Building Human Capacity through Peer Mentorship in Lao PDR

MCSP Lao PDR Case Study

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The United States Agency for International Development's (USAID) Maternal and Child Survival Program (MCSP) aims to prevent child and maternal deaths in high-priority countries. This case study is part of a larger case study series documenting MCSP's approaches to human capacity development (HCD). From the diverse portfolio of HCD work across MCSP's 52 country programs in 32 countries, case studies from specific countries were selected to illustrate innovative approaches that go beyond traditional clinical training. Each of these case studies highlights alternative combinations of approaches to strengthen and sustain health worker skills and competencies.

This case study describes a mentorship approach used in Lao PDR to support the MOH's reproductive, maternal, newborn, and child health (RMNCH) strategy by providing in-service capacity strengthening to skilled birth attendants (midwives, nurses, doctors and other health staff). Additional information on MCSP's global work in HCD is available online: Strengthening Human Capacity Development to Improve RMNCH Outcomes.

Background

In Lao PDR, the Ministry of Health (MOH) has responded to high rates of maternal mortality (206/100,000)[1] and infant mortality (57/1000) [2] by prioritizing health workforce development and increasing the numbers of midwives available to provide maternal and newborn health (MNH) services at health centers, district hospitals, and provincial hospitals under the skilled birth attendant development plan (MOH). In 2009, there were only 100 midwives in Lao PDR; but by 2015, there were more than 1,700 new midwives in facilities. However, the newly deployed midwives lacked skills, experience or support in practice. In addition to human resource challenges, the health system was also facing a high number of home births and low levels of MNCH service utilization.

MCSP was fully integrated into Save the Children's Primary Health Care (PHC) Program[3] in ten districts of Luang Prabang and Sayaboury provinces, which allowed MCSP to leverage the government partner relationships established by the PHC and to augment the PHC's health systems strengthening approach. Mentorship focused on skills for quality care at the time of birth, including infection control and respectful maternal care. The target cadres for mentorship were all MNH providers that support deliveries in health

[1] Lao PDR Population and Housing Census 2015, Lao Statistics Bureau: https://www.lsb.gov.la/pdf/updatePopulation2005.pdf
[2] Lao PDR Population and Housing Census 2015, Lao Statistics Bureau: https://www.lsb.gov.la/pdf/updatePopulation2005.pdf
[3] The Primary Health Care (PHC) Program has been implemented by Save the Children in Lao PDR since 1992, with a focus on strengthening RMNCH care in select areas. MCSP Lao PDR activities under PHC initially included coverage for both Sayaboury and Luang Prabang provinces, but Sayaboury was phased out in the last year of the program when cost sharing for that activity ended.

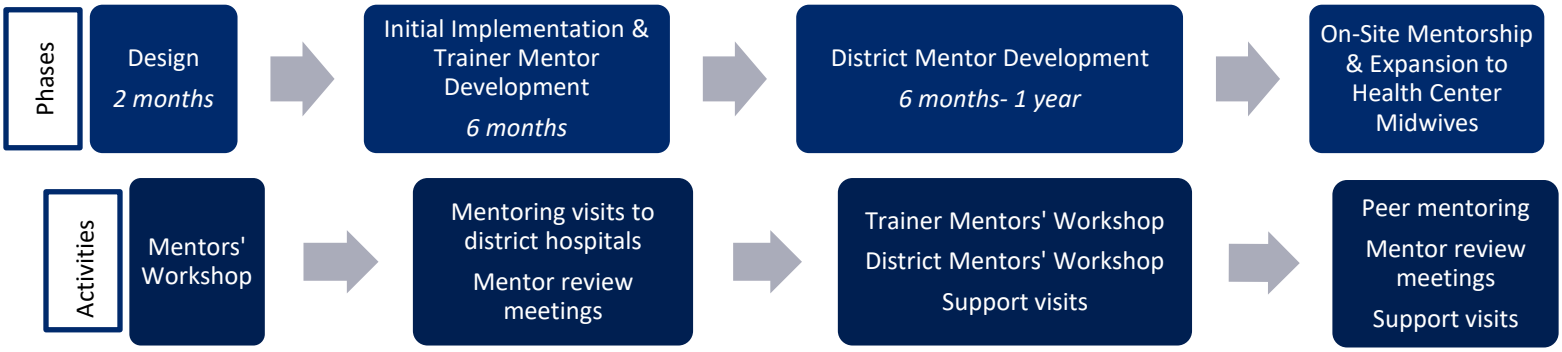
facilities: midwives, nurses, doctors, and assistants. This broad net for capacity development was intended to increase the quality of maternal and newborn care services in facilities, and to ensure that care was standardized to global best practices. The rationale for instituting a mentorship approach was to provide capacity building that ensured staff were not diverted from their clinical work (as they would be with off-site trainings) and to implement a model of supportive supervision and continuing professional development that is feasible and sustainable in a developing country context.

Despite the close of MCSP at the end of 2018, activities for mentorship continue under Save the Children's PHC program in Luang Prabang, with a focus on bringing mentorship to the community level. PHC will continue to engage with national capacity building programs to share MCSP lessons learned and support initiatives to integrate mentorship into national guidelines and approaches.

Methodology

The introduction of mentorship in MCSP-supported areas was gradual and iterative. Phases of the introduction are illustrated in Figure 1, and the process is outlined below.

Figure 1. Phases of mentorship introduction



Provincial and district MNH providers worked with MCSP staff to develop a contextually suitable mentorship approach using both the "external mentor" (external expert provides mentorship to an assigned facility) and "internal mentor" (internal staff member is trained to provide peer mentorship) models.[4] The first cadre of mentors jointly standardized key clinical competencies for normal deliveries and newborn resuscitation as the initial focus of mentorship. In the later stages of the program, mentor capacity for management of post-partum hemorrhage and breastfeeding counseling support were also strengthened. The process of mentorship at the provincial, district, and health center levels is described below.

I. Establishment of Initial Mentor Cadre: The introductory phase at the provincial level was marked by a consultative, consensus-building process to develop ownership of the mentorship approach among provincial and district facility leadership. Efforts at the provincial level included:

- ***Strategic selection of initial mentors***: Provincial Health Office leadership selected mentors from among staff at the provincial hospitals, district hospitals, and the technical college (in Luang Prabang), using criteria jointly developed with MCSP.
- ***Introductory workshop***: An eight-day participatory workshop organized by MCSP was held at the Luang Prabang Technical School that included the following activities:
  - ***i.*** Development of clinical mentorship guidelines based on local and global best practices.
  - ***ii.*** Field testing of guidelines.
  - ***iii.*** Skills standardization among mentors to follow established guidelines (for e.g. partograph use, newborn resuscitation).

[4] *Strengthening Health Provider Performance for Maternal Newborn Care in Lao PDR through a Mentoring Approach: Implementation & Training Guide*, September 2018. www.mcsprogram.org

iv. Development of mentorship skills (for e.g. demonstration, coaching and providing constructive feedback).

- ***Introduction of mentorship in district and provincial facilities:*** Mentor visits began as soon as possible after the workshop. Two to three provincial mentors and MCSP staff conducted mentoring and on-site skills sessions in 10 district hospitals and two provincial hospitals with up to 15 mentees (a 1:5 mentor to mentee ratio), using anatomical models for practice.
- ***Mentor review meetings:*** Organized quarterly by MCSP at the provincial-level, these meetings included provincial leadership, district hospital leadership, and mentors. Participants shared quarterly mentoring results, fostered mentor ownership to make adjustments based on experience, developed action plans with involvement of mentors and leadership from each district, ensured provincial leadership support and understanding of the program, and provided mentors with peer recognition.
- ***Development of trainer mentors:*** Out of the original 15 mentors, a team of eight trainer mentors was selected to participate in a five-day trainer mentor workshop conducted by MCSP on clinical, mentorship, and training skills that allowed trainer mentors to prepare, teach, and receive feedback on conducting their own training. Immediately following this ToT, the new trainer mentors trained a cohort of district mentors as outlined below.

II. Establishment of District Mentors: Lessons learned from the establishment of the initial mentor cadre, primarily at the provincial level (described in the text box to the right), prompted MCSP to shift focus and develop mentorship capacity within the district hospitals. This shift to district-based "internal" mentors integrated mentorship into daily practice, ensured more 1:1 coaching, and was more sustainable. The process of building mentorship capacity at the district level included:

Mentorship Integration into Routine Supervision
MCSP encouraged the supervision teams to ensure that a mentor is always part of supervision visits to the districts and health centers. This integration enabled visits to be more supportive and include skills building, feedback, and guidance, rather than focusing only on a supervision checklist.

- ***Selection and training of district-level mentors:*** Hospital directors, in consultation with MCSP, selected district MNH providers to be trained as mentors. Provincial trainer mentors trained a team of four district-level mentors in each district.
- ***The mentor buddy system:*** Unlike their provincial counterparts, district-level mentors had limited prior teaching experience. To develop the district mentors, provincial trainer mentors were initially paired with district hospital mentors to conduct quarterly visits and to provide supportive supervision for the continued development of district mentors' clinical and mentoring skills.
- ***District mentorship practice:*** MCSP facilitated joint quarterly visits to the district and provincial hospitals to establish regular mentorship practice, provide on-site support to mentors, assess skills and collect MCSP monitoring data. MCSP staff attended these two-day visits, along with a provincial mentor OR a district mentor from a different district (as an inter-district exchange to support other districts and to share experience from their own district).
- ***Development of district trainer mentors:*** MCSP further consolidated district capacity by establishing one mentor in each district as a team leader for the district mentor team. They ensured that mentoring occurred at their own facilities on a daily basis and supported district mentors to provide mentorship to health center midwives (as described in the next bullet).
- ***Extension to health center midwives.*** During MCSP's last year, health center midwives were invited to participate in mentorship activities in the district facilities. In addition, district mentors began to join supervision visits to midwives and staff at health centers. Because of the low number of deliveries at the health center level, Save the Children also identified complementary funding to pilot two-week internships for health center midwives to practice in district hospitals that have a higher number of deliveries.

Course Corrections

MCSP maintained a flexible and responsive approach to the program design, informed by regular reviews. This approach allowed for course corrections when needed. Some examples include:

- A six-month reflection on initial progress identified challenges with the model of provincial mentors visiting district facilities for mentorship: provincial mentors were not always available due to other obligations, and the approach limited district ownership and responsibility for building skills among providers. In response, MCSP adjusted the program to focus on strengthening *district* mentorship capacity. In the final year of the program, MCSP also worked to bring mentorship practice to the health center level.
- Due to large numbers of health provider participation in mentorship sessions, initial mentorship visits were held in training rooms; later, mentorship was moved to the delivery room, where providers could practice skills in their work environment.
- Initial district mentor workshops were held over five days but were later adapted to take place over eight days. This change addressed the need to standardize mentor clinical skills and to develop their new mentoring and teaching skills.

Results

Data presented in this case study starts from September 2016 and continues through October-December 2017 for Sayaboury and from September 2016 through October-December 2018 for Luang Prabang. Every three months, MCSP staff and select mentors conducted two-day mentoring visits to all 10 district hospitals and two provincial hospitals to reinforce skills and collect data. Mentors collected quantitative data as they assessed their peers, and MCSP staff collected quarterly facility data. Quantitative data sources included:

- **Objective structured clinical examinations (OSCEs):**[5] Along with MCSP staff, mentors and trainer mentors administered these clinical skills assessments of mentors and mentees on a quarterly basis.
- **Mentoring skills assessment**: observations conducted quarterly by trainer mentors.
- **Facility delivery records**: Every quarter, MCSP staff reviewed select records in program facilities to collect data on provider practices during deliveries.
- **Facility service delivery readiness checklist**: administered by MCSP quarterly in each facility.

Qualitative information came from observational data and key informant interviews. Sources include:

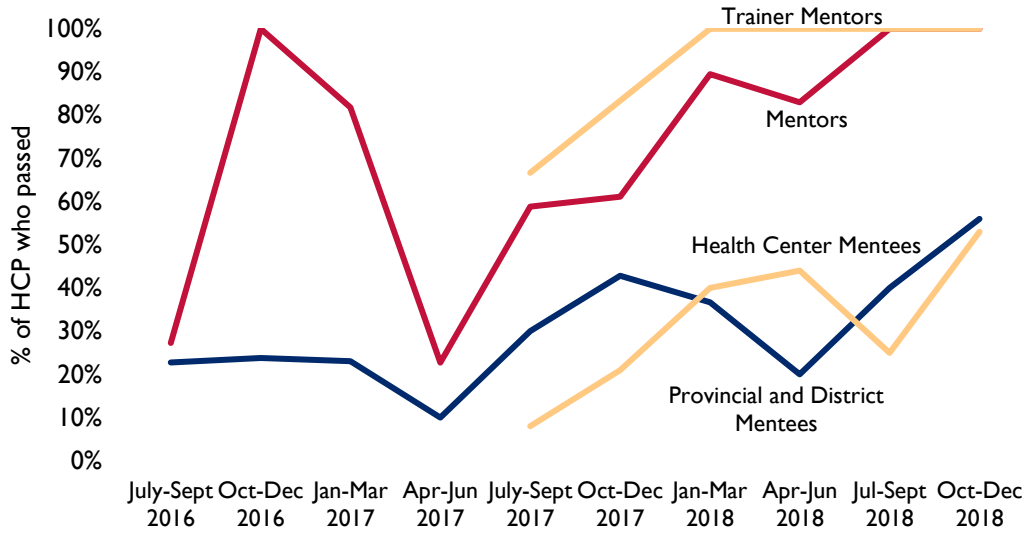
- **Exit interviews with postnatal mothers**: MCSP staff conducted these interviews quarterly to determine the mothers' experiences in the facility and to validate indicators obtained from facility records.
- **Facility-specific quality improvement action plans**: prepared by mentees and mentors quarterly.
- **Internal review**: This one-time review conducted in August of 2017 (year two) included interviews with MCSP staff, provincial leadership, facility leadership, and health providers in select program areas and facilities.

Changes in Provider Skills

Results from MCSP's mentorship activities to improve MNH provider skills and practices are promising and contribute to the further development of skills introduced in Lao PDR through other national capacity building programs (such as the Early Essential Newborn Care/EENC package introduced by the Ministry of Health with support from WHO).

[5] An OSCE is a methodology to evaluate health care providers. An assessor observes the provider as they conduct a skill or procedure and scores them against a clearly defined set of components.

Improving provider skills in Luang Prabang Province:
Percentage of health care providers (HCP) who demonstrate at least 7/9 key skills for normal delivery if the baby is not breathing, according to OSCE standards



Mentor OSCE Results

- Mentors' clinical skills were standardized during the district mentor workshop in September 2016. Over the course of the next two quarters, mentors experienced a period of skill attrition before the gradual development of skills to a complete pass rate in September 2018. The skill attrition was largely a result of mentors not regularly practicing their skills after the initial intensive training.
- Skill attrition is a reality and an important learning for the program. Implementers need to ensure that innovative approaches are developed to retain skills sustainably over time

Province and District-Level Mentee OSCE Results*:* The district-level providers have been exposed to and participated in MCSP mentorship activities for three years. OSCE scores assessed for district-level providers showed the following:

- Pass rates on OSCEs increased overall between October 2016 - December 2018 for all skills for the trainer mentors, mentors and provincial and district mentees.
- While select indicators steadily increased, others showed fluctuations that highlighted challenges and areas where focused program efforts were needed, such as the need to increase leadership support for regular skills practice in facilities.
- Overall progress on skills requires behavior change, which takes time. The results reflect the need in Lao for long-term support and capacity building to achieve and sustain change.

Health Center-Level OSCE Results: The health center is the first point of care for communities, and providers in these facilities are generally midwives who have received between one and three years of training and have been posted at their facilities for no more than a few years. They were exposed to MCSP-supported mentorship activities for less time than district-level providers (just five quarters as of December 2018). OSCE scores assessed for health center-level providers showed the following:

- The overall trend in pass rates increased from July 2017 – December 2018 for nearly all quarters and for all standards except bag and mask ventilation for newborns.

- Pass rates increased considerably in the first several quarters for health center midwives, from 8% in July-September 2017 to 60% in April-July in 2018. For one set of skills—monitoring progress of a woman in labor—the increase in pass rates among health center midwives was higher than changes seen among district providers over a longer period: district midwives improved eight points over eight quarters, while health center midwives improved by twelve points over five quarters.

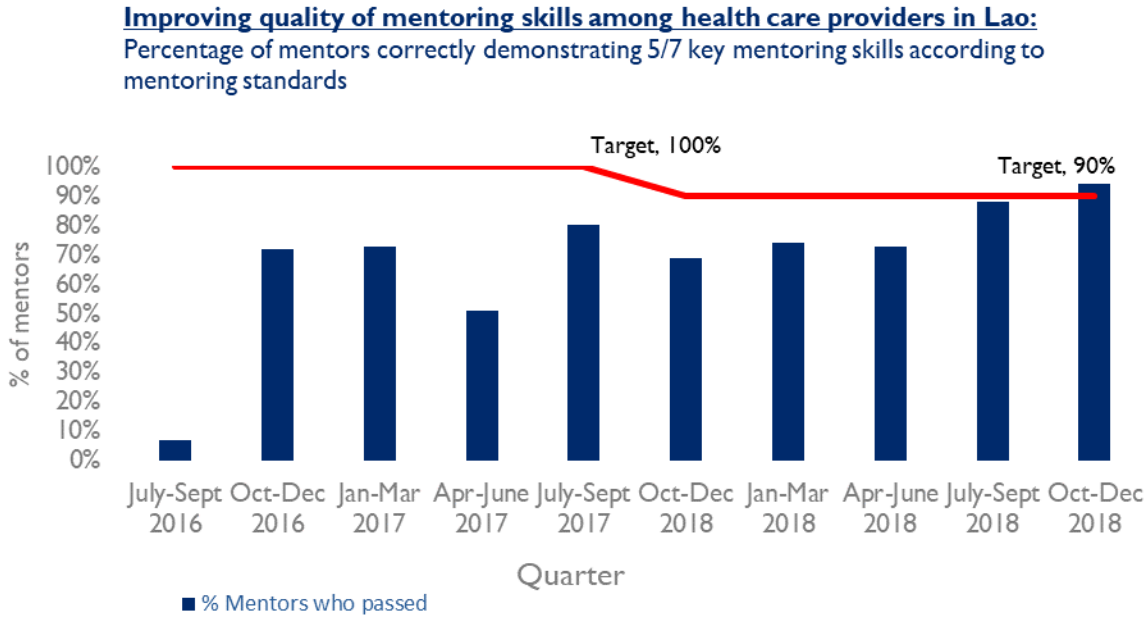
Constructive Feedback in the Lao Culture

At the onset of the MCSP Lao PDR program, public health professionals and clinicians—both Lao and international—raised concerns that the mentorship approach would fail in Lao PDR. They felt, for example, that because Lao culture is strongly oriented towards hierarchical structures of authority and because people hold such a deep respect for their seniors and elders, mentors and health workers would not feel comfortable giving or receiving feedback.

One of the inspiring lessons learned from MCSP's experience is that constructive and respectful feedback is not only possible in Lao PDR but that when it is practiced, it can contribute to stronger relationships, increased trust, and improved quality of care by service providers (as evidenced by data provided in the next section).

Improved Mentor Skills Assessment Results

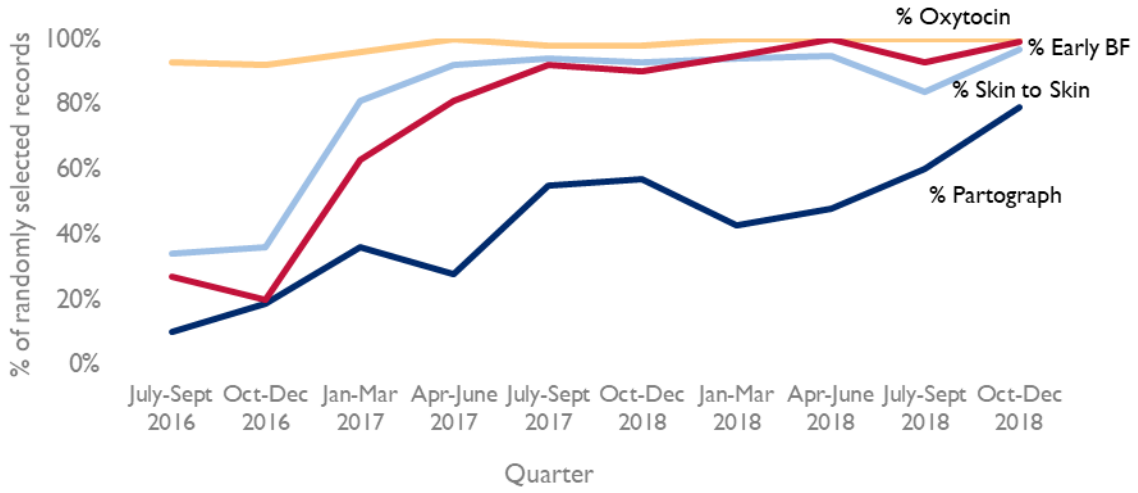
Figure 3 shows the results of regular mentorship skills assessments. Mentoring skills significantly improved between July-September 2016 and October-December 2016. From October-December 2016 to April-June 2018, pass rates on mentoring skills remained relatively constant, and by July-December 2018 the target of 90% was surpassed and reached 94%.



Changes in Quality of Care in the Facilities

MCSP collected data from randomly selected clinical records in MCSP-supported facilities on key indicators to understand changes in practice over the program period (see Figure 4). A summary of these changes is below.

Improving quality of maternal and newborn health services:
Percentage of randomly selected records that demonstrate implementation of key quality of care interventions for mothers and newborns during labor, delivery and pre-discharge postpartum.



- **Women receiving a uterotonic (oxytocin IM) in the third stage of labor in MCSP-supported areas reached 100%**: Performance on this indicator has been high since MCSP data collection began, showed incremental increases during initial quarters, and reached 100% during the last few quarters.
- **Newborns achieving early initiation of breastfeeding within 90 minutes at targeted health facilities increased from 34% to 99%:** There were significant improvements for breastfeeding practice from January-March 2017 through April-June 2017, with more moderate improvements later.
- **Newborns placed "skin to skin" immediately after birth for at least 90 minutes in targeted facilities increased from 36% to 99%**: Skin-to-skin practice increased along with early breastfeeding, reaching 96% in April-June 2018 and increasing further to 99% in December 2018.
- **Deliveries of randomly selected partographs filled in as per protocol at target health facilities increased from 10% to 79%:** Workshops, mentoring visits, and mentor meetings focused much time and effort on teaching and providing feedback on partograph completion. In spite of fluctuations, performance on this indicator moved from 10% in July-September 2016 to 79% by October-December 2018.

In addition to the indicators collected every quarter and summarized above, qualitative data from interviews with health providers during the program review suggests that mentorship prompted a number of additional improvements in quality of care. Example improvements include better infection control practices (wearing protective items such as gloves, masks, and gowns and changing protective wear if attending more than one delivery at a time), suctioning the infant only when necessary (instead of at every delivery), and keeping the infant with the mother.

Nearly every provider interviewed also cited improvements in respectful maternal care. Following the practices taught during mentorship sessions, providers say they now greet the mother, provide an explanation of what they are going to do, and ask about the mothers' preference for birth position and a birth partner.

Finally, nearly every provider interviewed during the program review commented on the positive contribution of mentorship towards strengthening relationships between providers in the facilities. Changes in relationships mentioned by providers included increased communication, improved feedback, stronger relationships between supervisors and direct reports, and more active staff that learn from each other and give feedback to colleagues on areas for improvement.

Lessons Learned

Two years of implementing the mentorship approach in Lao PDR has shown promising results for building capacity of MNH providers and for improving quality of care in facilities. Mentorship presents an opportunity to standardize skills for best practices at all levels—provincial, district, and health center—and creates regular learning opportunities for health providers in their places of work. Mentorship practice also creates a culture of collaboration, learning, and quality improvement that has resulted in better communication among providers in the facility, between providers and their supervisors, and between providers and their patients in MCSP program areas.

The challenges and lessons learned faced during implementation help to highlight areas of focus for strengthening on-going mentorship activities as well as for other programs that integrate mentorship into their capacity building approach. Some of these include:

- **Prioritize leadership engagement**: In facilities with strong leadership support, mentor motivation and availability during quarterly visits was well-established. MCSP prioritized leadership engagement from the outset of the program, particularly through the facilitation of review meetings that involved both facility and provincial leadership.
- **Recognize that skills building is behavior change, and behavior change takes time**: Changes in skills were not seen immediately, and there was variance in progress between quarters. When teaching new skills, mentorship programs must build in sufficient time and develop innovative methods to encourage providers to change old habits, refine their new practices, and establish new standards.
- **Ensure regular practice for skills retention**: Correspondingly, skill retention is an on-going challenge and requires a combination of capacity building approaches for changes to take root and continue. Inconsistency in mentee participation also leads to variable skill retention. MCSP actively supported regular skills practice in the facility outside the quarterly program mentorship visits by encouraging mentors to share photos of their activities on the mentors WhatsApp group (see box below) and giving recognition of their independent activities at mentor review meetings. Engagement of hospital leadership has been another important way to encourage regular practice.
- **Recognize challenges with newborn resuscitation using bag and mask**: This skill persisted as a challenge for all health providers that participated in mentorship activities, both mentors and mentees. OSCE pass rates on this skill were inconsistent but improved overall by 10 percentage points. This is one of the hardest OSCE standards to pass because there are more steps than any other standard, and these skills are not practiced routinely during births. Of note, the newborn resuscitation steps of clearing the airway and stimulating the baby have not experienced the same limitations in progress. Methods to improve this skill include dividing the bag and mask ventilation step into two separate steps and encouraging focused practice of this skill in isolation.
- **Target health center midwives**: Results over five quarters of engaging health center midwives indicate that this cadre has been relatively quick to strengthen their skillsets. Many of the midwives at the health center level are at an earlier stage of their career, are more open to change, and motivated to learn. Programs may be able to strengthen delivery care through targeted approaches that effectively engage this cadre.

Recommendations

Sustainability of mentorship activities and support for the approach was integral to MCSP's activities and program strategy. Mentorship activities can feasibly be incorporated into the government system, with engagement of established leadership and local champions. As a result, provincial leadership in both Sayaboury and Luang Prabang have taken a long-term perspective on planning and budgeting for mentorship. In Sayaboury, where MCSP and PHC support has ended, the provincial and district facilities continue to practice mentorship under their own initiative and budget. In Luang Prabang, mentorship will continue to be

supported through the PHC's funding sources, but the government has already started to plan for integration of mentorship into their own budget.

A summary of the best practices that cultivated this sustainability and fostered positive results from the mentorship approach is listed below. These best practices and principles are recommended for inclusion in mentorship programs in Lao PDR or as relevant in other implementation contexts:

- **Engagement of leadership**. Leadership was engaged from the outset of the program in selecting the first cadre of MNH providers to train as mentors. Continued engagement was ensured through participation in on-site visits and through participation of provincial and district leadership at mentor review meetings. Leadership support is essential to ensure mentor recognition and motivation for their role.
- **Mentor review meetings**: The benefits of regular mentor review meetings with leadership and mentors are foundational to developing commitment and momentum for mentorship, and are a cornerstone of instituting the practice of mentorship in Lao PDR. Rotating joint meetings between the two MCSP-supported provinces provided more opportunity for sharing and inspired healthy competition.
- **Focus on district-based capacity:** The development of mentorship capacity within the district hospitals yielded significant benefits for ownership, continuity, and institutionalization of mentorship for skills strengthening and quality improvement within facilities.

Mentorship & eHealth: MCSP established a WhatsApp group that included all mentors. The group proved useful for sharing materials and information, maintaining motivation, and exchanging examples of mentoring practice. Use of mobile applications can be further explored in future mentorship programs.

- **Time to develop partnerships**: External partners, such as non-governmental organizations and donor programs, must take time to develop strong relationships with and understand the priorities of the government of Lao PDR at the national, provincial, and district levels. MCSP was built into an existing program (Save the Children's PHC program), under which strong government partnership had already been established. This arrangement allowed MCSP to successfully introduce the mentorship approach within a three-year timeframe and, most importantly, allows the program to continue beyond MCSP support.
- **Program adaptability and responsiveness to feedback:** In implementing this program, MCSP took a dynamic approach to the program design. Throughout implementation, adjustments were made to strengthen efforts where additional needs were identified and to pare down activities or approaches that did not work well or required adjustments (see "Course Corrections" box in the methodology section).
- **Building local champions:** Mentors and facility leadership are active in sharing mentorship experiences during national conferences, meetings and technical workshops so that benefits and lessons learned are accessible to national capacity building programs (for example, EENC and Emergency Obstetric Care). In addition to sharing important programmatic information on strengthening the capacity of health providers, sharing their own experiences has strengthened the ownership and advocacy abilities of the mentors themselves.

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