale County KWL002**

Reduction in mortality

Respondents perceived a reduction in maternal and perinatal mortality in their facilities due to improved ability to manage complications.

> "For the perinatal deaths for those who had no skills of resuscitation, they gained the resuscitations skills, and now, the perinatal deaths have reduced"
>
> **Mentee, Kwale County KWL 009**

Challenges

Mentees also reported some challenges with the mentorship programme, particularly related to its structure and internal facility challenges:

- **The mentorship sessions were too short:** although most mentees reported meeting their set objectives, some were missed largely due to women not presenting specific complications during their rotation days.
- **Competing priorities and staff shortages** meant that health facilities sometimes had insufficient staff available to provide cover or that sessions were interrupted when mentors were needed elsewhere in the facility.
- In all counties, **a lack of equipment or drugs** sometimes hampered the ability of mentees to implement their newly refreshed skills to manage complications, especially during emergencies.
- The onset of the **COVID-19 pandemic** led to changing workloads and duties, which interrupted the mentorship programme.

Recommendations

- **Increase** the length of the mentorship period from 1-2 weeks to at least 2-3 weeks.
- Make **mentorship an ongoing** rather than one-off exercise to reach more health workers, maintain their skill levels, and allow continued exposure to complicated cases.
- **Invest in a fully equipped skills lab at tertiary facilities**. This would enable mentees to refresh their knowledge in the skills labs before proceeding to wards to manage patients.
- **Institutionalise** the mentorship programme as an EmONC training model with counties so that participating in the programme could be listed as training days.
- **Prioritise** the rollout of the National EmONC Learning Resource Package developed by the Ministry of Health in collaboration with partners, including Options, to ensure programme's sustainability.

Conclusion

Health care workers require frequent mentorship exposure and supervision to advance and retain their clinical skills. Scaling up the mentorship of primary-level care facilities improves their quality of care, minimises unnecessary referrals, and improves working relationships amongst various health sector stakeholders. The mentorship model is an adaptable, innovative, and economical method of training and addressing quality of care.

References

[1] WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (2019) **Trends in maternal mortality 2000 to 2017 estimates**

[2] UN Inter-Agency Group for Child Mortality Estimation (UN IGME) (2019) **Levels and Trends in Child Mortality**

[3] Government of Kenya (2017) Kenya Confidential Enquiry into Maternal Deaths.

[4] *The proportion of major direct obstetric complications throughout pregnancy, delivery and immediately postpartum is estimated to be 15% of expected births.* WHO (2009) **Monitoring emergency obstetric care: a handbook**

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About Options

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