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MINISTRY OF HEALTH·ETHIOPIA
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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

Integrated Catchment Based Clinical Mentorship for Reproductive, Maternal, Newborn, Child, Adolescent and Youth Health and Nutrition Guideline

Second edition

Maternal, Child and Adolescent Health services LEO
May, 2023

Table of Contents

ACRONYMS

ANC	Antenatal care
BEmONC	Basic Emergency Obstetric and Newborn Care
CBCM	Catchment Based Clinical Mentorship
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CPD	Continuing professional development
DHS	Demographic Health Survey
EmONC	Emergency Obstetric and Newborn Care
MOH	Ministry of Health
FP	Family Planning
HEWs	Health Extension Workers
IESO	Integrated Emergency Surgical Officer
KMC	Kangaroo Mother care
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
PNC	Postnatal Care
RMNCAYH	Reproductive, Maternal, Newborn, Child, and Adolescent and Youth Health
RHBs	Regional Health Bureaus
WoHOs	Woreda Health offices
ZHOs	Zonal Health offices

Foreword

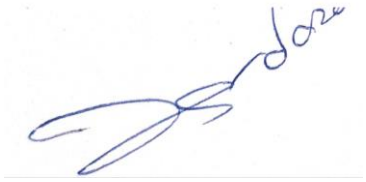
The Government of Ethiopia has pursued its commitments to improve the health and wellbeing of women, children and families by adopting and implementing a series of policies and strategies that ensure all Ethiopians to have access to basic and quality health services. Apart from strengthening the health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

Cognizant of the magnitude of the problem of quality of RMNCAYH-N services and the related maternal mortality and morbidity, the FMOH developed tan integrated Catchment-based RMNCAYH-N 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 RMNCAYH-N service.

The Federal Ministry of Health, with the support of development partners, proved its commitment to institutionalize and operationalize catchment-based RMNCAYH-N mentoring and cascaded its implementation throughout the country. Program reports showed that Catchment based clinical mentorship facilitated referral with in the catchment and again bidirectional post referral feedbacks.

To further standardize the catchment-based Clinical mentoring, To augment the national continuing professional development(CPD) program in the country, the FMOH has developed an integrated RMNCAYH-N catchment based clinical mentorship guide.

Finally, we assure that the Ministry will be committed to support the implementation of this integrated approach Catchment Based Clinical Mentorship (I CBCM) guideline and strongly liaise with stakeholders in any aspects of need.



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Acknowledgment

This Integrated Catchment Based Clinical Mentorship guide is one of the standard materials and will highly guides mentors and their supervisors to improve their mentoring ability to the mentees and as a result it would accelerate access, equity and quality of RMNCAYH services in aligned with the HSTP II strategic directions.

The MCAHS LEO will ensure access to this guideline to all cadres including mentors, supervisors and mentoring facilities. The MOH would like to thank (MSIE, Engender Health, Maternity Foundation, JSI-TPHC&CIFF) for the financial support of the development of this guide. The Ministry would also extend its gratitude to the following experts who have wielded efforts during the guide development process.

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1. INTRODUCTION

Over the last two decades, Ethiopia has made significant progress in improving maternal, newborn, and child health status. According to the UN estimates, maternal mortality has decreased by 72% from 1990`s maternal mortality ratio of 1250 per 100,000 live births to 401 per 100,000 in 2019[1]. Neonatal mortality has also shown significant improvement over the years, from 49 in 2000 to 33 in 2019[2]. Coverage for a skilled birth attendant, antenatal care, and postnatal care has also significantly improved over the years.

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's (2016) assessment findings show low levels of knowledge in key maternal and newborn care areas among midwives and nurses[3]. 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 the newborn. Among nurses, the score was even lower. Although several in-service trainings are widely instituted to upgrade 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 newborn receives at every encounter.

In addition to in-service trainings that offered at various levels, many clinical mentorship initiatives have been implemented to improve the skill and knowledge of health care providers. One of the most successful mentorship programs implemented in Ethiopia, as well as in other countries, is for the integration of HIV/AIDS care into routine services.[4]

In the area of reproductive, maternal and newborn, adolescent & youth health and nutrition services, the government, as well as many partner organizations, has introduced mentorship programs to primarily support health centers. In addition, maternal health, as well as family planning mentorship programs[5], have been implemented and found to be productive. Most of these mentorship approaches used external mentors that are placed at health centers for a specific period of time. These mentorship approaches lacked uniformity and were dictated by the supporting partners' plans and available resources. As these approaches use mentors that are not an integral part of the system,

[1] UN Inter-agency Group for Maternal Mortality Estimation (MMEIG) in Ethiopia, 2019 (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division)

[2] Mini EDHS 2019

[3] Ethiopian Public Health Institute, Emergency Obstetric and New born Care Assessment, 2016

[4] Guideline for HIV care/art clinical mentoring in Ethiopia, 2018

[5] Ministry of Health, special bulletin 22nd annual review meeting, 2020

issues of standardizations, cost, and sustainability have always been at stake.

The Ethiopian Ministry of Health intends to implement a catchment-based clinical mentorship program as a better long-term alternative to contracting external mentors to run mentorship programs. In catchment-based mentorship, the mentors will be selected from within the existing health care system and be responsible for mentoring the facilities within their catchment. In the long-term, it is expected that through strong catchment-based mentorship, each facility will have an adequate number of competent staff that will take up the mentoring role for any beginner staff joining the facility. The Ethiopian Ministry of Health is developing this guideline to standardize the clinical mentorship approaches and to provide guidance for planning and implementation of the program.

2. RATIONALE FOR REVISING OF THE GUIDELINE AS A SECOND EDITION

The rationale behind revising the guideline was prompted considering the following reasons.

- To expand the Scope of clinical mentorship considering the wide range of RMNCAYH-N.
- To align with second Health Sector Transformation Plan (HSTP_II and 2021-2025 RH strategy)
- To standardize clinical mentoring activities for improving quality of RMNCAYH-N services in health facilities.
- The second edition CBCM is organized in to themes

In the long term, it is expected to integrate clinical mentoring with Continuous Professional Development (CPD) where each mentor and mentee gets accredited continuing education units. Each mentoring facility will be responsible in facilitating the integration of CBCM with CPD.

3. CATCHMENT BASED CLINICAL MENTORSHIP

3.1 Goal and Objectives

Goal:

- The goal of the clinical mentorship is to improve the quality of RMNCAYH-N services.

Objectives:

- To guide implementation of catchment-based clinical mentorship program.
- To set standards for catchment-based clinical mentorship monitoring and evaluation.
- To improve the service quality of RMNCAYH-N programs.

3.2 Scope of Clinical Mentorship

Catchment based clinical mentoring for RMNCAYH-N services is implemented based on the national three tiers health care delivery system', the national guideline categorized the program into three levels of clinical mentoring: primary, secondary, and tertiary catchment level mentorship. The essence of this classification is to ensure that the program will address the mentoring need of health care providers in the area of RMNCAYH-N care along the continuum of care across the level of care. Catchment based clinical mentoring programs at tertiary level support their catchment general hospitals, general hospitals support primary hospital, primary hospital health centers and health centers improve the quality of RMNCAYH-N services

3.3 Target audiences

The target of this guideline are:

- ✓ Directorates at MOH, RHBs, Zonal, Woreda health offices, Health facilities, implementing partners, Health care professionals, mentors, and mentees
- ✓ Universities and Colleges and Professional Associations engaged in RMNCAYH-N program support and implementation.

3.4 Concepts of clinical mentoring

Definition of clinical mentoring:

The World Health Organization defines mentoring as "Mentoring is a personal **learning relationship outside of hierarchies** and operations. A **mentor** (an experienced person) allows a **mentee** (a less experienced person) to gain and develop **knowledge, abilities, and maturity** in a **specific position** or a professional area that they share.

Even though there is no single intervention to improve the capacity of individuals, mentoring is one approach to building the competence of individuals. It is known for a long time and serves to help to train and build the capacity of individuals. It can be used at an organizational level as well as an individual level. In recent years, it is widely used in medical and nursing education centers as clinical services require complex clinical skills which require a longer time to master.

Mentoring is a relationship between two people aimed at professional development which is based on mutual respect, trust, and integrity. It is widely used interchangeably with other related approaches such as coaching, supportive supervision, and preceptorship (see table-1 below).

Mentoring

- Growing an individual, both professionally and personally.

Coaching

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

Supportive supervision

- 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.

A preceptor

- is an experienced individual who provides clinical and professional support to facilitate new graduates learning to enable individuals to develop knowledge and competence after someone has recently qualified, or when someone needs to learn a specific skill

CATCHMENT BASED CLINICAL MENTORING (CBCM) is a clinical mentoring approach where both mentors and mentees work in health facilities that have direct referral linkage within a catchment. In the context of Ethiopian health care system structure, catchment based clinical mentoring is believed to be effective and sustainable approach, given that it is tailored to the needs of individual mentees.

3.4.1 CBCM Theory of Change

Health workers need competency for providing quality RMNCAYH-N services. The competencies gaps may affect the quality of care directly and others indirectly.

A theory of change (TOC) explains the relationships between the intervention components needed to achieve the intended result and the assumptions are contextual factors that need to be addressed for effective implementation of the CBCM. Figure 1: illustrates how the clinical mentorship initiative will bring about improvement in providers' competencies and quality RMNCAYH-N services.

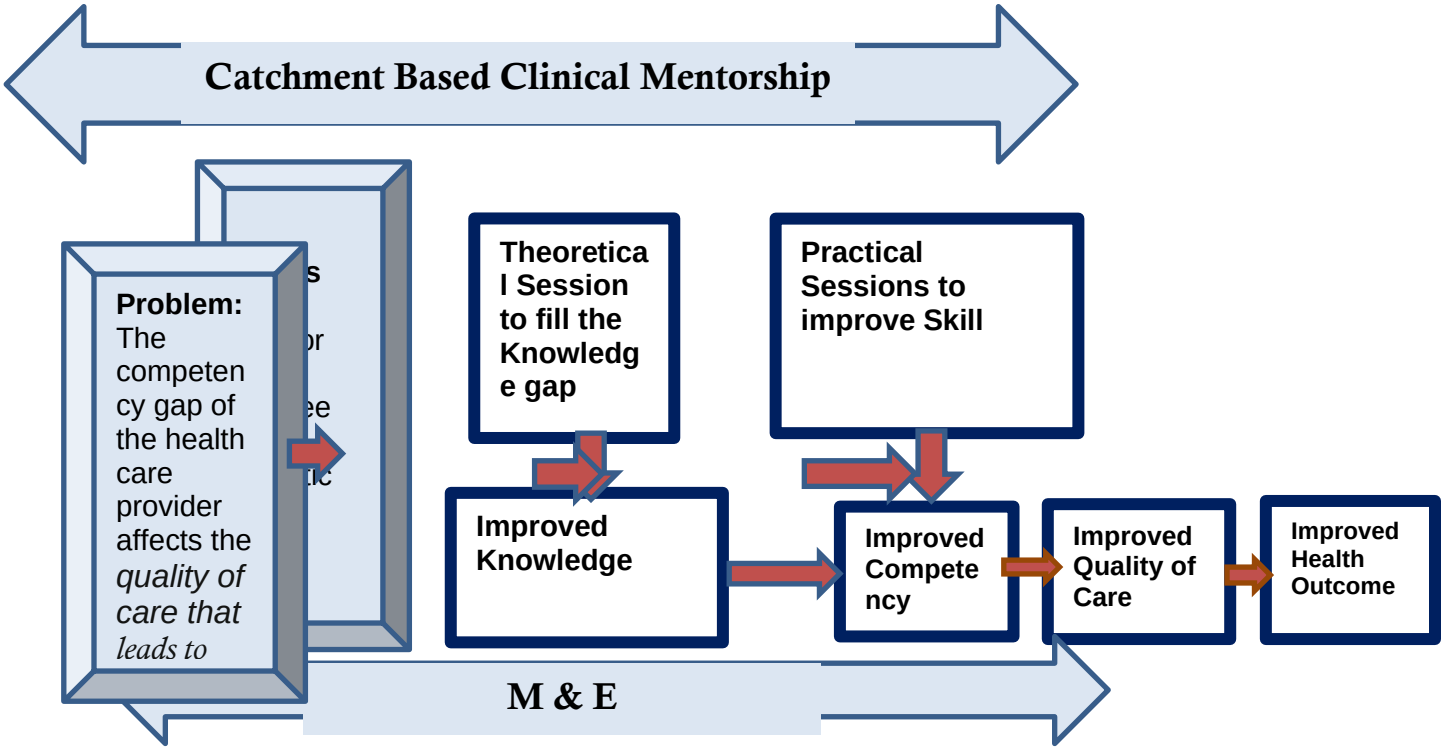

FIGURE 1THEORY OF CHANGE, CBCM

Assumptions for successful CBCM

The effectiveness of CBCM can address the existing wide gaps in skill and knowledge regarding RMNCAYH-N services is primarily based on three basic assumptions:

1. CBCM allows to use of local mentors (clinical expertise) available within a network of health facilities that might have previous experience of supporting each other;
2. Allocation of resources for mentorship program by the regional health bureau
3. Regular support of the health facility managers to achieve the intended result
4. The mentored facility institutionalized mentorship within a short time.

In addition, it complements EHAQ and EPAQ quality initiatives and in-service training initiatives. This mentorship is designed by Leveraging coverage EHAQ initiative.

4. PLANNING AND IMPLEMENTATION OF CBCM

Implementation of CBCM should be planned annually and will be revised biannually at all levels of the health system. The plan should be prioritized depending on the existing needs for mentoring support and capacity to implement (availability of experienced mentors and resources). Then annual implementation plans need to be aligned with respective levels of the health system (MOH with RHBs, RHBs with their respective zones/Woreda, and similarly zone with Woreda and implementing partners at all levels).

During the implementation process, all implementers of CBCM (including mentoring facilities, mentors, and mentees) must adhere to the CBCM principle and standards including the mentor's guide. The quality of the implementation process should be monitored and periodically evaluate by each health management level including MOH, RHBs, and ZHOs/WoHOs, and health facilities.

4.1 Planning Clinical Mentoring

Planning of CBCM encompasses activities including analysis of evidences to identify a need for clinical mentoring (gaps), deciding approaches of mentoring and matching mentors with a mentee, and identify and arranging logistics needed. The mentoring facility should prepare resources to complete a minimum of one mentoring cycle.

4.1.1. Need Assessment

Catchment Based Clinical Mentorship should start with need assessment among catchment health facilities. The aim of the assessment is to determine gaps in competency among healthcare providers of RMNCAYH-N services and specific interventions to address these gaps. The need may arise from newly initiated services, the low performance of the facilities or its districts/zone/regions, and morbidity and mortality data captured through routine reports and supervisions. The findings from the assessment will be used to plan effective mentoring activities aligned with national priorities and existing needs.

The assessment has to be done by the leadership of the RMNCAYH-N program owners (MOH, RHBs, and ZHOs/WoHOs, and health facilities) who will establish a joint team of RMNCAYH-N experts in collaboration with a mentoring team at the mentoring facilities. The team may use various data collection techniques including direct observation, document review, interview, and group discussion.

4.1.2. Selection and Training of Clinical Mentors

Selection criteria for Clinical Mentors (Who Should Be a Mentor?)

In this guideline, a clinical mentor is an experienced professional and currently practicing RMNCAYH-N service. Health Facilities select a proficient mentor to be a mentor using criteria listed in the table-2

T a b l e - 1 Criteria for selection of clinicians to serve as mentors by level

Level-3 Tertiary Hospital CBCM	**Level-2 General Hospital CBCM**	**Level-1PHCU CBCM**
-A team of well experienced Obstetrician/ Gynecologist, IESO, pediatrician, Masters in RH, MSC Clinical Midwife, Master in Nutrition Who is currently engaged in provision of care -A well experienced midwife, a clinical nurse who is currently engaged in reproductive, maternal, newborn and child care adolescent and youth and nutrition services delivery **In addition, the mentor should:** • Have current training on mentorship. • Be willing to share experience, resources, and knowledge and career development skills with the mentee. • Have the capacity to gather and analyze information	- A team of well experienced general practitioner, IESO, MSC Clinical Midwives, midwife, a Health officers, clinical nurse who is currently engaged in reproductive, maternal, newborn and child care adolescent and youth and nutrition services delivery **In addition, the mentor should:** • Have current training on mentorship. • Be willing to share experience, resources, and knowledge and career development skills with the mentee. • Have the capacity to gather and analyze information.	- A team of well experienced general practitioner, IESO, MSC Clinical Midwives, midwife, a Health officers, clinical nurse who is currently engaged in reproductive, maternal, newborn and child care adolescent and youth and nutrition services delivery **In addition, the mentor should:** • Have current training on mentorship. • Be willing to share experience, resources, and knowledge and career development skills with the mentee. • Have the capacity to gather and analyze information.

Training of Mentors

The main aim of mentor`s training is to standardize skills and knowledge among mentors and to ensure that they are competent to conduct effective mentoring sessions. Therefore, mentors training shall provide using the approved national mentors training manual.

4.1.3. Selection of Health Facility and Mentee

Selection of mentee health facility

In every catchment, the number of available mentors and resources including logistics determines the number of health facilities from where mentees are selected for one cycle of mentorship period. Therefore, priority should be given to:

- Health facilities with low performance or a high number of referrals
- Health facilities with unacceptable complications due to competency gap
- Distance and availability of transportation (hard to reach areas)

Selection of Mentee

A mentee should fulfill the following conditions:

- Mentee should be engaged in provision of RMNCAYH-N services and permitted to do their respective scope of practices.
- If health care provider scores between 50-84% in knowledge asseeemnet he/she eligible to be a mentee.
- If health care providers scored below 50 % in knowledge assessment, he /she will be eligible for onsite/ offsite basic trainings
- If the health care provider scores **> =85 %** in knowledge assessment, he She will go for skills assessment and if he/she is not competent in a certain procedure. If competent he/she will not be eligible to be a mentee

NB: Mentees are expected to continue providing the service and also share their experience for peers

Table-2 Decision making matrix for selection of mentee

S.N	Knowledge Assessment outcome and decision	
	Score/100	**Decision**
1	• <50%	He/she is not eligible to be a mentee. Needs basic training (Onsite/offsite)
2	• ***50-84%***	*Eligible to be a mentee for clinical mentoring both knowledge and skill*
	• ***>=85***	In the knowledge assessment he/she is not eligible to be a mentee, however skill assessment should be provided to them to check their skill competency. If he/she is competent, exclude from mentorship. if he/she not competent they will be eligible to be a mentee

For the skills assessment use the following definitions (competent and not competent)

N.B. Not competent- means. If he/she misses critical steps in skill demonstration (the critical steps are to be determined by the mentors)

Competent - If he/she completely addresses all the critical steps in the skill demonstration (the critical steps to be determined by the mentors)

4.2. Implementing CBCM

4.2.1. Initiation of Catchment Based Clinical Mentoring

The ultimate goal of the catchment-based clinical mentorship initiative is to establish clinical support at the catchment level that continuously assesses and addresses gaps in skill, knowledge, and attitudes among health care providers working in the area of RMNCAYH-N services. Catchment level clinical mentoring is a continuous clinical competency building consisting of a cycle of four key steps including **identifying, acting, monitoring, and evaluating the change**. The CBCM is focusing on reproductive, maternal and newborn, child adolescent, youth health and Nutrition services along the continuum of care. This requires institutionalizing clinical mentoring, as part of a continuous professional development initiative, into routine functions of the health system.

Catchment-based mentoring will be conducted in Ethiopia using the already existing Ethiopian primary health care service Alliance for Quality (EPHAQ) and Ethiopian Hospitals Alliance for Quality (EHAQ) platforms.

4.2.2 Mentoring Team Composition

Once a health facility is selected to initiate clinical mentoring for RMNCAYH-N services in its catchment, it can organize a clinical mentoring team composed of an experienced team in each specific service area. They should be selected based on the criteria indicated in the mentor's selection criteria above. The composition of the team may vary from thematic areas of mentoring package and facility to facility across the levels of catchment mentorship for RMNCAYH-N services. The mentoring team could be 2-4 members from various experts.

4.2.3. Clinical Mentoring Package by Thematic Areas

The guideline will integrate clinical mentoring by organizing mentoring package by the thematic area. Listed below recommended the minimal clinical mentoring packages:

- Maternal, PMTCT, newborn health, EPI, Adolescent and youth RH service and Nutrition
- Sick newborn, Child Health Service and Nutrition
- Family Planning, Adolescent and youth RH service, EPI and Nutrition

NB: Whenever possible and applicable, it is recommended to use an integrated mentoring package where thematic areas are integrated.

4.2.4. CBCM implementation modality

There are various modalities of implementation of CBCM; however, on-site mentoring is the mainstay modality of implementation. This approach is recommended since it allows mentees to learn while continuing to provide services in their respective sites. However, if on-site mentoring is found to be difficult, it is possible either to mix it with the off-site approach or use the off-site mentoring approach alone depending on Mentoring Approach Decision-Making Matrix described the Table 4. There are different types of mentoring such as One to one mentoring, Group mentoring, Team mentoring, Peer mentoring, and joint mentoring.

Table -3 Mentoring Approach Decision-Making Matrix for onsite and off site

Factors		**On-site mentoring**	**Mixed**	**Off-site**	**Supplemented with**	
					Consultation through Phone call/text message	**telemedicine**
Is there adequate number of cases for practical exercises available at mentee`s site	Yes	X			x	
	No		x		x	
Cost of visiting the mentee`s facility compared to Placing mentee at mentoring health facility e.g. Remote health facility	Higher			x	x	
	Lower	X			x	

On-Site Mentoring

On-site Mentoring- is a common approach to catchment-based clinical mentoring where face-to-face or in-person clinical mentoring is provided at mentee facility. It is easier for mentees to integrate new skills and practices in the facility when they can be put to use immediately. In addition, mentees may be more comfortable in their environment and are likely to easily initiate the clinical services and maintain their competencies. For mentors, there are likely to be fewer distractions, and being on-site makes it easier to tailor support to

mentees' needs. For follow-up over time, mentors can see firsthand how the new skills are being developed.

This approach differs from shadowing in that it is about sharing or demonstrating the way things are done within the mentee's facilities.

Off-site mentoring

Off- site mentoring- is an approach to catchment-based mentoring where face-to-face or in-person clinical mentoring is provided on the site of the mentors' facilities.

Off-site mentoring can be considered:

- if the mentees' facility does not have the resources or the clinical set-up to ensure appropriate follow-up to integrate the new skills and practices into its work,
- The mentees' facility is not yet providing the intended services or there is no adequate cases flow.

It is recommended to shift from off-site to on-site mentoring as the mentees' facility improved (the resources or the clinical set-up and the case flow improved).

Virtual mentoring

Virtual mentoring refers to any mentoring activity that does not take place face-to-face. This includes video conferencing, telephone, email, and text messaging. Both on-sites and off-sites mentoring can be supplemented with virtual mentoring. Virtual mentoring can keep the mentoring relationship active while still allowing for productive interactions between mentors and mentees. A virtual program has some clear advantages – for example, the ability to provide mentoring access to anyone, anytime, opens mentoring to people working in different and multiple locations. However, virtual mentoring will not be a standalone mentoring approach.

4.2.5 Approach for Catchment Based Clinical Mentoring

Empirical evidences indicate that, nowadays, clinical mentoring is considered as part of the continuum of education required to create competent healthcare providers. It is widely used not only to address gaps in competencies of healthcare providers but also in keeping the quality of care during the implementation of task shifting/sharing and scaling up of health services to improve access to health care. In general, its success is dependent on the extent to which its design and implementation adapted to the local context, the ownership, and the support of leadership and management structures. Hence, the design of this clinical mentoring approach for RMNCAYH-N services and the implementation modalities is based on the three-tier health care delivery system as well as the catchment-based networking of health facilities.

For this purpose, the MOH has developed a mentor guide that direct the clinical mentoring approach these include **one on one case management observation**, **review of medical records**, **clinical case review, discussions, multidisciplinary team meeting, and documentation**, etc. that mentor should adhere to during implementation.

4.3. Implementation Standards

4.3.1. Matching Mentor to Mentees

Every facility is different according to the number of mentees, the type of facility and the service delivery thematic area.

In order to have an effective clinical mentoring, at one mentoring cycle (3-6 months):

- Mentors have to use integrated mentoring package using recommended minimal clinical mentoring packages
- A mentor should not be assigned to mentor utmost two to three mentees per health facilities.
- A mentor shouldn`t conduct mentoring in more than two health facilities within catchment
- A mentee should not be mentored for two or more thematic area at a time.

4.3.2. Timelines of Mentoring (Duration, Frequency of Contacts)

According to this guide, one cycle of mentoring may last between 3 to 6 months depending on the extent of gaps in the knowledge and skill among the healthcare providers (need identified during the baseline assessment) and targeted clinical services. After the initial visit, the mentor should conduct a minimum of one site mentoring every month for the remaining months. The duration of stay during each visit should be 5 working days excluding travel days. The purpose and objective of each mentoring visit have been outlined in the mentor's guide.

4.3.3. Resources for CBCM planning, implementation and evaluation

Resource materials including national training materials, clinical guidelines and references, pocket guide and tools can be used during clinical mentoring. The national training manual for the CBCM (Participant Manual) that has been approved by MoH should be used as a resource for mentors. Mentors need to be familiar with the relevant clinical protocols, recommended and used by all health care workers.

To ensure that mentors are sharing or transferring the most up-to-date, relevant, and accurate knowledge and skills to their mentees, the content of the mentoring sessions should be prepared according to national guidelines, clinical protocol, and services standards that are in use in the area of RMNCAYH-N health services delivery. In addition, the mentors` guide should be used as a reference during the implementation of clinical mentoring.

The CBCM uses the routine formats and registrations to facilitate/systematizes planning, implementation and monitoring, and evaluation at all levels. There are two types of tools (general and specific tools) that are annexed in the mentor guide.

5. FINANCIAL ARRANGEMENT

Budgeting for mentorship initiative should be included in the annual health budget plan at regional, zonal, Woreda as well as health facilities. The budget includes initiative and operational costs that are necessary for planning, implementation and monitoring, and evaluation of the initiative. The following cost items should be arranged.

- Perdiem
- Budget for supportive supervision
- Budget for review meeting: bi-annual at the regional level and quarterly at zonal level
- Budget for communication, fuel, printing of formats and tools

6. MONITORING AND EVALUATION OF THE INITIATIVE

It is essential to continuously assess whether the mentorship initiative 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 RMNCAYH-N service delivery at large. Timely monitoring of progress will allow for appropriate changes to be instituted as needed on time.

6.1 Assessment of performance of the mentee

Assessment of the knowledge and skill of the mentee should be conducted at the beginning, middle, and end of the mentorship initiative. Assessment of the performance of the mentee includes assessment of the knowledge and skill at the beginning, middle, and end of the mentorship program. Timely monitoring of the progress of the mentee's performance will allow appropriate changes to be instituted as needed in a timely manner. These should be done through self-assessment by the mentee as well as by the mentor.

6.2 Assessment of the mentorship initiative

Assessment of the mentorship initiative can be done by conducting periodic supportive supervision as well as review meetings.

6.2.1. Supportive Supervision

Supportive supervision should be conducted jointly by the program team in the respective woreda, zone, and region and by the mentorship team at least once every three months to follow on the progress of the mentorship initiative. 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 enrolled and successfully completed the mentorship initiative.

6.2.2. Review Meeting

Review meetings will be conducted bi-annually at regional level and every three months at the Woreda level or catchment level.

Key areas of discussion during review meetings should include:

- Progress of the mentorship initiative
- Challenges faced
- Possible solutions

6.3 Reporting

The mentors will report using the mentorship reporting format in monthly basis following each mentoring visit and summit to the mentee facility, mentoring facility and woreda health office. The woreda health office submits quarterly report to zonal health department and then ZHD report to RHB. Finally, the RHB compile and submit the annual report to MoH.

Table-4 Key Performance Indicators:

S/N	Indicators	Data sources	Frequency of data collection	Responsible body	Information Use/Audience
1	Number of mentees enrolled	Mentoring Report Monthly Report	Monthly	Mentors	Mentoring Facility, Woreda, zonal and Regional Health bureau, MOH
2	# Of mentees mentored	Mentoring Report Quarterly report Annual Report	Monthly, Quarterly, Bi-annual	Mentor, Mentoring HF	Mentoring Facility, Woreda, zonal and Regional Health bureau, MOH
3	Proportion of mentees graduated	Mentoring Report Quarterly report Annual Report	Every three to six months	Mentor, Mentoring HF	Mentoring Facility, Woreda, zonal and Regional Health bureau, MOH
4	Number of health facilities mentored	Mentoring Report Quarterly report Annual Report	Every three to six months	Mentor, Mentoring HF	Mentoring Facility, Woreda, zonal and Regional Health bureau, MOH
5	Number of health facilities that have mentees graduated and	Mentoring	Every three to six	Mentor, Mentoring HF	Mentoring Facility, Woreda, zonal and Regional Health

	have become mentors	Report Quarterly report Annual Report	months		bureau, MOH
6	# health facility/catchment supervised	Supervision report Quarterly Report Annual Report	Every three months	Mentoring Facility, Woreda, zonal and Regional Health bureau	Mentoring Facility, Woreda, zonal and Regional Health bureau, MOH
7	# Of review meetings held	Review Meeting report Quarterly Report Annual Report	Every three months	Mentoring Facility, Woreda, zonal and Regional Health bureau	Mentoring Facility, Woreda, zonal and Regional Health bureau, MOH
8	Number of monthly reports submitted to the next administrative level	Monthly report Quarterly Report	Monthly, Quarterly Annually	Mentor, Mentoring HF	Mentoring Facility, Woreda, zonal and Regional Health bureau, MOH
9	Trend over time in the number of referrals made	Monthly Mentoring Report Quarterly Report Annual Report	Monthly Quarterly	Mentor, Mentoring HF	Mentoring Facility, Woreda, zonal and Regional Health bureau, MOH
10	Tool developed, printed and distributed (Guideline, Mentor`s pocket guide)	Guideline distribution report	Annually	MOH, RHB, Zonal and Woreda Healthy office	Woreda, zonal and Regional Health bureau, MOH

6.4 Promote best practices and operational research

Promote operational research

Operational research likewise is needed to develop best practices and assess the validity of the developed mentorship tools and to evaluate the impact of mentorship. In addition, new tools need to be tested for the validity of the information and reliability of the mentorship tool to improve the quality of the mentorship at all levels across the RMNCAYH-N continuum of care.

Identify best practices and communicate

The national and regional experts are expected to evaluate local and international experiences regularly to identify best practices on RMNCAYH-N mentorship.

7. ROLE AND RESPONSIBILITIES

Ministry of Health (MOH)

- Develop and update mentorship guidelines, training materials for mentors and dissemination.
- Resource mobilization for RMNCAYH-N mentorship imitative
- Lead and facilitate RMNCAYH-N partnership among different stakeholders to complement Mentorship imitative.
- Facilitate partners mapping to avoid duplication
- Conduct research on the impact of RMNCAYH-N mentorship.
- Integrate RMNCAYH-N mentorship initiative at national level review meetings, with other relevant directorates with in the ministry,
- Monitor the implementation of the initiative, evaluate and scale up

Regional Health Bureau

- Identify and designate a focal person for RMNCAYH-N mentorship initiative
- Disseminate RMNCAYH-N SOP, training manuals, formats and tools to zonal health departments, Woreda health offices and health facilities.
- Mobilize resources (including budget) for RMNCAYH-N mentorship implementation
- Facilitate partners mapping to avoid duplication
- Advocate on RMNCAYH-N scale up and expansion in all health facilities in the region.
- Coordinate the capacity enhancement for RMNCAYH-N staffs and engagement of stakeholders to complement the RMNCAYH-N mentorship initiative
- Guide and monitor implementation of the RMNCAYH-N mentorship initiative in their respective Zone health departments and health facilities.
- Monitor and evaluate the implementation of the RMNCAYH-N mentorship initiative

Zonal Health Department

- Identify and designate a focal person for RMNCAYH-N mentorship initiative
- Allocate budget for the mentorship initiative.
- Coordinate resource mobilization (secure budget) for the initiative together with development partners in the respective Zone.
- Overall led and guide RMNCAYH-N mentorship implementation all woreda in zone.
- Monitor and evaluate the implementation of the RMNCAYH-N mentorship initiative.
- Disseminate RMNCAYH-N SOP, training manuals, forms and tools to zonal health departments, health offices and health facilities.
- Ensure documentation of the implementation of the RMNCAYH-N mentorship.
- Document lessons learned and best practice from the implementation of the RMNCAYH-N mentorship.

Woreda Health Office

- Identify and designate a focal person for RMNCAYH-N mentorship
- Avail RMNCAYH-N mentorship guideline, training manuals, SOP and monitoring tools.
- Allocate budget for the mentorship initiative.
- Ensure allocation of resources and collaborate engagement to complement the mentorship initiative.
- Select health facilities to be mentored by Hospitals
- Coordinate transportation
- Document lessons learned and best practice from the implementation of the RMNCAYH-N mentorship.

Mentoring Facility

- Identify and designate a focal point for RMNCAYH-N mentorship initiative
- Assess, plan, and prepare schedule for catchment health facilities
- Allocate budget and related resources for mentorship initiative.
- Organize review meeting with health facilities in the catchment area.
- Conduct supportive supervision on the implementation of the catchment based RMNCAYH-N mentorship initiative.
- Generate progress report on RMNCAYH-N mentorship initiative, including proper documentation.
- Arrange logistics, including transportation and appropriate formats are available for mentors.
- The facility would involve during selection of health facility and mentor
- Ensure documentation of all activities related to the implementation of the RMNCAYH-N mentorship.

- Ensuring the presence of functional RMNCAYH-N mentorship team

Mentee Facility

- Collaborate the mentoring facility with transportation services and fuel as needed
- Closely monitor implementation of the mentoring initiative
- Support smooth communication between mentor and mentee
- Participate in regular review meeting
- Ensure availability of supplies and equipment's needed for mentorship initiatives
- Ensure availability of SOP, job aids, checklists, tools,
- Ensure documentation of all activities related to the implementation of the RMNCAYH-N mentorship.
- Support the graduated mentee to mentor their peers.
- Identify and document best practices in RMNCAYH-N mentorship

Partner Organizations

- Provide technical and financial support for the mentorship implementation
- Align their mentoring plan with respective government health system at all levels
- Support sustainability of mentorship for RMNCAYH-N services at catchment levels
- Provide technical support in implementation of mentoring at national, regional and facility levels
- Support training of mentors
- Support disseminate RMNCAYH-N SOP, training manuals, forms and tools to zonal health departments, health offices and health facilities.
- Document lessons learned and best practice from the implementation of the RMNCAYH-N mentorship

Mentor

- Establish effective communication with mentee, other clinical staffs and patients/clients
- Implement key mentoring activities/standards, focusing on RMNCAYH-N services and obstetric referral.
- Conduct baseline, mid-term and end-term Assessment
- Arrange the working set up in collaboration with mentee
- Develop actions plans for each visit
- Conduct mentoring and coaching
- Produce and submit monthly report to mentee facility, woreda and his/her facility
- Provide written feedbacks at the end of each visit
- Arrange respectful and good working atmosphere for mentorship
- Identify and document lessons learned and best practice from the implementation of the RMNCAYH-N mentorship

Mentee

- Complete self-assessment on knowledge and skills in RMNCAYH-N service.
- Develop action plan based on identified gaps in collaboration with mentor
- Demonstrate effort to learn and acquire the expected skills.
- Actively participate in the RMNCAYH-N mentorship initiative.
- Demonstrate commitment in carrying out assignment.
- Arrange respectful and good working environment for mentorship.
- Willing to learn and accommodate constructive feedback
- Be adaptable and flexible for the mentorship challenges

ANNEXES

Annex1: Indicator reference sheet

	Type of Indicators	Source of data	Frequency	Responsible
Input Indicator	RMNH mentorship guide line developed.	Administrative report	Once	MOH
	RMNH monitoring tools /primary hospital,health center checklist/ developed	Administrative report	Once	MOH
	Qualified expertise's in RMNH mentorship initiatives	Administrative	Once	MOH, RHB
	Budget allocated	Annual plan	Biannual	MOH, RHB, ZHD, Hospitals, Woreda Health centers
Output Indicators	# of Supportive supervision Visit conducted	Administrative Report	Quarterly report	RHB, ZHD, Hospitals and Health centers

# of review meeting conducted	Administrative Report	Quarterly	FMOH, RHB
# of mentors trained	Activity report	Quarterly	FMOH, RHB
# of catchment meeting conducted	Administrative report	Monthly	Hospitals and health

center	# of Mentees mentored	Routine activity report	Annual	Hospital, Health
	% of health facilities enrolled in mentorship initiatives	Routine activity reports FMOH	Quarterly	ZHD, RHB and
	% hospitals providing RMNH mentorship initiatives	Administrative activity report	Biannual	ZHD and RHB
Outcome indicators	% of health facilities graduated in mentorship initiatives	Administrative report ZHD and Region	Biannual	Hospital, Woreda,
	Increased RMNH service utilization	HMIS	Routine	Health Facility
	Increased proportion of skilled birth by health personal	HMIS	Routine	Health facility
	Decreased proportion of still birth	HMIS HMIS	Five years Routine	Health Facility Health facility
	Decreased proportion of postpartum sepsis			
	% of health facility readiness	SARA	Annual	EPHI

Annex 2: CBCM Implementation report template

Reporting template by the Region

Region :		
Woreda/ Sub city:		
Details of the mentor facility (hospital CEO, Hospital phone #		
Name of Mentor Facility		
Name (#) of health facilities mentored in the reporting period	Name	
	Number	
Total # of mentees enrolled		
Total number of Mentees graduated		
Reason for the mentees not graduated in the mentoring process		
List Major RMNCAYH program related gaps identified before initiating the mentorship process	List/write any skill gaps providers have on MH, FP, CH, AY & RH, EPI, PMTCT, Nutrition.	
List Major RMNCAYH program related supply, equipment and any pother IF related gaps identified before initiating the mentorship process	List/write any supply, commodity and or equipment in the facility Has	
List Major RMNCAYH program related skills , knowledge providers proven improved		
List Major RMNCAYH program related supply, equipment and any pother IF related gaps solved after mentorship		
Major positive response on the mentoring process		
Changes observed in the mentee facility at the end of mentoring period		
Any major challenge identified during the mentoring process		

2.Reporting temple by the woreda

Region :		
Woreda/ Sub city:		
Details of the mentor woreda health office head phone #		
Name of Mentor Facility		
Name (#) of health facilities mentored in the reporting period	Name	
	Number	
Total # of mentees enrolled		
Total number of Mentees graduated		
Reason for the mentees not graduated in the mentoring process		
List Major RMNCAYH program related gaps identified before initiating the mentorship process	List/write any skill gaps providers have on MH, FP, CH, AY & RH, EPI, PMTCT, Nutrition.	
List Major RMNCAYH program related supply, equipment and any pother IF related gaps identified before initiating the mentorship process	List/write any supply, commodity and or equipment in the facility Has	
List Major RMNCAYH program related skills , knowledge providers proven improved		
List Major RMNCAYH program related supply, equipment and any pother IF related gaps solved after mentorship		
Major positive response on the mentoring process		
Changes observed in the mentee facility at the end of mentoring period		
Any major challenge identified during the mentoring process		

Reporting template by the mentor

Region :		
Woreda/ Sub city:		
Details of the mentor Name Phone #:		
Name (#) of health facilities mentored in the reporting period by the mentor	Name	
	Number	
Total # of mentees enrolled		
Total number of Mentees graduated		
Reason for the mentees not graduated in the mentoring process		
List Major RMNCAYH program related gaps identified before initiating the mentorship process	List/write any skill gaps providers have on MH, FP, CH, AY & RH, EPI, PMTCT, Nutrition.	
List Major RMNCAYH program related supply, equipment and any pother IF related gaps identified before initiating the mentorship process	List/write any supply, commodity and or equipment in the facility Has	
List Major RMNCAYH program related skills , knowledge providers proven improved		
List Major RMNCAYH program related supply, equipment and any pother IF related gaps solved after mentorship		
Major positive response on the mentoring process		
Changes observed in the mentee facility at the end of mentoring period		
Any major challenge identified during the mentoring process		

Reporting template by the mentor facility

Region :		
Woreda/ Sub city:		
Details of the mentor facility (hospital CEO, Hospital phone #		
Name of Mentor Facility		
Name (#) of health facilities mentored in the reporting period	Name	
	Number	
Total # of mentees enrolled		
Total number of Mentees graduated		
Reason for the mentees not graduated in the mentoring process		
List Major RMNCAYH program related gaps identified before initiating the mentorship process	List/write any skill gaps providers have on MH, FP, CH, AY & RH, EPI, PMTCT, Nutrition.	
List Major RMNCAYH program related supply, equipment and any pother IF related gaps identified before initiating the mentorship process	List/write any supply, commodity and or equipment in the facility Has	
List Major RMNCAYH program related skills , knowledge providers proven improved		
List Major RMNCAYH program related supply, equipment and any pother IF related gaps solved after mentorship		
Major positive response on the mentoring process		
Changes observed in the mentee facility at the end of mentoring period		
Any major challenge identified during the mentoring process		

Annex 3: Tools for RMNCAY-N Catchment Based Clinical Mentorship

The purpose of the RMNCAY-H area tools

This document provides guidance on using specific tools to all mentorship implementing organizations in general and the public health sector in particular, especially for individual mentors while conducting mentorship. The tool contains respective checklists that can be used for facility assessment, and also enhances provider's knowledge and skill for maternal health, family planning, CAC, AYRH and child health service. Hence; the tool:

- Reviews important steps and provides practical guidance for mentors on the introduction of specific tools;
- Helps mentors to refer related documents and get prepared ahead of the actual mentoring time;

RMNCHAY_N Mentorship

Health Facility Baseline Assessment tool for RMNCHAY_N Mentorship

Health Facility Information

Region:	**Zone:**
Woreda:	**Kebele:**
Name of mentee Health facility	**Catchment population:** **Expected pregnancy/delivery:**
Type of health facility	☐ Non PMTCT site ☐ PMTCT only site ☐ PMTCT and ART site
Name of mentor health facility	Distance to catchment hospital_____Km.
Date of Facility Assessment (dd/mm/yy):	
Name of mentor	Telephone /email

Human Resources (health professionals)

Profession	**Total #**	**Training attended since last three years**
General practitioners		☐BEmONC ☐PMTCT ☐ CAC ☐ MPDSR ☐RMC ☐PPFP ☐IMNCI ☐ FP ☐ MIYCF
IESO		☐BEmONC/ ☐PMTCT ☐ CAC ☐ MPDSR ☐RMC ☐PPFP ☐IMNCI ☐ FP ☐ MIYCF
Health Officer		☐BEmONC ☐PMTCT ☐ CAC ☐ MPDSR ☐ MIYCF ☐RMC ☐PPFP ☐IMNCI ☐ FP
BSc Nurse		☐BEmONC ☐PMTCT ☐ CAC ☐ MPDSR ☐ MIYCF ☐PPFP ☐IMNCI ☐ FP
BSc Midwife		☐BEmONC ☐PMTCT ☐ CAC ☐ MPDSR ☐ MIYCF ☐RMC ☐PPFP ☐IMNCI ☐ FP
Nurse (Diploma)		☐BEmONC ☐PMTCT ☐ CAC ☐ MPDSR ☐ MIYCF ☐RMC ☐PPFP ☐IMNCI ☐ FP
Midwife (Diploma)		☐BEmONC ☐PMTCT ☐ CAC ☐ MPDSR ☐ MIYCF ☐RMC ☐PPFP ☐IMNCI ☐ FP
Pharmacy tech.		☐ IPLS ☐ Other related trainings (Specify)_____

Lab Tech.		☐ Gene expert (for POC for HIV EID) ☐ Other related trainings (Specify)_____

Service Availability

Maternal and Neonatal Health Services

S. No.	Type of service	Available		Comment
Maternal and Neonatal Health Services		**Yes**	**No**	
1.3.1	ANC service			
1.3.2	Delivery			
1.3.3	Essential New Born care			
1.3.4	Post-Natal			
1.3.5	PPFP			
1.3.6	C/S			
1.3.7	Post abortion care			
1.3.8	Safe abortion care			
1.3.9	Does this facility have pharmacy/drug store and dispensary separately			
1.3.10	Is the pharmacy/drug store accessible 24/7 hours?			
1.3.11	Does this facility have maternity waiting home?			

EmONC Signal Functions

EmONC signal functions	**Performed in past 3 months? (Y//N)**	**If not performed in past 3 months, specify the reason for each signal function from the listed below** 1) HR/training issues 2) Supplies, equipment, drug issues 3) Management issues 4) Policy issues **5)** No indications **6)** Other ---------
1. Administer parenteral antibiotics (IV Ampicillin, Gentamycin, Metronidazole)	Yes No	
2. Administer Uterotonic drugs (e.g., parenteral **oxytocin**, ergometrin,	Yes No	
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (e.g., **magnesium sulphate**)	Yes No	
4. Perform manual removal of placenta	Yes No	
5. Perform removal of RPC (Retained Parts of Conceptus) (e.g., manual vacuum aspiration,	Yes No	
6. Perform assisted vaginal delivery (e.g., vacuum extraction,)	Yes No	
7. Perform newborn resuscitation	Yes No	
8. Perform C/S	Yes No	
9. Perform blood Transfusion	Yes No	
Other maternal		
10. Provider use partograph	Yes No	
11. Apply NASG (Non- pneumatic anti-shock garment) for PPH	Yes No	
12. apply Uterine Balloon tamponade	Yes No	
13. Administer Tranexamic acid (TxA)	Yes No	
13. Provide Postpartum family planning method	Yes No	

Availability of Essential Drugs and Supplies

	Items	**Yes**	**No**	**Remarks**

Antibiotics	Amoxicillin / Ampicillin			
	Ceftriaxone			
	Clindamycin			
	Cloxacillin Sodium			
	Erythromycin			
	Metronidazole (Injection)			
	Gentamycin (Injection)			
	Ampicillin (Injection)			
	Penicillin G (Benzyl)			
	Benzanthine Penicillin			
	Cotrimoxazole			
	TTC eye ointment			
	Chlorohexidine ointment (cord care)			
Anticonvulsants	Magnesium Sulfate (Injection)			
	Diazepam (Injection)			
Antihypertensive	Hydralazine			
	Methyldopa			
	Nifedipine			
uterotonics	Oxytocin			
	Ergometrin (Injection)			
	Misoprostol			
	Carbitocin			
Emergency drugs	Adrenaline			
	Aminophylline			
	Atropine sulfate			
	Calcium gluconate			
	Digoxin			
	Diphenhydramine			
	Ephedrine			
	Frusemide			
	Hydrocortisone			
	Naloxone Hydrochloride			
	Nitroglycerine			
	Promethazine Hydrochloride			
Anesthetics	Lignocaine/ Lidocaine 2% or 1%			
	Ketamine			
	Bupivacaine			
	Thiopental			
	Halothane			
	Propofol			
Analgesics	Acetylsalicylic acid (ASA)			
	Indomethacin			
	Paracetamol			
	Pethidine hydrochloride			
	Diclofenac			

	Ibuprofen			
Steroids	Betamethasone			
	Dexamethasone			
	Prednisolone			
IV fluids	Dextrose in water 5%(DW)			
	Dextrose in normal saline (DNS)			
	Glucose 40%			
	Normal saline			
	Ringer Lactate			
Antimalarials	Chloroquine			
	Coartem (artemether-lumefantrine)			
	Quinine			
	Artesunate (Amodiaquine)			
Other Drugs	Vitamin K (for newborn)			
	ORS			
	Iron folate			
	Mebendazole/Albendazole			
	TD			
	Anti- Rho (D) Immune globulin			
	Mife +miso			
Equipment and supplies	BP cuff			
	Stethoscope (Adult)			
	Fetoscope			
	Thermometer			
	Adult ventilator bag and mask			
	Baby weight scale			
	Wheel chair			
	Heater			
	Newborn corner			
	Beds			
	PPE (Mask, cape, goggle, plastic apron, boots and gown)			
	Screen			
	Delivery coach			
	Towel for new born			
	Blanket			
	cord tie			
	Elbow length glove			
	Glove			
	Syringe with needle			
	Syphilis test kit			
	Hepatitis B test kit			
	C/S kit			
	Complete Delivery sets (in number)			
	(PPH, Pack			

	Preeclampsia Eclampsia			
	Episiotomy/ perineal tear repair set (In number)			
	Vacuum extractor (Electrical/Manual)			
	MVA sets (Ipas MVA syringe and cannulas Tenaculum, speculum, sponge forceps)			
	Mucus extractor			
	Infant face mask (size 0,1,)			
	Adult Ambubag			
	Pediatric Ambubag			
	Suction catheter			
	Suction apparatus			
	None Pneumatic anti-shock garment (NASG)			
	Low level Forceps			
	Uterine balloon tapenade			

Guidelines and protocols

		Yes	No	Remark
Guidelines, protocols and Job aids	Partograph			
	MgSO4 Protocol			
	BEmONC Manual			
	Helping baby breath (HBB)			
	Antenatal care guideline			
	CAC manual			
	Technical and procedural guidelines of Safe abortion services			
	Obstetric management protocol			
	Family planning guideline			
	PNC 24 hours care and stay implementation guideline			
	Maternity waiting home implementation guideline			
	Infection prevention guideline			
	Obstetric referral protocol			
	Fistula screening algorithm			
	Counseling job aid (Laminated REDI counseling framework)			
	Pregnancy Screening checklist Job aid			
	FMOH Safe abortion care service guidelines			
	FMOH Infection prevention guidelines, New guideline			
	IP Wall Chart/Job aids			
	CAC post service brochure			
	Audio visual aids			
Registration	ANC register			
	Delivery register			

	PNC register			
	CAC Register			
	Surgery register			
	referral register or log book			
	Reporting formats			

MNH service in the last 3 months	**Performance indicators/ Data element**		**3rd month**	**2nd month**	**1st month**
	Total number of women enrolled to ANC1				
	Total number of women completing ANC 4				
	Total number of women completing ANC 8				
	Total number of pregnant women provided nutritional screening and counseling				
	Total number of normal deliveries				
	Total number of women delivered with C/S				
	Total number of PAC conducted				
	Total number of SAC conducted				
	Number of newborns got essential care				
	Number of newborns resuscitated				
	Proportion of newborns resuscitated and survived				
	Total number of assisted instrumental deliveries				
	Total number of assisted Breech deliveries				
	Number of postnatal women stayed for 24 hours in the health facility				
Cases of Obstetric and neonatal complications seen, managed or referred during the last 3 months	Complications	# of cases seen	# of cases managed	# Of cases referred	# Of deaths
	Women with APH				
	Women with PPH				
	Ruptured uterus				
	Prolonged labour				
	Complications of abortion				
	Pre-eclampsia/ Eclampsia				
	Post-partum sepsis				
	Birth Asphyxia				
	Neonatal sepsis				
	Preterm complications (respiratory distress syndrome (RDS))				
	Malaria in pregnancy				
	Severe anemia in pregnancy				
Deaths recorded for the last 6 months	Total number of maternal deaths				
	Total number of still births				
	Total number of neonatal deaths				

. Knowledge and Skill Assessment Checklists

The purpose of the knowledge assessment tool is to test the mentee's knowledge with a main focus on BEmONC services. The assessment will take place in mentees working place It shouldn't take

more than an hour.
The knowledge assessment and scoring[6] should be done three times during the mentoring period: at the **beginning**, **midterm** and at the **end** of the mentoring session.
Mentee: _____Mentor: _____ Date: _____
Health Center_____ Type of assessment (baseline, mid-term or final) _____

a) Knowledge Assessment

Scoring:

i. >85- pass for knowledge assessment
ii. 61 – 84: needs mentoring
iii. 50-60%- needs extended mentoring
iv. <50%- consider retraining and re-mentoring

INFECTION PREVENTION

1. **Infection can be transmitted from clients to health care workers through**
   A. Contaminated needles or other sharps instruments that pierce the health worker's skin
   B. Splashes in the health care worker's eye of contaminated blood or body fluids
   C. Broken skin that is exposed to contaminated blood and body fluids
   D. All of the above

EARLY VAGINAL BLEEDING

2. **The immediate management of ectopic pregnancy involves**

   A. Cross-matching blood and arranging for immediate laparotomy
   B. Making sure that blood is available for transfusion before surgery is performed
   C. Observing the woman for signs of improvement
   D. All of the above

3. **MVA procedure is complete when**

   A. The wall of the uterus feels smooth
   B. The vacuum in the syringe decreases
   C. No more tissue is visible; but, red or pink foam in the cannula
   D. The uterus relaxes

RAPID INITIAL ASSESSMENT AND MANAGEMENT OF SHOCK

4. A woman who suffers shock as a result of an obstetric emergency may have

A. A fast, weak pulse
B. Low blood pressure
C. Rapid breathing
D. All of the above

CHILD BIRTH CARE

5. Active management of the third stage of labor is believed to

A. Reduce blood loss
B. Shorten the third stage of labor
C. Minimize the time at which the woman is at risk of hemorrhage
D. All of the above

UNSATISFACTORY PROGRESS OF LABOR

6. Cervical dilation plotted to the right of the alert line on the partograph indicates

A. Satisfactory progress of labor
B. Unsatisfactory progress of labor
C. The end of the latent phase
D. The end of the active phase

7. Which of the following is <u>false</u> about Postnatal care?

A. After delivery all mothers should stay for 24 hrs. in the facility for frequent follow up and care
B. PNC is necessary only for mother, once the baby start feeding no need of follow up &care
C. Provider should be check mother's general condition, vital sign, uterus, amount of bleeding frequently till discharge.
D. By Frequent assessment of mother and newborn in 1st 24hr Postnatal period provider can detect complications early and manage it.

8. Conditions for vacuum extraction includes

A. A term fetus, vertex presentation
B. A fully dilated cervix
C. Fetal head at least at 0 station or not more than 2/5 above the symphysis pubis
D. All of the above

MALPOSITIONS AND MALPRESENTATIONS

9. In a breech presentation, the fetal heart

A. Can usually be heard at a location higher than expected for a vertex
B. Can usually be heard at a location lower than expected for a vertex presentation
C. Can usually be heard in the same location as for a vertex presentation
D. Is not able to be heard

10. The presence of meconium is common with breech labor and is

A. Always a sign of fetal distress
B. Not a sign of fetal distress if fetal heart rate is normal
C. An indication for cesarean section
D. An indication for breech extraction

Hypertensive Disorder in Pregnancy

11. Diastolic blood pressure 90 mm Hg or more before 20 weeks of gestation is symptomatic of

A. Mild pre-eclampsia
B. Chronic hypertension
C. Superimposed mild pre-eclampsia
D. Pregnancy-induced hypertension

12. Elevated blood pressure and proteinuria in pregnancy define

E. Pre-eclampsia
F. Chronic hypertension
G. Pyelonephritis
H. None of the above

13. In a patient with hypertension and proteinuria, severe headache is a symptom of

A. Mild pre-eclampsia
B. Moderate pre-eclampsia
C. Severe Pre-eclampsia
D. Impending eclampsia

14. The loading dose of magnesium sulfate is given via

A. IV over 5 minutes, followed by deep IM injection into each buttock.
B. IV over 5 minutes, followed by deep IM injection into one buttock
C. Simultaneous IV and IM injections
D. IV bolus, followed by deep IM injection into each buttock

15. An antihypertensive drug should be given for hypertension in severe pre-eclampsia or eclampsia if diastolic blood pressure is

A. Between 100- and 110-mm Hg
B. 110 MM Hg or more
C. 115 mm Hg or more
D. 120 mm Hg or more

VAGINAL BLEEDING AFTER CHILDBIRTH

16. Postpartum hemorrhage is defined as;

A. vaginal bleeding of any amount after childbirth
B. sudden bleeding after childbirth
C. vaginal bleeding in excess of 300 mL in SVD and 1000 ml in C/S after childbirth
D. vaginal bleeding in excess of 500 mL in SVD and 1000 ml in C/S after childbirth

17. When a woman develops heavy bleeding after delivery due to atonic uterus, which of the following is <u>NOT done</u>

A. Begin IV fluids, take blood for hemoglobin & cross matching
B. Massage the uterine fundus
C. Give oxytocin or ergometrine (IV or IM)
D. Use NASG
E. None

18. Cervical, Vaginal or Perineal tear should be suspected when there is immediate postpartum hemorrhage and

A. A complete placenta and a contracted uterus
B. An incomplete placenta and a contracted uterus
C. A complete placenta and an atonic uterus
D. An incomplete placenta and an atonic uterus

19. If the uterus is contracted; but a retained placenta is undelivered after 30 minutes of oxytocin administration and controlled cord traction:

A. More aggressive controlled cord traction should be attempted
B. Controlled cord traction and fundal pressure should be attempted
C. Manual removal should be attempted
D. Ergometrine should be given

20. **To perform manual removal of the placenta**

A. Give ergometrine prior to the procedure
B. Give antibiotics 24 hours after the procedure
C. Place one hand in the uterus and use the other hand to apply traction on the cord
D. Place one hand in the uterus and one hand on the abdomen to provide counter traction on the uterine fundus.

21. If there is continued heavy bleeding after manual removal of the placenta

A. Ergometrine 0.2 mg should be given by mouth
B. Ergometrine 0.2 MG should be given IM
C. Oxytocin 10 units should be given as an IV bolus
D. Prostaglandin 2.5 mg should be given IM

22. FEVERThe treatment of metritis should include

A. IV Ampicillin or IV Gentamicin or IV Metronidazole
B. IV Ampicillin, plus IV Gentamycin and IV Metronidazole.
C. A combination of oral antibiotics
D. A broad-spectrum oral antibiotic

FANC

23. **Which women do <u>not</u> require a special care plan**?

A. Women who have had a cesarean section scar
B. Previous neonatal death
C. Previous instrumental delivery (vacuum extraction, forceps)
D. Previous obstetric fistula repair
E. None

NEW BORN QUESTION

24. Newborn cord care involves

A. Applying a dry dressing to the cord stump
B. Swabbing the cord stump with alcohol and applying a dry dressing
C. Keep the cord stump dry and not apply anything except chlorhexidine.
D. Covered with antiseptic-soaked wet gauze

25. For asphyxiated Newborn baby the correct rate for ventilation using bag and mask is:

A. 20- 40 ventilation per minute
B. 30-60 ventilation per minute
C. 40 to 60 ventilations per minute
D. 80 ventilations per minute

Knowledge assessment for mentees on CAC in CBCM

Instruction A: Mark "T" or "F" in the blank to indicate true or false.

1. ……..Mifepristone will result in detachment of the fetus in the uterine cavity.
2. ……. A breast feeding woman can have medication abortion.
3. ……. Ultrasound is not a requirement (is optional) for provision of medication abortion
4. ……. Tissue inspection is necessary after MVA
5. ……. MVA aspirators is not a must to be sterile for reuse
6. ……. Pain medication is an important quality indicator for abortion care

Instruction B: **Circle the letter that corresponds to the correct answer.**

1. Which of the following is not mandatory in clinical assessment of a client coming for abortion care?

A. Client's complete clinical history
B. Psychosocial assessment of the client
C. Physical examination
D. Laboratory test

2. No-touch technique means

A. The provider should not touch the woman
B. The provider can use the tips of the fingers to unclog a cannula
C. The vaginal walls cannot be touched
D. The tip of the instrument should not touch anything that is not sterile

3. Which of the following method of contraceptive cannot be given immediately after MVA?
   A. Oral contraceptive pills
   B. Injectable
   C. Implants
   D. IUCD
   E. None

4. When can a woman start hormonal contraceptives after medication abortion?
   A. On the day of administering misoprostol
   B. Beginning of the next period
   C. In the day of administration of mifepristone
   D. All of the above

5. Which of the following statement is true?
   A. MVA is used to terminate pregnancies up to 12 weeks of gestational age
   B. Both MVA and MA can be used to manage incomplete abortion
   C. Both MA & MVA have same level of effectiveness in terminating 1st trimester pregnancy
   D. Failure of medication abortion can be effectively managed by MVA
   E. All

6. One of the following is correct statement about counselling for abortion care

   A. Effective counselling requires privacy and confidentiality
   B. The provider is the decision maker on the choice of method of abortion (MA/MVA) because the woman doesn't know about these technologies
   C. The information to the woman will not be shared to others without her knowledge
   D. The nonverbal communication is equally important as the verbal communication in the process of counseling
   E. All

7. Which of the following is an indicator of quality of abortion care services?
   A. Providing Pain Medication to all abortion care seekers
   B. Providing post abortion family planning counselling to all women seeking services
   C. Using only the recommended methods of abortion (MA and MVA) to all first trimester abortion care services
   D. Timely and complete recording and record keeping of all abortion care services provided
   E. All

8. The standard protocol of medication abortion for first trimester pregnancy up to 9 completed weeks of GA in Ethiopia is:
   A. Mifepristone 600mg orally, followed by 400ug misoprostol orally after 48 hours
   B. Mifepristone 200mg orally, followed by 800ug misoprostol vaginally after 48 hours
   C. Mifepristone 400mg orally, followed by 400ug misoprostol orally after 48 hours
   D. Mifepristone 200mg orally, followed by 400mg misoprostol orally after 48 hours

9. Following Medication abortion, client may need to go to the health settings when having:
   A. Fever of >38 degree
   B. Fully soak 2 thick pads after one hour for 2 continuing hours
   C. A & B

Knowledge assessment result at the beginning, midterm and end of mentoring and coaching

Mentee's Name	Result at Baseline	Result at mid-term	Result at end-term
1.			
2.			
3.			
4.			

Essential Newborn Care at Birth & KMC Checklist

The mentor can use the following learning checklist to monitor progress while teaching to care for the newborn at birth.

Directions

Rate the performance of each step or task using the following rating scale:

Yes= Performs the step or task completely and correctly.

No= Is unable to perform the step or task completely or correctly or the step/task was not observed.

N/A (not applicable) = Step was not needed.

Sr. No	**Preparedness for the birth**	Yes	No
1	The room temperature is between 25-30 °C		
2	Is there wall thermometer in the room and temperature is recorded		
3	there is a wall clock		
4	Are surgical and clean glove available		
5	Alcohol-based solution is available for cleaning hands quickly		
6	all sterile instruments are ready for use		
7	cloths and warm towel are ready to dry and cover the infant		
8	clean and pre-warmed surface is prepared for resuscitation		
9	Resuscitation kit and suctioning device are clean, complete and ready to be used		
10	Cord clamping devices are available		
11	Infant weight scale is available		
12	Is Chlorhexidine available		
13	TTC eye ointment is available		

Task

Observation checklist:

Newborn infant assessment and immediate care. (This checklist will be case scenario if there is no direct case observation)

Step 1:	Dry the baby and keep him/her warm by placing on the mother's abdomen.		
Step 2:	Assess breathing. Make sure the baby is breathing well.		
Step 3:	If the baby does not breathe, clamp/tie and cut the cord immediately and start resuscitation. If the baby cries /breathes well, clamp/tie and cut the cord after pulsations stop or after 2-3 minutes.		
Step 4:	Place the infant in skin-to-skin contact on the mother's chest and cover both with clean linen and blanket as required. Carry out all the steps noted below up to #9, preferably with the baby on the		

	mother's chest.		
Step 5:	Initiate breastfeeding within the first hour. Select the appropriate method of feeding for the HIV-infected mother, based on informed choice.		
Step 6:	Administer eye drops/eye ointment.		
Step 7:	Administer vitamin K1.		
Step 8:	Place the baby identification bands on the wrist and ankle.		
Step 9:	Weigh the infant when he/she is stable.		
Step 10:	Record observations and treatment provided in the registers/appropriate chart/cards.		

Checklist for KMC

SN	**Task**		
1.	Inform parents and discuss the process of Birth Kangaroo Care		
2.	Counsel the mother, Provide privacy to the mother. Request the mother to sit or recline comfortably		
3.	Undress the baby gently, except for cap, nappy and socks.		
4.	Place the baby prone on mother's chest in an upright position with the head slightly extended, between her breasts in skin-to-skin contact in a frog like position; turn baby's head to one side to keep airway clear. Support the baby's bottom with a sling/binder.		
5.	Cover the baby with mother's 'Shema' or gown; wrap the baby-mother pair with an added blanket or wrap depending upon the room temperature		
6.	Advise mother to breastfeed the baby frequently		
7.	Ensure warm room with room temperature Maintained between 26 – 28^0 C.		
8.	Advise the mother to provide KMC for at least 1 hour per session. The length of skin-to-skin contact should be for as long as possible		

Mentee`s clinical Skill assessment checklist

I. Instruction:

- Arrange models and necessary materials for demonstration
- Ask the mentee to demonstrate the task on model and observe
- Conduct the assessment after the mentee finished the daily activity
- Note down points in the boxes every time a consideration is mentioned and or shown correctly
- Note down the numerical order in which the mentee mentions or performs the steps
- The assessment shouldn't take more than an hour
- The mentee`s skill in performing each task/procedure will be scored as follows
    - ✓ Score 0 – for not considering/demonstration of the critical steps
    - ✓ Score 1– for partially demonstration of the critical steps
    - ✓ Score 2 – for full demonstration of the critical steps
    - ✓ Each row is scored 2 points
    - ✓ Standardized the grade total score by multiplying it with 100%

II. General Information

Mentor_____

Mentee: _____

Facility Name: _____

Type of Facility: _____

Region_____

Zone_____ Woreda_____

Date of assessment (DD/MM/YY): _____, _____, _____

S/N	Skill/Procedure	Score			
		Base line	Mid term	End line	Remark
1	**Antenatal Care**				
1.1.	Proper history taking				
1.2	Proper physical examination				
1.3	Proper counselling/Provide advice on danger signs, birth preparedness complication readiness				
1.4	Proper weight gain measuring and interpretation				
1.5	Maternal nutrition screening(MUAC) and counseling				
	Subtotal score				
2	**Administration of parenteral antibiotics**				
2.1	Secure IV line				
2.2	Assess for any contraindications to client receiving Antibiotics and check expired date				
2.3	Administer IV Antibiotics as per the standard.				
2.4	Document according to procedure in patient card				
	Subtotal score				
3	**Have you ever administered parenteral Uterotonic? If yes, please demonstrate the steps. If no mark as "Zero"**				
3.1	Locate correct site using landmarks				
3.2	Administer medication (Oxytocin 10 IU or Ergometrin 2mg (if no heart disease or elevated BP))				
3.3	Document according to procedure with in patient card				
	Subtotal score				
4	**Administration of parenteral anticonvulsant and antihypertensive**				
4.1	Ensure condition for MgSo4 administration				
4.2	Explain the procedure and side effect of the treatment to the patient				
4.3	Administering Loading Dose of Magnesium Sulphate: MgSO4 20% solution, 4gm IV over 5 min followed by 10gm of 50% MgSO4 solution,5 gm in each buttock as deep IM with 1ml of 2% Lidocaine in the same syringe. If convulsions recur after 15 min, give 2gm MgSO4 20% solution IV over 5min (check the 20 % solution preparation)				
4.4	Maintenance dose: MgSO4 50% solution 5gm +1ml Lidocaine 2% IM every 4 hrs. into alternative buttock for 24 hrs. after delivery or the last convulsion whichever occurs last. Before repeat administration, ensure RR≥12 per min, Patellar reflex present, Urine output ≥30ml per Hr.				
4.5	Keep antidote ready (Calcium gluconate 1gm of 10ml of 10% solution)				

4.6	If the diastolic pressure is 110 mm Hg or more: Give hydralazine 5 mg IV slowly (3-4minutes). If hydralazine is not available, give labetalol 10 mg IV OR Nifedipine 5mg under the tongue				
	Subtotal score				
5	**Manual removal of placenta**				
5.1.	Inform the procedure to the mother and take consent				
5.2.	Empty her bladder or inserts a catheter.				
5.3	Provide analgesics				
5.4	Administers prophylactic antibiotics in one dose only: 2g IV Ampicillin + 500mg IV Metronidazole				
5.5	Wear elbow-length gloves,				
5.6	Hold the umbilical cord with a clamp, pulling the cord gently until it is lightly taut or tense				
5.7	Place one hand into the vagina then into the uterine cavity following the cord and locate the placenta edge				
5.8	Move fingers of the hand gently between the placenta and the uterine wall if cleavage find				
5.9	Gradually move the hand back and forth in a smooth lateral motion until the whole placenta is separated from the uterine wall				
5.10	Slowly withdraw the hand from the uterus bringing the placenta with it while continuing to provide counter traction abdominally				
5.11	Explore the uterine cavity for placental fragments				
5.12	Administer or continue the infusion of 20 units of Oxytocin in 1L of normal saline or Ringer's lactate, at a rate of 60 drops per minute.				
513	Monitor vaginal bleeding. Take the woman's vital signs. Makes sure that the uterus is firmly contracted.				
	Subtotal score				
6	**Spontaneous Vaginal Delivery (Normal Birth)**				
6.1	Assemble equipment required, Wash hands thoroughly, and put on 2 pairs of sterile surgical gloves.				
6.2	Clean the woman's perineum and place one drape under the woman's buttocks and one over her abdomen - ask woman to pant or give only small pushes with contractions.				
6.3	Control the birth of the head; maintain flexion with one hand, while allowing natural stretching of the perineal tissue, prevent tear using the other hand to support the perineum.				
6.4	Wipe mucous or membranes with gauze if needed from baby 's eye and mouth				
6.5	Feel around the baby 's neck for the cord and respond appropriately if the cord is present.				
6.6	Allow the baby 's head to turn spontaneously and,				

	with the hands on either side of the baby's head, deliver the anterior shoulder.				
6.7	When the arm fold is seen, guide the head upward as the posterior shoulder is born over the perineum and lift the baby's head anteriorly to deliver the posterior shoulder.				
6.8	Support the rest of the baby's body with both hand as it slides out, and place the baby on the mother's abdomen.				
6.9	Thoroughly dry the baby and assess breathing. If baby does not breathe immediately, begin resuscitative measures (see Checklist- Newborn Resuscitation).				
6.10	Remove wet towel and ensure that the baby is kept warm, using skin-to-skin contact on the mother's chest. Cover the baby with a cloth or blanket, including the head (with hat if possible).				
6.11	Note and tell to the mother the time and sex of the baby				
6.12	Palpate the mother's abdomen to rule out the presence of additional baby (ies) and proceed with active management of the third stage.				
	Subtotal score				
8	**Assisted vaginal delivery with vacuum extraction**				
8.1	Ensure that the conditions for vacuum extraction are present.				
8.2	Check all connections on the vacuum extractor and test the vacuum.				
8.3	Assess the position of the fetal head and identify the posterior fontanelle.				
8.4	Apply the largest cup that will fit (5 and 6mm) & Perform episiotomy if necessary for placement of the cup.				
8.5	Check the application and ensure there is no maternal soft tissue within the rim of the cup.				
8.6	Have assistant create a vacuum of negative pressure and check the application of the cup.				
8.7	Increase the vacuum to the maximum and then apply traction. Correct the tilt or deflection of the head.				
8.8	With each contraction, apply traction in a line perpendicular to the plane of the cup rim and assess potential slippage and descent of the vertex.				
8.9	Between each contraction, have assistant check fetal heart rate and application of the cup.				
8.10	Continue the "guiding" pulls for a maximum of 30 minutes. Release the vacuum when the head has been delivered.				
8.11	Check the birth canal for tears following childbirth, and repair if necessary. Repair the episiotomy, if				

	one was performed.				
	Total score				
9	**Newborn resuscitation**				
9.1	Dry the baby, remove the wet cloth, and wrap the baby in a dry, warm cloth.				
9.2	Place the baby on his/her back on a clean, warm surface; keep covered except for the face and chest.				
9.3	Position the head in a slightly extended position to open the airway				
9.4	Clear the airways by suctioning **the mouth** first and **then the nose**				
9.5	Place the mask on the baby's face so that it covers the chin, mouth and nose.				
9.6	Squeeze the bag with two fingers only or with the whole hand, depending on the size of the bag.				
9.7	Checks the seal by ventilating two or three times and observing the rise of the chest.				
9.8	If the baby's chest is rising, ventilate at a rate of 40-60 breaths per minute, and observe the chest for an easy rise and fall.				
9.9	If the baby's chest is not rising, determine why, rectify problem and continue to ventilate.				
9.10	Ventilate for 1 minute and then stop and quickly assess the baby for spontaneous breathing and color; if breathing is normal, stop ventilating, and provide routine newborn care				
9.11	If the baby's heart rate is normal but breathing is less than 30 breaths per minute or irregular, continue to ventilate for 3-5 minutes until the baby is breathing well				
9.12	If breathing is not normal, and the heart rate is normal or slow manage accordingly (call for help and improve ventilation; continue ventilation with oxygen if available)				
9.13	If the baby is not breathing regularly after 20 minutes of ventilation, continue ventilation with oxygen, organize transfer and refer baby to a tertiary care center, if possible.				
9.14	If there is no breathing at all after 20 minutes of ventilation stops ventilating, provide emotional support to mother and family.				
	Subtotal Score				
10	**Active management of the third stage of labor (AMTSL)**				
10.1	Within one minute of the delivery of the baby, palpate the abdomen to rule out the presence of an additional baby(s)				

10.2	Within the first minute of the birth, administer 10 units of IM Oxytocin. If Oxytocin is not available, administer 0.2 mg of Ergometrine (NOT for elevated blood pressure)				
10.3	Clamp and cut the umbilical cord. (Clamp near the perineum.)				
10.4	With one hand, maintain slight tension on the cord and wait for a strong uterine contraction (when the cord stretches, the uterus becomes round).				
10.5	During the contraction, apply controlled traction to the cord so as to deliver the placenta: Pulls gently, firmly, while applying counter traction with the other hand delivering the placenta slowly				
	Subtotal score				
11	**Partograph use**				
11.1	Start partograph only when a woman is in active phase of labor				
11.2	The dilatation of Cervix is plotted with an 'X'. Vaginal examinations are done at admission and once in 4 hours.				
11.3	Descent of fetal head is measured in terms of fifths above the pelvic brim hand fingers and plotted with an "O' on Partograph				
11.4	Uterine Contractions: Observations are every half hour in active phase (Check for frequency every 10 min and duration in second)				
11.5	Observe the shading of contraction duration on the graph (<20sec, 20-40sec, and > 40sec)				
11.6	Monitor FHB every 30 minute for normal case and every 15 minutes for abnormal case. Take action for three abnormal FHB records				
11.7	Record membranes & liquor as: (Membrane intact=I, Clear= C, Meconium= M, Absent=A, Blood stained=B				
11.8	Record state of molding as: 0= Bones are separated & sutures felt, 1^{+}= Bones are just touching each other, 2^{+}= Bones are overlapping				
11.9	Record maternal condition at the foot of the Partograph: (Oxytocin & drugs, PR every half hour, BP & Temp every four hours)				
11.10	Between Alert and Action lines = Transfer to hospital with facilities for Cesarean section, unless Cervix is near full dilatation				
	Subtotal score				
12	**Assisted breech delivery**				
12.1	Ensure that the conditions for breech delivery are present.				
12..2	Catheterize the bladder, if necessary.				
12.3	When the buttocks have entered the vagina and the cervix is fully dilated, tell the woman she can				

	bear down with contractions.				
12.4	Perform an episiotomy, if necessary.				
12.5	Let the buttocks are delivered until the lower back and shoulder blades are seen.				
12.6	Gently hold the buttocks in one hand.				
12.7	If the legs do not deliver spontaneously, deliver one leg at a time.				
12.8	Hold the baby by the hips.				
12.9	If the arms are felt on the chest, allow them to disengage spontaneously.				
12.10	If the arms are stretched above the head or folded around the neck, use lovest's maneuver				
12.11	If the baby‘s body cannot be turned to deliver the arm;				
12.12	Deliver the head using the Mauriceau Smellie Veit maneuver.				
12.13	Assess the baby‘s condition for breathing and complete the delivery as in normal birth				
12.14	Following delivery, check the birth canal for tears and repair, if necessary. Repair the episiotomy, if one was performed.				
12.15	Provide immediate postpartum and newborn care, as required.				
	Subtotal score				
13	**Perform episiotomy**				
13.1	Cleanse perineum with antiseptic solution.				
13.2	Give local anesthesia and wait to perform episiotomy until: - perineum is thinned out; & 3–4 cm of the baby's head is visible during a contraction.				
13.3	Insert open blade of scissors between perineum and two fingers; Cut the perineum about 3–4 cm in a mediolateral direction and cut 2–3 cm up middle of posterior vagina.				
13.4	Control birth of head and shoulders to avoid extension of the episiotomy.				
13.5	Repair the episiotomy with catgut as per the standards				
	Subtotal score				
14	**Perform bimanual compression of uterus**				
14.1	Tell the woman what is going to be done & provide continuous emotional support.				
14.2	Put surgical gloves on both hands.				
14.3	Clean the vulva and perineum with antiseptic solution.				
14.4	insert a fist into the anterior vaginal fornix and apply pressure against the anterior wall of the uterus and place the other hand on the abdomen behind the uterus, press the hand deeply into the abdomen, apply pressure against the posterior wall of the uterus by maintaining compression				

	until bleeding is controlled and the uterus contracts				
	Subtotal score				
15	**NASG application**				
15.1	Place the NASG under the woman; the top of the NASG should be at the level of her lowest rib.				
15.2	Starting at the ankles, close segment #1 tightly around each ankle. Make sure it is tight enough so that you can snap it and hear a sharp sound				
15.3	Close segment #2 on each leg as tight as possible. Try to leave the woman's knee free in the space between segments so that she can bend her leg. She may be in the NASG for a long time				
15.4	Apply segments #3, the thigh segments, in the same way as segments #1 and #2. Remember: close segments tight enough so that you can snap it and hear a sharp sound!				
15.5	Apply segment #4, the pelvic segment, goes all the way around the woman at the level of the pubic bone.				
15.6	Place segment #5 with the pressure ball directly over her umbilicus.				
15.7	Then close the NASG using segment #6. If there are two people present, they can rapidly apply the three leg segments together, each working on one leg, starting at the ankle. However, only one person using as much strength as possible should close the pelvic and abdominal segments				
15.8	Make sure the patient can breathe normally with the NASG segment #6 in place.				
15.9	If the source of bleeding appears to be uterine atony, administer uterotonic drugs and massage the uterus. The NASG stretches, allowing room for your hand to fit between the woman's abdomen and the NASG				
15.10	Wash hands thoroughly with soap and water and dry them.				
15.11	Monitor vaginal bleeding. Take the woman's vital signs. Make sure that the uterus is firmly contracted.				
	Subtotal score				
16	**Postnatal Care**				
16.1	Proper history taking				
16.2	Proper physical examination				
16.3	Proper counseling /Danger sign /PMTCT/PPFP/hygiene/ maternal nutrition /optimal breast feeding practice				
16.5	Laboratory				
	Total score				

	MVA				
	Pre-Procedure				
1	Review client information in her record and reconfirm counseling on PAFP including the method chosen				
2	Written consent signed				
3	Provides pain medication				
4	Provides prophylactic antibiotics				
5	Confirms the client has recently emptied her bladder				
6	Performs bimanual exam and reconfirm uterine size size and position				
7	Arrange instruments and supplies required for the procedure				
8	Charges the MVA aspirator and check for vacuum retention				
	Procedure				
9	Inserts vaginal speculum, visualizes the cervix, place and screw and lock the speculum				
10	Cleans the cervix and the vagina with antiseptic solution (iodine) 2 times				
11	Gently grasp the cervix with tenaculum or forceps horizontally at the 2 and 10 o'clock positions.				
12	Administers para cervical block if needed.				
13	Dilates the cervix. If necessary				
14	Suctions uterine contents with appropriate cannula size by rotating 180 degrees				
16	Inspects the tissue to confirm evacuation of tissue proportional to gestational age				
17	Performs any concurrent procedure. E.g.,' PAFP such as IUD insertion if client has chosen prior to the procedure and eligible				
	Post procedure				
18	Monitors post procedure vital signs				
19	Completes the client record and register				
20	Provides post procedure counseling				
	Sub Total				
	Grand total score out of 100				

Respectful Maternal and newborn care Assessment checklist

Purpose: To assess the level of compassionate care provision by providers

Instruction: observe mentee while providing care in his/her routine work and rate as follows

- 0= Not performed
- 1= Performed but unsatisfactory
- 2 = Performed

S. No	Expected behavior	Score			Remark
		Base line	Mid term	End term	
1.	Provider greets and introduces himself				
2	Allow companionship if necessary				
3.	provider actively listens to patients				
4.	provider allocates adequate time to the client to discuss issues				
5.	provider respects patient's view on treatment and care				
6.	provider obtains consent before examination and procedures				
7.	provider ensures confidentiality of patient information				
8.	provider maintains privacy in providing clinical care				
9	provider responds promptly and professionally when patients ask for help				
10	provider gives adequate information regarding patient treatment and care				
Total score					
Score out of 100(%)=					

Chart/mentee Log Book Review Checklist

Expected or Minimum exposure of the Mentee during the Mentoring period

S#	Skill/Procedure	Minimum # of 1-on-1 case management	# Of 1-on-1 case management during mentoring period	Minimum # of clinical case discussions	# Of clinical case discussions during mentoring period
	MNH Signal Functions/Essential Services				
1	Administered parenteral antibiotics for sepsis cases in the last three months?	3		3	
2	administration of parenteral uterotonics in the last three months?	5		5	
3	administration of parenteral anticonvulsants in the last three months?	2		2	

4	Nutritional screening and counseling performed in the last three months?	3		3	
5	Manual removal of placenta performed in the last three months	2		2	
6	Vacuum assisted delivery performed in the last three months?	1		3	
7	Neonatal resuscitation with mask and bag performed in the last three months?	2		2	
8	Spontaneous vaginal deliveries attended in the last three months?	5		5	
9	Active management of the third stage of labor in the last three months (AMTSL)	5		5	
10	Partographs filled in the last three months?	5		5	
11	Diagnosed and managed breech presentation including referral in the last three months	1		2	
12	Episiotomy performed in the last three months?	1		1	
13	Bimanual compression of uterus performed in the last six months?	1		1	
14	Performed manual removal of placenta	1		1	
15	Performed removal of retained conceptus	2		2	
16	DBS performed	2		2	

Observation/Comments:

_____

Competency rating

Mentee/Provider name: _____

Mentee /Provider is	_____ Competent
	_____Not Competent
Follow-up action/Recommendation	
Mentor /Assessor's name	
Mentor /Assessor's signature	Date

PMTCT

PMTCT Service Availability

S. No.	Type of service	Available		Comment
	PMTCT services	Yes	No	
1.1.1	PMTCT/test and treat/			
1.1.2	Point of Care Testing (POC) for HIV EID			
1.1.3	Point of Care Testing (POC) for viral load			
1.1.4	Integrated Family planning in PMTCT			
1.3.7	Integrated Family planning in ART clinic			

Mentee's Knowledge assessment on PMTCT

1. Which one of the following is prong 3 of PMTCT?

A. Prevention of unintended pregnancy in HIV positive women
B. Primary prevention of HIV infection focusing on keeping people HIV negative
C. Provision of treatment, care and support to woman living with HIV and their infants, partners and families
D. Prevention of HIV transmission from women living with HIV to their infants

2. One of the following is correct about HEI prophylaxis currently

A. AZT+NVP is given for six weeks only
B. AZT+NVP given for 12 weeks
C. AZT+NVP for 6 weeks and then NVP only for the next six weeks
D. Only NVP prophylaxis 6 six weeks

3. Which one of the following is correct on HEI diagnosis?

A. A DNA PCR test result negative means that the infant/child is not infected but could become infected if the child is still breast feeding
B. Serologic test does not determine HIV status below the age of 18 months
C. Serologic test result is a confirmatory test for HIV infection below 18 months
D. The infant can stay at PMTCT even if positive by DNA PCR
E. A&B

4.Which one of the following is the preferred 1st line ARV regimen in PMTCT

A. AZT+3TC+EFV
B. TDF+3TC+DTG
C. TDF+3TC+ATV/rt
D. None of the above

Knowledge assessment result at the beginning, midterm and at the end of the mentoring and coaching.

Name of Mentees	Result at Baseline	Result at mid-term	Result at end-term
1.			
2.			
3.			
4.			

Mentee Competency level assessment category

X= **not applicable**

1 = **none**: No demonstrated skills at all or does not perform the task (s) completely. Needs a lot of support

2 = **limited: Mentee** demonstrates very limited strengths or skills in this area and needs additional support

3 = **some: Mentee** demonstrates some ability or skills in this area.

4 = **Strong: Mentee** demonstrates excellent skills or strengths in this area

Completeness of Mentor's assessment

A =Comprehensive assessment– skill was assessed completely; Mentor was able to observe fully

B = Satisfactory assessment– assessment was satisfactory, although Mentee's skill may exceed that observed

C =Partial assessment—observations and scores based on incomplete information.

R = **Resource limits**–skill or care limitation clearly related to resource limits.

Use the "comments" column to note key observations to be discussed later with the Mentee. In addition, this space should be used to record explanations to why recommended practices were not followed, to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by the Mentor to the Mentee.

Note: Clinical Mentors need to focus on knowledge and skill capacity building of mentees providing care and treatment services using the Preceptor check list (A). The chart abstraction tool (B) is intended to be used to review client charts, registers and oversee service integration/linkage with other units.

	Professional and Interpersonal skills	**Comments**	**Codes1-4, A-C,R,X**
1	Provider welcome the client (Greets with dignity and respect)		
2	Briefly describe the purpose of the mentorship program to the patient (i.e., the mentee needs to explain to his/her clients who the mentor is and mentor's purpose)		
3	Attentively listens the client (Patient centered)		
4	Create trusting /supportive rapport with the patient (encourages open communication- Use recommended communication skills to encourage and open the client to tell their stories)		
5	Timeliness; (doesn't rush or take unnecessary too		

	much time)		
6	Treat client with empathy, dignity and respect (including confidentiality; maintain slow speaking voice)		
7	**Assessment**		
8	Conduct focused and open discussion of medical, social and family history relevant to current complaint including assessment of adherence		
9	Use team approach for efficient interaction and to avoid duplication (share information with adherence counselor,)		
10	Conduct adequate physical examination (pertinent and related to medical story and current complaints)		
11	Accuracy of assessment and diagnosis (including WHO staging)		
	Patient management and care plan		
12	ART adherence, tolerance and side effects addressed.		
13	Appropriate involvement of patient in development of a focused management plan		
14	Appropriateness of recommended drug treatment (ART and OIs)		
15	Appropriateness of recommended laboratory tests		
16	Patient education on sexual and other risk behavior		
17	Emotional and psycho-social support needs discussed and addressed		
18	appropriate Referral given as required		
19	Develop appropriate follow up schedule		
	Documentation and recording		
20	Appropriate history and physical examination findings are documented completely and consistently on the respective formats		
21	All required formats are updated and complete		

PMTCT Chart Abstraction tool and document review

	Review the ANC register at least 2 months from the date of visit.	**Performance (Document percentage for each observation)**	**Bottle necks (Causes for low performa**	**Actions Planed (Mitigations to address**

			nce	**the bottle necks**
22	What percentage of pregnant women have a documented HIV status? (Total number of women who have test results / total ANC clients in the last two month)			
23	What percentage of pregnant women are HIV positive?			
24	What percentage of pregnant women have documentation of receipt of ARVs? (Check cohort and ANC register)			
25	What percentage of pregnant women have documented syphilis testing?			
26	What percentage of syphilis positive pregnant women are treated for syphilis?			
27	What percentage of pregnant women have documented HBV testing? And interventions			
	Check pregnant women, who are on cohort register for the last 6 months, what percentage of the eligible pregnant mothers have got the below services in a timely manner.			
28	**CD4 (%)**			
29	Viral load test			
	Take 5 random charts of HIV positive pregnant women, who are on cohort register for the last 6 months, what percentage of the eligible pregnant mothers took:			
30	TB screening			
31	INH preventive therapy			
32	CPT			
33	Have timely CD4			
34	Have timely VL			
35	Have documented wt, ht, BMI or MUAC			
36	Prevention counseling (FP, condom use)			
37	WHO clinical staging/ T-staging			
38	Prevention plan (disclosure, STI, Psychosocial support) Proper Counselling on family planning and condom use/dual method /			
39	Check intake form for completeness and update on index case family testing			

40	Review re-testing practice by checking recently initiated clients against the retesting register (draw 3 newly initiated client charts)			
	Check HEI, who are on cohort register for the last 6 months,			
41	what percentage of HEI have documentation of their AZT+NVP receipt			
42	How many of the identified HEIs have DBS done (No.& %)			
43	How many HEI who are 18 months old have Antibody test			
44	How many HEI who are 18 months old have positive antibody test.			
45	How many of HEI have DBS positive results			
46	Number of confirmatory tests done for infants diagnosed HIV positive			
47	Number of infants diagnosed HIV positive and linked to ART			
	Take 5 random HEI charts, what percentage of HEI have documentation of their status of:			
48	AZT+NVP			
49	CPT			
50	Growth chart monitoring			
51	Immunization			
52	Review last three months record on mother baby cohort register (Completeness and updates)			
53	Probe: check like NVP, CPT, INH areas for completeness			
54	PMTCT cohort monitoring reporting format properly filled Probe: - Is it up to date, and legible? Abbreviations used are standard ones			
55	Maternal & HEI PMTCT Cohort Wall Charts displayed on the wall in the PMTCT clinic and properly filled If Not, why?			
56	facility implementing continuous quality to improve the quality of RMNCH/PMTCT services			
57	How often is the CQI project implemented?			
58	use of data for planning and decision making at facility level?			

	If No, why? ---------- If yes, verify documentation of regular data analysis and use evidences.			
59	What has been done for those LTFU (e.g., Tracing) Observe evidences of those lost are brought back to care Mechanisms of tracing lost to follow clients			
	AVAILABLITY OF TOOLS	YES	No	
60	Revised PMTCT guideline			
61	PMTCT services desktop reference			
61	Revised enhanced postnatal prophylaxis job aid for HEI			
62	Maternal and HEI report format			
63	Maternal and HEI wall chart			
64	PMTCT cohort monitoring SOP			
65	Continuous quality improvement (CQI) checklist			
66	FP register			
67	Mother baby cohort register			
68	DNA PCR specimen tracking log book			
69	PMTCT appointment &LTFU tracking log book			
70	referral register or log book			
71	Maternal and HEI report formats			
	L&D			
72	Check the availability and expiry date of 1j, NVP and AZT syrup prophylaxis			
73	Review the L&D register at least 3 months prior to the current date of visit,			
74	I routine provision of PITC for eligible pregnant women attending L&D(Y/N)			
75	percentage of new pregnant women who have documented HIV status during L&D			
76	percentage of new HIV positive pregnant women who have documentation of receiving receipt of ARVs during L&D receipt			

77	percentage of HIV exposed newborns who have documentation of receiving ARV prophylaxis (AZT+NVP) (Out of those who are born within 3 months prior to the visit).			
78	Do you communicate PMTCT provider to document AZT+ NVP prophylaxis immediately? If not why ----------			
79	Take 5 random MRN from L&D register which is AZT+NVP documented and what percent of AZT+NVP documented on Mother baby cohort register at PMTCT room			
	MSG			
80	No of HIV positive pregnant & BF mother's registered on MSG register in this month.			
81	lost to follow up HIV positive pregnant & BF mothers in this month? If Yes, are Do Lost to follow up cases traced and their tracing outcomes properly registered?			
82	How many times per week did MSG members participate in coffee ceremony? Check the lesson discussed during coffee ceremony.			
82	Laboratory (If **YES** specify which machine):	Yes	No	
83	Do you use GeneXpert devices for EID			
84	Stock out of Lab Supplies (sample collection as well as reagents)			

Interpretation of performance observation findings: Poor <50%, Fair=50-75%, Good= 75-90%, Very good >90%

3.3 ART Pharmacy Mentoring Tool

General direction to the mentor:

This checklist is to be filled by the mentor during every mentoring visit. If an activity is covered during mentoring (i.e., mentored), write YES, otherwise write NO. Write challenges (bottle necks) encountered during the mentoring process and write the assignments given to the mentor and the mentee or to any other party.

Mentee name: _____; Mentee mobile: _____
Mentor name: _____ ; Date of mentoring: _____
Mentoring area: _____
Major activities covered during mentoring
Yes / No
Challenges faced
Assignment for mentee **or** mentor

	4.1. ART pharmacy service related	Yes / No	Challenges faced	Assignment for mentee **or** mentor
1	Briefly describe the purpose of the mentorship program to the patient (i.e., what the Mentor is)			
2	read the prescription correctly (**including patient name & age,**			

	medicine description, dosage instructions)			
3	Check understanding of HIV/AIDS and ARV therapy			
4	Ensure patients readiness and willingness for ARV therapy			
5	Discuss importance of lifelong treatment adherence and identify adherence barriers.			
7	Suggest possible solutions with the patient to improve adherence			
8	Educate patients on the importance of adherence in the prevention of resistance			
9	Encourage the use of adherence aids/reminder devices (e.g. alarms).			
10	communicate the patient politely and provide proper information (medicine name, dose, frequency and route of administration, medicine handling at home, cautions)			
11	Counsel patients/care taker during initiation of ART on potential side effects and how to cope with them.			
12	Explain medication dosing and how to handle missed doses.			
13	Advise patients about medication toxicities, how to prevent or control them and when to seek medical assistance.			
14	Discuss potential drug-drug, drug-food, or drug-alternative medicines interactions			
15	Ensure patients get drugs with sufficient shelf life for use until next appointment (more attention to clients on ASM)			
16	Correctly label all ARVs and OI medicines (patient name, medicine description, dose, frequency of administration)			
17	Provide drug information specific to pregnant and breastfeeding mothers as well as children.			
18	Counselling on family planning and condom use			
19	Discuss with patients the importance of regular follow-up and scheduled follow-up appointment (for refill to assess and identify clinical efficacy or treatment failure and to detect drug related toxicity).			
20	Involve patients and their families as an active participant in their adherence plan.			
21	Monitor and support adherence regularly at each visit (especially in children)			
22	Assess the patient about their current medications whenever filling a prescription that is new for them.			
23	Monitor the ART outcomes and potential side effects of ARV medicines.			
24	Monitor and identify potential drug–drug interactions, and recommend for dose adjustment or prevent co-administration of contraindicated medications.			
25	Dispense Plump nut and Plump sup and counsel patients on their proper use.			

26	Recommend dosage adjustment in renal and hepatic dysfunction.			
27	Provide information to other healthcare providers about the next regimens to be used after switching or changing of therapy.			
28	Should educate healthcare team members on ARV drug interactions, and its management			
29	Participates in the MDT meetings regularly			
30	Should have excellent coordination with multidisciplinary team to avoid/manage drug interactions or to monitor patients for treatment failure or toxicity.			
31	Provide information for other healthcare provider on regimen selection, the availability of different options, dosage forms and consult on drug-drug interaction.			
32	Discuss with professionals on general issues related to treatment failure and potential prevention strategies.			
33	Uses team approach (shares information with adherence counselor/case managers & data clerks)			
34	Closely work and collaborate with prescribers in prevention and treatment of OIs.			
35	Recommend drugs for the prophylaxis and treatment of common OIs.			
36	Filling the patient information sheet (the yellow sheet) properly for every visit of each patient (check for its availability, completeness for each patient, updating practice and the sequential arrangement)			
37	If available check for EDT functionality and updating practice			
38	Check for the completeness of drug dispensing register			
39	Check for the presence and completeness of monthly consumption summary			
40	Provide appointment for next visit date			
	ARV supply chain related			
41	Continuously avail required medicines for prophylaxis and treatment of OIs.			
42	Ensure that LPV/r suspension is kept in refrigerator. (N.B: If unable to refrigerate, use within 60 days. AZT, ABC & NVP suspensions DO NOT need refrigeration)			
43	Arranging containers/packs/ with labels, expiry dates and manufacturing dates clearly visible in a way to facilitate FEFO.			
44	Check for Bin Card availability, completeness and updating practice at both ART pharmacy and health facility store.			
45	Check for RRF (completeness, timeliness, accuracy and chronological filing)			
46	Check for IFRR (completeness, timeliness, accuracy and chronological filing)			

47	Check for stockout of 1st line ARV drug (TDF/3TC/DTG)			
48	Nevirapine/NVP/ + /Zidovudine/AZT/ prophylaxis for newborn			
49	Check for stock out of 2nd line ARV drugs (LPV/r)			
50	Check for stock out of 100mg INH for IPT			
51	Check for stock out of 300mg INH for IPT			
52	Check for stock out of Co-trimoxazole for CPT			
53	Check for stock out of Fluconazole for FPT			
54	Check for stock out of rapid HIV Test Kits			
55	Check for stock out of DBS Kits/accessories			

Clinical Mentoring Activities Logbook

This is a tool to document routine mentorship activities at facility level

Types of cases discussed

_____

_____

Majorachievements_____

_____

_____

_____

Gapsidentified_____

_____

_____

_____-

Challenges_____

_____

_____

_____

Actionstaken_____

_____

_____

_____

Recommendation/Plannedactions_____

_____

_____

_____

Mentor's name and signature _____

Mentee's name and Signature _____

Facility head name and signature _____

Annex 4: Vaccination Service Mentoring Checklists

Facility Readiness Assessment for Vaccination Service

Facility Information

Region:	**Zone:**	
Woreda:	**Kebele:**	
Name of Health Facility:	**Catchment population:**	
Name of satellite HPs and number of HEWs	Name of the Health post	# of HEWs
	1.	
	2.	
	3.	
	4.	
	5.	
Date of Facility Assessment (dd/mm/yy):		
Name of mentor:_____	*Telephone /email*	
Name of mentee:_____		

Human Resources

STAFFING OF EPI ROOM (ASK)	YES (#)	NO	TRAINING STATUS: IS STAFF WORKING AT THE EPI ROOM TRAINED ON IIP? (ASK & CIRCLE)	
1. Medical Doctor (GP)	Yes	No	Yes	No
2. Health Officer (HO)	Yes	No	Yes	No
3. Nurse (BSC)	Yes	No	Yes	No
4. Nurse (Diploma)	Yes	No	Yes	No
5. How frequent is staff rotation done? (Fill)				
6. Is there a need for additional HR	Yes	No		

Service and Functional Space Availability

S. No.	Type	Available (circle "yes" & "No")		Issues & actions taken to address gaps
1	Vaccination service available in all working days and hours	**Yes**	**No**	
2	Designated EPI Room Available	**Yes**	**No**	

Availability of guidelines and Printing Materials

AVAILABILITY OF GUIDELINES, PRINT MATERIALS, AND JOB AIDS		
1. EPI Implementation Guideline	Yes	No
2. Revised IIP Training Material	Yes	No
3. EPI Registration	Yes	No
4. Vaccine stock recording/ledger book	Yes	No
5. Tally sheet	Yes	No
6. Temperature Monitoring chart	Yes	No
7. Reporting Formats	Yes	No
8. Vaccination Card	Yes	No
9. Vaccine requisition (VRF) format	Yes	No

Refrigerators and passive containers

AVAILABILITY OF REFRIGERATORS AND PASSIVE CONTAINERS					
(Ask, Observe)	Availability *(circle)*		**Functionality**		Action
1. Refrigerator	Yes	No	Yes	No	
2. Cold box	Yes	No	Yes	No	
3. Vaccine carriers	Yes	No	Yes	No	
4. Ice pack	Yes	No	Yes	No	
5. Fridge Tags	Yes	No	Yes	No	

Availability of Vaccines and Supplies

AVAILABILITY OF VACCINES AND DRY SUPPLIES IN THE LAST THREE MONTHS INCLUDING ON THE DAY OF THE VISIT			
1. BCG Vaccine	Yes	No	
2. OPV Vaccine	Yes	No	
3. Pentavalent Vaccine	Yes	No	
4. IPV Vaccine	Yes	No	
5. PCV Vaccine	Yes	No	
6. Rota Vaccine	Yes	No	
7. Measles Vaccine	Yes	No	
8. Hepatitis B Vaccine	Yes	No	
9. BCG Diluent	Yes	No	
10. Measles Diluent	Yes	No	
11. BCG Syringe (0.05 cc)	Yes	No	
12. AD Syringe (0.5 cc)	Yes	No	
13. 5ml Syringe	Yes	No	
14. 2ml Syringe	Yes	No	
15. OPV Dropper	Yes	No	
16. Safety Box	Yes	No	
17. Covid-19 Vaccine	Yes	No	
18. HPV Vaccine	Yes	No	
Stock-outs with reasons and actions taken			
Timely refill/requisition of vaccines and dry supplies (*check date of the last request*)	Yes	No	

Performance Monitoring and evaluation

DATA USE (TARGET VS. PERFORMANCE)	(CIRCLE)		
1. Updated Immunization monitoring chart	Yes	No	
2. RED categorization/prioritization	Yes	No	
3. Monthly Performance monitoring by PMT and actions taken	Yes	No	
4. Vaccination session monitoring	Yes	No	
5. Regular defaulter tracing	Yes	No	
6. Integration of vaccination services with other MCH services			

Mentee self-assessment Tool

Ask the mentee to present his/her experiences based on the following questions:

- How should the HC work to improve Vaccination services performance?
- What support does the mentee expect from the mentorship? (*Probe: To what depth does the mentor provide support, what tools do to use during the visit etc.)*

Tool for mentee's self-assessment To be completed by mentee submitted to Mentor: Frequency: *Baseline,-mid line and at last mentorship visit*		
Clinical competency assessment: Mentee self-assessment		
Directions for the mentee: The following tasks ask how confident you feel about your ability to do specific tasks at the EPI room. Please complete the form and submit to the mentor.		
1	I am not at all confident: I do not know how to do this task	
2	I am somewhat confident: I can perform the task with support	
3	I am extremely confident: I am capable of doing this task and consider myself competent/ proficient	
4	I consider myself to have expertise and can teach this task to others	
Task/Competency		**1-4**
	Vaccination Services	
Inter-personal Communication with care takers		
1	*Attentive listening: make the caretaker feel important, acknowledged and empowered*	
2	*establishing relationship i.e. harmonious/sympathetic to build trust between yourself & care taker*	
3	*What disease do the vaccines prevent (which her child received today)*	
4	*Number of visits the client still needs in order to be fully immunized or protected*	
5	*What side effects may occur and how can be treated*	
6	*Date, time and place of next immunization*	
7	*Remind a mother to keep the card and bring it with her*	
Shake Test Procedures		
1	***Prepare a frozen control sample****: Take a vial of vaccine of the same type and batch number as the vaccine you want to test, and from the same manufacturer. Freeze the vial until the contents are solid, (at least 10 hours at -10°C) and then let it thaw. This vial is the control sample. Mark the vial clearly so that it is easily identifiable and will not be used by mistake*	
2	***Choose a test sample****: Take a vial of vaccine from the same batch that you suspect has been frozen*	
3	***Shake the control and test samples****: Hold the control sample and the test sample together in one hand and shake vigorously for 10-15 seconds*	
4	***Allow to rest****: Leave both vials to rest*	
5	***Compare the vials****: View both vials against the light to compare the sedimentation rate. If the test sample shows a much slower sedimentation rate than the control sample, the test sample has most probably NOT BEEN FROZEN and can be used. If the sedimentation rate is similar and the test sample contains flakes, the vial has probably been damaged by freezing and SHOULD NOT BE*	

	USED.	
6	*If the test procedure indicates that the test sample has been damaged by freezing, you should notify your supervisor immediately*	

Assessment by mentor
Knowledge assessment questions

1. The standard temperature for vaccine storage in a health facility refrigerator should be between:
    A. +2 - +8 degree C
    B. 0 - +8 degree C
    C. +4 –+9 degree C
    D. +1 –+10 degree C
2. Which of the following vaccines need conditioned icepacks during transportation?
    A. Pentavalent
    B. PCV
    C. Rota
    D. Td
    E. All
3. Which of the following practice is wrong in terms of injection safety?
    A. Recapping
    B. Manual removal of needle from syringe
    C. Disposing used needles and syringes in a safety box
    D. A and B
    E. All
4. Which of the following need to be met for opened vials of vaccines of Td, IPV or OPV to be used in subsequent EPI sessions within 28 days?
    A. The VVM should not reach discard point
    B. The vaccine should not be expired
    C. The vaccine have not been immersed in water
    D. All

5. Which of the following EPI target disease is not transmitted by droplet?
    A. Measles
    B. Tetanus
    C. TB
    D. Pertussis
    E. All
6. Which one of the following is not the key consideration to conducting a Kebele-level micro plan?
    A. Target population
    B. Cold chain inventory
    C. Identifying service delivery strategies
    D. Developing operational map
    E. Knowing the target population of the neighboring Kebele
7. During preparation for the vaccination session, which one of the following would not be the most important?
    A. Knowing the team composition & target for the session
    B. Applying Infection prevention technique
    C. Mapping of Session organization
    D. None of the above
8. Which of the following is not a serious AEFI?
    A. AEFI that resulted in the death
    B. AEFI that resulted in minor swelling and redness at the injection site
    C. AEFI that resulted in disability/incapacity
    D. AEFI that resulted in hospitalization
9. Which of the following are the recommended practices during COVID-19 vaccine administration?
    A. Checking the expiry date of the vaccine
    B. Ensure the right matches for a vaccine with diluent as per the manufacturer's recommendation Discard the used needle and syringe without recapping them in the safety box
    C. Label each vaccine vial with the date and time immediately when opened
    D. All of the above
10. What should you do if you suspect a vial of PCV may have been frozen?
    A. Perform the “shake test”
    B. Discard the vial.
    C. Place it at +2°C to +8°C until it thaws

Vaccination Services counseling competency assessment checklist

Instructions: mark one of the following scores to represent the performance level of each task/ step observed

2 = correctly performed: step or task performed correctly according to the standard.
1 = partially performed: step or task partially performed
0 = not done or done incorrectly: step or task not performed correctly

Mentee Name _____ Date _____
Profession _____ Name of Health Facility_____

	Step/Task	Rating scale	Remark
Assess and counsel the care taker			
1	Establish good relationship i.e. harmonious/sympathetic to build trust between with the care taker		
2	Tell what disease do the vaccines prevent (which her child received today)		
3	Tell number of visits the client still needs in order to be fully immunized or protected		
4	Tell what side effects may occur and how can be treated		
5	Tell date, time and place of next immunization		
6	Remind a mother to keep the card and bring it with her		

Annex 5: Family Planning Care and Services

4.1 Facility readiness assessment for FP on CBCM :

See General Mentoring Tool at the Beginning of this document

4.1.1 Availability of modern contraceptives methods and services:

S.N	Type of service	Available		Remark
		Yes	No	
1.1	COC			
1.2	POP			
1.3	Emergency contraceptive			
1.4	Condom			
1.5	DMPA			
1.6	Implanon/Next Implanon			
1.7	Jadell			
1.8	IUCD			
1.9	PPIUCD			
1.10	Bilateral tubal ligation (RTL)			
1.11	Non scalpel vasectomy (NSV)			

4.1.2 Availability of FP Kits, commodities, supplies, equipment's

	Items	Available		Stock out in the last 03 months		Remark
FP Commodity	OCP	Yes	No	Yes	No	
	POP					
	Condom					
	Implanon/Next Implanon					
	Jadell					
	IUCD					
FP kits	Implant insertion set					
	Implant removal set					
	IUCD insertion sets					
	IUCD removal sets					
Medical supplies & equipment for FP service						
	Basic supplies for FP such as glove, syringe, alcohol, Iodine, lidocaine					
	Beds, coach, screens…					

4.1.3 Guidelines, protocols, Job aids and registrations

Guidelines, protocols and job aids availability and use					
No	**Are the following materials available in respective unit?**	**Response**			
		FP unit		**CAC unit**	
		Yes	**No**	**Yes**	**No**
1	Counseling job aid (Laminated REDI counseling framework)				
2	Tiahrt Chart/FP options chart				
3	WHO MEC summary job aid (laminated summary chart or wheel)				
4	Pregnancy Screening checklist Job aid				
5	WHO MEC for contraceptive use for family planning				

6	FP Reference Manual (Global Hand Book)				
7	FMOH FP guidelines				
8	FMOH Safe abortion care service guidelines				
9	FMOH Infection prevention guidelines, New guideline				
10	IP Wall Chart/Job aids				

4.1.4 IEC/BCC Materials availability

S. No	Are the following materials available in respective unit?	Response	
		FP unit	
		Yes	No
1	FP counseling flip chart		
2	LAPM pre service brochures		
3	LAPM Post service booklet		
4	CAC post service brochure		
5	Audio visual materials		

4.1.5 Service Integration: How many clients were served during the last 3 months for FP through internal referral?

S. No	Type of service	# Clients who received FP service at FP unit via internal referral			# Clients served for FP services at FP unit via internal referral		# Client who received FP service at HIV, MCH, CAC unit			# Client served for FP at HIV, MCH, CAC unit	
		Referring service unit			**Previous 6 months**	**Recent 6 months**	FP service offering unit			**Previous 6months**	**Recent 6 months**
		HIV	MCH *	CAC			HIV	MCH *	CAC		
1	Pills										
2	Injectable										
3	Condom										
4	IUD										
5	Implants										
6	Tubal ligation										
7	Vasectomy										

4.1.6 Registers (recording and reporting forms-availability and use)

S. No	Are the following materials available in respective unit?	FP		CAC		Options for "No"
		Yes	No	Yes	No	
1	Client card					1= No budget, printing 2= Not supplied/refilled
2	FP register					
4	Logistic Request/LR forms at the pharmacy / FP unit					

5	Internal referral form (for integrated service provision)					3= Other specify _____
6	Quarterly/Monthly reporting form (ABRI- or MOH?)					

*MCH unit refers to: Antenatal, postnatal, delivery and EPI unit

Instruction: Circle or underline the letter/ word that answers the question.

Name of health facility .....

Region ..... zone ..... Woreda .....

1. Select the available type of modern contraceptives methods:

A. IUCD B. PPIUCD C. Implanon /Implanon NXT D. Jadell E. DMPA F. COC
G. condom (..... M/ ..... F) H. pop I. EC

2. Is there trained provider for PPFP? A. ..... Yes (how many .....) B. No

3. Availability of FP Kits & commodities, list stock outs at the moment

.....
.....
.....
.....

4. Availability of FP Kits & commodities, list stock outs at the moment (in 03 months)

.....
.....
.....

5. List the guideline and protocols found in the FP rooms

.....
.....
.....

6. Any additional comment on the readiness assessment of this facility for FP

.....
.....
.....
.....

4.2 Mentee's Knowledge assessment on FP in the CBCM.

4.2.1 Knowledge Assessment - Comprehensive Contraception (CC)

Instruction A: Mark "T" or "F" in the blank to indicate true or false

1. …… COCs can be used by women who are breastfeeding after six weeks postpartum.
2. …… If the client wants to continue using the implant, a new set of rods/rod can be inserted at the time the current set is removed.
3. ……The most common side effect with the use of implants is a change in the menstrual bleeding pattern
4. …… Counseling about side effects scares clients away and decreases method continuation.
5. …… Implants protect against STIs and HIV by thickening cervical mucus.
6. …… the type of anesthesia used for implants insertion and removal is 2 % lignocaine without adrenaline.
7. …… After removal of implants, a healthy woman may expect several months in return of fertility.
8. …… Implant is one of the most effective type of modern contraceptive options

Instruction B: Circle the letter that corresponds to the correct answer.

1. If a client forgets to take 1 pill, she should:
   A. Take the forgotten pill as soon as she remembers and take the next pill at the regular time
   B. discard the forgotten pill
   C. take 2 pills as soon as she remembers
   D. start a new pack of pills

2. The IUCD may not be the best method for woman who has:
   A. Gallbladder disease
   B. Acute/sub-acute pelvic infection
   C. No child
   D. Hypertension

3. IUCDs can be inserted:
   A. Any time during the menstrual cycle provided that the client is not pregnant.
   B. Immediately after delivery
   C. Immediately after non-complicated abortion.
   D. All of the above

4. Which one of the following is correct about counseling?
   A. REDI framework for counseling helps in assessing and addressing the needs of the client.
   B. Clients have the right and responsibility to make decisions and carry them out.
   C. An important role for family planning (FP) counselor is to assist clients in anticipating and strategizing about how to overcome the barriers that might prevent them from implementing their decisions.
   D. All

5. Which of the following is not required for a client to be able to make an informed choice?

A. Service provider's recommendation
B. Availability of appropriate information
C. Voluntary decision-making process
D. Availability of adequate service options

6. For breastfeeding women, combined estrogen and progestin pills can be initiated
   A. Starting at 3 weeks after birth.
   B. Immediately following birth
   C. 6 months after birth.

7. When one talks about dual protection:
   A. It is about condom
   B. It is about prevention of pregnancy and prevention of sexual transmission infection
   C. A and in B

8. When one gives option for emergency contraception; it can be of using:
   A. combined oral pills
   B. IUD (Cu T)
   C. Levonorgestrel only pill
   D. All

9. Which is part of the criteria to use lactation amenorrhea methods as a contraceptive;
   A. Baby less than 06 months
   B. The baby fully/nearly fully breast feed
   C. Menstrual bleeding not resumed
   D. All

4.2.2 Knowledge assessment - Post Partem Family Planning (PPFP)

Instruction A: Mark "T" or "F" in the blank to indicate true or false

1. .....When an IUCD is inserted 2 weeks postpartum, the risk of expulsion is very low because it is easier to reach the fundus

2. ..... The standard IUCD inserter tube can be used to place both interval IUCDs and postpartum IUCDs

3. ..... In order to reach the fundus in the PPIUCD insertion, the uterus must be "elevated" (pushed up in the abdomen) to smooth out the vagino-uterine angle.

4. ..... Women who choose the PPIUCD should limit breastfeeding in order to reduce the risk of expulsion

5. .....Placement of an IUCD during the immediate postpartum period has higher risk of uterine perforation than placement during the interval between pregnancies

Instruction B: Circle the letter that corresponds to the correct answer.

1. For health reasons, how long should women wait after delivering a baby before trying to become pregnant again?
   A. For at leastıyear
   B. For at least 2 years
   C. Until regular monthly periods have started again

2. Which of the following is an acceptable time to insert an IUCD postpartum?
   A. Within one day of postpartum
   B. Within one week of postpartum
   C. Within one month of postpartum

3. For breastfeeding women, combined estrogen and progestin pills can be initiated
   A. Starting at 3 weeks after birth.
   B. Immediately following birth
   C. 6 months after birth.

4. For breast feeding women, all progestogen-only methods – progestogen-only pills and implants can be initiated
   A. less than 6 weeks following birth
   B. Only 6 months afterbirths.
   C. Only 3 months after birth.

5. If a woman has had a normal vaginal delivery and an immediate/post placental IUCD insertion is planned:
   A. The IUCD should be inserted 30 minutes after active management of the third stage of labor is performed
   B. Active Management of the third stage of labor should be performed as usual, immediately before the IUCD Is inserted
   C. Active management of the third stage labor should be avoided, if possible, if the woman is having a PPIUCD

6. If a woman was successfully treated for Chlamydia during this pregnancy and wants an IUCD, the provider can:
   A. Insert the IUCD if the infection has been gone for more than 6 weeks
   B. Insert the IUCD but provide antibiotics for ıweek
   C. Tell the woman to return for insertion at 4 weeks postpartum

7. Which of the following is a condition of which PPIUCD insertion is considered Category 4 (meaning the method should not be used), according to the World Health Organization's Medical Eligibility Criteria (WHOMEC)?
   A. AIDS
   B. Puerperal Sepsis
   C. Cesarean section

8. Among natural method, LAM is working in:
   A. Baby is less than 6-month-old and breast feeding exclusively and menses not returned
   B. Baby is seven months old but exclusively breast fed and menses not returned
   C. Baby breast fed exclusively, baby less than six months old and menses returned

9. If a woman chooses Jadell while being counselled during immediate post-partum, when should be given the service?
   A. Right away before discharge from the facilities
   B. After two weeks of delivery
   C. After 6 weeks of delivery

4.3 FP Skill Assessment

4.3.1 FP COUNSELING COMPETANCY ASSSESSMNT CHECKLIST

Instructions: mark one of the following scores to represent the performance level of each task/ step observed

2 = correctly performed: step or task performed correctly according to the standard.

1 = partially performed: step or task partially performed

0 = not done or done incorrectly: step or task not performed correctly

Mentee Name _____ Date _____

Profession _____Name of Health Facility_____

STEPS/TASKS	Rating scale	Remark
Rapport Building		
1. Greeting the client with respect		
2. Ensures confidentiality and privacy throughout the session		
3. Make introductions and identify category of client—new, satisfied return, or dissatisfied return.		
4. uses communication skills effectively (active listening, open-ended questions, using clear and simple language) throughout the phases		
5. Use visual aids (brochures, contraceptive samples, posters, etc.)		
Exploration		
6. Explore the client's reason for the visit		

STEPS/TASKS	Rating scale	Remark
***FOR NEW CLIENTS ONLY**: If return client, **skip to** ⇒⇒ 11*		
7. Asks about the client's past experience with FP and assess the client's knowledge about FP		
8. Rule out pregnancy, about STIs, HIV, and possible domestic violence		
9. Gives appropriate information to the client based on the client's needs (i.e., tailored to the need of the client)		
10. Screen client for FP method use according to medical eligibility criteria		
***FOR RETURN CLIENTS ONLY**: If new client, **skip to** ⇒⇒ 14*		
11. Asks if the client has any problems or concerns with the method		
12. Asks about possible changes in client's life (new health-related problems or concerns, new partner(s)/possible exposure to STIs/HIV, Change in fertility plans)		
***FOR DISSATISFIED RETURN CLIENTS ONLY**: If satisfied return client, **skip to** ⇒⇒ 14*		
13. **Address the concerns or problems** raised by the client and help the client develop possible solutions?		
Decision Making		
14. Help the client consider his or her different options or reconfirm his or her choice (about side effects, health benefits, and health risks of suitable methods, needs for FP and STI/HIV prevention and reconfirm her choice)		
Implementing the Decision (the provider often does not need to cover all of these tasks with satisfied return clients)		
15. Help the client make a plan for implementing the decision by asking about next steps and the timeline for implementation.		
16. Help the client consider ways to overcome potential barriers to implement his or her decision(s)		
17. Ensure that the client has adequate knowledge and skills to implement the decision(s) (e.g., how to use the method, condom demonstration/practice,		

STEPS/TASKS	Rating scale	Remark
18. Ensure that the client understands what the possible side effects; warning sign, what follow-up is required (return visits, referral, and/or resupply)?		
19. Assure the client that he or she is welcome to return to the facility any time that he or she has concerns or problems or thinks he or she might prefer to switch to another method		

Observation/Comments

……
……

……
……

……
……

Competency rating

Mentee/Provider name:

……**……**

Mentee /Provider is	_____ Competent in performing FP counseling clinical skill
	_____Not Competent in performing FP counseling clinical skill
Follow-up action/Recommendation ➢ – ---------- ---------- ---------- ---------- ➢ – ---------- ---------- ---------- ----------		
Mentor /Assessor's name		
Mentor /Assessor's signature	Date	

4.3.2 IMPLANON INSERTION COMPETENCY ASSESSMENT CHECKLIST

Mentee Name: _____ **Date:** _____

Profession: …… **Health facility name:**

_____

Instructions: mark one of the following scores to represent the performance level of each task/step observed:

<u>Rating scale:</u>

2 = correctly performed: step or task performed correctly according to the standard.

1 = partially performed: step or task partially performed

0 = not done or done incorrectly: step or task not performed correctly

Implanon NXT Insertion clinical skills		
Tasks/steps	Cases	
Pre-insertion Tasks	Rating scale	Remark
1. Ensures that the client is appropriately counselled and eligible		
2. Describes insertion procedure and what is expected		
3. Ensures that all supplies and equipment are available and made ready for use		
4. Determines and marks insertion site		
5. Washes hands thoroughly, dries them and puts on surgical gloves		
6. Cleans the insertion site two times with iodine and put fenestrated towels over the arm		
7. Injects local anesthetics about 2ml (1% lidocaine without epinephrine) just under the skin		
8. Removes preloaded sterile applicator carrying the Implanon NXT from its blister		
9. Holds the applicator above the needle and removes the protection cap and confirm the presence of the implant capsule		
Insertion Tasks		
10. Stretches around the insertion site and punctures the skin with the tip of the needle angled 30 degrees		
11. Lowers the applicator to the horizontal position, keeps the needle parallel to the skin and slides the needle to its full length		
12. Unlocks the slider pushing it slightly down and moves the slider back until it stops and leaves the implant in its subdermal position		
13. Removes the applicator and verifies the presence of the implant by palpation		
Post-insertion tasks		
14. Applies band aid plaster and sterile gauze dressing with pressure bandage		
15. Disposes waste material by putting in leak proof container		
16. Wash hands thoroughly		
17. Completes client record		
18. Provides complete post-procedure instruction		

Observation/Comments:

_____

Competency rating

Mentee/Provider name: _____

Mentee /Provider is	_____ Competent
	_____Not Competent
Follow-up action/Recommendation	
Mentor /Assessor's name	
Mentor /Assessor's signature	Date

4.3.3 Implanon NXT REMOVAL COMPETENCY ASSESSMENT CHECKLIST

Mentee Name: _____ Date: _____

Profession: ..... Health facility name: .....

Instructions: mark one of the following scores to represent the performance level of each task/step observed

Rating scale:

2 = correctly performed: step or task performed correctly according to the standard.

1 = partially performed: step or task partially performed

0 = not done or done incorrectly: step or task not performed correctly

Implanon NXT removal clinical skills

Steps/ tasks		
Pre-removal Task	Rating scale	Remark
1. Ensure that the client is appropriately counselled and including the options to shift to another method		
2. Describes removal procedure and what is expected		
3. Ensures that all supplies and equipment are available and made ready for use		
4. Washes hands and puts gloves		
5. Cleans the area two times with iodine solution		
6. Localizes the implant and covers with fenestrated drape		
7. Injects local anesthetics (2ml of 1% lidocaine) to the incision site below each implant.		
Removal Tasks		
8. Makes a small transverse incision (4 mm) on the lower tips of the implant/s		
9. Pushes the ends of the implant easiest to move towards the incision and grasps it with mosquito forceps when visible and cleans off the fibrous sheath with sterile gauze /scalpel		
10. grasps exposed end with curved artery forceps and removes		
11. Using the same technique, removes the remaining capsule		

12. Brings the edge of the skin together and close with band aid plaster and apply pressure dressing comfortably		
Post-removal Tasks		
13. Disposes waste material by putting in leak proof container		
14. Washes hands thoroughly and Completes client record		
15. Provides FP method, if she wants		
16. Provide nutrition counseling and preconception folic acid supplementation, if she plans to be pregnant		
17. Provides complete post-procedure instruction		
18. Documents on client record and register		
19. Makes ready all used instruments for processing		

Observation/Comments:

_____

Competency rating

Mentee/Provider name: _____

Mentee /Provider is	_____ Competent
	_____Not Competent
Follow-up action/Recommendation	
Mentor /Assessor's name	
Mentor /Assessor's signature	Date

Mentee Name: _____ **Date:** _____

Profession:_____**Health facility Name:** _____

Rating scale:

2 = correctly performed: step or task performed correctly according to the standard.

1 = partially performed: step or task partially performed

0 = not done or done incorrectly: step or task not performed correctly

4.3.4 JADELLE INSERTION COMPETENCY ASSESSMENT CHECKLIST

Jadell Insertion clinical skills

Steps/ tasks	**Rating scale**	**Remark**
Pre-insertion Tasks		
1. Ensures that the client is appropriately counselled and eligible		
2. Describes insertion procedure and what is expected		
3. Ensures that all supplies and equipment are available and made ready for use		
4. Determines, and marks the insertion site		
5. Washes hands and puts surgical gloves		
6. cleans site with iodine two times and put fenestrated towels over the arm		
7. Injects local anesthetics about 2ml (1% lidocaine without epinephrine) just under the skin		
Insertion Tasks		
8. Inserts the trocar the disposable trocar directly through the skin tenting the skin advances trocar and plunger to mark (1) and remove plunger loads capsule in to trocar with gloved hand or forceps		
9. Reinserts and holds the plunger firmly in one hand and slid trocar out of the incision until it reaches the plunger handle.		
10. Withdraws the trocar with the plunger Until mark (2)		
11. Moves the tip of the trocar to the incision and redirects and advances to mark (1) and inserts the remaining capsule using the same technique		
12. Removes the trocar after insertion the last capsule		
Post-insertion tasks		
13. Brings the edge of the skin together and close with band aid plaster and apply pressure dressing		
14. Disposes waste material by putting in leak proof container		
15. Washes hands		
16. Completes client record		
17. Provides complete post-procedure instruction		

Observation/Comments:

_____

Competency rating

Mentee/Provider name: _____

Mentee /Provider is	_____ Competent
	_____Not Competent
Follow-up action/Recommendation ➢	
Mentor /Assessor's name	
Mentor /Assessor's signature	Date

4.3.5 JADELLE Removal COMPETENCY ASSESSMENT CHECKLIST

Removal of Jadell follows the same procedure to that of Implanon NXT removal.

4.3.6 IUCD (Copper T 380A) Insertion COMPETANCY ASSSESSMNT CHECKLIST

Instruction: mark one of the following scores to represent the performance level of each IUCD insertion task/step observed:

Rating scale:

2 = correctly performed: step or task performed correctly according to the standard.

1 = partially performed: step or task partially performed

0 = not done or done incorrectly: step or task not performed correctly

Mentee/Provider Name _____ Name of Health Facility_____

Profession; _____ Date observed _____

IUCD insertion clinical skills		
TASK/STEPS	**CASES**	
Pre-insertion Tasks	**Rating scale**	**Remark**
1. Ensures client is appropriately counseled and eligible for IUCD services.		
2. Ensures that the client is not pregnant		
3. Wash hands and puts new examination glove		
4. Arranges instruments and supplies		

IUCD insertion clinical skills		
TASK/STEPS	**CASES**	
5. Performs bimanual examination. Carefully determines size, shape, consistency, position and mobility of uterus		
Insertion Tasks		
6. insert speculum to facilitate insertion		
7. Cleans cervix and the vagina 2 times with antiseptic solution		
8. Grasp the cervix with tenaculum		
9. Inserts uterine sounds while gently pulling the tenaculum to determine the uterine length		
10. Loads Copper T 380A while inside sterile package		
11. Adjust the uterine length to the corresponding measurement of the uterus with uterine sound		
12. Removes loaded inserter tube without touching anything that is not sterile		
13. Holds inserter tube with palms turned upwards while gently pulling on tenaculum, and passes loaded inserter tube through cervix until flange touches the cervix		
14. Holds tenaculum and white rod stationary in one hand and releases the arms of IUD using withdrawal technique.		
15. Removes the white road		
16. gently pushes the inserter tube for fundal placement		
17. Partially removes the inserter tube, cuts IUD strings 3 cm and removes the inserter		
18. Gently removes the tenaculum, gently removes the speculum		
Post-Insertion Tasks		
19. Disposes wastes		
20. Makes ready all used instruments for Processing		

IUCD insertion clinical skills		
TASK/STEPS	**CASES**	
21. Washes hands		
22. Completes the client record and register		
23. Provides post-insertion instructions		

Observation/Comments:

_____
_____

_____
_____

Competency rating

Mentee/Provider name:
_____

Mentee /Provider is	_____ Competent
	_____Not Competent
Follow-up action/Recommendation	
Mentor /Assessor's name	
Mentor /Assessor's signature	Date

4..7 IUCD (Copper T 380A) Removal COMPETANCY ASSSESSMNT CHECKLIST

Instruction: mark one of the following scores to represent the performance level of each task/step observed:

Rating scale:

2 = correctly performed: step or task performed correctly according to the standard.

1 = partially performed: step or task partially performed

0 = not done or done incorrectly: step or task not performed correctly

Mentee/Provider Name _____ Name of Health Facility_____

Profession _____ Date observed _____

IUCD insertion clinical skills		
TASK/STEPS	**CASES**	
Pre-removal Tasks	**Rating scale**	**Remark**
24. Ensures client is appropriately counseled		
25. Describes the removal procedure and what to expect.		
26. Ensures that needed supplies and equipment are ready		
27. Washes hands thoroughly and dries them		
28. Puts new/clean examination gloves on both hands		
REMOVAL OF THE COPPER T 380A IUCD		
29. Inserts the bivalve speculum, examines and cleans cervix and vagina		
30. Grasps the strings close to the cervix with hemostat or other narrow forceps		
31. Pulls on the strings slowly but firmly to remove the IUCD		
32. Gently removes the speculum		
33. disposes of waste materials and make ready all necessary materials		
34. Washes hands thoroughly and dries them		

IUCD insertion clinical skills		
TASK/STEPS	**CASES**	
35. Records the IUCD removal in the client record and register		
36. Provide nutrition counseling and preconception folic acid supplementation, if she plans to be pregnant		

Observation/Comments:

_____

Competency rating

Mentee/Provider name: _____

Mentee /Provider is	_____ Competent
	_____Not Competent
Follow-up action/Recommendation	
Mentor /Assessor's name:	
Mentor /Assessor's signature:	Date:

4.3.7 COMPETANCY ASSSESSMNT CHECKLIST for Immediate Postpartum /Post-placental (Instrumental) Insertion of the IUCD (Copper T 380A)

This checklist is used for the assessment of skills during follow-up visits when mentee is ready for assessment of competency in this clinical skill. The competency assessment checklist includes only the critical steps of the procedure. The mentor should rate the mentee competency as per the following rating scales.

Rating scale:

2 = correctly performed: step or task performed correctly according to the standard.

1 = partially performed: step or task partially performed

0 = not done or done incorrectly: step or task not performed correctly

Mentee /Provider Name _____ profession _____

Name of Health Facility_____ Date _____

CHECKLIST FOR EARLY POSTPARTUM / Post-placental (Instrumental) INSERTION OF IUCD		
TASK/STEPS	**CASES**	
Pre-insertion Task	**Rating scale**	**Remark**
1. Reviews the woman's record to ensure that she has chosen IUCD		
2. Checks that she is appropriately counseled and screened for PPIUCD insertion.		
3. Greets the woman with kindness and respect and confirms that woman still wants IUCD.		
4. Explains that the IUCD will insert following of baby within 48 hrs. Briefly describes procedure. Answers any question the woman might have.		
5. Confirms that correct sterile instruments, supplies and light source are available for early/immediate postpartum insertion; obtains PPIUCD kit/tray.		
6. Confirms that IUCDs are available on labor ward; obtains a sterile IUCD, keeping the package sealed until immediately prior to insertion.		
7. Confirms that there are no delivery-related conditions that preclude insertion of IUCD now: – Rupture of membranes for greater than 18 hours – Chorioamnionitis – Puerperal sepsis – Continued excessive postpartum bleeding and genital trauma		
8. Ensures that woman has recently emptied her bladder and helps the woman onto table. Drapes her lower abdominal/pelvic area.		
9. Determines level/length of uterus and confirms that there is good uterine tone.		
10. Performs hand hygiene and puts HLD or sterile surgical gloves on both hands.		
Insertion of the IUCD		
11. Confirms that the woman is ready to have the IUCD inserted. Answers any questions she might have and provides reassurance if needed.		
12. Open the PPIUCD kit/tray and arranges insertion instruments and		

CHECKLIST FOR EARLY POSTPARTUM / Post-placental (Instrumental) INSERTION OF IUCD		
TASK/STEPS	**CASES**	
supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry, sterile cloth on the woman's abdomen.		
13. Gently inserts Simms speculum and visualizes cervix by depressing the posterior wall of vagina.		
14. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.		
15. Gently grasps anterior lip of the cervix with the ring forceps and leaves forceps aside, still attached to cervix.		
16. With non-dominant hand still holding the IUCD package (stabilizing IUCD through the package), with dominant hand uses Kelly forceps to grasp IUCD inside sterile package.		
17. With dominant hand, uses Kelly forceps to grasp IUCD inside sterile package. Holds IUCD by the edge, careful not to entangle strings in the forceps.		
18. Gently lifts anterior lip of cervix using ring forceps.		
19. Gently insert Kelly forceps with IUCD further into uterus toward point where slight resistance felt against back wall of lower segment of uterus.		
20. "Elevates" the uterus. Place base of non-dominant hand on lower part of uterus (midline, just above pubic bone with fingers toward fundus); and – Gently pushes uterus upward in abdomen to extend lower uterine segment.		
21. Gently inserts Kelly forceps with IUD through vagino-uterine angle and moves upward toward uterine fundus, in an angle toward umbilicus		
22. Continues gently advancing forceps until uterine fundus reached, when provider feels a resistance and confirm with the abdominal hand that the IUCD has reached the fundus.		
23. While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUCD at fundus.		
24. Slowly remove the forceps from uterine cavity by sweeping forceps to the sidewall of uterus and sliding instrument alongside wall of uterus.		
25. Keeps stabilizing uterus until forceps are completely withdrawn. Place forceps aside on sterile towel.		
26. Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix.		
27. Repairs any lacerations (episiotomy) as necessary.		
28. Removes all instruments used and places them for cleaning.		
Post-Insertion Tasks		
29. Disposes of waste materials appropriately and performs hand		

CHECKLIST FOR EARLY POSTPARTUM / Post-placental (Instrumental) INSERTION OF IUCD		
TASK/STEPS	**CASES**	
hygiene.		
30. Provide post insertion instruction		
31. Record information and documentation		

Observation/Comments:_____
_____

_____
_____

Competency rating

Mentee /Provider name: _____

Mentee /Provider is	_____ Competent
	_____Not Competent in performing PPIUCD clinical skill
Follow-up action/Recommendation ➢ – ---------- ---------- ➢ – ---------- ----------		
Mentor /Assessor's name:		
Mentor /Assessor's signature:	Date:	

4.3.8 COMPETANCY ASSSESSMNT CHECKLIST for Removal of Immediate Postpartum /Post-placental (Instrumental) IUCD (Copper T 380A)
Removal of Immediate Postpartum /Post-placental (Instrumental) IUCD (Copper T 380A) follows the same procedure to that of the removal of the regular IUD

Annex 6: **Adolescent and Youth Health Services**

Facility Readiness Assessment for Adolescent and Youth Health

Date of the visit /assessment: _____
Region: _____Zone/Woreda _____Name of the HF: _____
Name of HF Director: _____Phone Number of HF Director_____
Name of Mentor: _____ Name of Mentee: _____
Name of AYH clinic head: _____
Phone number of health facility: _____Phone No. of Mentee_____

Please answer each question	***Circle answer***		***Issues & actions taken to address major gaps***
Part I: Availability & Functionality of Space For AYH Service (ASK, Observe, Circle)			
1. Waiting area with free access for AYRH related information (leaflets, posters, TV…)	Yes	No	
2. All the health-care delivery points have AY specific signboard that mentions working hours and what services are provided specifically for AY	Yes	No	
3. Stand-alone exam room for AYRH service	Yes	No	
4. AY responsive services are integrated within a service delivery points	Yes	No	
5. Is the service provided in convenient time (this includes lunch time and after working hours (5 to 6 PM) and weekends)	Yes	No	
6. Stand-alone procedure room for SRH (FP and CAC) for AYRH	Yes	No	
7. Procedure room for SRH (FP and CAC) for adolescent and youth is integrated with general SRH service	Yes	No	
8. Room location is accessible to the gates near other OPDs	Yes	No	
9. Is the service provided for free	Yes	No	
10. Does the service also address psychosocial problems, nutritional assessment & counseling adolescents and youths (ask)	Yes	No	
11. Are adolescents and youth engaged in planning, designing, implementing, or evaluating /feedback sessions in relation to AYH service(ask)	Yes	No	
12. Functional Hand washing area with water & soap	Yes	No	
Part II: Staffing of AYH Service	**YES**	**NO**	Training Status: Is Staff Working at the Clinic Trained on AYH (Ask and Circle)
	#	**#**	
7. Medical Doctor (GP)	Yes	No	Yes / No
8. Health Officer (HO)	Yes	No	Y / No

			es		
9. Nurse (BSC)	Yes	No	Yes	No	
10. Nurse (Diploma)	Yes	No	Yes	No	
11. Is there staff rotation to other service unit from AYRH Unit	Yes	No			
12. How frequent is staff rotation done? (Fill)					
Part III: Availability of Print Materials, Job AIDS (Check)					
1. Latest national AYRH guideline	Yes	No			
2. Adolescent and youth health training manual	Yes	No			
3. Minimum service package	Yes	No			
4. National FP guideline	Yes	No			
5. Technical and procedural guideline for abortion	Yes	No			
6. REDI counseling framework	Yes	No			
7. FP wheel /Tiahrt chart	Yes	No			
8. National adolescent nutrition implementation guideline	Yes	No			
9. WHO BMI for age monitoring chart for adolescent	Yes	No			
10. Adolescent nutrition counseling card	Yes	No			
Part IV: Availability of Medical Equipment, Supplies and Consumables					
(Ask, Observe)	**Available &functional (circle)**				
Examination room supplies					
6. Examination Couch	Yes		No		
7. BP apparatus	Yes		No		
8. Statoscope	Yes		No		
9. Thermometer	Yes		No		
10. Weight scale	Yes		No		
11. Fetoscope	Yes		No		
12. Pulse oximetry	Yes		No		
13. Safety box	Yes		No		
14. Height board	Yes		No		
15. Penile model	Yes		No		
10 Surgical face masks	Yes		No		
16. Hand sanitizer	Yes		No		
PART V: MONITORING & EVALUATION TOOLS AND FORMATS (ASK, CHECK)	**(CIRCLE)**				
1. National DHIS-2 monthly reporting forms	Yes		No		
2. Referral forms (inter-facility, Intra-facility)	Yes		No		
PART VI: SERVICE CONTINUITY (ASK)					
1. Were there any interruptions in provision of care in the last three months during; If '***Yes',*** for how long, reasons and actions taken ▪ Duty hours,	Yes		No		
▪ Weekends	Yes		No		
▪ Holidays	Yes		No		

▪ Working hours	Yes		No
2. Solution tried for any interruption (if any, otherwise skip this question)	Yes		No
Part VII: On site Data Use (Targets and Reporting) for Services Provided at Stand-Alone AYH Service Unit			
7. Are reports reviewed by AYRH service delivery staff? **If yes**, mentor review last report with staff discusses on the following.	Yes	No	
a. Have catchment youth population data	Yes	No	
b. Sending reports on AYH services timely and complete	Yes	No	
c. Are catchment area targets met? Review and make plans with staff to meet targets.	Yes	No	
d. Practice of interpreting results of reports and making plans for quality improvement	Yes	No	
e. Are service provided under privacy and confidentiality setup (Observe)	Yes	No	
f. Is provider aware of unique needs of adolescent and youths (ask)	Yes	No	
Part VIII: Data Use (Target and Reporting) for Services provided in Integrated Approach with Other SRH service Unit			
1. Are reports reviewed by AYRH service delivery staff? If yes, mentor review last report with staff discusses on the following.	Yes	No	
a. Is the service delivery convenient for adolescent and youths (ask provider)	Yes	No	
b. Were data disaggregated by age and result interpreted by provider(observe)	Yes	No	
c. Are catchment area targets met? Review and make plans with staff to meet targets	Yes	No	
d. Documenting addresses AYRH related data (registries, tally sheets, charts…), observe	Yes	No	
e. Is integrating the service create any challenge (ask to describe)	Yes	No	
f. What solutions are tried for the challenges listed above (ask to describe)	Yes	No	
g. Is provider aware of unique needs of adolescent and youths (ask)	Yes	No	
Part IX: Availability of Essential Drugs and Commodities for AYH service in the Last Three Months including on the day of the visit (Unexpired); It can be in Stand-Alone or in Integrated AYH Service Delivery Approach			
19. Albendazole / Mebendazole	Yes	No	
20. Amoxicillin tabs	Yes	No	
21. Iron tablets /Fefol tablets	Yes	No	
22. Gentamycin Injection	Yes	No	
23. Ceftriaxone injection	Yes	No	
24. Metronidazole drip	Yes	No	
25. Ciprofloxacin tab	Yes	No	

26. Spectinomycin Vial	Yes	No	
27. Doxycycline tab	Yes	No	
28. Tetracycline tab	Yes	No	
29. Erythromycin tab	Yes	No	
30. Benz penicillin vial	Yes	No	
31. Acyclovir tab	Yes	No	
32. Anti-pains	Yes	No	
33. IV fluids	Yes	No	
34. IV cannula	Yes	No	
35. TT vaccine	Yes	No	
36. HPV vaccine	Yes	No	
37. Post exposure prophylaxis ART drugs	Yes	No	
Contraceptives			
1. COC			
2. POP	Yes	No	
3. Injectable	Yes	No	
4. Implants	Yes	No	
5. IUCD	Yes	No	
6. Condom	Yes	No	
7. Emergency contraceptives	Yes	No	
MA drugs			
1. Mifepristone	Yes	No	
2. Misoprostol	Yes	No	
Equipment			
1. MVA set	Yes	No	
2. Implant insertion set	Yes	No	
3. Implant removal set	Yes	No	
4. Delivery set	Yes	No	
Actions for any interruption/stock outs			
1.			
2.			
3.			

AYRH service in the last 3 months	**Clinical Service Outcome, Morbidity and Mortality Data on AYH in the last 3 months Before the Day of the Visit**	**Age 10-15**	**Age 16-19**	**Age 20-24**
	Total number enrolled to ANC1			
	Total number completing ANC 4			
	Total number of pregnant tested for syphilis			
	Total number of normal deliveries			
	Total number of delivered with S/c			
	Number of their newborn got essential care			
	Number of their newborn resuscitated			
	Proportion of their newborn resuscitated and survived			
	Total number of assisted instrumental deliveries			
	Total number of assisted Breech deliveries			
	Total Number stayed for 24 hours in the facility			

	Total number provided with nutritional assessment and counseling				
	Total number adolescent girls take WIFAS				
	Total number adolescents take deworming tablet				
	Total number provided with PPFP				
	Percentage of pregnant tested for HIV				
	Percentage of HIV positive pregnant received ART				
Abortion care service	Total number provided with PAC				
	Total number provided with CAC	MA			
		MVA			
		STA			
	Total numbers provided with PPFP				
AYRH deaths			10–15-year-old	16-19 years old	20-14 years old
Deaths recorded for the last 6 months	Total number of maternal deaths (adolescent and youth)				
	Total number of still births born to Adolescent and youths				
	Total number of neonatal deaths to adolescent and youths				
	Total adolescent and youth deaths from other causes	Female			
		Male			

1.2. MENTEES ASSESSMENT for adolescent and youth health

1.2.1. Mentee self-assessment Tool:

- ***Ask the mentee to present his/her experiences based on the following questions:***

  - ✓ How should the HC work to improve adolescent and youth health performance?
  - ✓ What support does the mentee expect from the mentorship? (*Probe: To what depth does the mentor provide support, what tools do to use during the visit etc.)*

	Adolescent and youth service	
1	Assess, counsel and provide service	
2	Able to assess AYRH client	
3	Able to provide client centered counseling for adolescent and youth	
4	Able to assess, classify and provide counseling on nutrition and healthy life skill	
5	Able to provide short acting family planning service for adolescent and youth	
6	Able to provide LARC service for adolescent and youth	
7	Able to provide medication abortion service to adolescent and youth	
8	Able to provide MVA for abortion service to adolescent and youth	
9	Able to provide second trimester abortion service to adolescent and youth	
10	Able to provide STI management service to adolescent and youth	
11	Able to provide HCT and linkage to ART for HIV positives of AYRH clients	

12	Able to provide post-exposure prophylaxis for HIV exposed adolescents and youths	
13	Able to provide delivery service to youths	
14	Able to provide addiction/ drug abuse related services	
15	Able to provide mental health service to adolescent and youths	

1.2.1. Mentee assessment by mentor

Assessment by mentor

The mentor should assess knowledge and skill of AYRH provider
For the knowledge part use the following 10 questions extracted from standard questions
The skill part and attitude part will be assessed by checklist in this guide used for specific service area. The skills include counseling, FP, CAC and delivery as well as other focused to the unit

Knowledge assessment questions during mentorship

[The questions are adapted from AYRH training materials]

1. Which of the statements **is not true?**

A. Child marriage is marriage before age 18
B. Child marriage is violation of human right
C. It is an acceptable tradition and practice
D. Ethiopia is among the countries with high child marriage
E. None

2. The third of Ethiopian population is adolescent and youth (10-24 years)
A. True B. False

3. **T**he following are factors that make difficult for adolescents to get contraceptives **except**

A. The unexpected and unplanned nature of their sexual activities
B. Lack of information and knowledge about contraceptives and where to get them
C. Judgemental attitude of and resistance from service providers
D. Fear of violence from parents and partners
E. None

4. Which of the following is effective preventive interventions of cervical cancer in Adolescents?

A. Screening with VIA
B. Immunization for HPV
C. Intermittent antibiotics
D. TT immunization
E. None

5. Student" A" is 16 years old woman came to you for spurt physical examination, she told you she is recently sexually active with a boy at her school, what additional information you need to know that student "A" is not sexually healthy?

A. None, student "A" 's age and history of sexual activity is enough to classify her as sexually unhealthy
B. Whether her sexual partner is going to marry her
C. Whether student "A" has more than one partner
D. Whether student "A" 's partner is the age with her

E. None

6. Student "B" has been in union with Bernard for 5 months and met two additional boys at a party in her high school with whom she had un protected sexual intercourse. Recently she started to have vaginal discharge which is not typical with her, how do you diagnose and treat her?

A. It is normal flora related and doesn't require treatment
B. It is a reproductive tract infection and has to be treated with metronidazole and cotrimoxazole
C. It is vaginal candidiasis and treated with clotrimazole vaginal tab
D. It is STI and has to be treated with spectinomycin, ciprofloxacillin and metronidazole

7. If safe abortion service is available for adolescent and youths, it will encourage proximity

A. Trues
B. False

8. Which of the following **<u>is trues</u>** about adolescent and youth nutrition?

A. Adolescent and youth period is also a period of spurt, psychological and physical change and requires balanced and diverse macro and micronutrient
B. Only micronutrient deficiency is common during this period
C. Obesity is not a problem of adolescent and youths as they are active
D. Adolescents & youth nutritional status only depends on family income
E. none

9. Which measurement methods is recommended for Adolescent and youth nutritional screening?

A. MUAC
B. Weight for Height
C. BMI
D. BMI for age
E. None

10. Family planning or contraceptive service counselling for adolescent should address **<u>all except</u>**

A. Efficacy /effectiveness of method
B. Dual method
C. Benefit, side effect and contraindication
D. The right of provider to choose the method on behalf of the adolescent
E. The source where to get supplies for use and follow-up information

11. Quality continuum of care for adolescent includes?

A. Early diagnosis of pregnancy
B. Effective ANC
C. Effective nutritional assessment and counselling
D. Effective care during labour and delivery
E. Effective PNC
F. All

Mentee`s clinical Skill assessment checklist

Skill/Procedure for ANC, administration of parenteral antibiotics, parenteral Uterotonic, anticonvulsant and antihypertensive, manual removal of placenta, Spontaneous Vaginal Delivery (Normal Birth), Assisted vaginal delivery with vacuum extraction, Newborn resuscitation, active management of the third stage of labor, Partograph use, assisted breech delivery, Perform episiotomy, Perform bimanual compression of uterus, NASG application, Postnatal Care , HEI and Manual Vacum Aspiration (MVA), use maternal health competency assessment checklist

1. Clinical skill for the insertion of **Implanon NXT,Jadelle and** IUD, use family planning checklist
2. Clinical skill for the removal of ImplanonNXT , Jadelle and IUD, use family planning checklist

1.4. Developmental appropriate counseling for Adolescent clients

Instructions: mark one of the following scores to represent the performance level of each task/ step observed

2 = correctly performed: step or task performed correctly according to the standard.

1 = partially performed: step or task partially performed

0 = not done or done incorrectly: step or task not performed correctly

Mentee Name _____ Date _____

Profession _____Name of Health Facility_____

STEPS/TASKS	Rating scale	Remark
Rapport Building		
20. Greeting the client with respect		
21. Ensures confidentiality and privacy throughout the session		
22. Make introductions and identify category of client— whether adolescent came for SRH or other AYH		
23. Uses developmental appropriate communication skills effectively (active listening, open-ended questions, using clear and simple language) throughout the phases		

STEPS/TASKS	Rating scale	Remark
24. Use visual aids (brochures, contraceptive samples, posters, etc.)		
Exploration		
25. Explore the client's reason for the visit		
FOR SRH CLIENTS ONLY*: If other client,* ***skip to*** ⇒⇒ ***11***		
26. Asks clients on SRH history based on age and development appropriate questions		
27. Rule out pregnancy, about STIs, HIV, and possible domestic violence accordingly using age appropriate developmental specfifc communication		
28. Conduct H.E.A.D.S.S. - A Psychosocial Interview		
29. Provide testing service for pregnancy or and HIV accordingly		
30. Gives appropriate information and service to the client based on the client's needs (i.e., tailored to the need of the client) if the age group 10-14 focus on delaying sexual debut…. If late adolescent provide specific service based on the need (pregnancy termination/follow-up, STI/HIV screening and treatment , information, counseling and service on FP, counseling ,management or referral for SGBV ete)		
FOR other CLIENTS ONLY*:*		
31. Asks if the client has any problems or concerns in line with other health problems like mental health , substance abuse, nutrition, injury, suicide, NCD etc		
32. Asks about possible changes in client's life ,		
33. Conducted HEADSS assessment		
34. Uses smart start discussion guide for married adolescents		
Decision Making		
35. Help the adolescnt consider his or her different options or reconfirm his or her choice (about the conditions the adolescent is and helps to decide on options but not to suggest)		
Implementing the Decision (the provider often does not need to cover all of these tasks with satisfied return clients)		
36. Help the adolescent make a plan for implementing the decision by asking about next steps and the timeline for implementation.		
37. Discussed on possible barriers for implementing the decision(s)		
38. Ensured that the client has adequate knowledge and skills to implement the decision(s) (e.g., how to use the method, condom demonstration/practice,) how to be assertive on per influence		
39. Maintains the interest of adolescent through out the implementation phase discussion		

STEPS/TASKS	Rating scale	Remark
40. Consult/involved parents /guardian for minors (early adolescents) or for any adolescent who wanted the presence of parent/guardian		

Observation/Comments.....
.....
.....

Competency rating

Mentee/Provider name:
.....

Mentee /Provider is	_____ Competent for providing developmental specific adolescent counseling
	_____Not Competent for providing developmental specific adolescent counseling
Follow-up action/Recommendation ➢ – ---------- ➢ – ----------	
Mentor /Assessor's name	
Mentor /Assessor's signature	Date

Annex 7: Nutrition service – Focusing on the first 1000 days Nutrition
(Service delivery unit - ANC, PNC, under –five OPD, Nutrition room and Immunization room)
Facility readiness assessment for NUTRITION service

1.1.1. Health Center Information

Region:		**Zone:**	
Woreda:		**Kebele:**	
Name of Health Centre:		**Catchment population:**	
Name of Referral Hospital:		Distance to Referral hospital:_____|Kms	
Name of satellite HPs and number of HEWs	Name of the Health post		# of HEWs
	6.		
	7.		
	8.		
	9.		
Date of Facility Assessment (dd/mm/yy):			
Name of mentor:_____	*Telephome /email*		
Name of mentee:_____			

1.1.2. Human Resources (health professionals)

I. STAFFING OF UNDER-FIVE OPD / NUTRITION ROOM (ASK)	YES (#)	NO	TRAINING STATUS: IS STAFF WORKING AT THE CLINIC TRAINED ON CMAM? (ASK & CIRCLE)		TRAINING STATUS: IS STAFF WORKING AT THE CLINIC TRAINED ON AMIYCN? (ASK & CIRCLE)	
13. Nutritionist (applied, clinical or public health nutrition)	Yes	No	Yes	No	Yes	No
14. Medical Doctor (GP)	Yes	No	Yes	No	Yes	No
15. Health Officer (HO)	Yes	No	Yes	No	Yes	No
16. Nurse (BSC)	Yes	No	Yes	No	Yes	No
17. Nurse (Diploma)	Yes	No	Yes	No	Yes	No
18. How frequent is staff rotation done? (Fill)						
19. Is there a need for additional HR assignment	Yes	No				

II. STAFFING OF ANC CLINIC (ASK)	YES	NO	III. STAFFING OF PNC CLINIC (ASK)		TRAINING STATUS: IS STAFF WORKING AT THE CLINIC TRAINED ON AMIYCF? (ASK & CIRCLE)	
1. Health Officer (HO)	Yes	No	Yes	No	Yes	No
2. Midwifery	Yes	No	Yes	No	Yes	No
3. Nurse (BSC)	Yes	No	Yes	No	Yes	No
4. Nurse (Diploma)	Yes	No	Yes	No	Yes	No

1.1.3. Service Availability

S. No.	Type of service	Available		Area of service/ Comment
Adolescent, Maternal and Child Nutrition Services		**Yes**	**No**	
1	Maternal nutrition/PLW			
2	GMP			
3	Under-five screening			
4	OTP			
5	SC (Stabilization center)			
6	Adolescent Nutrition			

1.1.4. Availability of functional space

Please answer each question	Circle answer		Issues & actions taken to address major gaps
I. AVAILABILITY & FUNCTIONALITY OF SPACE FOR NUTRITION (UNDER-FIVE/ NUTRITION ROOM) RELATED SERVICES (ASK, OBSERVE)			
13. Triaging area	Yes	No	
14. Adequate Nutrition screening area	Yes	No	
15. Adequate nutritional assessment and counseling area	Yes	No	
16. Appetite testing corner	Yes	No	
17. Adequate ventilation and light in the room	Yes	No	
18. Room location distant from adult OPD (*Should be located within the MCH block to reduce risk of cross-infection*)	Yes	No	
19. Functional Hand washing area with water & soap	Yes	No	

1.1.5. Availability of guidelines and protocols

I. AVAILABILITY OF PRINT MATERIALS, JOB AIDS (CHECK) AT UNDER-FIVE CLINIC/NUTRITION ROOM					
	UNDER-FIVE OPD		NUTRITION ROOM/ OTP/ SC		
10. Guideline for the management of SAM	Yes	No	Yes	No	
11. Quick reference guide	Yes	No	Yes	No	
12. Management of SAM register	Yes	No	Yes	No	
13. WFH/L reference tables	Yes	No	Yes	No	

14. SAM classification Wall chart	Yes	No	Yes	No	
15. RUTF reference card	Yes	No	Yes	No	
16. OTP treatment and follow up card?	Yes	No	Yes	No	
17. CINS (comprehensive, Integrated Nutrition Service) register	Yes	No	Yes	No	
18. CINS tally sheet	Yes	No	Yes	No	
19. Growth monitoring chart/ register	Yes	No	Yes	No	
20. Nutrition IEC materials and calendars (if 'yes', please specify)	Yes	No	Yes	No	
II. AVAILABILITY OF PRINT MATERIALS, JOB AIDS (CHECK) AT ANC AND PNC					
	ANC		PNC		
1. Pregnant and lactating women register	Yes	No	Yes	No	
2. Nutrition IEC materials and calendars (if 'yes', please specify)	Yes	No	Yes	No	

1.1.6. Medical equipment and supplies

AVAILABILITY OF MEDICAL EQUIPMENT, SUPPLIES AND CONSUMABLES AT UNDER-FIVE/ NUTRITION ROOM					
Equipment and Supplies: (*Ask, Observe)*	Availability *(circle*)		**Functionality**		
17. Weight Scale (Infant)	Yes	No	Yes	No	
18. Weight Scale (Child) (Uni- Scale/ Salter scale (25 kg) plus pants)	Yes	No	Yes	No	
19. Thermometer	Yes	No	Yes	No	
20. Height measurement board	Yes	No	Yes	No	
21. Gloves	Yes	No			
22. MUAC tape	Yes	No	Yes	No	
23. Alcohol/ Hand sanitizers	Yes	No			
AVAILABILITY OF MEDICAL EQUIPMENT AND SUPPLIES AT ANC					
1. Weight scale (Adult)	Yes	No	Yes	No	
2. Adult MUAC	Yes	No	Yes	No	

1.1.7. Availability of essential drugs and supplements

I. AVAILABILITY OF ESSENTIAL DRUGS IN THE LAST THREE MONTHS INCLUDING ON THE DAY OF THE VISIT (UNEXPIRED) AT UNDER-FIVE OPD/ NUTRITION ROOM			
38. Albendazole	Yes	No	
39. Amoxicillin DT	Yes	No	
40. Vitamin A	Yes	No	
41. Plumpy Nut/ RUTF	Yes	No	
42. Stock outs or interruptions in dispensing nutrition commodities with reasons and actions taken	Yes	No	
43. Timely refill of requisition and reporting forms (RRF) at pharmacy store (*check date of the last request*)	Yes	No	

II. AVAILABILITY OF ESSENTIAL DRUGS IN THE LAST THREE MONTHS INCLUDING ON THE DAY OF THE VISIT (UNEXPIRED) AT ANC			
1. IFA	Yes	No	
2. Albendazole for deworming	Yes	No	

1.1.8. Monitoring and evaluation tools and formats

I. MONITORING & EVALUATION TOOLS AND FORMATS (ASK, CHECK)	(CIRCLE)		
1. National DHIS-2 monthly reporting forms/ nutrition data elements	Yes	No	
2. Monthly statistic reporting forms for SAM/MAM/GMP/PLW	Yes	No	
3.Monthly Supplies Report for SAM and MAM	Yes	No	
4. Referral forms/Slip (inter-facility, Intra-facility)	Yes	No	
II. DATA USE (TARGETS & REPORTING)			
8. Are reports reviewed by under-five OPD/Nutrition room staff? Review last report with staff.	Yes	No	
9. Practice of using/interpreting Growth Monitoring charts	Yes	No	
10. Sending reports on time; Accuracy/quality of reports	Yes	No	
11. Are catchment area targets met? Review and make plans with staff to meet targets.	Yes	No	
12. Practice of interpreting results of reports and making plans for quality improvement	Yes	No	
13. Does the HW get referral feedback?	Yes	No	
III. REFERRAL SYSTEMS (BIDIRECTIONAL I.E. ABOVE & BELOW):			
1. System for tracking linkage within the HC/ integration with other services	Yes	No	
2. System for tracking Outside referrals	Yes	No	
3. System to link to social support/ TSFP, PSNP	Yes	No	
4. Using referral and feedback forms	Yes	No	
5. Documenting attempts to track loss of follow-up visits/ defaulters	Yes	No	

Mentee self-assessment Tool:

- ***Ask the mentee to present his/her experiences based on the following questions:***
  - ✓ How should the HC work to improve nutrition services performance?
  - ✓ What support does the mentee expect from the mentorship? (*Probe: To what depth does the mentor provide support, what tools do to use during the visit etc.)*

Tool for mentee's self-assessment
To be completed by mentee
submitted to Mentor:
Frequency: *Baseline,-mid line and at last mentorship visit (visit no. 6)*

Clinical competency assessment: Mentee self-assessment

Directions for the mentee: The following tasks ask how confident you feel about your ability to do specific tasks at the ANC, PNC, and under-five OPD/Nutrition room. Please complete the form and submit to the mentor.

1	I am not at all confident: I do not know how to do this task
2	I am somewhat confident: I can perform the task with support
3	I am extremely confident: I am capable of doing this task and consider myself competent/ proficient
4	I consider myself to have expertise and can teach this task to others

		Task/Competency	1-4
		PREGNANT and LACTATING WOMEN	
		Assess and counsel the pregnant women	
Pregnant and Lactating women	**1**	*Perform nutritional screening (Adult MUAC, managing accordingly)*	
	2	*Perform nutrition assessment and counseling*	
	3	*Checking for Weight gain during pregnancy*	
	4	*Advise on ITN use for Malaria endemic areas*	
	5	*Checking for Iron Folate and Folic acid supplementation adherence*	
	6	*Deworming the pregnant women*	
		Counsel the lactating mother	
	7	*Counsel on healthy eating, diversified meal and use of Iodized salt*	
	8	*Advice on use of ITN*	
	9	*Advice on Family Planning*	
	10	*Counsel on Optimal breast feeding (early initiation, proper attachment and positioning, feeding on demand, EBF, benefits of BF)*	
	11	*Advice on exposing the child on direct sunlight*	
		BABY FROM BIRTH UP TO 6 MONTHS	
young infant Birth up to six months		***Assess the Young Infant and Counsel the Mother***	
	12	*Assessing the Young Infant from Birth Up to 6 Months*	
	13	*Checking for Underweight from Birth Up to 6 Months/ Growth monitoring and promotion/*	
	14	*Checking for early initiation of breast feeding and colostrum feeding*	
	15	*Checking for exclusive breast feeding practice*	
	16	*Checking for proper positioning and attachment of BF*	
	17	*Checking for Breast Feeding Problem/ Pre-lacteal feeding, any bottle feeding, formula feeding*	
	18	*Checking for Feeding Problem: HIV Positive Mother Not Breastfeeding*	
	19	*Checking & classifying the child for Acute Malnutrition*	
		Treating the Young Infant and Counsel the Mother	
	20	*Care for the child with Acute malnutrition (0-6 months)*	
	21	*Keeping the Young Infant Warm*	

	22	*Teaching early initiation of BF within one hour and avoidance of prelacteal feeding and exclusive BF practice*	
	23	*Teaching Correct Positioning, Attachment, frequency, mechanism for Breastfeeding and benefits of BF*	
	24	*Teaching the Mother to Continue breast feeding during illness and recovery*	
	25	*Teaching the Mother to Breast feed on demand*	
		CHILD 6 MONTHS UPTO 5 YEARS	
CHILD 6 MONTHS UPTO 5 YEARS		***Assess and Classify and Identify Treatment***	
	26	*Checking & classification the child for underweight/ Growth monitoring and promotion/*	
	27	*Plotting & Interpreting WFA Chart (Birth to 5 years Z-Score)*	
	28	*Checking initiation of complementary feeding practice*	
	29	*Check quality of complementary feeding; diet diversity and frequency*	
	30	*Perform cooking demonstration for improved CF*	
	31	*Check & classifying the child for Acute Malnutrition (6- 59 months)*	
	32	*Plotting & Interpreting WFL/H (Z-Score)*	
	33	*Measuring & Interpreting MUAC*	
	34	*Check appetite test*	
	35	*Checking the Child's Immunization, Deworming and Vitamin A Status*	
		Treat the child and counsel the mother	
	36	*Giving Vitamin A*	
	37	*Giving Albendazole for Deworming*	
	38	*Treating the child for acute malnutrition according to the protocol*	
	39	*Teaching age appropriate Complementary Feeding (IYCF) and continuation of BF until 2 years and beyond*	
	40	*Teaching WASH practices*	
	41	*Link the child with underweight to TSFP*	
		COUNSELING THE MOTHER	
	42	*Assessing the Child's Feeding*	
	43	*Counseling the mother on early initiation of breast feeding and avoidance of prelacteal and bottle feeding*	
	44	*How to Feed a Baby with a Cup*	
	45	*Advising the Mother to Increase Breast feeding During Illness*	
	46	*Counseling the Mother About Her Own Health and Nutritional status*	
	47	*Use of the Family Health Card*	
	48	*Giving Follow-up Care*	
	49	*Every month growth monitoring and promotion (GMP)*	
	50	*Uncomplicated Severe Acute Malnutrition follow up visit*	
	51	*Moderate Acute Malnutrition management*	
	52	*Vitamin A and Deworming supplementation every six months*	

Assessment by mentor

1.3.1. Knowledge assessment questions

What is the first 1000 days nutrition? (Circle all the correct options)

A. It focus on child nutrition from birth to three years of age
B. It is the period from the time of conception up to the second year of a child
C. It includes both maternal and child nutrition
D. It is a window of opportunity to shape a child's development and growth

What is the recommended weight gain during pregnancy for a woman with a normal BMI?

A. 12-13 kg
B. 11–16 kg
C. 20 kg
D. 10 kg

Which of the following are among the nutritional services that are provided at ANC? (Circle all the correct options)

A. Nutrition assessment and counseling
B. Nutritional screening
C. Weight gain measurement
D. Micronutrient supplementation
E. Deworming

Which of the following are a good advice to reduce side effects of IFA supplementation during pregnancy? (Circle all the correct options)

A. Advice the mother to take the IFA tablet with food
B. Take iron with foods containing vitamin C because it improves absorption of iron
C. Advise the mother to avoid taking iron tablets with tea or coffee because it decrease absorption
D. Advise the mother to drink plenty of water
E. Provide anti acids if gastric symptoms persist

Which of the following are good nutritional advises during pregnancy at ANC visit? (Circle all the correct options)

A. Advice diversified and nutritious foods with one extra meal every day
B. Advice the mother to ensure adequate weight gain through sufficient protein and energy intake
C. Advice the mother to take IFA tabs to prevent anemia during pregnancy
D. Advice the mother to take enough rest and sleep
E. Advice the mother to use iodized salt
F. Advice the mother to reduce sugar and salt in food
G. Advice on safe food handling practices and hand washing

Which of the following are good nutritional advice during the third trimester of pregnancy?

A. Advice the mother to initiate Breast Feeding immediately after birth (within one hour) even before placenta is expelled
B. Advice the mother to give colostrum (the first yellow milk)
C. Advice the mother to avoid pre-lacteal feeding
D. Advice on feeding the newborn only breast milk for the first 6 months not even giving water
E. All

Which of the following is not among the component of optimal breast feeding practice?

A. Early initiation of breast feeding within one hour
B. Give water to under six month children when they have abdominal pain
C. Exclusive breast feeding for the first six month
D. Demonstrate proper positioning and attachments
E. Breast feeding on demand day and night
F. Continue breast feeding at least to 24 months and beyond

Which of the following are among the benefit of early initiation of breast feeding?

A. Helps to stimulate milk production
B. Helps to expel placenta
C. Reduces post-partum bleeding
D. Creates mother and baby bonding
E. Reduces the risk of neonatal mortality
F. Colostrum is the first natural vaccination that prevents against infection
G. All

Which of the following are among the component of optimal Complementary feeding practice?

A. Timey initiation of age appropriate complementary feeding
B. Age appropriate feeding; amount and density
C. Responsive feeding
D. Feeding frequency and diversity
E. Food Hygiene (hand washing on critical time and proper storage of food)

Which nutritional indices used to assess and classify malnutrition for children under-five? (Circle all the correct options)

F. Weight for height
G. Weight for length
H. Body Mass Index (BMI)
I. MUAC
J. BMI-for-Age

Which of the following are classification of malnutrition? (Circle all the correct options)

F. Sever acute malnutrition
G. Moderate acute malnutrition
H. Underweight
I. Overweight
J. Obesity
K. All

Which measurement score is correct to classify children 6-59 months as Sever Acute Malnutrition (SAM)? (Circle all the correct options)

A. Weight-for-height < -3 Z-score
B. MUAC < 11.5 cm
C. Weight-for-age < -3 Z-score
D. MUAC < 11 cm
E. WFH/L ≥ -3 Z-score to < -2 Z-score

Which measurement score is correct to classify under five children as Severely Underweight?

A. MUAC < 11.5 cm
B. Weight-for-age < -3 Z-score
C. Weight-for-age < -2 Z-score
D. Weight-for-age ≥ -3 Z-score to < -2 Z-score

Nutrition skill assessment

1.4.1. Nutrition counseling competency assessment checklist

Instructions: mark one of the following scores to represent the performance level of each task/ step observed

2 = correctly performed: step or task performed correctly according to the standard.
1 = partially performed: step or task partially performed
0 = not done or done incorrectly: step or task not performed correctly

Mentee Name _____ Date _____
Profession _____ Name of Health Facility_____

		Step/Task	Rating scale	Remark
		PREGNANT and LACTATING WOMEN		
		Assess and counsel the pregnant women		
Pregnant and Lactating women	**1**	*Perform nutritional screening (Adult MUAC, managing accordingly) If needed link: to TSFP/ Food support, PSNP, Reproductive health services*		
	2	*Perform nutrition assessment and counseling*		
	3	*Checking for Weight gain during pregnancy*		
	4	*Counsel on one extra meal and rest during pregnancy*		

	5	*Counsel on healthy eating, diversified meal and use of Iodized salt*		
	6	*Advice on early initiation of breast feeding and feeding of colostrum*		
	7	*Advise on Avoidance of pre-lacteal feeding*		
		Counsel the lactating mother		
	8	*Counsel on two extra meal and rest during lactation*		
	9	*Counsel on healthy eating, diversified meal and use of Iodized salt*		
	10	*Counsel to continue use of Iron folate*		
	11	*Counsel on Optimal breast feeding (early initiation, proper attachment and positioning, feeding on demand, EBF, benefits of BF)*		
		BABY FROM BIRTH UP TO 6 MONTHS		
young infant Birth up to six months		***Assess the Young Infant and Counsel the Mother***		
	12	*Checking for Underweight from Birth Up to 6 Months/ Growth monitoring and promotion/*		
	13	*Checking & classifying the child for Acute Malnutrition*		
		Treating the Young Infant and Counsel the Mother		
	14	*Care for the child with Acute malnutrition (0-6 months)*		
	15	*Keeping the Young Infant Warm*		
	16	*Counselling the mother on exclusive breast feeding up to 6 months*		
	17	*Teaching Correct Positioning, Attachment, frequency, mechanism for Breastfeeding and benefits of BF*		
	18	*Teaching the Mother to Continue breast feeding during illness and recovery*		
	19	*Advising the Mother to bring the child for growth monitoring and promotion monthly*		
		CHILD 6 MONTHS UPTO 5 YEARS		
CHILD 6 MONTHS UPTO 5 YEARS		***Assess and Classify and Identify Treatment***		
	20	*Checking & classification the child for underweight/ Growth monitoring and promotion/*		
	21	*Plotting & Interpreting WFA Chart (Birth to 5 years Z-Score)*		
	22	*Check & classifying the child for Acute Malnutrition (6- 59 months)*		
	23	*Plotting & Interpreting WFL/H (Z-Score)*		
	24	*Measuring & Interpreting MUAC*		
	25	*Check appetite test*		
		Treat the child and counsel the mother		
	26	*Treating the child for acute malnutrition according to the protocol*		
	27	*Counseling on optimal Complementary Feeding (IYCF) practice and continuation of BF until 2 years and beyond*		
	28	*Counseling the mother on age appropriate complementary feeding after 6 months*		
	29	*Counseling on quality of complementary feeding; diet diversity and frequency*		
	30	*Feeding Recommendations for All Children During Sickness & Health and including HIV Exposed Children on ARV Prophylaxis*		
	31	*Feeding Recommendation for a child with Uncomplicated SAM*		
	32	*Feeding Recommendations for A Child with Persistent Diarrhoea*		
	33	*Feeding Recommendation for a non-breast-feeding child (any reason)*		
	34	*Counseling the Mother About Feeding Problems*		
	35	*Counseling the Mother about Safe Preparation of complementary feeding preparation*		
	36	*Counseling the HIV+ Mother who has Chosen Not to Breastfeed/ Appropriate*		

		Amount of Formula Needed per Day		