IMA WORLD HEALTH

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Clinical Mentoring

in the Democratic Republic of Congo

ASSP and ASSR - 2013 to 2022

CLINICAL MENTORING PILOT TO IMPROVE ESSENTIAL AND EMERGENCY OBSTETRICS CARE

BACKGROUND

Clinical mentoring is an approach to learning adopted by the DRC Ministry of Health, Hygiene and Prevention to improve and maintain the skills of front-line providers following in-service didactic training. After the model demonstrated improved quality of care in Kwango and Kwilu provinces, with UNICEF support, the pilot was expanded to other provinces. ASSR introduced clinical mentoring into its activities in the second half of the project in eight pilot health zones: four in Kasai and four in North Ubangi. The pilot later added four health zones in Kasai Central province. In all, the pilot covered 60 health facilities supported by ASSR.

EMERGENCY ONCOLOGIC AND NEONATAL CARE IN ASSR I

Enhanced Emergency Oncologic and Neonatal Care, or EmONC, at the health facility level is a priority of the National programme to prevent avoidable maternal and neonatal deaths. ASSP/ASSR invested heavily in health centres and reference hospitals to allow adequate geographic coverage of EmONC in health zones and access to skilled birth attendants for remote communities. During the project period health facilities meeting EmONC-b (basic) and/or EmONC-c (comprehensive) increased from a baseline of 11 percent in November 2019 to 86 percent in August 2021. In addition, ASSR Extension I piloted clinical mentoring in EmONC using seasoned obstetrics providers paired with newer front-line nurses and midwives to engage in continuous learning. This pilot is evidence of ASSR's flexibility of programming, which can improve effectiveness as well as efficiency. Part of this clinical mentoring was to increase correct use of the partograph, a simple, evidence-based tool to track labour and delivery and alert providers to early warnings of complications during delivery that warrant referral to a higher level of care. At the start of the period, only 11 percent of surveyed health facilities used partographs correctly. At the end of ASSR Extension I, 82 percent of health facilities were using them correctly.

THE PILOT INTERVENTION

The objective of the pilot was to strengthen service provision in Essential Obstetric Care (EOC), Essential Newborn Care (ENC), EmONC, and Maternal and Perinatal Death Surveillance and Response (MPDSR).

After careful selection of 40 local clinical mentors, provision of anatomical models and equipment for practice, and assessment of health facilities to establish a practice baseline, the mentors were each assigned two providers per health facility to accompany over time.

The mentors' responsibilities consisted of identifying the organizational deficiencies in each health facility and developing a correction plan, identifying the providers' support needs, accompanying each mentee to produce his/her personal learning plan, and supporting each mentee following the three-phase learning process: I do, you observe me; I do, we do it together; and you do, I observe you.

Tomuna Ngudi and her daughter, Muyanda, are two of many who have benefited from safer birth practices in Kasai Central.

Final evaluation of the clinical mentoring pilot was conducted in two groups of health facilities: four intervention health facilities and four control health facilities, randomly selected in the provinces of Kasai and North Ubangi. The evaluation examined:

EmONC: Providers' theoretical knowledge, confidence and skills in EmONC.

Partograms: Correct use of the partogram.

Readiness: The level of readiness of the health facility to offer quality EmONC.

Provision: Data on the provision of EmONC in the heatlh facility.

IMPACT Safe Deliveries

356,997 deliveries were attended by a skilled birth attendant in supported health zones during the project period. Each skilled birth attendance cost the project about £1.33. However, when including all efforts aimed at ensuring the quality of care during labour and delivery (e.g. correct use of partograph, clinical mentoring and supervision), the overall cost can be valued at about £4.92.

To achieve EmONC-b and -c level of services offered in 88 percent of surveyed health facilities, up from 11 percent at baseline, the overall cost was £749,715.59, or approximately £433.61 per health facility.

LESSONS LEARNED

Adult learning and retention is supported by hands-on practice. Clinical mentoring of front-line providers by seasoned practitioners can improve providers' confidence and evidence-based practice in even remote health facilities in DTo save the lives of women and newborns, it is critical to ensure that health facilities are properly equipped and have qualified providers with good skills in EmONC. Without support for clinical practice following in-service didactic learning, these skills tend to weaken over time. Anatomical models and essential equipment are critical to allow adequate hands-on practice.

REFLECTIONS FOR FUTURE PROJECTS

Pre-selecting mentor candidates: In order to have a large pool of competent mentors and to avoid having invalid mentor candidates in the room, we are thinking of pre-selecting mentor candidates by SZ by administering practical and theoretical competency tests in the SZ before organising the clinical mentoring training;

Expanding provider reach: In order to cover all health facilities with competent providers, consider identifying 1 provider for 2 or 3 health facilities depending on their proximity.

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