FEDERAL MINISTRY OF HEALTH ETHIOPIA

CATCHMENT BASED RMNCAH MENTORING

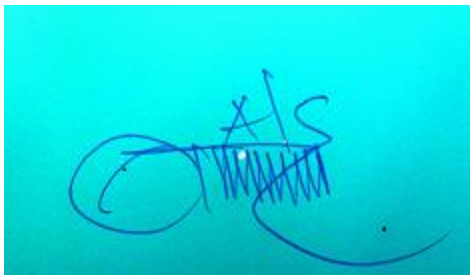
PARTICIPANT MANUAL

Version: 1.02

APPROVAL STATEMENT OF THE MINISTRY

The Federal Ministry of health of Ethiopia has been working towards standardization and institutionalization of In-Service Trainings (IST) at national level. As part of this initiative the ministry developed a national in-service training directive and implementation guide for the health sector. The directive requires all in-service training materials fulfill the standards set in the implementation Guide to ensure the quality of in-service training materials. Accordingly, the ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST implementation guide.

As part of the national IST quality control process, this ophthalmic equipment IST training package has been reviewed based on the standardization checklist and approved by the ministry in September , 2019.



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Forward

The Government of Ethiopia has pursued its commitments to improve the health and wellbeing of women, children and families by adopting and implementing a series of policies and strategies that ensure all Ethiopians to have access to basic health services. Apart from strengthening the health system, largely by expanding the health infrastructure and work force, the health sector has been undertaking a number of actions to overcome various forms of Reproductive Health related problems of the people.

Cognizant of the magnitude of the problem of quality of RMNCAH services and the related maternal mortality and morbidity, the FMOH developed the Catchment-based RMNCAH national guideline. This in turn led to the recognition of the need for an integrated approach to improve the competencies of health care workers thereby improving quality and equity of RMNCAH service to reduce maternal morbidity and mortality.

The Federal Ministry of Health, with the support of its development partners, proved its commitment to institutionalize and operationalize catchment-based RMNCAH mentoring and cascaded its implementation throughout the country. To further standardize the catchment-based RMNCAH mentoring, the Federal Ministry of Health developed and implemented a standard training manual for catchment-based RMNCAH mentoring.

Finally, I would like to thank partner organizations and individuals who invested their time, expertise and skill during the development of the training manual.

Signature

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Abbreviations

ANC	Ante Natal Care
ARM	Annual Review Meeting
ART	Anti-Retroviral Treatment
AYSRH	Adolescent and Youth Sexual Reproductive Health
BEmONC	Basic Emergency Obstetrics and Newborn Care
BP	Blood Pressure
CASH	Clean and Safe Hospital
CB CM	catchment based clinical mentoring
CBNC	Community-Based Newborn Care Management
CBT	Competency-based training
CHAI	Clinton Health Access Initiative
CPD	Continues Professional Development
CSA	Central Statistical Agency
DHS	Demographic Health Surveys
EDHS	Ethiopian demographic health surveys
EFY	Ethiopian Fiscal Year
EH	EngenderHealth
EHAQ	The Ethiopian Hospitals Alliance for Quality
EHCRIG	Ethiopian health center reform implementation guideline
EHSTG	Ethiopian hospital services transformation guideline
EmONC	Emergency Obstetrics and Newborn Care
EMwA	Ethiopian Midwife Association
ENBC	Established Newborn Corner
EPHAQ	The Ethiopian primary health care service Alliance for Quality
FHR	Fetal Heart Rate
FMOH	Federal Ministry of Health
HCW	Health Care Worker
HDP	Hypertensive Disorders of Pregnancy
HIV	Human Immune deficiency Virus
HR	Heart Rate
HSTP	Health Sector Transformation Plan

IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IST	In-Service Training
IUCD	Intra Uterine Contraceptive Device
JSI/L10K	John Snow, Inc: The Last Ten Kilometers
JSI/T: PHC	John Snow, Inc Transform Primary Health Care
KM	knowledge Management
LB	Life Birth
MMR	Maternal Mortality Rate
MNCH	Maternal Newborn and Child Health
MPDSR	Maternal and Perinatal death surveillance and response
NCSS	National Newborn and Child Survival Strategy
NICU	Neonatal Intensive Care Units
OR	Operation Room
PHEM	Public Health Emergency Management
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Post Natal Care
PPFP	Post-Partum Family Planning
PPH	Post-Partum Hemorrhage
PR	Public Relation
QITP	Quality Improvement and Transition Plan
RHB	Regional Health Bureau
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RR	Respiratory Rate
SBL	Simulation based Learning
SNNPR	South Nation Nationalities People Region
TOT	Training of Trainers
TPS	Think-Pair-Share
TWG	Technical Working Group
UN	United Nation
UNFPA	United Nations Population Fund
WHO	World Health Organization
WoHO	Woreda Health Office
ZHD	Zonal Health Department

Legend and Symbol Guide

1.  : Key issues to learn and understand for future application
2.  : Questions that will help you apply the critical points to your situation
3. 

: Brainstorming
4.  : Group Activity
5.  : Individual Exercises that reinforce your learning experience
6.  : Refer to the Pocket guide
7.  : Checklists that will help you identify important issues for future application
8.  : Real-world case studies that will help you apply the information you've learned
9. 

: **Think-pair-share (TPS)** is a collaborative learning strategy where students work together to solve a problem or answer a question about an assigned reading. This strategy requires students to (1) think individually about a topic or answer to a question; and (2) share ideas with classmates.
10. 

: Role play
11.  : Modular reading

Introduction to the manual

The rationale of the manual

Ethiopia has made significant strides in improving maternal, newborn and child health throughout the country. Pregnancy-related mortality has decreased from staggering 871 deaths per 100,000 live births to 412 from 2000 to 2016. Neonatal mortality has also shown significant improvement over the years, from 49 in 2000 to 29 in 2016, and is one of the indicators the country has achieved from the Millennium Development Goals. Coverage for the skilled birth attendant, antenatal care and postnatal care has also significantly improved over the years. Just over a decade ago, the country had a very limited number of health care providers, particularly midwives in its workforce. Although the number of midwives in the country is still below the WHO recommendation (one skilled birth attendant for every 175 pregnant women), there are now an estimated 12,500 midwives working throughout the country in all health care settings, primarily at the health center level, where over 80% of maternal and child health services are provided. The health care system is further strengthened by close to 40, 000 health extension workers that provide preventive and curative services at the community level and play a key role as frontline workers in the effort to reach every corner of the community to deliver quality health care.

However, despite all the progress and improvement, the quality of care at the facility level is not where it needs to be. There is still a significant gap in knowledge and skill among health care providers joining the workforce. EmONC (2016) assessment findings show low levels of knowledge in key maternal and new-born care areas among midwives and nurses. For example, out of 3,193 midwives in the survey, only about 50% or less correctly identified care for complications during the intrapartum period and for the new-born. Among nurses, the score was even lower. Although several in-service training is widely instituted with the goal of upgrading the knowledge and skill of health care providers, there needs to be a coordinated approach to improve the knowledge and skill of healthcare providers that can then translate into high-quality care each mother and new-born receives at each encounter. In addition, Weak mentorship to facility level is one of the challenges identified in 2018 ARM performance report and strengthening coordination platforms and mentorship at all levels by implementing catchment based clinical mentoring [CB CM] using trained mentors is one of the ways forwarded.

The CB CM approach to training recognizes that classroom-based training alone is not sufficient to support the application of complex clinical skills. It ensures that training programs result in the transfer of learning to the job site. The framework outlines a model in which the trainee progresses from the acquisition of new skills and knowledge in the classroom, to closely supervised clinical practice of new skills, to increasing independence and responsibility in practice RMNCH services supported by onsite mentoring, to initiation of the provision of guidance and advice on an as-needed basis. Responsibility and decision-making are thus gradually shifted to the trainee throughout this process as the trainee acquires increased skill and confidence.

Clinical mentoring is a critical component of a comprehensive in-service training program, as it provides a bridge between didactic training and independent clinical practice. Clinical mentoring enables health care workers (HCW) to practice new skills in clinical settings with the support and guidance of a more specialized and experienced clinician. Intensive, practical training is especially important in RMNCH training. As a result, this training is developed to complement the in-service training program but not a replacement nor a duplicate of it. The core competencies of this training are:

1. Visualize the role of Mentors in RMNCAH mentoring program
2. Building and managing the mentoring relationship
3. Effectively Teach mentees
4. Implement monitoring & evaluation of the mentoring process

Course Syllabus

(a) Course Description

This is four days in-service training designed to enable participants to initiate and maintain catchment based clinical mentoring and coaching for health care providers in order to maintain the quality of care provided at all levels in a standard fashion. Mentoring and coaching are a challenging task that requires flexibility, skill in coordinating disparate stakeholders, excellent communication and relationship-building skills, and the ability to cope with the rapid change of direction, in addition to up-to-date clinical knowledge and teaching skills. This training is designed to provide participants with the knowledge and skill of effective clinical mentoring and coaching.

(b) Course Goals

- This training is designed to enable health care workers to become knowledgeable and skilled clinical mentors with the right attitude.

(c) Participant Learning Objectives

By the end of this training course, the participant will be able to:

- Describe the goal, objectives, and role of Mentoring in RMNCAH
- Apply an effective mentoring process
- Analyze the basic concepts and principles of learning
- Practice the M & E tools of the RMNCAH mentoring process

(d) Training/Learning Methods

- Illustrated lectures and group discussions
- Case studies
- Roleplay
- Brainstorming
- Individual and group exercises

(e) Learning Materials

Learning materials for the course are as follows:

- Participant manual
- Flipchart, Markers and Masking tape
- A laptop computer and LCD projector

- Projection screen

(f) Participant Selection Criteria

Participants of this training will be health care providers working in RMNCAH clinics of selected mentor health facilities (according to the national catchment based RMNCAH mentoring guideline) who have taken the national RMNCAH trainings (Family Planning, compensative abortion care, BEmONC and related training), and who will serve as a RMNCAH mentor.

(g) Trainers' selection Criteria

Instructors will be selected from National TWG who have developed or have Training of Trainers /TOT/ or the basic training with facilitation skill. The trainer must have experience in adult learning approach to provide the training, which is conducted according to adult learning principles.

(h) Method of Evaluation

(i) Participant

Formative

- Individual learning plans
- Pretest questionnaire
- Checking participants understanding of principles during presentations and learner activities
- Evaluation of participant developed activities and materials throughout the course

Summative

- Knowledge assessment (60%): Pre/Post-course questionnaire
- Participant's activity and participation throughout the course (40%)
- Participants will be certified when they score 70% and above in the aggregate assessment score.

(ii) Course evaluation

- Each day's courses will be evaluated based on the developed format addressing the provided documents, Training contents, instructors, facilities, Time and Interactions. Feedbacks will be given based on the given comments immediately. End of course evaluation format will be used to assess the overall effectiveness of the course as

perceived by the trainees at the end of the course. (Refer from national IST Implementation Manual)

(i) Course Duration: **Four days**

Suggested Course Composition: Up to 20 professionals from different background and three trainers

Venue: The training will take place in the in-service training facility where participants have access to practice Mentoring skills.

Course schedule: See the 5 days course schedule of the training below

(j) Schedule/Course agenda

Table 1: Catchment-based RMNCAH mentoring training Schedule/Course agenda

Day 1	Time	Activity	Responsible	Remark
	8:30 – 9:00	Registration		
	9:00 – 9:10	Opening Speech		
	9:10 – 9:10	Introduction of Participants and Setting norms		
	9:10 – 9:20	Expectations & Objectives of the training		
	9:20 – 9:40	Pre-test		
	9:40 – 10:30	Chapter I: Session 1: Overview of RMNCAH in Ethiopia		
	10:30 – 11:00	Tea Break		
	11:00 – 12:00	Chapter I: Session 2: Introduction to CRC		
	12:00 – 1:00	Lunch Break		
	1:00 – 2:30	Chapter I: Session 3: Introduction to Mentoring		
	2:30-3:30	Chapter I: Session 4:		

		Catchment based mentoring system		
	3:30 – 4:00	Tea Break		
	4:00 – 5:00	Chapter II: Session 1: Building a relationship in the mentoring process		
	5:00 – 5:30	Wrap-up		
Day 2	Time	Activity		
	8:30 – 10:00	Chapter II: Session 1: Building a relationship in the mentoring process		
	10:00-10:30	Tea Break		
	10:30-12:30	Chapter II: Session 2: Effective communication and feedback mechanism		
	12:30 – 1:30	Lunch Break		
	1:30 – 3:00	Chapter II: Session 3: Initiation of the mentoring process		
	3:00-3:30	Tea Break		
	3:30-5:00	Chapter III: Session 1: Theories of Learning		
Day 3	Time	Activity		
	8:30 – 10:00	Chapter III: Session 2: Effective approaches for Adult Learners		
	10:00-10:30	Tea Break		

	10:30-12:30	Chapter III: Session 3: Application of learning theories and approaches to mentoring		
	12:30 – 1:30	Lunch Break		
	1:30 – 2:15	Chapter IV: Session 1: Basics of Monitoring & Evaluation		
	2:15-3:00	Chapter IV: Session 2: Assessment of the mentorship program		
	3:00-3:30	Tea Break		
	3:30-5:00	Chapter IV: Session 3: Assessment of the performance of the mentee		
Day 4	Time	Activity		
	8:30 – 10:30	Chapter IV: Session 4: Use of M&E tools and analysis of data		
	10:30-11:00	Tea Break		
	11:00-11:30	Practical exercise using the CB-CM checklist		
	11:30 -12:00	Post test		
	12:00– 12:30	Closing & end of course evaluation		

Chapter 1: Caring, Respectful and Companionate Healthcare Service

Chapter description: This chapter is designed to equip healthcare professionals and senior management in health facilities to increase core competencies of compassionate, respectful, holistic, scientifically and culturally acceptable care for patients and their families.

Chapter objective: By the end of this chapter the participants will be able to:

- Describe Compassionate, respectful and Caring (CRC) healthcare service delivery

Enabling Objectives: By the end of this chapter participants will be able to:

- Describe Compassionate, respectful and caring (CRC)
- List principles of health care Ethics
- Discuss components of compassionate care
- Explain principles of respectful care
- Discuss characteristics of Compassionate leader

Chapter Outline

1.1. Introduction to CRC

1.2. Healthcare Ethics

1.3. Compassionate care

1.4. Respectful care

1.5. Compassionate leader

1.1. Introduction to Compassionate, Respectful and Caring (CRC)

Individual reflection

What is Compassionate, Respect and Caring (CRC)?

Time Allowed 15 minutes

1.1.1. Definition of CRC

Compassion (ሩህሩህ)

Is a feeling of deep sympathy and sorrow for the suffering of others accompanied by a strong desire to alleviate the suffering? Therefore, we can say it is being sensitive to the pain or suffering of others and a deep desire to alleviate the suffering.

Respectful (ተገልጋይን የሚያከብር)

Is the kind of care, in any setting, which supports and promotes, and does not undermine a person's self-respect, regardless of any differences?

Caring (ተንከባካቢ)

Caring is an intensification of the affective dimension of empathy in the context of significant suffering. It is coupled with effective interventions to alleviate that suffering.

Compassionate, respectful and caring (CRC) - means serving patients, being ethical, living the professional oath, and being a model for young professionals and students. It's a movement that requires champions who identify with their profession and take pride by helping people.

- Why CRC a transformational agenda?

Time Allowed 10 minutes

1.1.2. Why CRC a Transformation agenda?

Helping health professionals' to become compassionate and respectful practitioners remains a major challenge for the healthcare. Compassionate and respectful care is not only morally and financially essential, but it is required in many countries through national legislation and/or national health policy.

The notion that healthcare services must be expanded beyond the prevention of morbidity or mortality is only one aspect of the agenda. It must encompass respect for patients' basic human rights, including respect for patients' autonomy, dignity, feelings, choices, and preferences. It must include choice of companionship wherever possible.

Taken from the United Nations human rights declaration, 'All human beings are born free and equal in dignity and rights.' The Ethiopian constitution of human rights article 25 and 26 states that the rights to equality and privacy.

In the Ethiopian health system, there are many health professionals who have dedicated their entire career to public service and are respected by the public they serve. However, a significant proportion of health professionals see patients as just 'cases' and do not show compassion. Lack of respect to patients and their families is also a common complaint.

A three-year report of the Ethics Committee and relevant documents in Addis Ababa showed that 39 complaints were related to death of the patient and 15 complaints were about disability. The committee verified that 14 of the 60 claims had an ethical breach and/or negligence and other study also indicated that forwarding bad words, shouting on patients, mistreatment, insulting and hitting of clients are some of unethical practices showed by the health professionals.

Studies showed the need for CRC

- Lack of role models in many health facilities.
- Measuring the worth of a profession by how much it pays.
- Senior physicians cancel their outpatient clinics without informing their patients.
- Elective surgeries get cancelled.
- Admitted patients are by default getting the care they need from relatives.
- Nurses, for various reasons, have limited their role to providing injections and securing IV lines.

- Proper counseling during dispensing of drugs is also becoming a rarity.
- The quality of lab tests and the quality assurance process that lab professionals have to take before issuing results is not practiced as expected.
- Lack of compassion, respect and care is the common source of grievances in health facilities.

1.1.3. The Benefits of CRC

Table 1.The benefits and beneficiaries of Compassionate and Respectful Care

Beneficiaries	Who	How
First	**Patients**	• When health professionals are compassionate, patients are less anxious • Adherence to medical advice and treatment plans • Compassionate care correlates positively with both prevention and disease management. Diabetic patients, for example, demonstrate higher self-management skills when they self-report positive relationships with their providers • Hostile emotional states in patients delay the healing processes • Quality of health professionals –patient communication with increased physical functioning, emotional health and decreased physical symptoms of pain in patients
Second	**Health Professionals**	• Health care Professionals satisfaction with their relationships with patients can protect against professional stress, burnout, substance abuse and even suicide attempts • Burnout is strongly associated with poorer quality of care, patient dissatisfaction, increased medical errors, lawsuits and decreased expressions of compassion • Participation in a mindful communication associated with short-term and sustained improvement in well-being and attitudes associated with patient care • A major predictor of patient loyalty • When health professionals are compassionate, they achieve earlier and more accurate diagnoses because the patient is better able to reveal information when he or she feels emotionally relaxed and safe • Respect from the client/patients • Health professionals will find their work more meaningful and gratifying
Third	**Students**	• Good role modeling is essential for students • Increased motivation to be CRC health professionals
Fourth	**Health care facilities**	• Patient satisfaction will rise • Quality of health care will be improved • Lower malpractice suits • Staff will be more loyal to their hospital or health care system • Patient adherence to treatment will rise • Resources can be conserved • Greater employee satisfaction and reduced employee turnover.

1.1.4. National Strategy and Approach of CRC

The development of caring, respectful and compassionate health workers requires a multi-pronged approach in order to make CRC as a culture, self-driven inner motive and a legacy that the current generation of practitioners leaves to their successors.

NATIONAL STRATEGY AND APPROACHES FOR CRC

- *Reforming the recruitment of students for health science and medicine programs.*
- *Improving the curriculum of the various disciplines.*
- *Ownership and engagement of the leadership at all levels of the system.*
- *Inspirational leadership that aims to create an enabling environment.*
- *National, regional and facility level ambassadors.*
- *An advocacy campaign through mass media will also be launched to project positive images of health professionals.*
- *Patients and the general public will also be engaged in this movement.*
- *An annual health professional recognition event will be organized*
- *Putting in place a favorable legislative framework to reinforce CRC which would include regulation on patients' rights and responsibilities (PRR)*
- *Measurement of health care providers on CRC*
- *Comprehensive projects will be designed.*
- *Conducting national assessment related to CRC.*
- *Provision of continuous CRC trainings.*
- *Engagement and ownership of professional associations.*
- *Experience sharing from national and international best practices.*

1.2. Healthcare Ethics

1.2.1. Principles of health care ethics

Individual reflection

- What is ethics?
- What is health care ethics?

Time: 5 Minutes

Ethics:

Ethics is derived from the Greek word *ethos*, meaning custom or character. Ethics is the study of morality, which carefully and systematically analyze and reflect moral decisions and behaviors, whether past, present or future. It is a branch of philosophy dealing with standards of conduct and moral judgment.

Health care ethics:

It is a set of moral principles, beliefs and values that guide us to make choices about healthcare. The field of health and healthcare raises numerous ethical concerns, including issues of health care delivery, professional integrity, data handling, use of human subjects in research and the application of new techniques.

Ethical principles are the foundations of ethical analysis because they are the viewpoints that guide a decision. There are four fundamental principles of healthcare ethics.

1. Autonomy
2. Beneficence
3. Non-maleficence
4. Justice

1. Autonomy

Autonomy is the promotion of independent choice, self-determination and freedom of action. Autonomy implies independence and ability to be self-directed in one's healthcare. It is the basis of self-determination and entitles the patient to make decisions about what will happen to his or her body.

Case one:

A 49-year-old client with diabetic finding came with right foot second finger gangrene to a hospital. The surgeon decided that the finger should be removed immediately. But the patient refused the procedure.

Question: How should the surgeon handle this case?

Time: 5 Minutes

2. Beneficence

Beneficence is the ethical principle which morally obliges health workers to do positive and rightful things. It is "doing what is best to the patient". In the context of professional-patient relationship the professionals are obliged to always and without exception, favor the wellbeing and interest of their patients.

Case two:

Ms. X was admitted to adult surgical ward with severe excruciating right flank pain with presumptive diagnosis of renal colic. Nurse Y was the duty nurse working that day. The physician who saw her at OPD did not write any order to alleviate the pain.

Question: What should the attending nurse do for Ms. X?

Time: 5 Minutes

3. Non-maleficence

The principle refers to "avoid doing harm". Patient can be harmed through omitting or committing

interventions. When working with clients, healthcare workers must not cause injury or distress to

clients. This principle of non-maleficence encourages the avoidance of causing deliberate harm, risk of harm and harm that occurs during the performance of beneficial acts. Non-maleficence also means avoiding harm as consequence of good.

Case Three:

Mr "X" is admitted to internal medicine ward with cardiac failure. The physician admitted Mr "X" and prescribed some medication which should be given regularly by the ward nurse. A nurse in charge of the ward does not give a patient medication timely and appropriately.

Question: What should the ward nurse do for Mr "X"

Time: 5 Minutes

4. Justice

Justice is fair, equitable and appropriate treatment. Justice refers to fair handling and similar standard of care for similar cases; and fair and equitable resource distribution among citizens. It is the basis for treating all clients in an equal and fair way. A just decision is based on client need and fair distribution of resources. It would be unjust to make such decision based on how much he or she likes each client.

Example:

- Resource scarcity is the common issue in healthcare settings. For example, there may be only one or two neurosurgeons and many patients on the waitlist who need the expertise of these neurosurgeons. In this case we need to serve patients while promoting the principle of justice in transparent way. Example, the rule of first come first serve could be an appropriate rule.
- Justice requires the treatment of all patients equally, irrespective of their sex, education, income or other personal backgrounds.

1.2.2. Confidentiality and informed consent.

Confidentiality

Confidentiality in healthcare ethics underlines the importance of respecting the privacy of information revealed by a patient to his or her health care provider, as well the limitation of healthcare providers to disclose information to a third party. The healthcare provider must obtain permission from the patient to make such a disclosure.

The information given confidentially, if disclosed to the third party without the consent of the patient, may harm the patient, violating the principle of non-maleficence. Keeping confidentiality promotes autonomy and benefit of the patient.

The high value that is placed on confidentiality has three sources:

- *Autonomy:* personal information should be confidential, and be revealed after getting a consent from the person
- *Respect for others:* human beings deserve respect; one important way of showing respect is by preserving their privacy.
- *Trust:* confidentiality promotes trust between patients and health workers.

The right of patient to confidentiality

- All identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind, must be kept confidential, even after death. Exceptionally, family may have a right of access to information that would inform them of their health risks.
- Confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other healthcare providers only on a strictly "need to know" basis unless the patient has given explicit consent.
- All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of its storage. Human substances from which identifiable data can be derived must also be protected.

Exceptions to the requirement to maintain confidentiality

- Routine breaches of confidentiality occur frequently in many healthcare institutions. Many individuals (physicians, health officers, nurses, laboratory technicians, students, etc) require access to a patient's health records in order to provide adequate care to that person and, for students, to learn how to practice care provision.
- Care providers routinely inform the family members of a deceased person about the cause of death. These breaches of confidentiality are usually justified, but they should be kept to a minimum and those who gain access to confidential information should be made aware of the need not to spread it any further than is necessary for descendants benefit. Where possible, patients should be informed ahead that such a breach might occur.
- Many countries have laws for the mandatory reporting of patients who suffer from designated diseases, those deemed not fit to drive and those suspected of child abuse. Care providers should be aware of the legal requirements to be able to disclose patient information. However, legal requirements can conflict with the respect for human rights that underlies healthcare ethics. Therefore, care providers should look carefully at the legal requirement to allow such an infringement on a patient's confidentiality and assure that it is justified.

Case four:

An HIV-positive individual is going to continue to have unprotected sexual intercourse with his spouse or other partners.

Question:

1. How do you manage such an individual?
2. Discuss situations that breach confidentiality.

Time: 5 Minutes

Ethiopia Council of ministers' regulation 299/2013, Article 77 Professional Confidentiality

Informed Consent

Informed consent is legal document whereby a patient signs written information with a complete information about the purpose, benefits, risks and other alternatives before he/she receives the care intended. It is a body of shared decision making process, not just an agreement. Patient must obtain and being empowered with adequate information and ensure that he/she participated in their care process.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:

A. *Voluntary*: the decision to either consent or not to consent to treatment must be made by the person him or herself, and must not be influenced by pressure from medical staff, friends or family. This is to promote the autonomy of the patient.
B. *Informed*: the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and the consequences of not doing the treatment. This will help to avoid harm—patients may harm themselves if they decide based on unwarranted and incorrect information.
C. *Capacity*: the person must be capable of giving consent, which means they understand the information given to them, and they can use it to make an informed decision.

General principle of Informed consent

Should be given by a patient before any medical treatment is carried out. The ethical and legal rationale behind this is to respect the patient's autonomy and their right to control his or her life. The basic idea of personal autonomy is that everyone's actions and decisions are his or her own.

The principles include:

1. Information for patients
2. Timing of consent process
3. Health Professionals responsibility for seeking consent
4. Decision making for incompetent patients
5. Refusal of treatment

Ethiopia Council of minister's regulation 299/2013, Article 52. Patient's informed consent

1.2.3. Preventive ethics in the aspect of CRC

What is preventive ethics?

Preventive Ethics is a systematic application of ethical principles and values to identify and handle ethical quality gaps, dilemmas, challenges and errors to appropriately and fairly. It could be carried out by an individual or groups in the health care organization to identify prioritize and systematic address quality gaps at the system level.

Why is preventive ethics important for CRC healthcare workers?

First and foremost, the CRC health workforce, patients, families and the community at large should have a common understanding that the experience of illness and the practice of medicine lead to situations where important values and principles come to conflict and ethical dilemmas and challenges arise everywhere. Moreover, the CRC health worker should always understand the context in which She/he operates (like the services, the clients, the providers, values, norms, principles, culture, religions, socio-economic-geographic…) as the way in which ethical dilemmas are handled vary from case to case and place to place.

Preventive ethics helps the CRC health workforce to predict, identify, analyze, synthesize and manage ethical dilemmas, challenges and errors to make the appropriate and fair decisions. Hence, preventive ethics enhances honesty and transparency between healthcare workers, patients, families and relevant others to make a deliberated joint decision. Moreover, it inspires mutual understanding and trust amongst the healthcare provider, recipient and the community at large.

Preventive ethics brings all efforts together productively and leads to the satisfaction of clients, providers and the community even if when the decisions are sometimes painful and outcomes are negative.

1.2.4. Ethics and law as enablers of CRC

The Relation between Ethics and Law

Individual reflection

- What is the relationship between ethics and law?

Time: 5 Minutes

Ethics as discussed in the previous sessions, is considered as a standard of behavior and a concept of right and wrong beyond what the legal consideration is in any given situation.

Law is defined as a rule of conduct or action prescribed or formally recognized as binding or enforced by a controlling authority. Law is composed of a system of rules that govern a society with the intention of maintaining social order, upholding justice and preventing harm to individuals and property. Law systems are often based on ethical principles and are enforced by the police and Criminal justice systems, such as the court system.

Ethics and law support one another to guide individual actions; how to interact with clients and colleagues to work in harmony for optimum outcome; provision of competent and dignified care or benefits of clients/ patients. Ethics serves as fundamental source of law in any legal system; and Healthcare ethics is closely related to law. Though ethics and law are similar, they are not identical.

Often, ethics prescribes higher standards of behavior than prescribed by law; and sometimes what is legal may not be ethical and health professionals will be hard pressed to choose between the two. Moreover, laws differ significantly from one country to another while ethics is applicable across national boundaries.

The responsibilities of healthcare professionals and the rights and responsibilities of the patient is stipulated in legal documents of EFMHACA like regulation 299/2013, directives and health facility standards.

1.3. Principles and Standards of Compassionate Care

1.3.1. Qualities of compassionate care

Compassion can be defined as: "sensitivity to the suffering of self and others with a deep wish and commitment to relieve the suffering".

Developing more compassion can be a way to balance emotions to increase the well-being of patients, healthcare professionals and facilitation of healthcare delivery. For patients, compassion can help prevent health problems and speed-up recovery. Compassion can improve staff efficiency by enhancing cooperation between individuals and teams and between patient and healthcare professionals.

Individual reflection

- **Can compassion be trained and learned?**

Time Allowed: 5 Minutes

Qualities of Compassionate Care

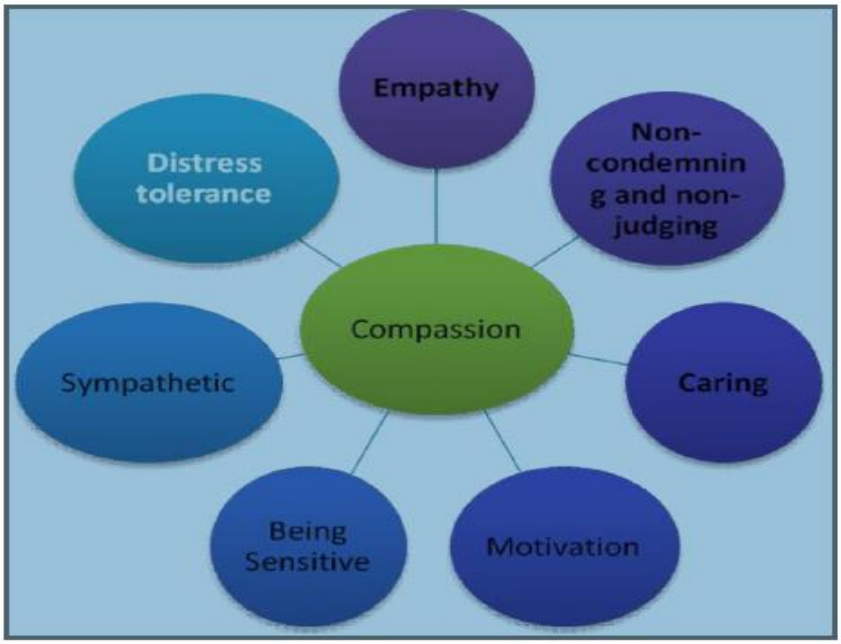

Figure 1: Qualities of compassion

Role play on qualities of compassionate care:

Instructions:

One participant will take the role of a healthcare provider and another participant will take the role of a mother [with limited mobility] of a sick child with a feeding problem. Other participants should observe and note the discussion.

Roles

Healthcare provider

A mother (with limited mobility) of a sick child:

Situation:

A mother with limited mobility brings her 3-month-old baby girl with cough and fever to the outpatient clinic. The healthcare provider seemed tired. By the time the mother enters the examination room, he was talking with his subordinate about last night's football game. He had already noticed her but did not let her to sit. Her child was crying and she was trying to quiet her.

All of a sudden the healthcare provider shouted loudly at the mother to quiet her child or they would have to leave.

While waiting and calming her child, the mother told the healthcare provider that her child is very sick and needs an urgent care. While facing to his friend, the healthcare provider told the mother that he would see her child in five minutes.

After waiting for 10 minutes, the healthcare provider started to examine the child and felt sad about the condition of the child; apologized to her for having let her wait so long. The healthcare provider evaluated the child gently, gave the child a proper treatment, reassured the mother, and the child went home better.

Discussion Questions

Did the health provider demonstrate the characteristics of compassion?

If not, what are the areas /conversation that show poor characteristics of compassion?

If yes, what are the areas /conversation that show good characteristics of compassion?

Time allowed: 30 minutes

1.3.2. Elements of compassionate care

According to researches the key elements of compassionate care has categories, each contains theme and subthemes.

1. **Virtue:** It is described as ‘‘good or noble qualities embodied in the character of the health care provider
2. **Relational space:** is defined as the context and content of a compassionate encounter where the person suffering is aware of and is engaged by, the virtues of the health care provider.

The category of relational space comprised two themes.

- Patient awareness which describes the extent to which patients intuitively knew or initially sensed health care provider capacity for compassion.
- Engaged care giving which refers to tangible indicators of health care provider compassion in the clinical encounter that established and continued to define the health care provider-patient relationship over time.

3. **Virtuous Response:** It is the “Enactment of a virtue toward a person in suffering,’’ and it is both an individual category and an overarching principle of care that functions as a catalyst to the three core categories of compassionate care giving: ‘‘**seeking to understand, relational communicating, and attending to needs**’’ The category of virtuous response contain three broad themes within it:
    - Knowing the person refers to the extent to which healthcare providers approached their patients as persons and view their health issues and suffering from this point of view.
    - Seeing the person as priority involves healthcare providers’ ability to priorities patient needs, setting aside their own assumptions and healthcare system priorities in the process.
    - Beneficence refers to healthcare providers wanting the best for the patient, informing the three more targeted core categories of compassionate care giving.
4. **Seeking to Understand:** refers to healthcare providers trying to know the patient as a person and his or her unique needs.

The need to understand a person's desires and tailor his or her care is identified by most patients as a fundamental feature of compassion.

- Seeking to Understand the Person.
- Seeking to Understand the needs of the Person

5. **Relational Communication:** is an important element of compassion identified by patients consisting of verbal and nonverbal displays conveyed by the healthcare provider's engagement with the person suffering.

There are four specific themes and associated subthemes that convey compassion within clinical communication:

- **Demeanor** (''being'')
- **Affect** (''feeling for'')
- **Behaviors** (''doing for'')
- **Engagement** (''being with'')

Attending to Needs

It refers to ''a timely and receptive desire to actively engage in and address a person's multi-factorial suffering''. Attending to patients' needs has three interrelated themes:

- Compassion-Related Needs: refers to the dimensions of suffering that patient feel compassion: physical, emotional, spiritual, familial and financial.
- Timely refers to addressing suffering in a ''timely'' manner.
- Action refers to the initiation and engagement of a dynamic and tangible process aimed at alleviating suffering. Compassion is more action.

1.3.3. Principles of compassionate care

Individual reflection

❖ **What are the principles of compassionate care?**

Time Allowed: 5 Minutes

The universal principles of compassion will help us know one another in a more meaningful way where we discover one another respectfully. They create the

conditions that allow a person who is suffering to experience the healing power of compassion.

1. **Attention:** is the focus of healthcare provider. Being aware will allow the healthcare provider to focus on what is wrong with a patient; or what matters most to the patient.

2. **Acknowledgement:** is the principle of what the healthcare professional says. The report of the examination or reflection on the patient's message. Positive messages of acknowledgment are buoyant; they let someone know that you appreciate them as a unique individual.

3. **Affection:** is how healthcare providers affect or touch people. Human contact has the ability to touch someone's life. It is the quality of your connection, mainly through warmth, comfort, kindness and humor. Affection brings joy and healing.

4. **Acceptance**: is the principle of being with mystery – how you stand at the edge of your understanding or at the beginning of a new experience, and regard what is beyond with equanimity. It is the quality of your presence in the face of the unknown, in the silence. Like the sun in the north at midnight, acceptance welcomes the mysteries of life and is at peace with whom we are and where we are, right now. It is the spirit of Shalom.

- The principle of acceptance is: being at peace with the way things are allows them to change.

1.3.4. Threats to compassionate care

There are factors preventing compassion and compassionate behavior for individual members of staff, teams and units and health facility. Most research discusses compassion at the individual level. In general, the most common threats for compassionate care are:

- **Compassionate fatigue:** Physical, emotional and spiritual fatigue or exhaustion resulting from care giving that causes and a decline in the caregivers' ability to experience joy or feel and care for others.

- A form of burnout, a kind of "secondary victimization" what is transmitted by clients or patients to care givers through empathetic listening.

- **Unbalanced focus between biomedical model (clinical training) and person:** Effective clinical care is clearly fundamentally important, but human aspects of medicine and care must also be valued in training and in terms of how to be a good healthcare professional.
- **Stress, depression and burnout:**
  - **Self-reported stress** of health service staff is reported greater than that of the general working population.
  - **Burnout** (or **occupation burnout)** is a psychological term referring to general exhaustion and lack of interest or motivation to work.
- **Overall health facility context:** Attention by senior managers and health facility boards to achieve financial balance that affects priorities and behaviors of staff in health facility.

Addressing Threats of compassion

- Overcoming compassion fatigue
- Developing an inner compassionate self
- Compassion to yourself
- Teaching compassion to professionals through, training and education
- Dealing with staff stress and burnout
- Dealing with wider health facility context

1.4. Respectful care

1.4.1. Definition of Concepts of Respectful and Dignified Care

1. Can you share us your experience with regard to respect and dignity in the health care setting?
2. What does respectful care mean to you?

Time Allowed: 10 minutes

Definition of Dignity (ልእልና)

The word dignity originates from two Latin words: 'dignitus' which means merit and 'dignus' meaning worth. It is defined from two perspectives:

- Dignity is a quality of the way we treat others.
- Dignity is a quality of a person's inner self.

Types of Dignity

There are four types of dignity: dignity of human being, personal identity, merit and moral status.

1. Dignity of human being

This type of dignity is based on the principle of humanity and the universal worth of human beings their inalienable rights-which can never be taken away.

2. Dignity of personal identity

This form of dignity is related to personal feelings of self-respect and personal identity, which also provides the basis for relationships with other people.

3. Dignity of merit

This is related to a person's status in a society.

4. Dignity of moral status

This is a variation of dignity of merit, where some people have a personal status because of the way they perceived and respected by others. (**N.B.** Refer to Hand-out 3.1 for details.)

Attributes of Dignity

There are four attributes of dignity:

1. Respect: self-respect, respect for others, respect for people, confidentiality, self-belief and believe in others
2. Autonomy: having choice, giving choice, making decisions, competence, rights, needs, and independence
3. Empowerment: Feeling of being important and valuable, self-esteem, self-worth, modesty and pride

4. Communication (may be verbal or non-verbal): explaining and understanding information, feeling comfort, and giving time to the patients / families

Definition of Respect (አክብሮት)

- It is a term which is intimately related to dignity
- It is probably the most important action verb used to describe how dignity works in practice.

The action meanings of the word respect are:

- Pay attention to
- Honoring
- Avoiding damage e.g. insulting, injuring
- Not interfering with or interrupting
- Treating with consideration
- Not offending

People can vary by their skills, educational background, gender, age, ethnicity, and experiences. But, as human being, all are entitled to get dignified and respectful care. Every human being must respect others and get respect from others. Therefore, dignity is brought to life by respecting people:

- Rights and freedoms
- Capabilities and limits
- Personal space
- Privacy and modesty
- Culture
- Individuals believes of self-worth
- Personal merits
- Reputation
- Habits and values

Dignity and respect in the health care setting

Treating clients with dignity implies treating them with courtesy and kindness, but it also means:

- Respecting their rights

- Giving them freedom of choice
- Listening and taking into consideration what they say and
- Respecting their wishes and decisions, even if one disagrees.

Treating clients with dignity implies being sensitive to clients' needs and doing one's best for them, but it also means:

- Involving them in decision making
- Respecting their individuality
- Allowing them to do what they can for themselves and
- Giving them privacy and their own personal space

1.4.2. Principles of Respectful Care

Individual reflection

❖ Think of a person who gave you the most respectful care/service.

- Describe the situation?
- What are the qualities of that person?
- What did you value most?

Time: 5 Minutes

The principles of respectful care guide actions and responsibility of care providers in ensuring dignified care for their service users. Dignified care has seven core principles.

- Recognize diversity and uniqueness of individuals
- Uphold responsibility to shape care
- Meaningful conversation
- Recognize the care environment
- Recognize factors affecting dignity
- Value workplace culture
- Challenge dignity barriers

1.4.3. Characteristics of Disrespectful Care

The situation where you received disrespectful care?

1. Describe the incident?

2. What was your reaction?

Time: 5 Minutes

The Seven categories of Disrespect and abuse

Category	example
Physical Abuse	Slapping, pinching, kicking, slapping, pushing, beating,
Non-consented care	Absence of informed consent or patient communication, forced procedures
Non-confidential care	Lack of privacy (e.g. Laboring in public or disclosure of patient information
Non-dignified care	Intentional humiliation, rough treatment shouting, blaming, treating to withhold services laughed at patients, provider did not introduce themselves, patients not called by their names throughout the interaction.
Discrimination based on specific patient attributes	Discrimination based on ethnicity, age, language, economic status, education level, etc.
Abandonment of care	Women left alone during labor and birth Failure of providers to monitor patients and intervene when needed
Detention in facilities	Detention of patients/family in facility after delivery, usually due to failure to pay

1.4.4. Factors affecting Respectful Care Provision

Individual reflection

1. What do you think hinders you from providing respectful care in your health facility?
2. What are the factors that facilitates provision of respectful care in your health facilities?

Time: 5 Minutes

Different Factors have a significant impact on hindering or facilitating the provision of respectful care service. These factors can be broadly classified in to three major groups; Health care environment, staff attitude & behavior and patient factors

Positive attributes of the physical environment which helped health professional to provide dignified care are related to aspects maintaining physical and informational privacy and dignity, aesthetically pleasing surroundings and single sex accommodation, toilet and washing facilities. Aspect of the environment that maintain physical and informational privacy are listed below

- Environmental privacy (for example curtains, doors, screens and adequate separate rooms for intimate procedures or confidential discussions (auditory privacy).
- Privacy of the body: covering body, minimizing time exposed, privacy during undressing and clothing are some of the enabling factors to ensure bodily privacy done by health professionals.
- Aesthetic aspects of the physical environment (for example space, color, furnishing, décor, managing smells); and the provision of accommodation, toilet and washing facilities
- Managing peoples in the environment: such as other patients, family and ward visitors/public contribute positively to maintain dignity in the health
- Adequate mix and proficient Staffing: adequately staffed with appropriate number and skill mix, as high workload affects staff interactions, and have strong leaders who are committed to patient dignity.

Physical environment which hinders health professional form providing respectful care are related to the overall health care system, lack of privacy, restricted access to facility /service and lack of resources. Aspect of the environment that hinders the provision of respectful care are listed below,

- The healthcare System: Shortage of staff, unrealistic expectations, poorly educated staff, 'quick fix' attitude, low wage, pay 'lip service' to dignity, low motivation, lack of respect among professionals, normalization/tolerance of disrespectful care, lack of role model, management bureaucracy and unbalanced staff patient ratio and skill mix.
- Lack of privacy: Lack of available single rooms, bath rooms and toilets without nonfunctional locks, use of single rooms only for infectious cases and lack of curtains or screens
- Restricted access to facility/service: Badly designed rooms, inadequate facilities (e.g. toilets, bath rooms), Cupboards with drawers that does not open, toilet and bath rooms shared between male and females.
- Lack of resource: Run out of hospital, gowns and pyjamas, Lack of medical equipment and supplies

The A, B, C, of respectful health care, is a tool designed to consider the attitudes and behaviors of health care providers

A –Attitude

Ask yourself:

- How would I be feeling if I was this person?
- Why do I think and feel this way?
- Are my attitudes affecting the care I provide and, if so, how?
- Are my personal beliefs, values, and life experiences influencing my attitude?

Action to be taken

- Reflect on these questions as part of your everyday practice.
- Discuss provider attitudes and assumptions and how they can influence the care of patients with the care team.
- Challenge and question your attitudes and assumptions as they might affect patient care
- Help to create a culture that questions if and

B- Behavior

- Introduce yourself. Take time to put the patient at ease and appreciate their circumstances.
- Be completely present. Always include respect and kindness.
- Use language the patient/family can understand

C-Communication

- Communication revolving around the patient's needs.
- Patient centered communication with defined boundaries
- Objectivity is an important attribute when assessing the clients' needs

Ten Mechanisms to mitigate threats to respectful care -

1. Support clients with same respect you would want for yourself or a member of your family
2. Have a zero tolerance of all forms of disrespect
3. Respect clients' right to privacy
4. Maintain the maximum possible level of independence, choice, and control
5. Treat each client as an individual by offering personalized care
6. Assist clients to maintain confidence and a positive self esteem
7. Act to alleviate clients' loneliness and isolation
8. Listen and support clients to express their needs and wants
9. Ensure client feel able to complain without fear of retribution
10. Engage with family members and care givers as care partners?

1.5. Compassionate leader

1.5.1. Quality of Compassionate Leadership

Group exercise

Discuss in a group of 4-5 and share your experience to the larger group.

- What does it mean for you to lead, and manage?
- Can you give an example of a leader whom you know in your professional or personal life? What makes him or her good leader for you?
- Do you know of any individuals in high positions or authority who demonstrate compassionate, respectful and caring practices when they deal with their staff and clients?

Duration: 20 minutes

Brief description of leadership theories

Introduces transactional, transformational, and servant leadership theories. It will also provide a better understanding of qualities of CRC leaders, which will enable participants to provide better service and increase awareness of CRC leadership.

- Transformational leaders: lead employees by aligning employee goals with their goals. Thus, employees working for transformational leaders start focusing on the company's well-being rather than on what is best for them as individual employees.
- Transactional leaders: ensure that employees demonstrate the right behaviors because the leader provides resources in exchange.
- Servant Leadership: defines the leader's role as serving the needs of others. According to this approach, the primary mission of the leader is to develop employees and help them reach their goals. Servant leaders put their employees first, understand their personal needs and desires empower them and help them develop their careers.

Characteristics of compassionate leaders

- 'In-tune' feeling: Their actions abide by their words – and they always have the time to engage with others.
- Manage their moods: They know feelings affect others and they use positive emotions to inspire, not infect others with negative feelings.
- Put people before procedures: They are willing to set aside or change rules and regulations for the greater good.
- Show sincere, heartfelt consideration: They genuinely care for the well-being of others and have a humane side that puts other people's needs before theirs.
- Are mindful: They are aware of their own feelings and their impact on others. They are also attentive and sympathetic to the needs of others.
- Are hopeful: They move others passionately and purposefully with a shared vision that focuses on positive feeling of hope.
- Courage to say what they feel: They communicate their feelings, fears, even doubts which builds trust with their employees.
- Engage others in frank, open dialogue: They speak honestly with humility, respect and conviction, and make it safe for others to do the same.
- Connective and receptive: They seem to know what other people are thinking and feeling.

- Take positive and affirming action: They carry out compassion. They do not just talk about it; they make a promise, act on it and keep it.

What does compassionate leadership do for the organization?

- Positively affects sufferers, clients, employees
- Increases people's capacity for empathy and compassion
- Promotes positive relationships
- Decreases the prevalence of toxic viral negative emotions and behavior
- Increases optimism and hope
- Builds resilience and energy levels
- Counteracts the negative effects of judgment and bias

Self-evaluation of compassionate behavior

Good leaders can evaluate their own behavior using different methodologies. The self-assessment of compassionate leaders should be conducted every six months to enhance self-compassion through mindfulness.

Mindfulness begins with self-awareness: knowing yourself enables you to make choices how you respond to people and situations. Deeper knowledge about yourself enables you to be consistent, to present yourself authentically. You will learn and practice different ways to develop mindfulness and explore how it can contribute to developing compassionate leadership practices through:

- Enhancing attention and concentration
- Increasing creativity and flexibility
- Working efficiently in complex systems and uncertain environments
- Creating meaning and purpose
- Making effective and balanced decisions
- Responding effectively to difference and conflict
- Acting with compassion and kindness
- Enhancing relationships and partnerships
- Enabling genuine and courageous action
- Working ethically and wisely
- Developing cultural intelligence

Systems Thinking for CRC

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Group activity in healthcare system thinking

Discuss in a group of 4-5 and share your experience to the larger group.

- Discuss concepts of Health System and how it relates with your Health Facility /Hospital and Health Center/ functions.
- Take your Health Facility/Hospital and Health Center/ and list the various department/core processes/support processes. Using a systems thinking approach, discuss how they interact with each other?
- Take in to account the CRC concepts and identify gaps you may have experienced in your facilities?

Duration: 20 minutes
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System: A system is a set of interacting or interdependent components forming an integrated whole.

Health System: A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health.

Fully functional health system: A point which various management systems and subsystems are connected and integrated to provide the best possible health services to all the intended beneficiaries of those services.

Management systems: The various components of the overall health system that managers use to plan organize and keep track of resources. Management systems are run by people living in different contexts.

Integrate CRC into Existing System

Integration of new initiatives into existing system has paramount importance in expediting the process of implementation and ensuring sustainability of CRC in a health system. Integration can be done using "AIDED" model.

Assess: Understand the capacity of the unit structure, especially in regards to the availability of resources, as well as human resource; also to assess the level of human capability when integrating and sustaining the CRC by determining the level of support the unit requires before or after carrying out CRC.

Innovate: Design and package the CRC to fit with the existing quality of unit structure and their environmental context to spread the CRC throughout the hospital departments.

Develop: Build upon existing knowledge of main stakeholders and opinion leaders by encouraging hospital policies, organizational culture, and infrastructure to support the implementation of principles of CRC.

Engage: Use existing roles and resources within the hospital units to introduce, translate, and integrate CRC principles into each employee's routine practices.

Devolve: Capitalize on existing organizational network of index user groups to release and spread the innovation to new user groups.

1.5.2. Organizational culture

Organizational culture consists of the values and assumptions shared within an organization. Organizational culture directs everyone in the organization toward the "right way" to do things. It frames and shapes the decisions and actions of managers and other employees. As this definition points out, organizational culture consists of two main components: shared values and assumptions.

1. *Shared Values:* are conscious perceptions about what is good or bad, right or wrong. Values tell us what we "ought" to do. They serve as a moral guidance that directs our motivation and potentially our decisions and actions.
2. *Assumptions:* are unconscious perceptions or beliefs that have worked so well in the past that they are considered the correct way to think and act toward problems and opportunities.

Five key systems influence the hospital's effective performance with respect to improving the safety and quality of patient care, as well as sustaining these improvements. The systems are:

1. Using data
2. Planning
3. Communicating
4. Changing performance
5. Staffing

Leaders create and maintain a culture of safety and quality throughout the hospital. Rationale

- CRC thrives in an environment that supports teamwork and respect for other people, regardless of their position in the organization.
- Leaders demonstrate their commitment to CRC and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis.
- Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care.
- Leaders must address disruptive behavior of individuals working at all levels of the organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Creating an Organizational culture of empowering employees for CRC

Having empowered employees is the aim of many leaders. Literature has reported that creating an organizational culture will empower employees to increase customer satisfaction levels, as well as to improve employee morale and productivity.

Employee empowerment encourages communication, participation in shared decision-making and enabling physicians and staff to reach their full potential by creating and optimal healing environment.

There are many different ways to build employee empowerment and engagement, but all share six fundamental actions to promote CRC on the part of leadership:

Share information and communication: Sharing information with employees is important because it not only helps to build trust; it gives employees important information to allow them to make the best possible decisions in critical situations when providing CRC services.

Create clear goals and objectives: Inspire employees to embrace the mission or changes of the organization by appealing to their innate desire to help patients and provide an efficient CRC service. Great leaders share important information in a structured and consistent manner.

Teach, accept and encourage: If you empower employees to make decisions that will help keep customers happy, then you have to be willing to allow them to make mistakes and learn from those mistakes.

Reward Self-Improvement: Create an environment that celebrates both successes and failures. A good leader celebrates successes; and employees who take risks for the benefits of patients/client; also, a good leader will assist employees to develop a plan for growth and reward them as they advance.

Support a learning environment: Listen to the voice of physicians, nurses and other staff to understand key barriers, issues, and opportunities to allow them to have a voice in crafting solutions for CRC challenges.

Create a clear role of autonomy: Enable frontline workers to execute change by supplying resources (education, funding, access to other skill sets within the health facility, etc.) and removing obstacles themselves.

1.5.3. Leading CRC Health Teams

Group activity

Discuss in a group of 4-5 and share your experience to the larger group.

- What principles do you think of when implementing CRC?
- Do you think there are differences between your current "leading" style and leading based on CRC? If yes, list the differences.

Duration: 10 minutes

Health facility leaders have intersecting roles as public servants, providers of health care, and managers of both healthcare professionals and other staff.

- As public servants, health facility leaders are specifically responsible for maintaining the public trust, placing duty above self-interest and managing resources responsibly
- As healthcare providers, health facility leaders have a fiduciary obligation to meet the healthcare needs of individual patients in the context of an equitable, safe, effective, accessible and compassionate health care delivery system.
- As managers, leaders are responsible for creating a workplace culture based on integrity, accountability, fairness and respect.

Ethical healthcare leaders apply at least the following six specific behavioral traits:

1. Ethically conscious: Have an appreciation for the ethical dimensions and implications of one's daily actions and decisions or, as described by author John Worthily, the "ethics of the ordinary" (reference?).
2. Ethically committed: Be completely devoted to doing the right thing.
3. Ethically competent: Demonstrate what Rush worth M. Kidder, president and founder of the Institute for Global Ethics, calls "ethical fitness," or having the knowledge and understanding required to make ethically sound decisions (reference).
4. Ethically courageous: Act upon these competencies even when the action may not be accepted with enthusiasm or endorsement.
5. Ethically consistent: Establish and maintain a high ethical standard without making or rationalizing inconvenient exceptions. This means being able to resist pressures to accommodate and justify change inaction or a decision that is ethically flawed.
6. Ethically candid: Be open and forthright about the complexity of reconciling conflicting values; be willing to ask uncomfortable questions and be an active, not a passive, advocate of ethical analysis and ethical conduct.

Problem-solving in healthcare

Steps of Scientific Problem Solving Skills

1. Define the problem
2. Set the overall objective
3. Conduct a root cause analysis
4. Generate alternative interventions
5. Perform comparative analysis of alternatives
6. Select the best intervention
7. Develop implementation plan and implement plan
8. Develop evaluation plan and evaluate

Best Practice Identification

Criteria to select best practices

- New/Novel idea- not much practiced in other hospitals in Ethiopia
- Effectiveness: has brought empirical change to the implementation of CRC specifically to patient satisfaction and quality of service provision. The practice must work and achieve results that are measurable.
- Relevant/impact: improved CRC and quality of patient experience (Explain the relevance of the innovation using a clear baseline and current performance of CRC)
- Diffusible: implemented at low cost in other facilities or implemented innovation in other hospitals.
- Sustainable: Innovation is easy to understand, easy to communicate and works for long time.
- Political commitment: The proposed practice must have support from the relevant national or local authorities.
- Ethical soundness: The practice must respect the current rules of ethics for dealing with human populations.

By definition, "Best Practices" should be "new/novel", "effectiveness" and "relevance".

Monitoring and Evaluation of CRC Health Team

Potential focus areas where leaders focus to evaluate their CRC staff

- Quality of work: Provide accuracy and thorough CRC service
- Communication and interpersonal skills: listening, persuasion and empathy to clients/patients and teamwork and cooperation in implementing CRC
- Planning, administration and organization: setting objectives, and prioritizing CRC practice
- CRC knowledge: knowledge-base training, mentoring, modeling and coaching
- Attitude: dedication, loyalty, reliability, flexibility, initiative, and energy towards implementing CRC
- Ethics: diversity, sustainability, honesty, integrity, fairness and professionalism
- Creative thinking: innovation, receptiveness, problem solving and originality

- Self-development and growth: learning, education, advancement, skill-building and career planning

Summary

- *Dignity of human being is the basis for healthcare delivery*
- *Clients should be treated as human being not as cases*
- *Disrespect and abuse is a problem in Ethiopia.*
- *Zero Tolerance to Disrespectful care shall be a motto for all health workers in the health facilities.*
- *Improving the knowledge of ethics is important to boost the ethical behavior in practice*

Chapter 2: Catchment-Based Mentoring in RMNCAH

Chapter Description:

This chapter is designed to help the participant to visualize the bigger picture of Catchment Based RMNCAH Mentoring in the Ethiopian health system by describing the overview of RMNCAH services, the role of mentoring, and integration of mentoring in the existing health system of the country.

Chapter Objective: At the end of this chapter participants will be able to:

- Describe the goal and role of catchment-based RMNCAH mentoring

Enabling Objectives: At the end of this chapter participants will be able to:

- Describe the overview of RMNCAH in Ethiopia
- Discuss Compassionate, respectful and Caring (CRC), and ethical healthcare service delivery
- Distinguish clinical mentoring and related concepts
- Explain the concept of catchment-based mentoring

Chapter outline:

- Overview of RMNCAH In Ethiopia
- Introduction to Compassionate, Respectful and Caring (CRC)
- Introduction to Clinical mentoring
- Catchment based mentoring system

Session 2.1. Overview of RMNCAH Services in Ethiopia

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) covers the health concerns and interventions across the life course involving women before, during and after pregnancy; newborns, that is, the first 28 days of life; children and adolescents. RMNCAH has been a priority for both governments and civil society in low- and middle-income countries (LMICs).

In 1994 the International Conference on Population Development (ICPD) defined Reproductive Health (RH) by adopting the definition of World Health Organization for Health as:

"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."

RH services encompass: -

i. **Family Planning services and information:** -Family-planning counselling, information, education, communication and services, including access to safe and effective contraceptive methods;

ii. **Maternal Health:** -Education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care;

iii. Prevention and appropriate treatment of **infertility**;

iv. **Abortion care** -Prevention of unsafe abortion and management of the consequences of abortion;

v. **Sexually Transmittable Infection (STI)**: Prevention and treatment of reproductive tract infections, sexually transmitted diseases and other reproductive health conditions;

vi. Prevention of **harmful practices**: such as female genital mutilation; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood.

The 2030 Agenda for Sustainable Development Goal contains a number of targets related to reproductive health.

1. target 3.1- reducing the global maternal mortality ratio to less than 70 per 100,000 live births
2. target 3.2- ending preventable deaths of newborns and children under 5 years of age
3. target 3.7- calls for ensuring universal access to sexual and reproductive health-care services,
4. target 5.3-eliminating all harmful practices, such as child, early and forced marriage and female genital mutilation

Brainstorm why focus on Health of Maternal, Newborn, Child and Adolescent? .

Some of the reason why there is a high focus on Health of Maternal, Newborn, Child and Adolescent includes:

i. They constitute nearly 80% of the total population. Therefore, their health has profound implications for social, political, and economic development.

- improving health and developing the capacity of adolescents and youth, will help in reaping the benefits of the demographic dividend.

ii. They have the right to health, which is a fundamental Human right, and should be fulfilled by the government.

- Ethiopia is signatory to a number of international, Regional and national conventions/treaties that aims to improve the health and well-being of women, children and adolescents and youth.

iii. The country is also signatory to: -

- ICESCR (article 12) -1978
- ICPD Plan of action-1994
- CEDAW -1981
- UN World Program of Action for Youth (WPAY) -1995
- Millennium summit on Youth-2000
- African Youth Charter -2006
- SDGs-2015

iv. Women are affected disproportionally by a number of risk factors, leading to unacceptable high burden of morbidity and mortality in women and children

v. Women play important role in community (families)

vi. Investment to improve the health of women would result in a substantial number of deaths and DALY`s averted at relatively lower cost (more beneficial)

vii. Children and Adolescents health is a base for healthy adolescence and childbearing ages.

viii. Adolescents and youth face challenges to their health and development into adulthood due to a variety of factors, including their age (*cognitive, emotional, physical, intellectual and attitudinal changes as well as changes in social roles, relationships and expectations) and* social and cultural beliefs and practices (harmful *social norms, child marriage and child-bearing and social discrimination)*

(k) Reproductive and maternal health services in Ethiopia

The Government of Ethiopia is committed to improve and maintain the health status of women, neonates, children, adolescent, and young people. The National Reproductive Health Strategy, Adolescent and Youth Health Strategy and different implementation guidelines were developed and widely distributed in the health system and to stakeholders. Availability/access to RMNCAH related services improved and the following graphs show the trend of health facilities since 2000 E.C

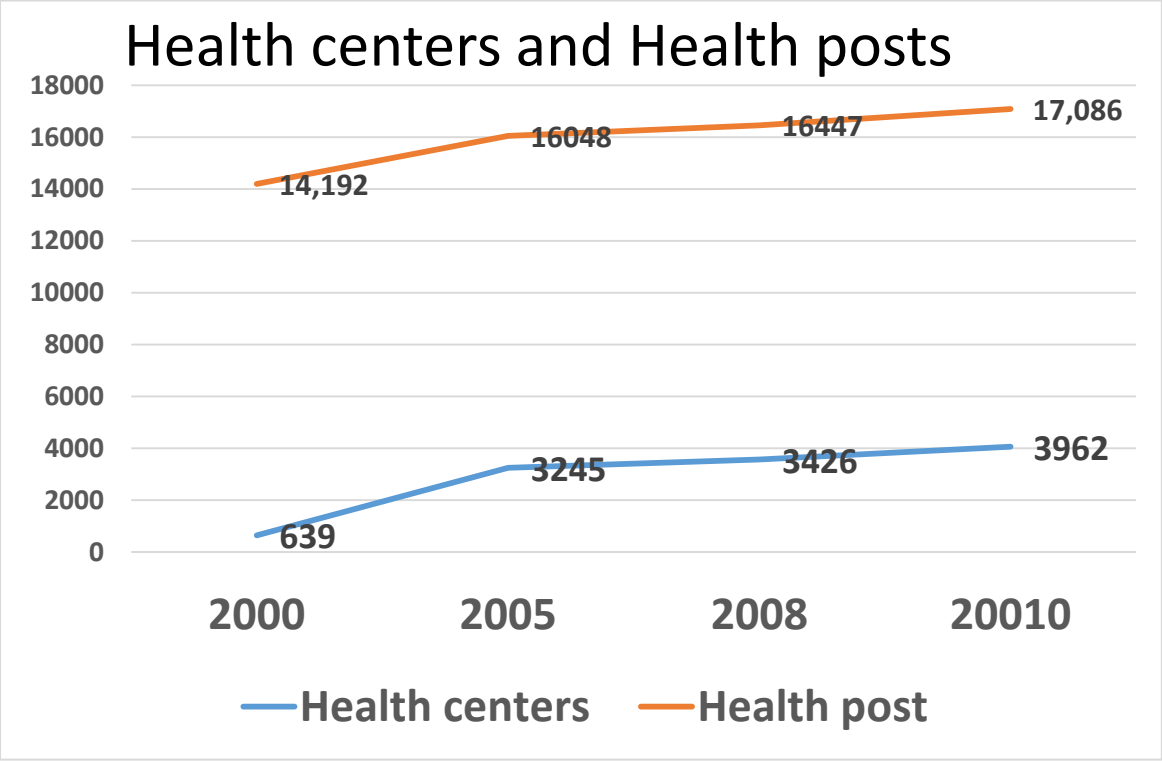


Figure 1: Trend of health facilities (HC and HP) since 2000 E.C

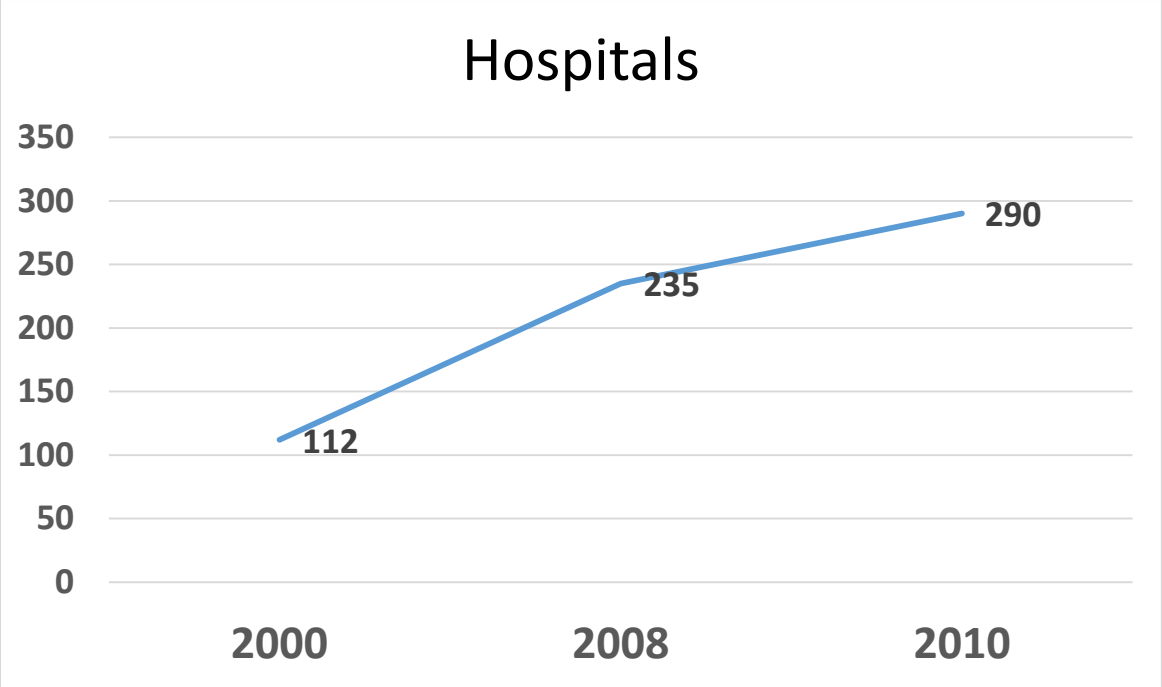


Figure 2 Trend of health facilities (Hospitals) since 2000 E.C

As demonstration of its commitment to gains in improving the health status of Ethiopians in general and women and children in particular, developed and implemented the following policy, plans, programs, and strategies since late 1980s.

- Health Policy in1985
- 20 years health sector development Program (HSDP) in 1988
- HEP – 1987
- SMH initiative in 1997
- Adolescent and youth Health strategy developed in 1997(1st) and 2008(2nd)
- Youth policy – 1998
- HSTP in 2008

As a result, Ethiopia has registered remarkable progress in the past two decades in improving the health service coverage and health status of the population. The country showed notable progress in reduction of maternal Mortality, Child mortality Infant mortality, and Neonatal mortality. There was also a sharp increment in Life expectancy and decline on Total fertility rate.

The following tables show the ratio of health facilities to population in 2008E.C, Availability of routine MNH services and emergency services, and Availability and Access to EmONC facilities based on Global recommendation, 2008E.C

Table 2: ratio of health facilities to population in 2008E.C

Type of HF	**National standard**	**Required # according to the standard**			**# HFs available in 2008E.C**			**% of recommended number available**		
		Total	**Rural**	**urban**	**Total**	**Rural**	**Urban**	**Total**	**Rural**	**Urban**
Referral hospitals:	1 per 3.5-5m	**18**	4	14	**29**	0	29	**161%**	0%	200%
General hospitals:	1 per 1.5-3m	**61**	50	12	**63**	4	59	**103%**	8%	400%
Primary hospitals:	1 per 60,000-100,000	**921**	743	178	**143**	13	130	**15.5%**	1.2%	73%
Health centers	Urban: 1 per 40,000 Rural: 1 per 15,000-20,000	**4157**	3,713	446	**3424**	2264	1160	**82.4%**	61%	260%

Table 3: Availability of routine MNH services and emergency services

Indicators		**Health centers (n=3426)**	**Hospitals(n=236)**	**Total health centers and hospitals (n=3662)**
1. Availability of EmONC	Provided all CEmONC signals	0% (0)	52% (123)	**3% (123)**
	Provided all BEmONC signals	5% (171)	17% (40)	**5.8 % (211)**

	Provided Partially BEmONC signals	94% (3220)	31% (73)	**90% (3294)**
1. Availability of routine essential RMNH services	Focused antenatal care			**100%**
	Normal delivery			**100%**
	Postnatal care			**97%**
	FP services			**99%**
	Post-abortion care			**69%**
	Safe abortion			**42%**
	Cervical screening (pap smear/VIA)			**14%**
	Diagnosis and treatment for STIs			**92%**
	PMTCT package			**85%**
	Adolescent/ youth friendly SRHS			**44%**

Table 4: Availability and Access to EmONC facilities based on Global recommendation, 2008E.C

Indicators	**Recommended EmONC facilities**	**Available percent of recommended**
1. Availability of EmONC *(standard: 5 EmONC per 500000)*	**921**	**370 (40%)**

1. Met need for EmONC *(% of expected complications treated)*	**100%**	**9%**

(i) Utilization and Impact of RH services

The following graphs show utilization and the impact of RH services from 2000 to 2016, particularly the trends in contraceptive use, Antenatal care coverage, place of birth, fertility by residence, pregnancy-related mortality ratio (PRMR) and early childhood mortality rates.

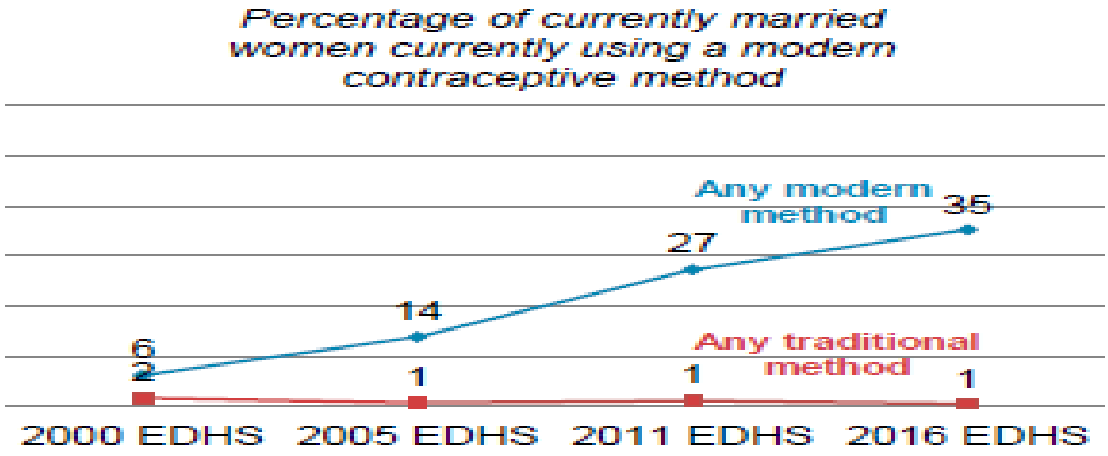


Figure 3: Trend in Contraceptive Use

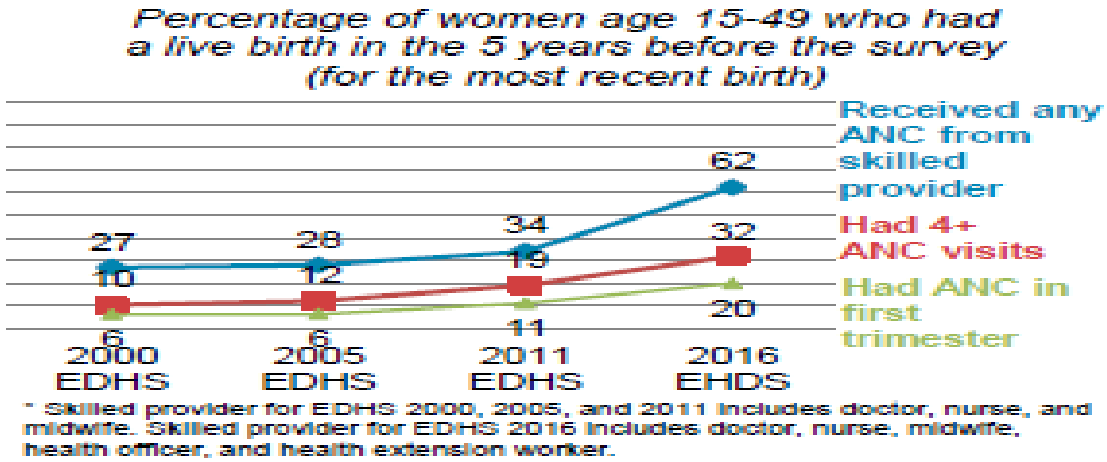


Figure 4: Trend in Antenatal care coverage

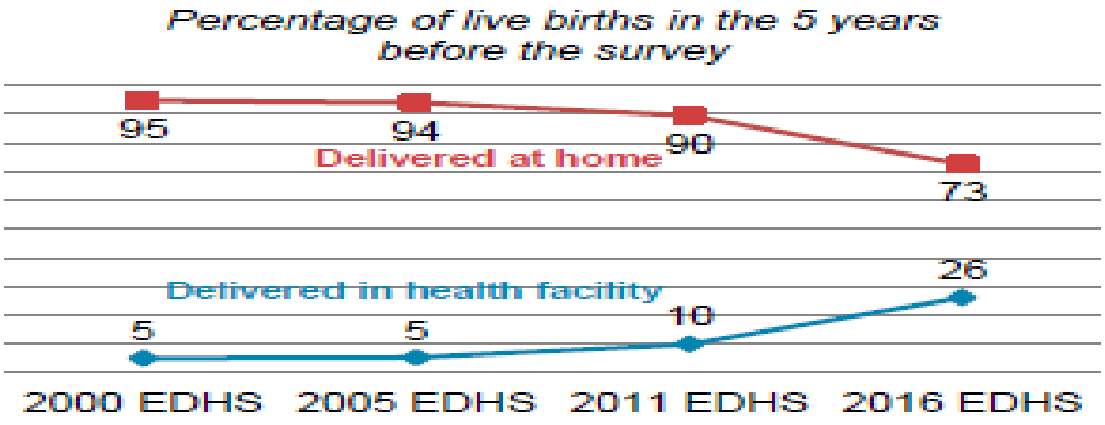


Figure 5: Trend in place of birth

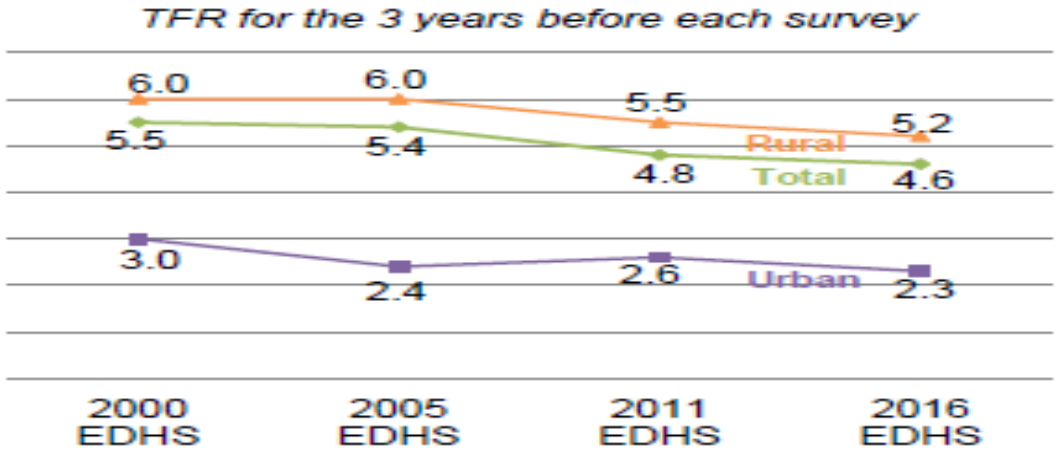


Figure 6: Trend in fertility by residence

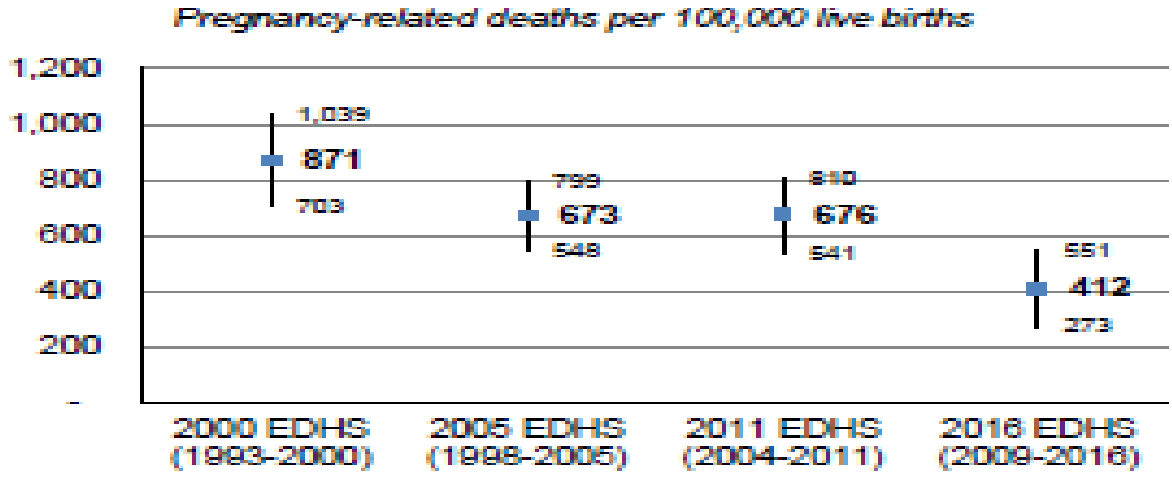


Figure 7: Trend in pregnancy-related mortality ratio (PRMR)

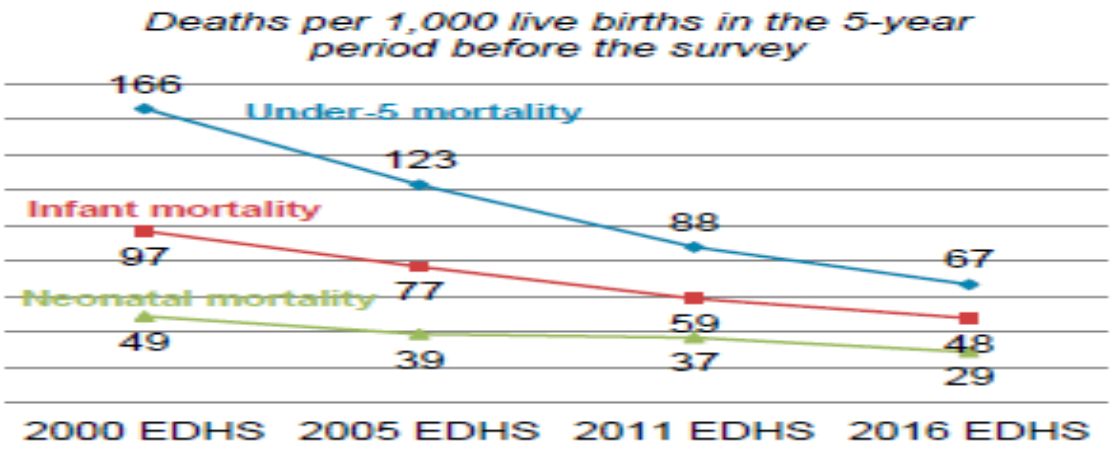


Figure 8: Trend in early childhood mortality rates

(ii) ADOLESCENT HEALTH SERVICES IN ETHIOPIA

Adolescents and youth are an important section of a population. This segment of the population exhibits a multitude of characteristics such as rapid physical, cognitive, social, emotional and sexual change. The broad and interlinked changes during adolescence (10-19 years of age) and youth (20-24) are profound with detrimental effects on young people's self-concept and future.

According to population projections of the Ethiopia Central Statistical Agency (CSA) for 2016, adolescents and youth 10 to 29 years are estimated to constitute 42% of the total population, which is estimated to hike to 42.5% by 2022. Those 10 to 24 years of age constitute 33% of the population.

In connection with the above, the first Adolescent and Youth Sexual Reproductive Health (AYSRH) strategy (2006-15) has guided the AYSRH response. The outcome of this 10-year strategic plan wasn't evaluated. However, useful lessons were drawn in terms of addressing the diverse interests of adolescents and youth. The current adolescent and youth health strategy (2016-2020) builds on the experiences gained and expanded to the broader frontier of health instead of a specific focus on sexual reproductive health.

(I) Target of HSTP (2016-2020)

By the end of 2020: -

i. Increase Contraceptive Prevalence Rate (CPR) from 42% to 55%
ii. Reduce Total Fertility Rate (TFR) from 4.1 to 3
iii. Reduce unmet need for family planning from 24% to 10%
iv. Reduce adolescent/teen age pregnancy rate from 12% to 3%
v. Increase proportion of women having at least 4 visits of Antenatal Care from 68% to 95%

vi. Increase deliveries attended by skilled health personnel from 60% % to
vii. 90%.
viii. Increase postnatal care coverage from 90% to 95%

(m) Challenges of RMNCAH

ix. Quality
x. Service Coverage (2016 EDHS)
xi. ANC frequency and timing -62%
xii. -Early ANC -20%
xiii. -ANC 4 - 32%
xiv. ANC components coverage
xv. < 3components
xvi. >4
xvii. Equity in terms of access and utilization of available care
xviii. Rich vs poor
xix. Urban vs Rural
xx. Educational status
xxi. Regions

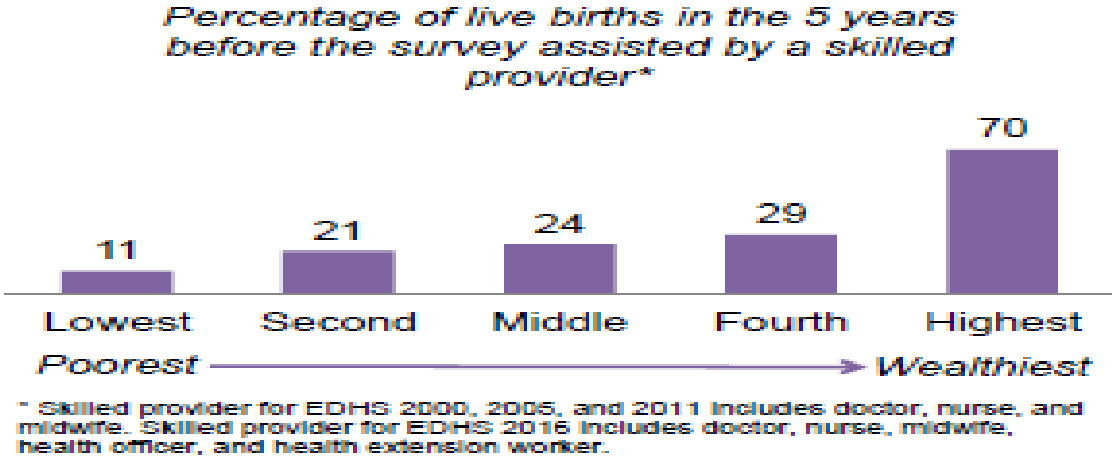


Figure 9: Skilled assistance at delivery by household

xxii. Low facility readiness
xxiii. Availability of Drugs, Supply, equipment ‘s
xxiv. Healthcare providers` competency
xxv. National MDSR Annual Reports
xxvi. delay in receiving appropriate care due to health care providers` lack of clinical competency is attributed in 34% of reported maternal deaths in 2017/18.

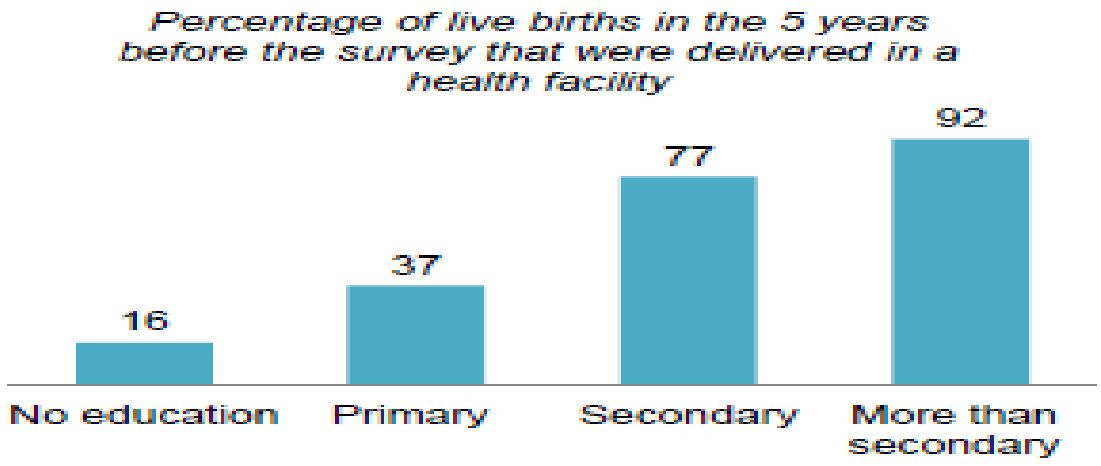


Figure 10: Equity of access

Session I.8: Introduction to mentoring

Think-pair-share (TPS)

(1) think individually about what mentoring is; and (2) share ideas with other participants

Mentoring has existed for thousands of years in a variety of cultures. The word 'mentor' originates from Greek mythology and the story of Odysseus, who, when setting off on his journey to Troy, entrusted his friend Mentor with the care and education of his son Telemachus. Legend has it that Odysseus instructed Mentor to 'Tell him all that you know', unwittingly setting the standard for aspiring mentors.

Mentoring is a transformational process that seeks to help individuals develop and use knowledge, skill, and attitude to improve themselves on an ongoing basis. It is a professional dialogue that encourages reflection and development, signposting mentees to other sources of help as required.

A review of mentoring in relation to general medical practice described mentoring as 'a way of helping another understand more fully, and learn comprehensively from, their day to day experience'. Another definition of mentoring stated as a 'process whereby an experienced, highly regarded, the empathic person (the mentor), guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development.

Another definition derived in an organizational context rather than applying specifically to a health setting, considered mentoring to be a 'complex, interactive process occurring between individuals of differing levels of experience and expertise which incorporates interpersonal or psychosocial development, and socialization functions into the relationship. This one-to-one relationship is itself developmental and proceeds through a series of stages which help to determine both the conditions affecting and the outcomes of, the process. To the extent that the parameters of mutuality and compatibility exist in the relationship, the potential outcomes of respect, professionalism, collegiality and role fulfillment will result.

Example of Mentoring:

Imagine that you are a new midwifery graduate who did not practice the provision of basic emergency obstetric care during your training. You have now been posted to the labor ward and want to develop your skills and competencies in basic emergency obstetric care. You want to be an expert in managing all EmONC signal functions. You have your own ideas about how you want to learn and how you want to achieve your goal. You are energetic, passionate and motivated to learn. You identify a senior midwife who is experienced, motivated and knowledgeable to help you. The senior midwife takes you to step by step covering each signal function. Along the way, both of you get tired and are busy but she pushes you encouraging you until you learn all seven signal functions. You are together during difficult or tough times. You both share joy and happiness in achieving your goal.

(a) What distinguishes a mentor from other supportive roles?

What other related terms or supportive roles related to mentoring?

You might be a mentor, coach, supervisor preceptor to several people, or more than one of these to the same person. There are many overlaps between all these terms but the differences in the role of each are distinct. The terms are all part of common parlance and those in authority may believe that people have the skills for a particular role by virtue of their position, not understanding the specific roles and responsibilities of being a good supervisor, trainer, mentor or careers counselor, etc. Sometimes one individual is expected to be a mentor, educational supervisor, line manager and careers counselor to the same person and conflicts of interest can arise. Some of the other roles can be described as follows.

 : **Group Activity**

Form four small group following the instruction given by the facilitator and Discuss

1. Group 1: Mentoring
2. Group 2: Coaching
3. Group 3: Supportive supervision
4. Group 4: preceptor in your small group.

Time allowed 15 minutes

(i) Coaching

Coaching is unlocking a person's potential to maximize their own performance. It is typically conceived as a narrower concept than mentoring, with an emphasis on the improvement of skills and performance.

A coach motivates, encourages and helps an individual to improve their skills, knowledge, and attitudes in their personal and professional lives so that the person:

- is challenged to perform at their best
- deepens their learning
- enhances their quality of life
- focuses on specific objectives within a defined time period.

A coach helps the person being coached:

- Understand his behavior and how it is related to his performance better
- Develop alternative behaviors that are more effective
- Build confidence to practice new behaviors to produce intended professional as well as organizational results

The distinctive features of coaching are that it takes place primarily in a one-on-one relationship (unlike supervision), does not require specialized training (unlike preceptorship), and focuses on an aspect of performance that needs to be improved (unlike mentoring). The manager as the coach helps the person being coached make distinctions about his own behavior at work and how this behavior is related to his performance. Mentoring is concerned with 'growing an individual', both professionally and personally. It is linked with professional and career development (rather than a specific goal or area as in coaching). A

mentor has a more personal and broader commitment to the individual (including their wellbeing) compared to a coach.

Example of coaching:

Imagine that you are a third-year university midwifery student and your goal is to develop your skill to the level of competency in manual removal of placenta. During your practical session your coach talks with you about the importance of removal of placenta and how it will save the life of the patient. She guides you and you learn to compensate for your weakness with strength. She pushes you beyond your limit. You ask questions and argue about issues that you do not understand and receive an explanation. The coach engages you in two-way communication and allows you to challenge her explanations.

(ii) Preceptorship

A preceptor is an experienced individual who provides clinical and professional support to facilitate new graduates learning:

- usually short term
- to enable individuals to develop knowledge and competence after someone has recently qualified, or when someone needs to learn a specific skill
- by supervising, teaching, role modeling and evaluating students – orientating the student to the role at work and monitoring progress.

(iii) Supportive Supervision

A supervisor conducts a professional conversation with another person and gives them constructive feedback about their performance in relation to personal and organizational goals, on behalf of an employing organization. They may provide assistance in progression to those goals. This process is known as Supportive supervision, it is “a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources promoting high standards, teamwork, and better two-way communication.” It is a management function planned and carried out in order to guide, support and assist health workers in carrying out their assigned technical tasks successfully.

Mentoring and supportive supervision are complementary activities that are necessary to build the health service delivery systems. They generally aim at a common set of outcomes as listed below but differ in the emphasis and approach given to each.

Table 5: Mentorship Vs. Supportive Supervision

Mentorship	Supportive Supervision
✓ Feedback on performance ✓ Case management and skills development ✓ Clinical case review ✓ Assist with care and referral of complicated cases ✓ Bedside teaching ✓ Acts as knowledge, skill and attitude resources ✓ Updates on current developments and guideline changes ✓ Guides career path ✓ More oriented to supporting health worker's development	✓ Provides managerial and administrative support ✓ Provides on the job training ✓ Feedback online management functioning ✓ Manages administrative and policy issues ✓ Resource for organizational policies and procedures ✓ Organizes some career development opportunities (other training, etc.) ✓ Patient satisfaction, linkage with the community.

- Protection – looking after both the client/patient interests and the health worker interests
- Enhancement – promoting and developing capacity and competencies
- Management – ensuring smooth functioning of the system and monitoring and evaluation

Supervision tends to emphasize protection and management. Supervision is often more hierarchical and managerially oriented. Mentorship, on the other hand, places more emphasis on the enhancement of professional skills and competencies. This is both an end in itself as a means to achieve positive outcomes in the other domains of protection and management.

Mentorship should be a voluntary contracted relationship. This is a crucial component of the definition of mentoring. Two parties enter into a contract and agree on a set of clear goals.

Often, supervision is mandatory in many organizational settings and the goals are predetermined by the system. The relationship with a supervisor is more hierarchical. Supervision may be more critical and evaluative than the more non-judgmental approach associated with mentorship. Making sure supervision is 'supportive supervision' may moderate this. The following table summarizes the focus of Mentorship Vs. Supportive Supervision.

(b) Types of Mentoring:

One to one mentoring: This type places one mentor in a relationship with a mentee. At a minimum, the mentor and mentee should meet regularly at least four times or more.

Group mentoring: involves one mentor forming a relationship with a group of up to five mentees. The mentor assumes the role of leader and makes a commitment to meet regularly with the group over a long period of time.

Team mentoring: involves several mentors working with small groups of mentees with a mentor to mentee ratio no greater than one to four.

Peer mentoring: Provides an opportunity for caring by developing a guiding and teaching relationship with a mentee. The program specifies activities that are curriculum based.

Telephone mentoring via phone is a short form of mentoring and is ideal for mentees wanting to address a single issue. In this type of mentoring, it is recommended that the mentee make the initial contact with his/her mentor, and provide the mentor with such information as a preferred time, phone number, and any specific reasons for participating in this type mentoring. Advice via phone would normally involve a single phone call, but possibly a second follow-up call if applicable.

Joint mentoring: provides the opportunity for mentees to have more than one mentors from different areas and experts. Interested mentees, in consultation with their primary mentor, may request joint mentoring from other related program, in order to obtain more specialized training in that area. The goal of joint mentoring is to facilitate further integration of the clinical and program aspects of RMNCAH and provide mentees with more comprehensive training in different aspects of RMNCAH program.

Depending on where the mentors come from, mentors can be internal or external. Internal mentors are mentors working with the same institutions as the mentees while external mentors are mentors come from outside the mentees' institutions.

(c) Benefit of Mentoring

Table 1: Benefits of mentoring

Benefits for mentee	Benefits for mentors	Benefits for the organization
Support, encouragement, friendship	Collegiality, collaboration, networking	Improved education, grades, the behavior of students
Help with teaching strategies/ subject knowledge	Reflection	Support, funds for school
Discussing, sharing ideas	Professional development	Contributes to/good for the profession
Feedback, constructive criticism	Personal satisfaction, reward/growth	Less work for principals or staff
Increased self-confidence	Interpersonal skill development	Retention/continuity of staff
Career affirmation, advancement, commitment	Enjoyment, stimulation, challenge	More effective school leadership
Observing a role model	Improved, revitalized teaching/practice	Improved communication/ partnerships with higher education
Reflection	Role satisfaction	Good PR for schools

(d) Approaches to mentoring

1. One-on-one case management observation
2. Review of clinic-based records
3. Clinical case review

4. Documentation of the visit (including recommendations)
5. Debriefing session

(e) Steps in Mentoring:

Step 1: Plan the program purpose and design

- A carefully-selected group of Mentoring Design team meets to design and develop program objectives, guidelines, and action plans based on specific needs.
- Produces a Mentoring Plan, which outlines the sequence of events necessary to implement the program.
- The Mentoring Plan addresses how the organization will approach each of The Mentoring Connection's core design principles

Step 2: Identify Potential Mentors and Mentees

- The success of any mentoring program depends on the careful recruitment and selection of mentors and mentees.
- Using specific criteria developed in the Program Design

Step 3: Facilitate a Joint orientation

- A joint orientation will help mentors, mentees, and supervisors to understand the concept and process of mentoring.
- A joint orientation process includes information about the history of the program, goals, roles, responsibilities, and program support structure.
- The orientation explains the matching process and offers participants characteristics to look for in a mentor or mentee.

Step 4: Match Mentors and Mentees

- Mentoring team will implement the matching process designed at the program's outset. Every effort will be made to match mentees with mentors who can best support their developmental needs.

Step 5: Provide training for mentoring program participants

- A great way to kick off the formal program is by training and providing tools they need to engage in successful mentoring relationships. The training provides mentors

with the right mix of coaching skills that will help them share their wisdom of experience.

- Mentees, too, receive training that will enable them to take advantage of this mentoring opportunity and encourages them to assume an active role in advancing their career.

Step 6: Implement the mentoring process

- Mentors and mentees will then implement their Mentoring Agreement and Mentoring Action Plans. Learning activities usually include both classroom training as well as more experiential activities such as special projects and self-study.
- It is recommended that the Program checks on the mentoring partnerships throughout the year by providing periodic progress reviews, mentoring forums and one-on-one personal contacts.

Step 7: Evaluate and track progress

There is a great benefit in having mentors and mentees participate in two "progress reviews one at mid-point and one at the end of the program. These reviews give participants the opportunity to ask questions and share their challenges and success stories. This kind of information also allows the program to make any mid-point or program-end adjustments that will enhance current or future programs.

Thank your mentor

(f) Characteristics of an effective mentor

An effective Mentor:

- Is proficient in the skills to be taught
- Encourages mentees in learning new skills
- Promotes open (two-way) communication
- Provides immediate feedback:
    - Informs mentees whether they are meeting the objectives
    - Does not allow a clinical task or skill to be performed incorrectly
    - Gives positive feedback as often as possible
    - Avoids negative feedback and instead offers specific suggestions for improvement
- Recognizes that clinical mentoring can be stressful and knows how to **regulate mentee as well as mentor stress**:
    - Uses appropriate humor

- Observes mentees and watches for signs of stress
- Provides regular breaks during mentoring periods
- Provides for changes in the mentoring routine
- Focuses on participant success instead of failure

Additional characteristics of an effective mentor are summarized in the table below:

Table 6: Additional characteristics of an effective mentors

• Being patient and supportive
• Providing praise and positive reinforcement
• Correcting mentees errors while maintaining mentees self-esteem
• Listening and observing
• good interpersonal skills
• objectivity
• role model
• flexibility
• peer respect
• demonstrable competence
• reflective practitioner
• non-threatening attitude
• facilitator of learning
• allowing the development of initiative and independence
• open-mindedness
• approachability
• self-confidence and self-awareness
• sincerity
• warmth
• commitment
• understanding
• aptitude for the role
• understanding of the level of competence of newcomer
• understanding of difficulties posed by the transition to personal professional accountability
• understanding of difficulties of integrating into the new work setting
• able to provide an objective assessment of progress
• Take responsibility for scheduling regular meetings with your mentor
• Acknowledge how busy your mentor is
• Be on time
• Be prepared
• Be honest
• Have a goal/goals in mind
• Stay focused on your goals
• Discuss whether your mentor's suggestions were helpful and what positive effects they have had on your career

To understand fully the role of the mentor, it is helpful to compare the **do's** and **don'ts** of effective mentoring. The effective mentor involves mentees in the mentoring process and provides them with positive feedback. A comparison of the **effective** and **ineffective** mentor is presented in the table below.

Table 7: Do 's and Don'ts of mentor

DO	DON'Ts
• Ask your mentee to have an agenda of work items prepared for your next meeting • Smile and be positive • Encourage development opportunities for your mentee as opposed to focusing on promotional opportunities • Bring the focus back to relevant topics when the conversation veers away • Give positive reinforcement when your mentee is doing something right • Share pertinent work experiences with your mentee • Set goals with your mentee	• Don't allow your mentee to have unrealistic expectations without explaining *why* they are unrealistic • Don't take over the conversation; give your mentee ownership of the conversation as well • Don't encourage the single-minded goal of a promotion • Don't attempt to resolve your mentee's problems yourself instead of leading your mentee to find answers on his or her own • Don't allow the focus of the conversation to get away from you

Session 2.2. Catchment-Based mentoring system in Ethiopia

Catchment area refers to the residential area of the catchment population served by health centers and hospital. Different approaches to defining catchment areas have been developed, the following table summarizes it.

In our healthcare system, the catchment area is on the process of being developed and follows generally the **structure of the Ethiopian health system** using the combination of distance, patient-flow and administrative boundary.

Table 8: Methods of defining the catchment area

Approach	Description	Remark
Distance from the facility	the straight-line distance, the distance patients have to travel or the distance traveled by patients in a given time.	it is assumed that people will visit the closest facility, which implies that distance is the overriding factor influencing attendance.
Patient-flow method	is based on the proportion of patients visiting or admitted to a health-care facility who come from a particular administrative area and if the proportion exceeds a set minimum, that administrative area is included in the facility's catchment area.	an arbitrary threshold is usually imposed on the minimum proportion of patients who must come from a particular area for it to be included in the catchment area.
statistical measure	a multivariate statistical approach	Believed to have several advantages

Catchment-based mentoring is conducted in Ethiopia using the already existing EPHAQ and EHAQ platforms.

EPHAQ: The Ethiopian primary health care service Alliance for Quality (EPHAQ) is the same kind of aliens for primary hospital and health centers clustering meant to transform our healthcare system into one that works better for the Ethiopian people. EPHAQ is learning collaborative where health facilities (health centers and primary hospitals) are clustered in small groups to exchange knowledge, best practice, and resources with each other. This initiative will empower all health facilities to develop quality improvement initiatives.

EHAQ: The Ethiopian Hospitals Alliance for Quality (EHAQ) is a platform that is meant to transform our healthcare system into one that works better for the Ethiopian people. EHAQ is learning collaborative where health facilities are clustered in small groups to exchange knowledge, best practice, and resources with each other. This initiative will empower all health facilities to develop quality improvement initiatives. Each network consists of a Lead hospital (selected based on performance in the last cycle of the EHAQ), a Co-Lead Hospital

(usually a university hospital) and a group of member hospitals to which the Lead and Co-Lead hospitals provide direct assistance in implementing health service quality improvement initiatives. So far two cycles, focusing on improving patient satisfaction and MNCH services, have been successfully completed and many public hospitals have tremendously improved their healthcare services delivery through graduating, (being recognized and awarded as best performing hospitals and clusters across the country). The current cycle focuses on Quality of Care and Saving Lives Through Safe Surgery.

In this scheme, four main criteria are used for all RHBs to consider while ranking their respective regional health institutions and those criteria are: -

1. Ethiopian hospital services transformation guideline (EHSTG) and Ethiopian health center reform implementation guideline (EHCRIG) performance
2. Improvement in "Delivery and obstetric cares "
3. CASH implementation performance and
4. Hospital to Health center supports to create a network of health institutions committed to helping one another improve services, with an initial focus on patient satisfaction and then improving maternity care.

In the past couple of years, several high performing facilities have been nominated as LEAD hospitals for “improving maternity care” cycle and have been responsible for mentoring and coaching other facilities. The regional referral hospitals with high performance among the clustered hospital serve as a lead hospital and the next best as co-lead hospital for the general/primary hospital in their catchment. The general hospitals, in turn, serve as a mentor for the health centers clustered under their catchment area.

Catchment lead hospital: hospital to which clients from catchment health centers are referred to. The lead hospital shall provide necessary obstetric care for referred mothers.

Catchment health center: health center found in the catchment area.

Building on this catchment linkage, the RMNCAH catchment-based mentorship approach has been introduced, where senior RMNCAH care providers from hospitals or selected high load/best-performing health centers will provide clinical mentorship to health centers within their catchment.

This approach is expected to sustain the outcomes and goals achieved in target woredas through health care provider capacity building an effective and sustainable referral linkage.

The FMOH plans to further roll out this mentorship program throughout the country, with a special focus on areas where maternal and newborn health outcomes are below the national average.

Mentorship is part of and complementary to the overall efforts to strengthen the health care delivery system. It is therefore critical that mentorship programs are an integral part of quality improvement efforts at all levels of the health system.

Each structural level from national, regional, zonal, woreda as well as health facility level has its own responsibilities in the successful implementation of the mentorship program.

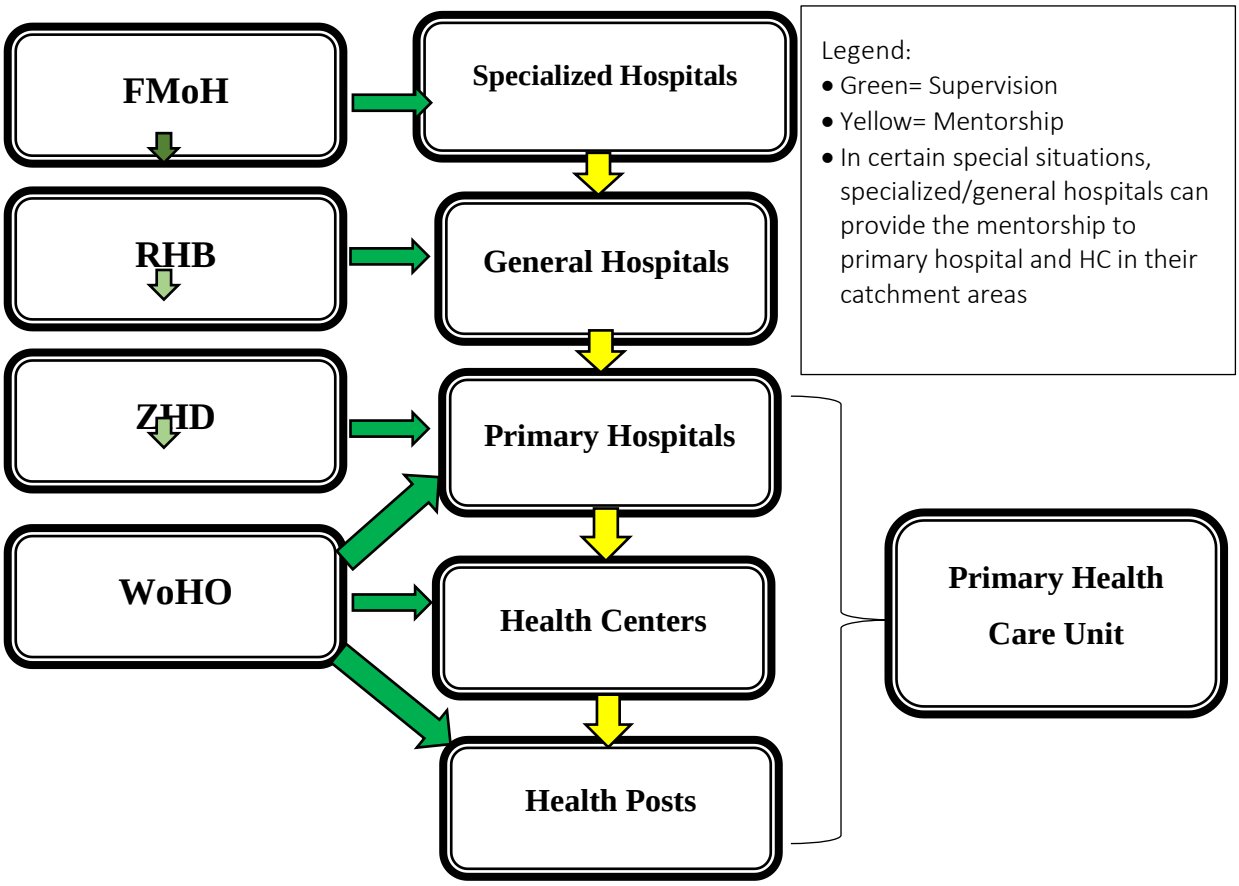


Figure 11: Mentorship and Supervision relationships at various levels

Chapter Summary

Ethiopia has achieved so much in RMNCAH service, a lot has to be done to achieve SDG and HSTP targets. To realize the RMNCAH targets, set in the HSTP and SDGs, the country has been designing different initiatives. To successfully implement these initiatives, it is necessary to capacitate the health care workers with effective approaches and RMNCAH Mentoring is one of it.

Mentoring, coaching, preceptorship and supportive supervision could be distinguished according to the relative emphasis each had in the two dimensions of ensuring and enabling functions. Ensuring is "making sure the job gets done" and enabling is "assisting practitioners to learn from their experiences and develop practice expertise and personal growth". Mentoring and coaching have more of enabling function while preceptor, and supervisor, have an ensuring function.

As a mentor, your relationship with your mentee should be one of mutual trust and respect in a supportive yet challenging relationship. You should not be put in the position of undertaking assessments or appraisals of a mentee, as this may undermine your relationship and create a conflict of interest. This will preclude you from being non-judgmental as a mentor, which is a cornerstone of mentoring.

Mentorship is part of and complementary to the overall efforts to strengthen the health care delivery system. It is therefore critical that mentorship programs are an integral part of quality improvement efforts at all levels of the health system. Each structural level from national, regional, zonal, woreda as well as health facility level has its own responsibilities in the successful implementation of the mentorship program.

Chapter III. The mentoring processes

Chapter Description: This chapter describes techniques of the mentoring processes including developing and managing the mentoring relationship; initiating the mentoring processes, and planning.

Chapter Objective: at the end of this chapter participants will be able to:

- Apply effective mentoring processes

Enabling Objectives:

- Describe building relationship in the mentoring processes
- Illustrate effective communication and feedback mechanism
- Prepare for initiation of the mentoring process

Chapter outline:

- Building a mentoring relationship
- Effective communication and feedback mechanism in mentoring
- Initiation of the mentoring processes

Session I.1: Building a mentoring relationship

Building relationship/rapport (BR) is the first of the five phases of mentorship. The other four phases (Figure below), according to clutter buck associates includes: Setting Direction (SD), Progression (P), Winding Up (WP), and Moving On (MO).

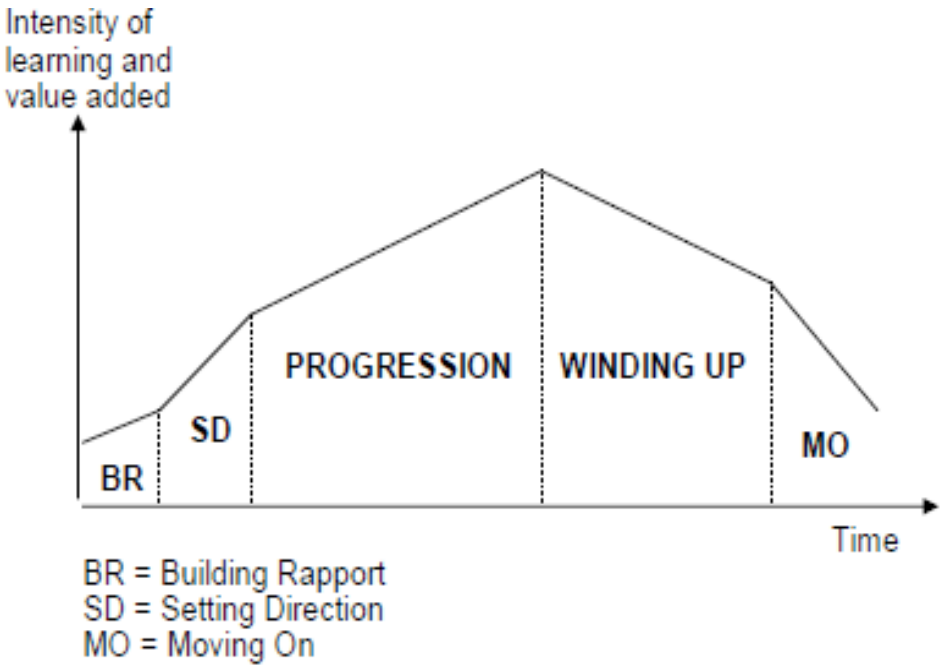


Figure 12: The five phases of mentoring according to clutter buck associates

: What are the components of building a relationship in mentoring processes?

Establishing and managing mentoring relationship are very critical to get off a mentoring process to a good start. In building a mentoring relationship, the mentor will initiate the relationship by getting to know the mentee and establish the ground for the mentoring relationship. Developing and managing the relationship for mentoring encompasses:

- Getting to know each other
- Establishing the grounds for relationship success.
- Rapport
- Setting expectations

The figure below indicates the value of a combination of rapport and goal clarity. Relationships with low rapport but high clarity can still deliver results in terms of performance, learning or both together. Relationships with low clarity but high rapport can be enjoyable but are likely to deliver less personal change. Relationships high in both can be argued to be the most rewarding and successful, in terms of measurable outcomes. Where both rapport and goal clarity is low, little can reasonably be expected.

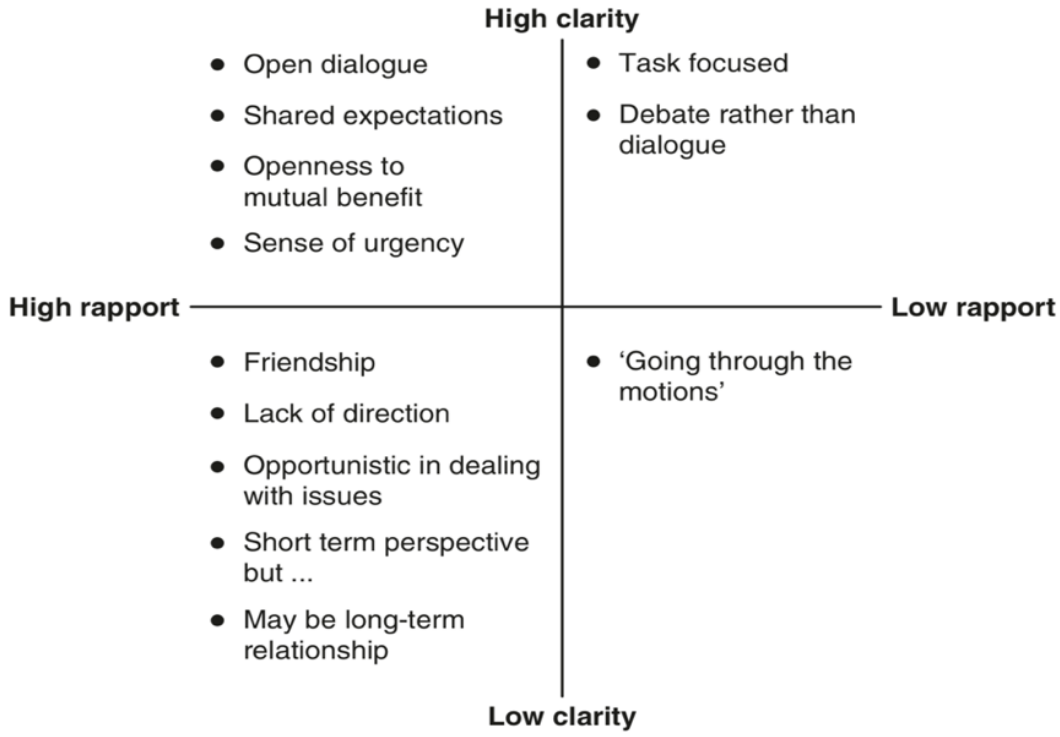


Figure 13: Relationship between Goal clarity and Rapport in mentoring

(a) Getting to know each other

People come mentoring relationships for a wide variety of reasons and in many different contexts. But a common factor is that the relationship is likely to proceed very far – or at least, is likely to produce substantial positive results – if there is the mentor and the mentee know each other. It is a mutual understanding of what the relationship is about, and have an element of being available, of being able to provide practical or psychosocial support from time to time. **Mutual consent, a willingness to participate in the relationship, is normally seen as an essential precursor to effective *relationships* in mentoring.**

(i) Techniques for Getting to know each other

Conversation ladder: is the technique of questioning a set of questions about topics of central concern to people, which they will love talking about. A typical list of steps on the ladder might be as follows:

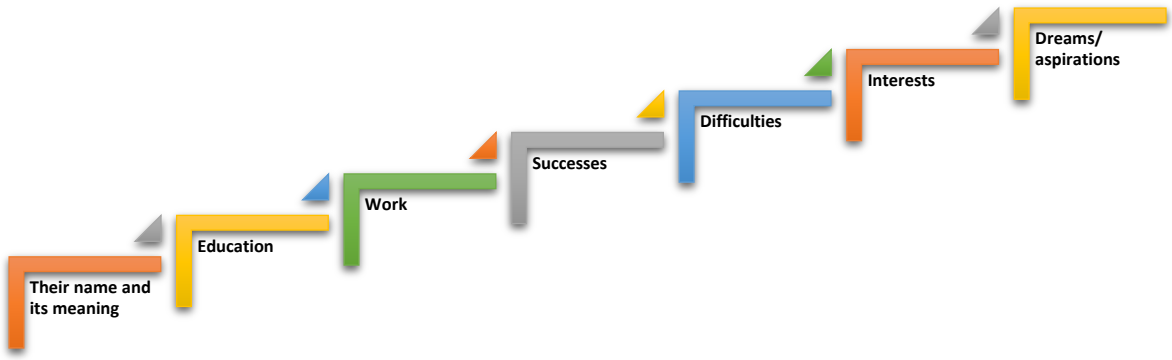


Figure 14: A typical list of steps on the conversation ladder

(ii) Establishing the grounds for relationship success

It is putting the principle the mentor and mentee need to understand what each expects of the other if they are to play their full part in the mentoring relationship. It is agreeing and clarifying ground rules for the relationship to work. Mentor and mentee should discuss the issues of relationship purpose and relationship management sufficiently to acquire a shared understanding of them.

(iii) Creating the environment for a successful relationship

: Case study

Instruction: Read and analyze this case study individually. When others in your group finished, discuss and answer the follow-up questions. Choose one person in your group to share your answers with the larger group.

The case study: Your 36-year-old newly transferred to labor ward mentee is unwilling and/or unable to share about himself. He doesn't want to talk about himself, his education, his prior work, and difficulties. When you ask him about his interest outside of work, he tends to cut short the conversation you want to build.

Questions:

1. What is your assessment of the situation?
2. What techniques you would like to take?

First it is important to look at what values the mentor and mentee share:

- Trust – there must be confidence that mentor and mentee will both keep confidential anything discussed between them, and that they will do what they say they will.
- Focus – the attention needs to be fully on the mentor/mentee. There should be active listening taking place, which must be open and non-judgmental.
- Empathy – there must be mutual respect between the mentor and mentee. Both need to try and understand the other's point of view, their feelings, ambitions and drives.
- Congruence – There should be a shared sense of purpose for the relationship and confidence to talk about some of the fears, weaknesses or mistakes of both individuals.
- Empowerment – The mentoring relationship needs to be liberating on both sides.

(b) Rapport

Building rapport is a typical example of where 'authenticity' is required more than **techniques**. This involves being present for – and open to – another person in a way that no technique (however skillfully used) will facilitate. The authentic meeting between two people is the opposite of a program series of moves, which are not engaged in for their own sake, but as a means to a pre-determined end.

Have you ever thought about a rehearsed/formatted communication like 'Have a nice day' fall short in building a relationship?

This is why 'Have a nice day' is counter-productive – the recipient knows only too well that this word has nothing whatever to do with a spontaneous expression of goodwill towards them as an individual. Consequently, being subjected to this type of formatted communication can be isolating, rather than bonding, in its effect. Building rapport, if it is to be successful, has to be authentic and spontaneous, as the interaction unfolds.

Building rapport is not just responsive – it is a reciprocal process, so the developing relationship co-evolves, in real time, in the space between mentee and the mentor. What are the essential constituents of this mutuality? For both, it is marked by carefully judged and authentic self-disclosure; coupled with evident attentiveness and sensitivity to 'who the other is', and 'where they are coming from'.

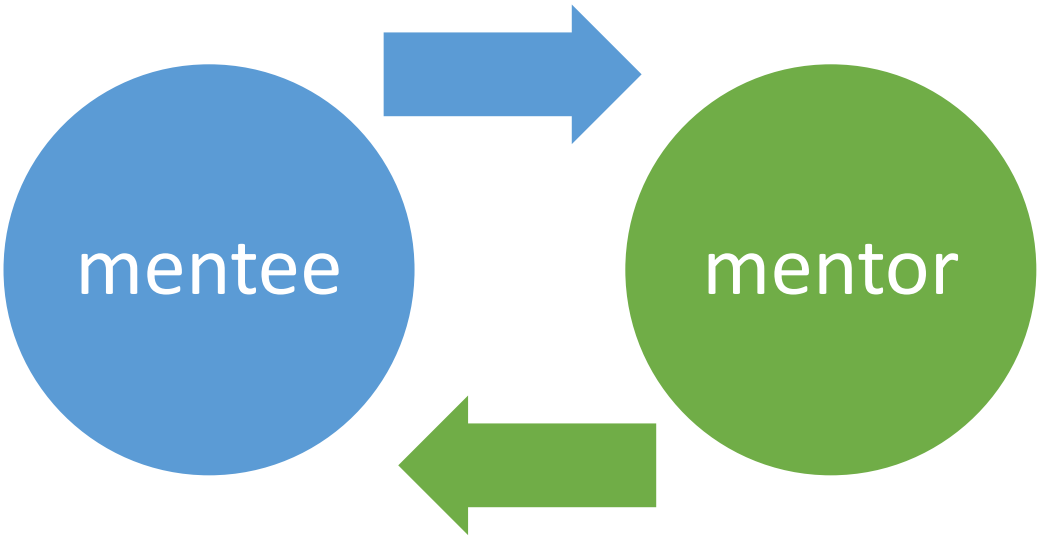


Figure 15 a reciprocal process of Building rapport

Often both self-disclosure and acknowledgment are largely silent, concerned as much with what isn't being said, as what is.

So, what *is* being said? What is the medium through which these tacit transactions can take place? The basic task of rapport building is to identify and begin to explore an area of common ground, in order to test for common values, attitudes, and experience. Therefore, rapport building requires trust, empathy, congruence and empowerment more than techniques.

The starting point for rapport building may be overtly trivial. It may be the weather, today's travel conditions, the mentee team's latest result, whatever. The content is relatively unimportant, except in so far as it demonstrates sensitivity on the initiator's part to the recipient. The following lists **Techniques of Building Rapport.**

- Greet with shaking hands and appropriate eye contact
- Introduce yourself, if possible, use the same language
- Give full attention to the mentee
- Have Positive attitude always
- Use affirming statements
    - Affirm: to acknowledge the positive in someone else to support and encourage that person to build upon his or her success.
    - Affirming statements: are words of encouragement that increase mentees belief in themselves and their abilities

Building rapport

Situations: This is where the mentee gives clear (though probably tacit) signals that they don't want to be there. And the mentor moves straight to unnecessary confrontation.

Role: There are two roles to play: the mentee and the mentor.

Instruction: two volunteer participants play out the roles identified above using the script described below and the participants focus on how the mentor handle the situation in an effort building rapport.

- mentee (gives a series of short answers to various approach from the mentor, accompanied by 'negative' non-verbal signals).
- mentor: 'It sounds as you don't seem like it the assignment in the labor ward and also you feel like to be mentored. I'm starting to feel the same...'
- mentee (reluctantly): 'Yeah – I feel I've been pushed into this.'
- mentor: 'How did that come about?'
- mentee begins to fill in the background – there is now something to explore together.

Questions:

1. How did the mentor handle the situation?
2. How would you handle it if you were the mentor?

(c) Setting expectations

How long do you wait to switch a radio channel when you hearing nothing?

It takes approximately 4.5 seconds of silence on the car radio for the average person in Western society to switch channels. Silence is a phenomenon we are ill-equipped to handle; we attempt to fill it as quickly as possible.

Yet silence truly can be golden. It is the quiet periods in a mentoring session where the deepest and most reflection occurs. Effective mentors create golden moments by looking for and recognizing when silence is better than asking yet another question.

The most important use of silence is to allow the learner to ruminate on the implications of a point that has just struck home. The ineffective or inexperienced mentor may simply rush in with a follow-up question. The effective mentor, on the other hand, allows the learner extra thinking time and allows the learner to decide when to move on. This can be very frustrating,

particularly if the mentee is an introvert and the mentor an extrovert, but the reward of patience is almost always a deeper insight and/or deeper commitment to a new course of action by the learner.

Figure 16:The seven layers of dialogue

In general, establishing a dialogue at the social level assists dialogue at the technical level; technical dialogue can evolve into strategic – and so on up the ladder. The most effective mentors invest considerable time and effort in building their range of skills, so they can both recognize the appropriate level of dialogue to apply at a particular point, and engage the mentee appropriately. Very often, the mentee has little or no experience of operating at the deeper levels of dialogue and the mentor has to work with them to establish successive layers of competence, one by one. It may take many sessions of building trust and practicing dialogue before the mentor can even begin to explore deeper issues with the mentee.

The concept of the seven layers has proven very helpful in directing attention to developing the necessary skills among professional mentors; it should also have considerable relevance for mentoring within organizations.

 Group Exercise using CB-RMNCAH mentoring checklist

Instruction: Form a small group of three, where one become a mentor, the other is a mentee and the third participant is an observer. Following the guidance of the facilitator, practice mentoring using CB-RMNCAH mentoring checklist (see annex- CB-RMNCAH mentoring checklist)

Session I.2: Effective Communication and Feedback Skills

Effective communication and feedback are an important part of the mentoring process that helps achieve the desired goal. Communication is a process by which two or more people exchange ideas, facts, feelings or impressions in ways that each gains a common or mutual understanding of the meaning and the use of the message. Communication, in general, is frequently divided into the following levels:

- Interpersonal communication
  - Sending/receiving (listening)
  - Oral/written/electronic (electronic can be computer-mediated oral or written communication)
  - Verbal/Nonverbal
- Group level communication
- Organizational level of communication
- Inter-organizational level communication
- Mass communication

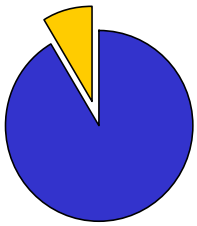
Although interpersonal and group level communications reside at a lower level, they are major forms of communication in mentoring.

The literature on communication generally acknowledges that the basic function of communication is to affect receiver knowledge or behavior by informing, directing, regulating, socializing, and persuading.

(a) Types of communication

Communication can be either:

Verbal: Spoken words (Smaller portion of the Pie)
The nonverbal :(Larger portion of the Pie)
The way we stand and sit
Facial expressions
Silence
Eye contact
Gestures (smiling, leaning forward, nodding)



: Group Activity

This exercise is to test your perception of nonverbal communication.

Instruction: Write down your perception about the emotion of the person in the

PowerPoint image as directed by the facilitator.

According to the work of Dr. Albert Mehrabian, words are only 7 % of the actual message we communicate. The tone of voice or voice inflection accounts for **38** % of our message, and nonverbal communication is by far the most important aspect, making up ***55*** % of the actual meaning of the communication. Obviously, what counts is not *what* you say but *how* you say it. Words primarily address the content of your message. All three combined, words, the tone of voice, and nonverbal communication convey the *emotional impact* of the message.

Figure 17: Elements of inter-personal communication

Effective communication means that the correct message goes from the sender to the receiver successfully, in the way the sender intended. Just because a message is sent does not mean that it was received accurately. **Effective communication is more than just providing information or giving advice.** It involves asking questions, listening carefully, trying to understand mentee concerns or needs, demonstrating a caring attitude, and helping to solve problems.

Effective communication components:

- **Active listening:** fully concentrate, understand, respond and then remember what is being said.
- **Reflecting listening: the** process of verbally "reflecting" back what someone has said
- **Summarizing: the** process of synthesizing and stating what a mentee has said in order to capture key concerns and issues

Consider these guidelines for vocal presentation:

- A low-pitched, well-modulated voice conveys strength and confidence.
- A high-pitched voice indicates excitement, lack of control, and perhaps panics.
- Speaking too softly conveys lack of confidence and fails to engage the listener.
- Speaking too loudly signals aggressiveness, intolerance, or lack of patience.
- Varied pace and tone indicate excitement and importance.
- Pausing adds emphasis to the last statement. Pausing also allows the receiver time to process the message.
- Raising, lowering, and altering the tone of voice overcomes a monotone delivery.
- Emphasize points by raising or lowering your voice (whispering can be very effective).
- Avoid vocal distractions, including the repeated use of words and phrases such as, "you know," "uh," "okay," "um's,'' and "er's'' (they distract the listener from concentrating on your message).

Barriers to Communication

Communication can be hindered by a number of things. Other ways of not communicating well including but not limited to

- Noise: Anything that inhibits an effective communication
  - ♣ Can occur in many forms
    - Receiver's Physical pain, fear, anxiety,
    - Language barrier
    - Lack of interest:
      - Looking out the window
      - Looking at the clock, watch or mobile phone repeatedly
      - Starting to speak to someone else.
      - Shuffling papers.
    - Hearing/sight impairment
    - Problems with channel

Negative nonverbal communication can have many consequences, such as:

- Information is not shared, understood.
- The client may ask fewer questions.

- The problem may be difficult to understand.
- The situation may be uncomfortable.
- Lack of adherence to medical appointments and/or treatment.

: Role play activity

Instruction: Pair all participants and provide them with a piece of paper of 12 vertical lines and 8 horizontal lines. Assign one participant voluntarily to be a mentor and the other a mentee (voluntarily). Instruct them to sit back to each other. Let all mentors instruct their mentee to draw something using the lines provided without mentioning what the mentor intend to draw. The mentor also draws what he/she is instructing. The picture at the end should look the same as what the mentor draws. After finishing the exercise, reconvene summarize on the following points.

Summary of the exercise

- The significance of using clear language in communication
- The effect of not ensuring privacy free from noise and physical barrier (eye contact) to clearly communicate

(b) Active Listening

Listening is the absorption of the meanings of words and sentences by the brain. Listening leads to the understanding of facts and ideas. It Is an essential component of good communication. Often, instead of truly listening to what the other person is saying, we're thinking about what our response will be to what they're saying, or what we want to say next, or something else entirely. 80-20 listening rule of listening a good listener should listen 80 percent of the time and talk no more than 20% of the time. People can speak at a rate of only 120-160 words per minute, but we can listen to more than 800 words per minute.

(i) Techniques of active listening:

- PARAPHRASE: Restate what was said in your own words
- QUESTION: Challenge speaker to think further, clarifying both your and their understanding, however suspend judgement
- SUMMARIZE: Pull together the main points of a speaker

(c) Effective Feedback

Feedback: is comment in the form of opinions about or reactions to something and its purpose includes are: to initiate and improve performance; is not to punish under performance; to look at our own attitudes, skills and knowledge; to evaluate a program and to provide information for future decision. It can also be defined as communication with a person that gives information about how his or her behavior is perceived by others and the effect it has on them. Feedback helps us to learn by increasing both the awareness of what we are doing and how we are doing it. Being able to seek and receive feedback about performance is, therefore, an important skill for mentee too. If sought and accepted, it will greatly increase their self-awareness by helping to build a more accurate picture of how they are perceived, and it will help them to monitor the progress of their learning and development.

Feedback is a critical component of mentoring but for feedback to be effective, it must be offered in a way that it can be received by the mentee and Vice versal

: **Think-pair-share (TPS)**

Activity 1

Instruction: 1) Think of a time when you received feedback that was helpful. And think of a time when feedback was not helpful. 2) Talk about these two experiences with another person at your table.

Activity 2

Instruction: 1) Think of a situation in which you wished you had given feedback or one where you would like to in the future. 2) Share it with your peer at your table.

In order for feedback to be helpful, you need to:

Be specific about the action that was not helpful—do not generalize by using words such as "always" or "never";

Describe the impact of the action on you and/or the work;

Make a specific request for another action.

Reflect your experiences to the larger group.

Practice giving feedback through a role-play

Session I.3: Initiating a mentoring Process

 What is the next step after you have built a relationship with your mentee?

Once a clinical mentor has built a relationship with the mentee, initiating the actual mentoring process will require a number of arrangements beforehand. The mentor should be able to arrange the time and settings of mentoring in discussion with the head of the health facility as well as the mentee.

As part of setting norms and explaining the purpose of the mentor's presence in that facility, the mentor will be required to explain about the components of his/her mentoring activities before initiating the mentoring process.

(a) Setting an appointment with the Mentee

The mentoring process starts with arranging an appropriate time for mentoring to take place. The arrangement should normally be done jointly by both the mentor and the mentee. The mentor should first contact the health facility head for facilitation to conduct the mentoring and subsequently contact the mentee and arrange on a suitable date and time for both.

Table 9: Things to do in the first and subsequent visits

 : What are the things to do in the first visit?
1. Explaining what mentoring is: Most mentees will not have been formally mentored before and it is important for the mentor to explain what mentoring is in the first visit and how the process works. It will be important to distinguish between mentoring and counseling, mentoring and teaching and mentoring and coaching, mentoring and supportive supervision
2. Explaining one's role: It will be helpful to define roles, for example, the mentor can explain that she or he will listen to the mentee's case presentation, explore and understand it well and develop solutions with the mentee. He or she will give expert input where it is necessary but will try to promote independent thinking and expert knowledge in the mentee. The mentee's role would be to think about a case presentation prior to the mentoring session, to prepare points and problems to share, to interact with the mentor in an open and collegial way, and be willing to receive constructive feedback.
3. Agreeing on expectations and outcomes: In the light of the roles described above, both the mentor and mentee should discuss expectations of each

other and the mentoring process as a whole and agree to what they believe they can reasonably achieve. If possible, these should be recorded.
4. Agreeing on how outcomes are to be evaluated: The mentor should explain how the mentee is to be evaluated. For example, the mentor could say "I will keep notes of each mentoring session and these, combined with my clinical impressions, will form the basis of how I will evaluate your progress." The mentor may go on to explain that the mentee will be assessed on general clinical skills on RMNCH, on skills in relating to client communication, on documentation and record keeping etc. The mentor should explain to whom he or she reports on the progress of the mentee.
5. Setting out parameters for an interaction: The mentor and mentee should discuss on duration of a session, frequency, and number of sessions according to the national guideline, confidentiality parameters of the discussions (especially if the mentee discusses personal information) and on how the mentor's assessment documents are communicated and kept for progress assessment and subsequent actions. `
6. Agreeing on how disagreement is to be managed: Because it is possible that the mentor and mentee will disagree at times, and even have serious arguments or points of difference, it may be useful to discuss how conflicts will be handled. The mentor needs to use his/her interpersonal skills to understand and resolve all disagreements as much as possible. When disagreements could not be resolved, issues in rare case need to be discussed with health facility leadership as well as relevant regional, zonal or woreda program managers.
7. **Context setting skills:** It is preferable to set up space which can help both mentor and mentee feel calm, private, appropriate and relaxed. Ideally, this means a space with comfortable seating set up in a conversational way, privacy from interruptions and intrusions such as a ringing telephone. The situation described above is an ideal one: if this is not possible try to create a similar effect with an attitude/approach of respectfulness and collegiality. Some mentoring needs to happen at the bedside of a patient or in the clinic and obviously, the mentor has less control over this situation. It would still be useful to maintain an attempt at privacy and respect by drawing curtains and by speaking in a quieter but still audible tone. Some mentors may be more comfortable to work from behind a desk and this is possible but likely to create a barrier and reinforces the power imbalance between mentor and mentee.
8. Managing Disagreement between a Mentor and a Mentee 9. Ask for time to think things over. 10. Pay attention to your body's reactions. 11. Don't snap at the person. 12. Determine what it is you want that you're not getting. 13. If the other person has "lost it", don't negotiate until calm returns. 14. Wait until the other person is willing to listen to your side of the story. 15. Make sure the other person knows you're listening.

16. If the other person doesn't seem to be listening to what you have to say, insist that you be listened to.
17. Ask: "What do you want me to do?"
18. State what you want, clearly and sequentially. Again, be willing to negotiate.
19. Once an agreement has been reached, summarize the particulars and go over pertinent areas again to reconfirm your understanding.

20. Subsequent visits: the mentee will, for the first 3 whole weeks, accompany the mentor in the hospital. This is so the mentee gets full exposure at a facility that has more complex as well as a higher number of cases to gain experience from. Upon the mentee returning to his/her facility following the first 3 weeks at the mentor's facility, the mentor will visit the mentorship at the mentee's facility for one week a month for 6 consecutive months.

21. The national RMNCAH mentoring guideline highly recommended that a staff that completes the mentorship program will be required to work in the area he/she is mentored for a minimum of 2 years following the completion of the mentorship program.

(b) Commencing mentoring

One of the big issues in mentoring is to decide what it is that the mentor will focus upon and change. A mentor can work with people at a number of levels:

- Changing the environment
- Changing the organization
- Changing a team
- Changing another individual
- Changing oneself.

For each of these levels, the mentor can attend to the following:

- Changing values and beliefs
- Changing attitudes
- Changing behaviors
- Changing thoughts/opinions.

What do you want to change first?

All these levels are legitimate foci of concern. However, in helping the mentee to navigate among these options, it is well to remember two principles:

1. There is a strong argument for starting with oneself.

2. If someone changes behavior and maintains the change for a month, then attitudes and even values and beliefs are likely to follow; sometimes it is necessary to change thoughts in order to be able to change behaviors.

Chapter Summary

In this chapter, important technics and approach use in building a relationship in the mentoring process have been discussed. **Effective communication components Including:**

- **Active listening:** fully concentrate, understand, respond and then remember what is being said.
- **Reflecting listening: the** process of verbally "reflecting" back what someone has said
- **Summarizing: the** process of synthesizing and stating what a mentee has said in order to capture key concerns and issues

And specific feedback techniques like:

- Being specific about the action that was not helpful
- Describing the impact of the action on you and/or the work;
- Making a specific request for another action.
- Reflecting your experiences to the larger group and
- Practicing giving feedback through a role-play

In addition, initiation of the mentoring process has been discussed and it has been also demonstrated and practices using selected cases and drills.

Chapter IV: Teach mentees

Chapter Description: This chapter will provide to the participant the basic concepts and principles of learning, effective approaches and its application to RMNCAH mentoring. Responsive mentoring will observe and assess the learning needs of the mentee that leads to the identification of areas for improvement. And establish learning goals and objectives for the mentorship and design effective methods and teach mentees.

Chapter Objective: At the end of this chapter participants will be able to:

- Apply the basic concepts and principles of learning to RMNCAH mentoring

Enabling Objectives: At the end of this chapter participants will be able to:

- Explain the learning process
- Describe the effective approaches of Adult learning
- Apply the learning theories and approaches to mentoring

Chapter outline:

- Theories of Learning
- Effective approaches for Adult Learners
- Application of learning theories and approaches to mentoring

Session I.1: Theories of Learning

(a) Introduction

: Think-pair-share (TPS):

- Think about the best learning experience you've ever had. What was it like?
- What about the opposite experience? one that gets forgotten as soon as the learner is done?
- How are the two experiences different?

Learning is the process of acquiring new, or modifying existing, knowledge, behaviors, skills, values, or preference. Mentoring is a process for providing directed practice, experience and designed to see a change in the learner's behavior. When considering whether to attend a learning event, people typically ask two questions:

1. "What must I know to do my job and, what don't I know?"

2. "What knowledge and skills do I need to proficiently perform my job?" and "In which of these do I need further development?"

Unless these questions are correctly answered, attending a learning event include mentoring can waste valuable staff time and limited resources.

In this case, the learning events will have done little to increase learners' competence, much less enhance RMNCAH services.

The goal of good learning is for learners to emerge from the learning experience with new or improved capabilities that they can take back to the real world and that help them do the things they need or want to do.

 : Individual Exercises:

Are the following statements true or false?

- If you teach people about how smoking is bad for them, they'll stop smoking.
- If someone reads a management book, that person will be a good manager.
- If someone takes a really good web design class, that person will be a good web designer.
- If you teach people the right way to do something, they won't do it the wrong way.

Learning is NOT ALWAYS ABOUT WHAT PEOPLE KNOW, it is a journey: The journey starts where the learner is now and ends when the learner is successful (however that is defined). The end of the journey isn't just knowing more, it's *doing* more.

The goal of clinical training and mentoring is to help health professionals achieve competency in providing safe, high-quality, standard-level health services to clients through improved work performance. Competence is the ability to perform successfully a specific task, procedure or activity—such as inserting an intrauterine contraceptive device (IUD), resuscitating asphyxiated newborn, or diagnosing and managing eclampsia/pre-eclampsia etc.

Mentoring deals primarily with continually developing and accessing learners' progress toward achieving competence, while transferring the knowledge, attitudes, and skills needed to carry out such health services.

(b) Basic Ways to Learn

There are multiple theories for how people learn. We often think about three basic types of learners. People may also use a combination of styles depending on what they are learning.

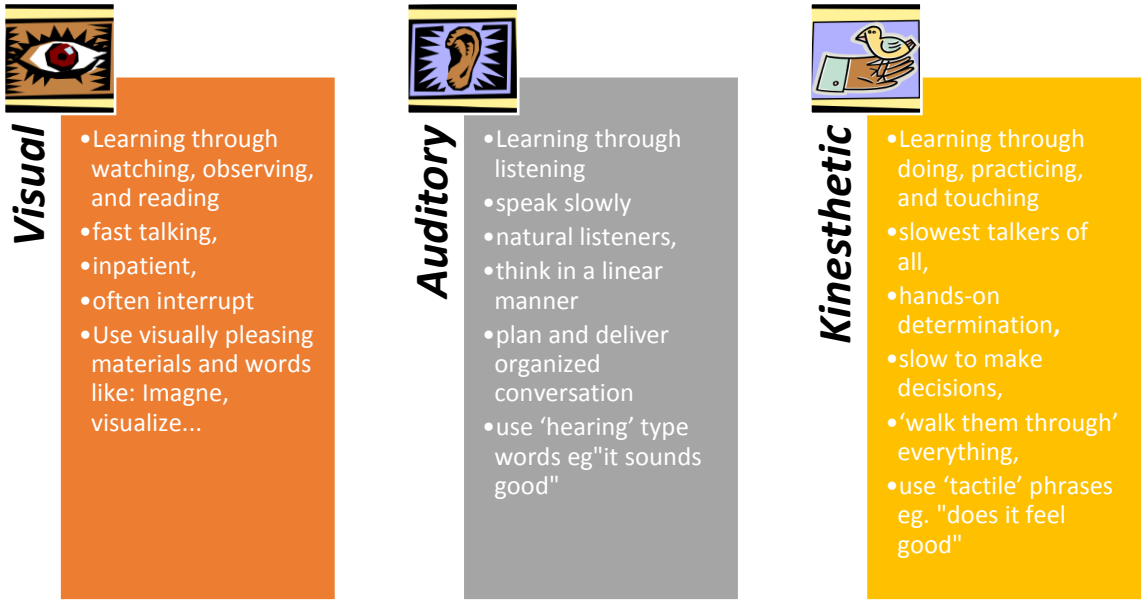


Figure 18: Learning preference and style

What is/are your learning preference/s? how does your learning style might impact your mentoring?

Knowing your own learning preference can help to:

- Understand the learning styles of the mentee
- Identify methods that will address learning styles other than your own.

But it is important to note:

Some people learn (and remember their learning) primarily by hearing others talk; Some people readily understand how to do something if they only see someone do an activity and yet others learn by doing. It is advised to step out of the comfort zone and/or natural learning preference and explore alternative ways to learn.

There are multiple theories for how people learn. In this session, we will discuss Mastery learning, Adult learning principles, and competency-based training.

(c) Stage of Learning

There are three stages of learning:

- Stage 1 Knowing: is learning new information and Acquire Knowledge and become intelligent.
- Stage 2 Know-how: apply what we learn by modifying our behavior and produce a new experience with a new emotion, create a new and more enriched experience
- Stage 3 Knowingness: becoming the knowledge through years of repetition.

Understanding your mentees is part of an effective approach for mentoring. If you don't understand your mentees learning stages, unfortunate things can happen. In addition to knowing what your mentees want, you also want to ask what they like- your mentees' preferences: *it's essential to know and understand our audience, not just the subject matter.*

There's a gap between a learner's current situation and where they need to be in order to be successful. Part of that is probably a gap in knowledge, there are other types of gaps as well. If you can identify those gaps, you can design better learning experiences.

(d) Types of learner's gap:

Knowledge Gap is the information your mentees need to have in order to perform. Having information doesn't accomplish anything by itself. Something is accomplished when the learner *uses* that information to do things. You also want your learners to know what to *do* with that information.

 Is it *Really* a Knowledge Gap?

There's a common tendency to assume that the gap is information—*if the learner just had the information, then they could perform*.

Skill Gap: Having a skill is different from having knowledge. To determine if something is a skill gap rather than a knowledge gap, you need to ask just one question:

 Is it reasonable to think that someone can be proficient without practice?

If the answer is no, then you know you are dealing with skill, and your mentees will need the practice to develop proficiency.

Attitude Gap: If somebody knows what to do but chooses not to do it, that's an attitude gap.

You may not force a learner to be motivated or have a favorable attitude towards a certain practice or behavior but there are ways you can help support motivation in a mentoring experience.

Old information and procedures *get in the way* of new information and procedures. If you are asking your learners to change existing practice, you are probably going to have some motivation issues to contend with. In those instances, there are a couple of things to be aware of.

1. First, change is a process, not an event. You absolutely cannot expect someone to change based on a single explanation of the new practice. They need time and repetition to ease back on the old habit and start cultivating the new one.
2. Second, backsliding and grumpiness are part of that process—they don't mean that the change has failed (although that can happen too), but they are frequently an unavoidable part of even successful changes.

Habit Gaps: Sometimes, people have the knowledge, skills, and attitude and there *still* may be a gap. For most of us, a large percentage of our day is habit-driven. habits need a different learning approach.

Environment Gaps: Let's say your mentee has good directions, is fully prepared, is in good shape, and is eager to go. But the unavailability of materials, references, job aids equipment & commodities and low clients flow can negatively influence the exposure of experience of mentees.

Communication Gap: Sometimes a failure to perform is due not to a lack of knowledge but is due to bad directions or instructions. This isn't really a learning issue—this is a case of miscommunication. Sometimes, the person communicating the direction doesn't really know where they want people to go; they don't know the goal. Or sometimes, the person communicating knows where they want people to go but can't adequately communicate that knowledge. Occasionally, the person giving the directions says one thing, but either doesn't support it or really intends something else. Communication issues can sometimes wrongly be considered as learning issues.

Frequently, the best you can do in those situations is document the issue, handle the politics, and do no harm to the learners, if possible.

(e) Identifying and bridging gaps

So, when you are mapping out your mentee's learning route, you need to ask yourself what the learning journey looks like. There are a variety of strategies to help identify the gaps. Here are a few for starters:

: Strategies to help identify the gaps

- Ask "What do they actually need to *do* with this?" (If you get the answer "They just need to be aware of it," then ask "Yeah, but what do they actually need to *do* with this?" *again*.)
- Follow a beginner mentee around and watch what they do; then observe an expert mentee and notice "What are they doing differently?"
- Ask yourself if the person *would be able to* do something if they wanted to badly enough. If the answer is yes, it's not a knowledge or skills gap.
- Ask the question "Is there anything-anything at all—that we could do, besides mentoring, that would make it more likely that people would do the right thing?"
- Ask "Is this going to involve changing the way they do things now?"
- Ask "What is the consequence if somebody does it wrong?"
- Ask "If someone is getting this exactly right, what would that look like?"
- Ask "Is it reasonable to assume that someone will get this right the first time out, or will they need to practice to get competent?

Understanding your mentees is part of an effective approach for teaching mentees. In addition to knowing what your mentees want, you also want to ask what they like- your mentees' preferences: *it's essential to know and understand our audience, not just the subject matter*.

Session I.2: Effective approaches for Adult Learners

Learning is effective when it is **relevant,** practical and **participatory**. Effective clinical training and mentoring is designed and conducted according to adult learning principles. It uses behavior modeling, is competency-based and incorporates humanistic training techniques.

(a) Adult Learning Principles

Effective clinical mentoring, like effective training, respect the adult learning principles. There are eight adult learning principles that all effective training and mentoring techniques and approaches respects:

ADULT LEARNING PRINCIPLES

- Learning is most productive when participants are ready to learn. Although motivation is internal, it is up to the Trainer to create a climate that will nurture motivation in participants.
- Learning is more effective when it builds on what the participants already know or have experienced.
- Learning is more effective when participants are aware of what they need to learn.
- Learning is made easier by using a variety of training methods and techniques.
- Opportunities for practicing skills initially in controlled or simulated situations (e.g., through role play or use of anatomic models) are essential for skill acquisition and for development of skill competency.
- Repetition is necessary for participants to become competent or proficient in a skill.
- The more realistic the learning situation, the more effective the learning.
- To be effective, feedback should be immediate, positive and nonjudgmental.

 Group Activity

Instruction: In your small group, discuss the following topic and present for the large group using flip chart.

(i) Competency-Based Training

Competency-based training (CBT) including mentoring is distinctly different from traditional educational processes. Competency-based training **is learning by doing**. It focuses on the specific knowledge, attitudes, and skills needed to carry out a procedure or activity. mentor facilitate and encourage learning through practice. Competency in the new skill or activity is assessed objectively by evaluating overall performance.

(ii) Behavior Modeling

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone perform (model) a skill or activity. For modeling to be successful, however, the trainer must clearly demonstrate the skill or activity so that participants have a clear picture of the performance expected of them.

Behavior modeling, or observational learning, takes place in three stages. In the first stage, skill acquisition, the participant sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the participant attempts to perform the procedure, usually with supervision. Next, the participant practices until skill competency is achieved and s/he feels confident performing the procedure. The final stage, skill proficiency, only occurs with repeated practice over time.

(iii) Humanistic Training Techniques

The use of more humane (humanistic) techniques also is one of an effective approach for adult learners. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other training aids such as slide sets and videotapes. The effective use of models facilitates learning, shortens training time and minimizes risks to clients. Before a participant attempts a clinical procedure with a client, two learning activities should occur:

1. The clinical trainer should demonstrate the required skills and client interactions several times using an anatomic model and appropriate audiovisual aids (e.g., training slide sets or videotapes).
2. While being supervised, the participant should practice the required skills and client interactions using the model and actual instruments in a simulated setting which is as similar as possible to the real situation.

Incorporating the use of anatomic models and other training aids can significantly reduce training time and the number of cases needed for skill competency. Moreover, practicing with models helps participant's correct mistakes in technique that could hurt the client.

When CBT is integrated with adult learning principles and is based on behavior modelling, the result is a powerful and extremely effective method for providing technical training. And, when the use of anatomic models and other training aids is incorporated, training time (and training costs) can be reduced significantly.

Session I.3: Application of learning theories and approaches to mentoring

How are you going to apply the learning theories and approaches to mentoring?

There are numerous ways to apply the learning theories and approaches discussed above during mentoring. In this session, the two most commonly uses approaches will be discussed.

During one to one micro teaching of Knowledge and Facilitation of skill development during skills transfer

(a) Microteaching

The art of teaching does not merely involve a simple transfer of knowledge from one to other. Instead, it is a complex process that facilitates and influences the process of learning. Microteaching is a training technique that helps to promote real-time teaching experiences. The core skills of microteaching such as presentation and one to one teaching help the mentors to teach mentees. The goal is to give mentors confidence, support, and feedback by letting them try out among friends and colleagues a short slice of what they plan to do with their mentees. It is a technique which allows well defined skill to a carefully prepared small lesson in a planned series of **five to ten minutes**. It is done with a small group of people with an opportunity to observe the performance, this makes it an ideal teaching method during mentoring.

(i) Presentation Principles of Microteaching:

- Utilize local environment as a source of learning
- Avoid talking while writing on flip chart
- Do not discussed a lot of content at a time
- Address mentees using their names
- Maintains eye contact with the mentee

(ii) Micro-teaching procedure

- Defining the learning piece/content during the teaching procedure
- Develop precise and measurable objectives for micro-teaching.
- Planning the lesson using a lesson plan
- Teaching the micro-lesson
- Discussion on the delivered lesson
- Providing feedback

(b) Facilitating Skill Development during mentoring

What do you think the mentor role in the skill development of the mentee?

Mentoring has a place in this life-long process of learning. Pre-service education and training should prepare individuals who are competent in providing high-quality services. But ongoing, mentoring for providers should also be available—to reinforce or update existing competencies; to gain new knowledge, skills, and attitudes for continued professional development throughout their professional careers. This is because what it means to be "competent" in a given service may change as new information becomes available or new problems emerge.

The process of facilitating a clinical skill within the mentorship process has three basic phases: demonstration, practice, and evaluation. These three phases can be broken down further into the following steps:

- First, **explaining** the skill or activity to be learned
- Next, **showing** the skill or activity to be learned
- Following this, **demonstrating** the skill or activity using an anatomic model (if appropriate) or case scenario (e.g., counseling demonstration)
- Then, allowing the participants to **practice** the demonstrated skill or activity with an **anatomic model** or in a simulated environment After this, **reviewing** the practice session and giving constructive feedback
- After adequate practice, **assessing** the mentees performance of the skill or activity on models or in **a simulated situation**, using the competency-based checklist
- After competence is gained with models or practice in a simulated situation, having mentees begin to **practice** the skill or activity with clients under a mentor's guidance
- Finally, **evaluating** the mentees ability to perform the skill according to the standardized procedure

The table below shows the three phases of the process used to help participants develop clinical skills successfully. Note how the roles shift during the process. During initial skill acquisition, the mentor demonstrates the skill as the mentee observes. As the mentee practices the skill, the mentor observes and assesses performance. When demonstrating skill competency, the mentee is now the person performing the skill as the mentor evaluates performance.

Table 10: Coaching in Clinical Mentoring

ROLES	**LEVEL OF PERFORMANCE**		
	Skill Acquisition	**Skill Acquisition/ Competency (with models)**	**Skill Competency (with clients)**
mentor	Demonstrates skill/activity	Coaches the participant and assesses participant performance	Evaluates participant performance
mentee	Observes the demonstration	Practices and performs the skill/activity	Performs the skill/ activity

The mentee progresses from skill acquisition to skill competency using anatomic models. After the mentee reaches skill competency using a model, the process begins again as the skill/activity is performed with clients.

(c) Conducting an effective clinical demonstration

When introducing any clinical skill, the mentor can use a variety of methods to demonstrate the procedure. For example:

- Show slides or animated video (e.g. as in SDA) in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.!
- Use anatomic models such as pelvic or implants training arm models to demonstrate a procedure and skills.
- Perform a role-play in which a mentee simulates a client and responds much as a real client would.
- Demonstrate the procedure with clients in the operating or procedure room.

Starting with demonstrations that do not involve clients enables the mentor **to take ample time, stop and discuss key points** and **repeat difficult steps without endangering the health or comfort of a client**.

When planning and giving a demonstration of a clinical procedure using anatomic models (or with clients if appropriate), the mentor should use the following guidelines:

- Before beginning, **state the objectives** of the demonstration and point out what the mentees should do (e.g., interrupt with questions, observe carefully, etc.).
- Make sure that **each mentee sees** the steps involved.
- **Never** demonstrate the skill or activity incorrectly.
- Demonstrate the procedure in as **realistic** a manner as possible, using actual instruments and materials in a simulated clinical setting.
- Include **all steps** of the procedure in the **proper sequence** according to the approved performance standards. This includes demonstrating "non-clinical" steps such as pre- and postoperative counseling, communication with the client during the procedure, use of recommended infection prevention practices, etc.
- During the demonstration, explain to mentees what is being done-especially any difficult or hard-to-see steps.
- **Ask questions** of mentees to keep them involved, such as, "What should I do next?" or "What would happen if...?"
- **Encourage** questions and suggestions.
- **Take enough time** so that each step can be observed and understood. Remember that the objective of the demonstration is for the mentee to learn the skills, **not** for the mentor to show handiness and speed.
- **Use equipment and instruments properly** and make sure mentees see clearly how they are handled.

(i) Safe Delivery App (SDA)

Medical simulation is a cross-disciplinary realistic and economical training and feedback method, in which learners can repeatedly practice and review tasks and processes in lifelike circumstances, using physical or virtual reality models We use simulation to develop, maintain and improve skills of health care providers until proficiency is achieved, without harming clients/patients.

The aim in Simulation based Learning (SBL) is to support learning through immersion in a scenario and includes reflection, debriefing, and application. This is well demonstrated in professional education. For example, within health professions mentorship, mentees are being encouraged to foster skills such as crisis situation management, systematic life support, clinical decision-making, and reasoning. In addition, SBL supports the development and reinforcement of team skills, empathy, compassion, and integrity in patient and professional interactions.

This simulation drill is a catalogue of different emergency case scenarios developed for exercise purpose. The aim for developing this simulation drills is to exercise on how to handle obstetric emergency situations. As part of the exercises, the Safe Delivery App can be used as a tool to manage these obstetric emergencies. The Safe Delivery App is primarily based on the latest WHO and the national clinical guidelines on Basic Emergency Obstetrics and Newborn Care (BEmONC) which includes animated clinical instruction films and reference materials. It mainly includes all the seven-signal function of BEmONC and additional important lifesaving procedures;

- Hypertension,
- Prolonged Labor,
- Post-Partum Hemorrhage,
- manual Removal of Placenta,
- Post-Abortion Care,
- Maternal Sepsis,
- Active Management of Third Stage of Labor,
- Neonatal Resuscitation,
- Newborn Management, care of the low birth weight infant, and
- Infection Prevention.

Use of SDA in Mentoring

Situation: Today, you will go to one of the health centers in your catchment for mentoring as per the previously developed action plan on the previous mentroing visit. According to your plan, you will discuss and simulate responding to post partum heamorhage.

Role: There are two roles to play: the mentee and the mentor.

Instruction: two volunteer participants play out the roles identified above using the script described below and the participants focus on how the mentor used the safe delivery application to communicate skill and knowledge of managing PPH. In addition, see how the mentor is communicating and giving fee back.

- Mentee- When you see the mentor coming to you, act as if you are busy filling out a report showing a sign that you are not interested to participate in the mentoring today.
- Mentor: Approach the mentee in kindness and greet respectfully; recognize the busyness of the mentee
- Mentee: Greet the mentor negligently and return to your work of writing the report
- Mentor: Show a helping hand to share the work. And gently remind that today is the mentoring visit day as per the action pan you developed together.
- Mentee: When mentor shows respect and helping hand, agree to finish the reporting work later and start to work with the mentor.
- Mentor: ask the mentee on the steps in responding to PPH. After the mentee explains the steps (could be right or wrong-don't judge), thank the mentee and ask him/her to reflect on the his/her performance. Following this, watch SDA Post-partum hemorrhage section together and ask his/her reflection now. At the end, provide your feedback on points that are not mentioned by the mentee and re-do the simulation and provide feedback.

Summary Questions:

1. How would you handle it if you were the mentor?
2. How will you be using the SDA in mentoring?
   - Use the SDA in between mentoring e.g. in role play, simulation or after carrying out a procedure on actual patient
   - Remind mentee to see SDA in team when mentor is not around including the "my learning" questions to self-assess their knowledge

(ii) Practical Exercise on RMNCAH Mentoring

Following the guidance of the facilitator, you will exercise RMNCAH mentoring in small Group. In this practice, you will use applicable sessions from the previous chapters, particularly the mentoring process.

Chapter Summary

When CBT is integrated with adult learning principles and is based on behavior modeling, the result is a powerful and extremely effective method for providing technical training. And, when the use of anatomic models and other training aids is incorporated, training time (and training costs) can be reduced significantly. For Every Skill Development, use an assessment tool (Checklist), demonstrate correct behaviors, provide coaching and supportive, feedback during practice and assess the mentee. And use learning guide, as it greatly facilitates skill development particularly difficult or complex tasks and also present the individual steps of a task in a standardized way which help mentees learn the correct steps for a task. The learning theories and approaches to mentoring can be utilized 1) During one to one micro teaching and 2) during transferring skills. When introducing any clinical skill, the mentor can use a variety of methods to demonstrate the procedure, SDA is one of the most important app mentors may use.

Chapter V: Monitoring & Evaluation of the mentoring program

Chapter Decryption: In this chapter, participants will learn the basics of Monitoring & Evaluation, and related concept, assessment of the mentorship program and the performance of the mentee. Participants will also demonstrate the proper documentation of the data using the M&E mentorship tools and checklist.

Chapter Objective: At the end of this chapter participants will be able to:

- Monitor and Evaluate the mentoring program

Enabling Objectives: At the end of this chapter participants will be able to:

By the end of this chapter participants will be able to:

- Explain the importance of monitoring and evaluation of the mentoring program
- Discuss the type of RMNCAH monitoring and evaluation tools of the mentoring program
- Describe how to analyze and use the facility and mentees performance data
- Demonstrate the proper documentation of the data using the M&E mentorship tools and checklist.

Chapter outline:

- Basics of Monitoring & Evaluation
- Assessment of the mentorship program
- Use of M&E tools and analysis of data

Session I.1: Basics of Monitoring & Evaluation

What is Monitoring and Evaluation (M&E)?

The M&E processes outlined in this document are not to be considered as standalone functions; however, each step is part of a continuum of processes that are essential for effective monitoring and evaluation of programs. The document is organized into the following main sections:

(a) Monitoring

Monitoring can be defined as the ongoing process by which stakeholders obtain regular feedback on the progress being made towards achieving their goals and objectives.

(b) Evaluation

Evaluation is a rigorous and independent assessment of either completed or ongoing activities (process evaluation) to determine the extent to which they are achieving stated objectives and contributing to decision making.

(c) Related concepts in Monitoring and Evaluation

Planning: Planning can be defined as the "process of setting goals, developing strategies, outlining the implementation arrangements and allocating resources to achieve those goals." A plan helps to define what an organization, program or project aims to achieve and how it will go about achieving that. It is also the basis by which programs will be monitored and evaluated.

Knowledge management: Knowledge Management (KM) is defined as the "discipline of enabling individuals, teams and entire organizations to collectively and systematically create, share and apply knowledge, to better achieve their objectives. Having a system in which the knowledge that is created through individuals and programs is captured will allow the health facilities to perform better; learn from our past experiences and design better programs in the future.

(d) The significance of Monitoring & Evaluation for the mentoring program

The significance of monitoring & evaluation for the mentoring program.

The monitoring and evaluation of any development program are essential not only to ensure that the program meets its desired outcomes and that value for money is being achieved but also to identify any areas of the program that would benefit from further development or modification. Such evaluation needs to be sufficiently in-depth that it actually achieves its aims and objectives but not so complex that essential information cannot be obtained as efficiently as possible with the least possible cost.

Figure 19: M&E Cycle

Session I.2: Assessment of the mentorship program

: Brainstorm on:

What can be done to monitor and evaluate the mentoring program?

It is essential to continuously assess whether the mentorship program is being implemented as planned and whether it is bringing the desired change in the mentees' knowledge, skill and attitude as well as the desired change in the primary health care unit at large. Assessment of the mentorship program can be done by conducting periodic supportive supervision as well as review meetings.

(a) Supportive Supervision

Supportive supervision should be conducted by the technical and supportive team at **least once every three months** to follow on the progress of the mentorship program. Supportive supervision activities should look into mentorship logs to check the number of clinical mentorship encounters for each mentor, assessment findings of mentees, and the number of mentees that have successfully completed the mentorship program.

(b) Review Meeting

Review meetings will be conducted every 3 months at regional health bureaus level and every two months at the woreda level or catchment level.

Key areas of discussion during review meetings should include:

- The progress of the mentorship program
- Challenges faced
- Possible solutions
- Best practice sharing

Additionally, during review meetings, an update on the following should be sought**:**

- A number of health facilities mentored.
- A number of health facilities that have mentees graduated and have become mentors.
- A number of monthly reports submitted to the next administrative level.
- The trend over time in the number of referrals made, and their appropriateness.

Recognition of Mentors and Mentees: upon successful completion of the mentorship program, both mentees and mentors should receive recognition. One way of recognizing mentors and mentees will be through awarding certificate of recognition/achievement.

Session I.3: Assessment of the performance of the mentee

It is essential to continuously assess whether the program is bringing the desired change in the competency of the mentee. Timely monitoring of the progress of mentee's performance will allow for appropriate changes to be instituted as needed in a timely manner.

Assessment of the performance of the mentee includes assessment of the knowledge and skill of the mentee at the beginning, middle, and end of the mentorship program. These should be done through a structured assessment by the mentor. The mentor may encourage the mentees to do self-assessment using different self-assessment tools (like SDA app-my learning feature which have three levels of questions for each module, familiar, proficient and expert, which increase in difficulty and requires critical thinking. Once reached 100% it leads to certificate exam which includes questions from all the modules and if a user score is above 70%, it generates a certificate with one's user name and email address which is used during registration).

Assessment of the performance of the mentee is part of the evaluation of the mentoring support given to the Healthcare worker (the mentee).,

Session I.4: Use of M&E tools and analysis of data

 Group Exercise on RMNCAH mentoring tools and checklist (see annex list)

The facilitator will provide orientation and instruction that guide this group exercise.

(a) Assessment forms

- Facility assessment
- Mentee's profile
- Knowledge Assessment
- Respectful Maternity care assessment
- Skill assessment
- Agreement form
- Action plan template: Mentoring Action Plan
- Report format
    - Monthly Mentor report format
    - Quarterly report format (Woreda, Zone, and Region)
    - Quarter review meeting

Time allowed 2 hrs.

Chapter Summary

In mentoring, evaluation can be defined as the systematic collection, processing, analysis and interpretation of data. An evaluation can determine whether mentoring has met its objectives (e.g., whether mentoring has improved an individual's knowledge, skills, and attitudes related to job performance) and identify aspects of the mentoring that should be strengthened.

Evaluation always should be an integral part of the mentoring process. This session assumes that a primary purpose for evaluating the mentoring program is to aid decision-making about the future of the mentoring program.

To make such decisions, evaluators/Mentors need to know how mentoring activities are implemented by the mentee, whether the mentoring is making any differences in mentees' on-the-job performance and how any change in performance affects program activities.

Bibliography: Lists of references for further reading

1. HIV Clinical Mentoring, Draft National Training Package (FMOH)
2. NMH Clinical Mentoring & coaching Draft National Training Package (FMOH)
3. RMNCH Clinical Mentoring & coaching Draft National Training Package (CHAI)
4. Mentoring & coaching for Midwife mentor Draft National Training Package (FMOH)
5. Mentoring Draft National Checklist and annex Tools (FMOH)
6. HIV Clinical Mentoring Training Package International (ITECH)
7. Clinical Mentorship Manual for Integrated Services, (South Africa)
8. Guidelines for In-Service Training in Basic and Comprehensive Emergency Obstetric and Newborn Care (JHPIEGO)
9. Draft National Guideline for Catchment-based Mentorship, (FMOH)
10. National Manual for Comprehensive Mentoring and Supportive Supervision in Maternal and Newborn Health Services (FMOH)
11. The Blackwell Handbook of Mentoring
12. Coaching, Mentoring, and Managing:
13. The Good Mentoring Toolkit for Healthcare
14. Techniques for Coaching and Mentoring
15. Mentoring in Nursing and Healthcare
16. 50 Activities for Coaching/Mentoring
17. National Annual health sector performance 2018 Report (FMOH)
18. Instructional Design Skill national training manual
19. The CPD & IST Guidelines National Guideline, FMOH

Annex-1: List of checklists and monitoring tools

The following list of checklists and monitoring tools are used to implement the monitoring and evaluation of catchment based RMNCAH mentoring program (will be provided as a handout during the Group Exercise session).

- Facility assessment
- Mentee's profile
- Knowledge Assessment
- Respectful Maternity care assessment
- Skill assessment
- Agreement form
- Action plan template: Mentoring Action Plan
- Report format
    - Monthly Mentor report format
    - Quarterly report format (Woreda, Zone, and Region)
    - Quarter review meeting

Annex-2: Catchment-Based RMNCAH Mentoring skill checklist

Instruction: This checklist is to be used for skills assessment during Catchment-Based RMNCAH Mentoring practical exercise and, it includes only the critical steps of the procedure that the trainee must perform satisfactorily and in the correct sequence to be considered competent to provide Catchment-Based RMNCAH Mentoring.

Use the following rating scale (tick: √ on each item)

- 0: Not done or done incorrectly: Step omitted or not performed correctly
- 1: Needs Improvement: Step performed correctly but out of sequence
- 2: Competently performed: Step performed correctly in proper sequence

Sr. No	Task/Competency	0	1	2
	Getting to know each other (the mentor and the mentee)			
1.	Greet the mentee with shaking hands with appropriate eye contact			
2.	Introduce your name and explain briefly why you meet the mentee			
3.	Ask the mentee's name			
4.	Arrange space for mentoring session with the mentees			
5.	Inform to the mentee about your work, education and, (family/home); your success/difficulties/challenges and interest in relation work			
6.	Asking the mentee's about his work, education and, (family/home); his success/difficulties/challenges and interest in relation work			
	Ground Setting			
7.	Explain in detail the purpose of mentoring, elaborate on the difference with other related roles such as supportive supervision, clinical auditing			
8.	Clarify on what is expected from the mentor and the mentee for the mentoring to succeed			
9.	Ensure to the mentee that every information with regard to the mentoring process is confidential			
10.	Demonstrate the mentorship relationship is based on mutual trust, , Empathy, Congruence and empowerment of the mentee (Focus on RMNCAH)			
11.	Inform the mentee • to feel free to highlight the source of discomfort and discuss to solve it whenever there is disagreement. • If it is not solved you may inform the catchment facility heads (mentees and mentor's health facility)			
	Rapport			
12.	Maintain proper eye contact and pay undivided attention			
13.	Use appropriate language(affirmative statements), consider the mentee's level and language preference			
Sr. No	**Task/Competency**	**0**	**1**	**2**
14.	Get voluntary consent from the mentee to participate in the			

	mentoring			
Setting Expectations				
15.	Explain the schedule of the mentoring saying E.g. " the mentoring program will take 1 year and we shall be meeting every two months based on the schedule that we will agree			
16.	Clarify on the use of learning guides and checklist for skills practice and assessment as per national guidelines			
17.	Set and agree up on date of mentoring visits (E.g. say every Tuesday of every two month)			
Assessment				
18.	Explain that you will do knowledge, skill and attitude assessment using national checklists (Pre, Mid and End of Mentorship)			
19.	Give feedback to the mentee on identified gaps			
20.	Develop an action points based on the gaps identified together			
21.	Agree on the action points and next mentoring visit; clarify on what you will do on the next visit			
22.	Thank the mentee and explain how the mentee can contact you until the next visit and adjourn			
23.	Provide learning resources such as training manuals, national guidelines, learning guides, teaching tools such as videos, mobile apps, work aids, mentors contact address etc.			

Develop a comprehensive mentoring report, share your mentoring report and action plan to the mentee and mentors' facility, RHB, ZHD and Implementing partner with in a week of the mentoring visit.