SBBC
Implementation Framework

March 2026

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INTRODUCTION

This framework guides SBBC implementation through government health systems. It organizes activities across five phases—from leadership engagement through long-term consolidation—showing how countries progress from initial rollout to sustained operations.

SBBC APPROACH

SBBC is a proven, practical pathway for countries to close persistent intrapartum quality-of-care gaps that continue to drive maternal and newborn mortality and stillbirth, even where coverage of institutional births has improved.

The SBBC approach integrates a coherent package (bundle) that changes what happens in labour and delivery rooms every day—blending clinical skills practice, interprofessional teamwork, debriefing, timely detection/treatment of complications, and continuous feedback. At scale, the SBBC approach has been associated with marked mortality reductions, including a ~75% reduction in maternal deaths and a ~40% reduction in early neonatal deaths (first 24 hours) in the Tanzania programme based on more than 280,000 births.

SBBC COMPONENTS AND MINIMUM HEALTH SYSTEM READINESS

The SBBC approach consists of four mutually reinforcing components:

Training Innovation

- ✓ Champion health professionals facilitate on-site simulation for colleagues, mentored and linked to national faculty for scalable sustainability.
- ✓ This is not standard clinical or simulation training—it takes simulation training into facilities through low-dose high-frequency practice combining individual skills sessions and team simulation drills.
- ✓ Structured debriefing fosters psychological safety and a "no blame-no shame" culture.
- ✓ Training covers both technical skills and non-technical skills like communication and teamwork, delivered through peer-to-peer learning where facility champions gain competencies to facilitate sessions for colleagues.

Clinical Innovation

- ✓ User-friendly devices designed for maternal and newborn care in resource-constrained environments.
- ✓ Fit for context clinical devices that enable early detection of fetal distress (e.g., Moyo fetal heart rate monitor) and timely neonatal resuscitation, (NeoBeat newborn heart rate monitor), Penguin sucker, Upright bag-mask devices)

- ✓ Training devices build competence through simulation (MamaNatalie PPH simulator, NeoNatalie Live for neonatal resuscitation).

Data-Driven Continuous Quality Improvement

- ✓ Regular, visual feedback of clinical and training data linked to concrete improvement cycles and peer-learning networks.
- ✓ This component is not optional—it drives sustained improvement by connecting data collection, analysis, champion-led improvement meetings, routine mentorship, and peer learning.

Integration & Readiness for Scale

- ✓ Facilities prepared to deliver SBBC interventions effectively. Training, equipment supply chains, data and CQI activities embedded within existing government health systems from day one.
- ✓ This component was added by GFF to ensure SBBC sustainability and scalability. Addresses facility readiness (infrastructure, staffing, equipment) and system integration (supply chains, clinical protocols, governance structures) designed from day one to ensure institutionalization.

Why SBBC Works

SBBC creates a supportive learning environment where clinical teams practice emergency scenarios, receive regular feedback, and drive continuous improvement. It builds on facility readiness—adequate infrastructure, minimum staffing, basic labor and delivery capacity.

SBBC transforms how labor wards function through innovation, skills practice, and quality improvement, strengthening both teamwork and outcomes.

It has a cross-cutting approach to quality improvement, therefore supports rather than competes with intrapartum recommendations e.g. the WHO Labour Care Guide and the EMOTIVE bundle.

Effective SBBC implementation **requires at a minimum a health facility that has sufficient health professionals in the labor and delivery wards to support a team-based learning approach**. In addition, there needs to be support from the facility and (sub)-national leadership to institute quality improvement actions that are identified as part of the SBBC simulations and structured debrief, ensuring that there are essential drugs and commodities available.

We propose SBBC at a minimum for all facilities that are providing care to more than 800 births per year and where there are at least 10 staff who routinely work providing intrapartum care.

SBBC as a Blueprint for Broader Service Delivery Redesign

This systematic approach to strengthening labor ward function offers broader application. The infrastructure that enables SBBC's effective teamwork—simulation training, data feedback loops, champion networks—offers a systematic implementation model applicable to other health priorities.

The bundle structure makes this infrastructure manageable—each component can be planned, costed, delivered, tracked, monitored, and improved independently while maintaining the integrated approach.

This provides a springboard for service delivery redesign. Once a sustainable SBBC infrastructure is established through government systems, it becomes reusable capacity:

- ✓ The simulation training cascade (Faculty → Mentors → Champions) can expand to other clinical areas at a relatively lower incremental cost
- ✓ The same simulation facilitation skills, debriefing methodology, and team-based learning approach can apply across clinical scenarios
- ✓ Data-driven CQI approaches can transfer across health programs

Countries that invest in building this training cascade, data systems, and support networks through their systems, can leverage them across multiple clinical priorities—from emergency obstetric care to pediatric resuscitation to surgical safety protocols

SBBC Implementation & Maturity Model

Institutionalization of SBBC follows a staged pathway from initial leadership engagement through long-term consolidation. We propose an operational plan that organises activities across five phases—ensuring that design choices, testing, scale, and consolidation are sequenced deliberately for sustainability (Figure 1).

The five phases described below place significant emphasis on activities and issues related to sustainability, recognizing that countries are expected to integrate SBBC into their health systems rather than implement it as a standalone intervention.

Phase 1: Leadership & Sensitization

Establishes the foundation by securing high-level commitment and creating awareness across all stakeholder levels. This phase focuses on appointing national coordinators, conducting sensitization meetings with national and regional leaders, and establishing governance oversight mechanisms to ensure sustained leadership support throughout implementation.

Phase 2: SBBC integration into country health systems

Completes all adaptation and integration activities required before implementation begins. Countries conduct facility readiness assessments, harmonize SBBC protocols with national guidelines, assess the potential for integration into health information systems, and adopt/adapt training materials. This phase ensures all health system-level preparations are in place before any facility-level activities commence.

Phase 3: Small-Scale Testing & Validation

Tests SBBC implementation (or selected components, such as CQI & data) in a limited number of facilities to assess and validate implementation requirements. This testing phase allows countries to identify and resolve implementation challenges before proceeding to full-scale rollout.

Might run in parallel with Phase 2 adaptation work, for example to inform the development of national materials and protocols. Establishes the adaptive learning cycle that continues through Phase 5.

Phase 4: Scale-Up Implementation

Expands SBBC to the full target number of facilities using the validated systems and procedures from Phase 3. This phase includes the main training cascade, equipment deployment, and establishment of ongoing mentorship and supervision systems across all implementation sites.

Phase 5: Maintaining It

Sustains SBBC implementation through ongoing governance and coordination, monitoring and evaluation, annual reviews, and learning workshops. Continues the adaptive learning cycle established in Phase 3 — using implementation data to identify challenges, adjust approaches, and share lessons across facilities and regions

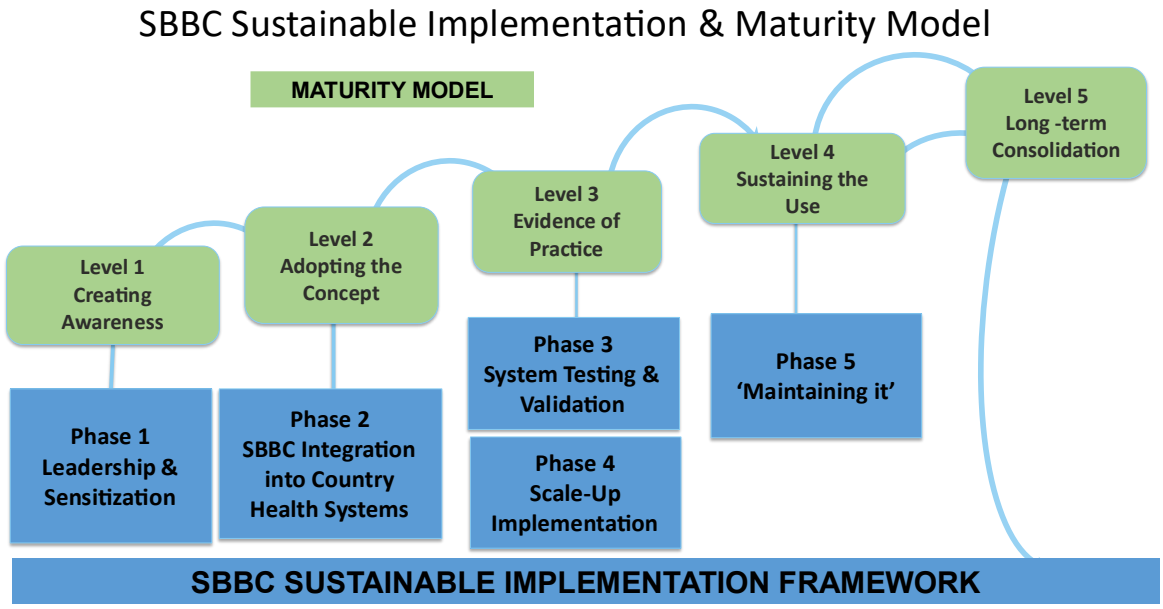

Figure 1. SBBC Implementation and Maturity Model.

Maturity Model Across SBBC Components

The maturity model also recognizes that different SBBC components mature at different rates and require different transition pathways:

Training Innovation:

Long term sustainability requires countries to transition from external technical assistance to independent local faculty capable of training other faculty. This progression typically spans 3-5 years in line with existing simulation training capacity in country. Will require realistic budgeting for intensive international support initially, then progressive reduction as local capacity develops. Countries that develop faculty independence can sustain SBBC training when external support phases out.

CQI & Data:

Countries cannot implement effective CQI if they have not first established functional data collection and feedback mechanisms. They must select approaches that match current health system infrastructure and technical capacity. The goal is not rapid digitization but establishing data governance, quality procedures, and feedback mechanisms that function within existing constraints while avoiding parallel systems that burden clinical staff.

From an implementation timeline perspective, a maturity model approach could for example be outline as: Year 1 establishes foundations—system design, standardized protocols and templates, pilot testing, and intensive mentorship. Years 2-3 introduce selective enhancements where infrastructure permits: basic digital tools (calculators, spreadsheets), monthly training completion summaries, and preliminary analysis of LDHF participation rates. Years 4-5 support advanced integration for facilities with proven capacity: linking training patterns with clinical outcomes to target simulation practice strategically.

Clinical Innovation:

Equipment follows a different pattern. Countries procure devices, integrate them into supply chains and maintenance systems, and operate them. The critical transition is one-time: moving from project-based procurement to routine government supply chain management through integration into essential equipment lists, procurement specifications, and maintenance protocols.

Integration & Readiness:

This SBBC component covers key activities in Phase 1 (Leadership & Sensitization) and Phase 5 (Maintaining It) and ensures cross-cutting system integration issues (Phase 2) such as facility readiness are included in the framework.

As an example of implementation line along the maturity model: Year 1 focuses on sensitization—creating awareness and securing leadership commitment. Years 2-3 emphasize adoption—integrating SBBC into government systems (equipment supply chains, clinical protocols, governance structures, coordination mechanisms). Years 3-4 demonstrate evidence of practice as systems operate with reducing external support. Years 4-5 achieve sustainability with SBBC fully embedded in routine operations and long-term consolidation.

This timeline progression requires explicit planning for coordination transitions: intensive national and regional coordinator support during establishment, reducing as systems stabilize. Long-term consolidation (Level 5 maturity) is achieved through the quality and integration focus of all preceding phases, rather than through separate end-stage activities. This approach, combined with ongoing monitoring and learning cycles built into Phase 5, ensures SBBC becomes an integrated part of routine health system operations and continuous quality improvement processes.

Implementation Activities Across SBBC Phases and Components

Table 1 organizes implementation activities across the five phases, showing how countries progress through maturity levels—from creating awareness to long-term consolidation.

Activities are grouped by phase, with each phase encompassing work across multiple SBBC components (Training Innovation, Clinical Innovation, CQI & Data, and Integration & Readiness). And while all components advance through the phases together, they mature at different rates in each country. Training capacity will develop over several years based on existing simulation training capacity; CQI systems will strengthen progressively as data systems improve, and clinical equipment transitions happen through one-time procurement shifts.

TABLE 1 – SBBC ACTIVITIES ACROSS PHASES AND COMPONENTS

Activity	Description/Notes
PHASE 1: LEADERSHIP & SENSITIZATION (Integration & Readiness Component)	
Secure Ministry of Health commitment	Obtain executive sponsorship and written commitment from MOH leadership Develop concept note outlining implementation approach & broader requirements
Engage professional associations	Secure support and engagement from relevant professional associations (i.e. obstetric, pediatric, midwifery, nursing) to ensure clinical buy-in and facilitate implementation through professional networks
Conduct sensitization meetings	**National level**: Conduct introductory (and sensitization) meeting with senior MOH leadership and key stakeholders to present SBBC approach and secure commitment **Regional level**: Conduct sensitization meetings with regional health leadership to ensure understanding and support across implementation areas Develop standardized presentation materials packages for consistent messaging.
Establish governance structure	Establish steering committee or governance oversight mechanism, potentially integrated with existing MOH committees. Include representation from professional associations and key stakeholder groups. Plan for quarterly governance review meetings with structured reporting.
Appoint national SBBC coordinator with protected time allocation	Designate dedicated national coordinator with sufficient protected time allocation to manage implementation activities. Define roles and responsibilities including coordination across levels, stakeholder engagement, problem-solving and technical support, progress monitoring and ensuring integration with other health system initiatives.
Develop implementation budget and secure financing	Translate MOH commitment into actual budget allocation and financing arrangements. Develop detailed implementation budget based on estimated costs across all SBBC components. Secure confirmation of budget allocation across fiscal years and financing source commitments

Regional Coordination & Support	Regional coordinators serve as critical bridges between national oversight and facility implementation. They provide direct technical support to facilities across multiple functional areas, including overall regional governance and implementation monitoring. Develop training on coordination and oversight responsibilities for regional coordinators, as needed
PHASE 2: SBBC ADAPTATION & INTEGRATION INTO COUNTRY HEALTH SYSTEMS (All Components)	
2.1 Facility Targets - Selection & Assessment	**(Integration & Readiness Component)**
Define facility selection criteria	Establish minimum number of deliveries and staff required for effective team-based approach (typically 3,000-5,000 annual deliveries & 20~25 staff) Establish criteria for facility selection and prioritization for scale-up, including facility size as per above, government strategic priorities and facility capacity and readiness baseline Set annual country targets (facilities & regions)
Review facility readiness requirements & adapt the facility readiness assessment tool	Review facility readiness requirements/minimum standards and adapt facility readiness assessment tool to country context. Incorporate agreed tool specifications and ensure alignment with national standards and local conditions. Consider capturing staffing levels and clinical workforce composition, essential obstetric and newborn equipment availability, infrastructure adequacy (e.g. space for skills corner & reliable power supply), data collection and reporting systems, clinical governance and supply chain functionality.
Undertake the facility readiness survey and analyse results	Conduct facility surveys with each facility completing their own assessment and reporting to regional and national levels. Based on assessment results, identify specific gaps that must be addressed before implementation.
Facility improvement plans & investments	Develop facility improvement plans and budgets addressing identified readiness gaps across target facilities
2.2 Training System Integration	**(Training Innovation Component)**
Assess existing simulation training capacity in country	Assess existing simulation training capacity with focus on maternal and newborn care. Consider clinical areas covered and type of institutions (e.g. universities, hospitals).

	Countries with established simulation training capacity may accelerate SBBC training faculty development.
Select training approach and procure/adapt training curricula	Decide whether to use SimBegin or develop an alternative training package.
Option A – Adopt SimBegin & Localize	If implementing SimBegin consider translation to local languages and cultural adaptation as needed. Also consider if reviews/adaptations of existing training materials, such as Helping Mothers Survive After Birth Complete, Essential Newborn Care, Helping Babies Breath, is needed to ensure adequate skills and competencies to deliver SBBC
Option B – Develop/Adopt Alternative Training Package	If developing/adopting an alternative training package, it is important to ensure fidelity to SBBC requirements, including cascade training & structured debriefing for psychological safety. The following three training components should be covered: **Facilitator Simulation Training** (How to use simulation as an education method). Requires assessing proposed program against SBBC requirements, robust simulation education methods, develop curriculum and cascade design, develop materials and competency assessment frameworks & institutionalization of training **Clinical Simulation Training** (Teaching What to practice, that is, SBBC specific clinical scenarios using simulation devices) Involves developing clinical simulation scenario and materials, such as debriefing guides and scenario cards **SBBC Clinical Training** (Skills and competencies in maternal and newborn care. Requires developing training materials for SBBC clinical protocols and equipment use.
Training system Integration	Integrate SBBC training into existing health system structures. This includes: ✓ Working with professional councils (nursing, midwifery) to accredit SBBC training for continuing professional development (CPD) credits ✓ Aligning SBBC training content with national clinical guidelines ✓ Adapting standardized SBBC job aids, reference cards, checklists, and wall charts to match country-specific protocols, terminology, and workflows

	✓ Develop Low Dosage High Frequency implementation guidance, including scheduling, and tracking to be incorporated into CQI systems and processes.
Institutionalization	Plan for linkages with local organizations, including universities, to embed SBBC training methods within the education system and institutionalize simulation education capacity in the long term
2.3 Clinical & Teaching Devices Integration	**(Clinical Innovation and Integration & Readiness Components)**
Identify Equipment Devices & Quantities	SBBC effectiveness requires specific clinical and simulation training devices. Equipment ratios below are based on a reference facility with 5,000 annual deliveries **Clinical Innovation Devices:** ✓ Fetal heart rate monitor (e.g., Moyo): 15 devices (~1 per labor bed) ✓ Electronic newborn heart rate meter (e.g., Neobeat): 5 devices ✓ Bag-mask device (e.g., Upright bag-mask): 8 devices ✓ Suction device (e.g., Penguin Sucker): 20 devices **Simulation Training Innovation Devices:** ✓ PPH simulator (e.g., MamaNatalie): 1 per facility ✓ Newborn ventilation trainer (e.g., NeoNatalie Live): 1 per facility ✓ Digital tablet for simulation feedback (if NeoNatalie Live acquired): 1 per facility
Equipment Choices & System Interlinkages	A critical strategic choice in equipment procurement: SBBC-specific devices (e.g., Laerdal Global Health products) or generic alternatives. This choice has implications not only for budgets, but also for data collection and CQI effectiveness. NeoNatalie Live paired with compatible software (e.g., LIFT platforms) enables automated training data collection. Generic devices require manual training logs, which increases facility workload and reduces data reliability.
Supply Chain Integration Costs	Integrate SBBC equipment into national supply systems, including: ✓ update essential device lists to include SBBC equipment ✓ develop standardised technical specifications ✓ integrate into supply chain systems ✓ ensure SBBC devices are included in national biomedical equipment management plans
Regional Maintenance Systems	Set up regional maintenance systems for SBBC equipment. Includes training of regional biomedical engineers (~2 days covering SBBC device maintenance and troubleshooting)

2.4. CQI & Data Integration	**(CQI & Data Component)** Note: CQI systems depend on the data systems established. Countries must avoid parallel systems and select approaches that match current health system infrastructure and technical capacity. Data collection frequency must balance performance monitoring needs against facility workloads and technical capacity
National Level -	**Develop Standards & Templates** ✓ Developing standardized data collection forms and routine compilation templates with validation procedures ✓ Design periodic audit newsletter templates with visualisation that enable easy interpretation of facility performance trends and regional comparisons ✓ Review and adapt SBBC job aids, checklists, wall charts, reference cards to ensure alignment with country protocols, terminology and workflows **Integrate Clinical & Training Data Systems** ✓ Integrate core SBBC clinical and training data into national HIS (e.g., DHIS2) building on current compilation cycles: defining indicators, mapping data flows, and establishing protocols for data collection, validation and reporting ✓ As needed, enhance existing health records to capture SBBC indicators, minimizing dual documentation ✓ Design data collection and compilation systems using standardized formats that can transition to digital tools when infrastructure permits ✓ Develop and/or integrate training dashboards that visualize progress to guide mentorship deployment - ensuring integration with existing systems, not parallel structures **CQI System Integration & Peer Learning Framework** ✓ Develop Peer Learning Framework & align SBBC CQI processes with existing quality improvement frameworks including MPDSR & facility quality committees to enable progressive integration. ✓ Establish peer support mechanisms including WhatsApp or messaging groups for ongoing peer support, resource sharing platforms, and virtual and in-person champion meetings ✓ Establish targets for low-dose high-frequency training, team simulation drills, and CQI meetings ✓ Create templates for CQI action plans and develop facility guidance for implementing rapid response cycles, including data-to-action decision guides and escalation criteria

	✓ Define CQI roles and terms of reference, clarifying expectations for different staff levels and ensuring alignment with existing QI structures. **Other** ✓ Consider designing non-monetary incentives such as certificates, public acknowledgements in newsletters, monthly "most improved" indicator, Quarterly CQI innovation recognition, Annual facility excellence awards
Regional Level -	**Clinical & Training Data Systems Setup & Integration** ✓ Establish data aggregation and validation protocols using standardized templates as per national guidelines ✓ Train regional data focal persons on aggregation, validation, and quality checking procedures ✓ Set up systems for comparative reporting and regular facility feedback, including routine reports showing facility performance against regional averages **CQI & Peer Learning Infrastructure Setup** ✓ Setup champion networks, peer learning platforms, communities of practice, inter-facility exchanges as per national guidelines **SBBC mentorship integration** ✓ Integrate SBBC into routine supervision, adapt checklists, establish protocols ✓ Provide orientation to supervisors on SBBC monitoring and support requirements
Facility Level -	Facilities should avoid parallel systems and build on their current systems. Prioritise establishing reliable data collection, periodic compilation and integration into existing reporting cycles (as feasible) **Clinical & training data collection setup** ✓ Establish routine data collection & validation procedures ✓ Train data focal persons ✓ Set up compilation workflows ✓ Develop protocols for quality checks ✓ Plan for integration with facility records and national HMIS. ✓ For training data, establish use of dashboards (LIFT platform or equivalent) to track individual and team simulation performance and plan for integration with facility reporting systems **CQI systems setup**

	✓ Establish visual management systems and performance displays. Includes printing and displaying clinical protocol materials, job aids, reference cards ✓ Set up CQI meeting structures integrated within current facility systems. ✓ Consider additional supportive measures such as restricting nursing rotation to maintain team stability and skill development.
PHASE 3: SMALL-SCALE TESTING & VALIDATION **(All Components)**	
Scope of small-scale testing & validation	Tests adapted SBBC systems in a limited number of facilities before full-scale rollout. ✓ Countries use this phase to identify what needs adjusting — whether new training materials translate well into practice, whether data systems integrate into existing reporting cycles, whether all components function together. ✓ The scope of testing varies: some countries focus on specific components, others pilot complete SBBC implementation. ✓ Desktop validation through structured stakeholder workshops may be appropriate for selected elements, such as adapted training materials. ✓ Learning from this phase directly informs Phase 4 rollout and establishes the adaptive cycle that continues through Phase 5.
Principles	**Define what success looks like — both for the system and for outcomes.** ✓ Can the training cascade, data collection, and CQI function through government structures and existing staff? ✓ And are early signals visible: teams practising more frequently, earlier detection and response times, improved clinical practices? These intermediate indicators can signal whether the country will be able to replicate the quality of care improvements and mortality reductions demonstrated in Tanzania. **Test within country systems, not alongside them** ✓ Do not focus on validating parallel systems that will not sustain after external support ends. ✓ Results from testing with dedicated project staff, standalone data collection, or processes that bypass existing reporting and governance structures will not predict what happens at scale **Small-scale testing may run in parallel with Phase 2 adaptation work**

	✓ for example, testing training delivery at a few facilities to inform national materials development, or trialling data collection forms before finalising national templates. **Implementation research to document what worked, what didn't, and what was adjusted.** ✓ This feeds directly into Phase 4 rollout plans and establishes the learning discipline that continues through Phase 5.
PHASE 4: IMPLEMENTATION & SCALE-UP	
4.1.Facility Readiness	**(Integration & Readiness Component)** Implement and fund plans to address the facility readiness gaps developed in Phase 2. Include both capital as well as recurrent budgets. Ensure capital investments cover adequate space for dedicated skills corners, other space upgrades and required general obstetric and newborn equipment. Additional recurrent budgets might be needed to ensure adequate general medical supplies (e.g. oxygen) to support SBBC clinical protocols and adequate staffing levels.
4.2 SBBC Equipment Procurement, Deployment & other	**(Clinical Innovation Component)** Acquire and deploy clinical and training equipment to all target facilities as per equipment ratios established in Phase 2. Include in facility budgets annual operational costs for maintenance, spare parts and consumables for SBBC clinical and training equipment.
4.3 Training Delivery	**(Training Innovation Component)**
Identify & Acquire Training Support Software	Identify and acquire digital tools that will support training delivery and data collection and consider compatibility with simulation devices for automated data collection. For reference: ✓ LIFT Scenarios or similar: Offline mobile application to guide simulation sessions, observe key performance steps, facilitate debriefs, and track team training frequency and quality LIFT Assessments or similar: Digital platform for knowledge checks and skills assessments with immediate feedback on gaps to target refresher training
Training independence and sustainability	**Long-term training independence** operates at two levels: ✓ Cascade independence: champions and mentors trained by country faculty

	✓ Faculty independence: progress from requiring intensive external supervision to training new faculty independently Countries starting with low simulation training capacity will require external support. The pathway to faculty independence might span several years with progressively reduced external technical assistance until full independence **Champion and mentor ratios should balance quality, efficiency and sustainability.** ✓ Establish champion-to-facility ratios (typically 2-3 champions per facility) and mentor-to-facility ratios appropriate for facility size and context. Additionally, to ensure **training sustainability**: ✓ Set **realistic timelines for expanding training capacity**: How many annual cohorts can faculty (country or international) handle per year ✓ Formal training days alone do not ensure competency. **Plan for additional coaching time** needed for faculty and mentors in their first year. ✓ Account for **ongoing replacement training** as staff leave positions, based on realistic annual turnover rates for faculty, mentors, champions and labor & delivery staff. ✓ As needed, establish **regular refresher training** cycles based on performance data at various cascade levels (for example every 2 or 3 years)
Conduct Level 3 - Faculty Training with clear pathway for Faculty Independence	Faculty Training develops national-level trainers who can facilitate simulation-based education and structured debriefing, apply adult learning principles in training delivery, train Level 2 mentors, train Level 1 champions and provide national-level oversight and quality assurance As reference, for SimBegin: ✓ Minimum 8 days of training which include co-delivering champion training with SimBegin faculty supervision plus 3 days for the EuSIM course. ✓ Additional coaching during the first year might be required. ✓ Assumes previous experience as champions and mentors For local faculty independently train new faculty without external support and to be fully integrated into national training institutions. ✓ Identify additional training requirements & level of external support needed during the first years ✓ Establish self-sustaining quality assurance systems, e.g. with national institutions managing certification

Conduct Level 2 Mentor Training	Facility-level mentors provide ongoing coaching, supportive supervision, and quality improvement support. They bridge national expertise and frontline implementation, ensuring continuous skill development and problem-solving at facility level. As reference, for SimBegin: ✓ Four virtual workshops and additional virtual coaching support during their first year ✓ Assumes mentors are selected from the pool of champions Undertake refresher training (e.g. every 2 years) as needed
Conduct Level 1 Champion Training	Facility champions lead day-to-day SBBC implementation, facilitate low-dose high-frequency training, conduct team simulations, and drive continuous quality improvement activities within their labor wards. As reference for SimBegin: ✓ Approximately 11 days of face-to-face training. ✓ Facilitator trainee ratios for face-to-face delivery: One facilitator per 8-12 trainees ✓ No additional virtual coaching needed o After formal training, champions use LIFT Scenarios for simulation session guidance o They receive ongoing support from mentors (virtual support and routine mentoring/supervision visits as per CQI systems) Undertake refresher training (e.g. every 2 years) as needed
Conduct initial training for facility labor & delivery staff	Initial training for all labor ward staff at each facility covering SBBC clinical protocols, equipment use (clinical device operation & simulation device use in skills corners), team-based care approaches and low-dosage-high-frequency practice. As reference for SimBegin: 2.5 days training duration Due to LDHF described below, there is no need of refresher training
Implement LDHF simulation training with structured debriefing system at each facility	**Low Dosage High Frequency (LDHF)** LDHF represents the core operational practice that maintains clinical competency ✓ Takes simulation training into the facility with peer-to-peer learning ✓ Champions schedule and facilitate regular individual skills practice (staff practice specific techniques using simulation devices during down time) and team simulation drills (full team practices managing clinical scenarios together). ✓ Champions facilitate **structured debriefing** after each simulation for reflection and learning creating psychological safety and a 'no blame-no-shame' culture

	✓ Facility targets for individual practice and team simulation drills should be incorporated into the facility CQI processes and systems.
4.4 CQI & Data	**(CQI & Data Component)** Note: Facilities will be at different stages of data system maturity and should build on their current capacity. The focus is on sustaining reliable data collection and using performance feedback to drive continuous improvement, progressively integrating into existing health systems as capacity strengthens.
National-level	**Technical support & oversight** ✓ Provide ongoing technical guidance to regions on data management and CQI implementation ✓ Conduct national-level data analysis and generate annual performance reports ✓ Coordinate overall SBBC implementation and progressive integration into existing health information systems **Other** ✓ Annual updates to data collection forms, reporting templates, and CQI materials as needed ✓ Conduct refresher orientations for regional and facility staff on data quality and CQI procedures ✓ Maintain and refine data systems and CQI frameworks based on implementation experience
Regional Level	**Data management & reporting** ✓ Conduct ongoing data aggregation and validation using standardized templates ✓ Generate routine comparative performance reports showing facility performance against other facilities/regional averages using standardized visual formats ✓ Provide technical support to facilities on data collection, compilation, and quality issues ✓ Produce periodic regional summaries for national reporting **Peer learning facilitation** ✓ Facilitate champion networks and maintain communication channels for ongoing peer support ✓ Coordinate learning exchanges and communities of practice ✓ Recognize high-performing facilities and support struggling facilities through targeted assistance

Facility Level	Facilities avoid parallel systems and build on their current data infrastructure, establishing reliable data collection and progressively integrating into existing reporting cycles as feasible. **Routine data management** ✓ Conduct ongoing collection and compilation of clinical and training data ✓ Perform basic analysis and quality checks ✓ Progressively integrate SBBC data into routine facility records and national HMIS reporting cycle ✓ Use training dashboards (LIFT platform or equivalent) to identify skill gaps and guide LDHF practice **CQI activities** ✓ Conduct regular CQI meetings (ideally chaired by facility executive sponsor/senior leadership) to review performance data, analyze patterns, and develop improvement action plans ✓ Implement improvement actions through rapid response cycles, with champions authorized to make quick fixes and small-budget facility improvements ✓ Maintain visual management systems and performance displays in labor wards ✓ Participate in peer learning networks and share improvement successes **SBBC mentorship integrated into routine supervision visits** ✓ During early implementation: Intensive structured mentorship visits (5 annual visits) to establish data collection routines, coach initial CQI meetings, support equipment setup, and build facility capacity for SBBC implementation ✓ Ongoing mentorship support (4 annual visits) focused on sustaining SBBC implementation, addressing challenges, and building facility independence
PHASE 5 'MAINTAINING IT' PHASE **(Integration & Readiness Component)**	
5.1. Integration & Readiness	
National Level	**Governance, coordination and oversight** ✓ Conduct regular steering committee meetings to maintain oversight and address implementation challenges ✓ Continue engagement with professional associations and stakeholder groups to sustain clinical buy-in and support

	✓ Monitor funding flows and budget allocation to ensure adequate resources for sustained implementation **Monitoring & Evaluation that continues the adaptive learning cycle from Phase 3 at full scale** ✓ Develop and implement M&E plan and national monitoring structures that complement facility-level CQI data systems ✓ Conduct mid-point and end-point implementation reviews that analyze what's working and what needs changing ✓ Organize annual learning workshops bringing together national and regional coordinators, facility champions, and mentors to review progress, share what works, and adjust national guidance based on field experience ✓ Document how SBBC infrastructure (simulation training cascade, data systems, champion networks) can be leveraged for other health priorities to inform broader service delivery redesign
Regional Level	**Regional coordination & support** ✓ Ongoing regional coordination, maintaining liaison between national and facility levels ✓ Execute regional maintenance protocols established in Phase 2 ✓ Monitor overall implementation progress within region and report regional status to national coordinator ✓ Provide ongoing technical support and problem-solving for facility-level implementation challenges
Facility Level	**Participation in Learning & Evaluation** ✓ Participate in annual or regional M&E and learning workshops, program reviews, and evaluation activities beyond routine facility-level CQI meetings