Mentoring for Human Capacity Development
Implementation Principles and Guidance

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Introduction

Efforts to improve health care provider performance in low- and middle-income countries (LMICs) extend beyond isolated in-service training and traditional supervision methodologies to include additional approaches such as mentoring. This brief presents principles and recommendations for the use of mentoring for human capacity development (HCD) within the Maternal and Child Survival Program (MCSP). The guidance stems from a review of the literature on mentoring in LMICs and a survey of MCSP country programs about their experiences. It is intended to help programs strengthen their approaches to improving health care provider performance, thus contributing to the overall MCSP quality improvement and health systems strengthening efforts.

Background

The need to expand HIV care and treatment in sub-Saharan Africa more than 20 years ago resulted in an increase in the use of clinical mentors to ensure provider competence in HIV care and treatment (World Health Organization [WHO] 2006). Since then, the practice has expanded, and as of 2017, many MCSP country programs reported using either mentoring or supportive supervision, or a combination of the two, in their efforts to improve health care provider performance and quality of care, both in health facilities and in communities.

To gather information and synthesize learning on mentoring as an HCD approach in health programming in LMICs, MCSP conducted a targeted literature review, a survey and validation process for MCSP country programs, an in-depth review of MCSP country program case studies, and a review by a technical working group (TWG) comprised of MCSP technical and crosscutting team leads.

The targeted literature review used *mentoring* and *clinical mentoring* as search terms, and identified 17 articles on public health programming in LMICs. A scoping review of the literature on mentorship for health personnel, published in October 2017, was particularly useful in gathering and examining the limited evidence available on the use of mentoring in LMICs to address quality of care and support health worker performance (Schwerdtle, Morphet, and Hall 2017). In recognition of the fact that mentoring has been used in LMICs to address quality of care issues and support health worker performance, but that limited evidence of its use exists, this review aimed to investigate the role of mentorship based on the evidence that is available. The authors note that, although limited, the existing evidence suggests that mentoring can lead to documentable improvements in quality of care.

In April 2017, 23 MCSP country programs from 19 countries responded to a 20-question survey on the rationale for mentoring, how mentoring compares to other HCD approaches, and mentoring methodology and sustainability. Based on their responses to the survey, four country programs were identified for in-depth country case studies (MCSP Lao People's Democratic Republic, MCSP Liberia/Restoring Health Services,

MCSP Rwanda, and MCSP Zambia/Family Planning), and these case studies were reviewed to contribute to this document. Finally, the MCSP TWG provided quality assurance through structured review cycles of the findings and recommendations in this brief.

Findings

MCSP defines human capacity development as the process used to develop individual and team abilities to set goals and strengthen and maintain the competencies required for individual and team roles. Mentoring is not a new method of HCD in health programming, but definitions of mentoring are different in different contexts. Because mentoring often occurs along with other capacity-building approaches, there is limited evidence to demonstrate the effectiveness of mentoring as an individual intervention. However, the evidence available from the literature and MCSP interventions provides some insights for ongoing and future programming.

Mentoring Definition and Principles

Based on the information gathered, MCSP developed a definition of mentoring along with several principles for mentoring interventions:

MCSP defines mentoring as **the process through which an experienced and empathetic person who is proficient in her/his content area (a mentor) teaches and coaches another individual (mentee) or group of individuals (mentees), in person and/or virtually, to ensure competent workplace performance and provide ongoing professional development.**

MCSP Mentoring Principles

- Mentoring complements other interventions, such as formal supervisory systems, quality improvement efforts, and/or instructor-led training, irrespective of training setting.
- Mentors must be proficient in the content area for which they provide mentoring.
- Mentors work in person and/or virtually with individuals and/or teams to build skills to ensure competent workplace performance and respectful provision of high-quality care in the workplace.
- Mentors develop rapport and build relationships with those they mentor. The relationships aim to empower, provide positive feedback, and motivate mentees to improve their performance.
- Mentoring is goal-based and usually has a formal ending point—the achievement of performance goals.
- The mentoring experience should be mutually beneficial; mentees benefit from the knowledge exchange and relationships with mentors, and mentors often benefit from knowledge exchange and relationships with mentees.

Rationale for Mentoring

Increasingly, donors and ministry officials recognize that historical approaches to training and supervision have not resulted in their desired changes in provider performance, quality of care, and health outcomes. A 2016 review of national surveys in sub-Saharan Africa found that these traditional interventions were associated with only modest improvements—"equivalent to 2 additional provider actions out of the 18–40 actions expected per visit" (Leslie et al. 2016). In addition, a robust systematic review identified a greater effect in improving a health care provider's performance when training was combined with other structural interventions (including supervision, performance and quality improvement, and community engagement) (Rowe et al. 2009). This has led countries and donors to support nontraditional approaches, including mentoring, to improve health care provider performance.

MCSP program representatives reported the following reasons for using a mentoring approach: (1) targeted identification of skills gaps, and dedicated support and feedback to address those gaps; (2) the benefit of working with providers on the job rather than offsite (saves time and allows providers to learn in real time); (3) perceived improvements in provider confidence and performance; and (4) the ability to monitor skills and competencies acquired through traditional training interventions.

Mentoring in Relation to Other HCD Approaches

Evidence on the effectiveness of mentoring in LMICs is limited. In addition, because mentoring is usually combined with other HCD interventions—such as quality improvement, on-the-job or facility-based (in-service) training, or supportive supervision—it is often difficult to attribute improvements specifically to a mentoring intervention. For example, the authors of the scoping review of mentoring in LMICs identified five studies that met their search criteria for mentoring. In four of the five, researchers observed improvements in quality of care and provider behaviors (Schwerdtle, Morphet, and Hall 2017). However, because the studies involved interventions that used mentoring in combination with other approaches, it is impossible to attribute the findings solely to mentoring.

This quote from one of the studies illustrates how mentoring is often combined with other approaches: *"Day 1 of the 2-day visit included group learning sessions and individual mentoring for the clinical and laboratory staff, encouraging members of the multidisciplinary team to learn together and examine systems issues that interfere with patient care. Day 2 was devoted to continuous quality improvement activities. The monthly learning sessions had two components: a 1-hour general session to discuss cross-cutting issues in the clinic and cadre-specific breakout sessions. The combination of general and break-out sessions among clinicians, laboratory professionals, and records clerks improved the quality of malaria case management in a similar setting. Each IDCAP learning session focused on a monthly theme." (Miceli et al. 2012).*

Schwerdtle, Morphet, and Hall (2017) note that, "Mentorship is a flexible teaching and learning process that serves specific objectives of the health worker and health care service. The term mentoring is sometimes confused with clinical teaching or coaching. Clinical teaching occurs when a student engages with a clinician who assumes responsibility for patient care and student learning, while coaching is a method of directing, instructing and training a person usually with the aim of developing specific skills in that individual." MCSP country programs use mentoring in contexts beyond just clinical practice, so the term clinical teaching is insufficient on its own. Likewise, coaching may be similar to mentoring, but it falls short on the principles of relationship building and empowerment embodied by mentoring.

Across MCSP country programs, integrated HCD strategies, including mentoring, address the continuum from competency development to competency management. Many MCSP programs implementing mentoring also include training and supportive supervision. Thus, it is helpful to distinguish between the approaches used and to understand the areas of overlap. Table 1 and Figure 1 list the HCD and performance improvement strategies used in MCSP country programs and their definitions.

Table 1. MCSP Definitions of Human Capacity Development Strategies

Pre-Service Education	In-Service Training	Mentoring	Supportive Supervision
The curriculum of studies that prepares health personnel for entry into the health profession	A structured and formal approach for health workers and managers (after completion of pre-service education) to reinforce existing competencies or develop new ones	The process through which an experienced and empathetic person who is proficient in her/his content area (mentor) teaches and coaches another individual (mentee) or group of individuals (mentees) in person and/or virtually to ensure competent workplace performance and provide ongoing professional development	A process of helping staff to improve their own work performance continuously; carried out in a respectful and non-authoritarian way with a focus on using supervisory visits as an opportunity to improve knowledge and skills of health staff*

*WHO. Department of Immunization, Vaccine and Biologicals. 2008. *Training for Mid-Level Managers. 4. Supportive Supervision.* Geneva.

Figure 1. MCSP Performance Improvement Initiatives
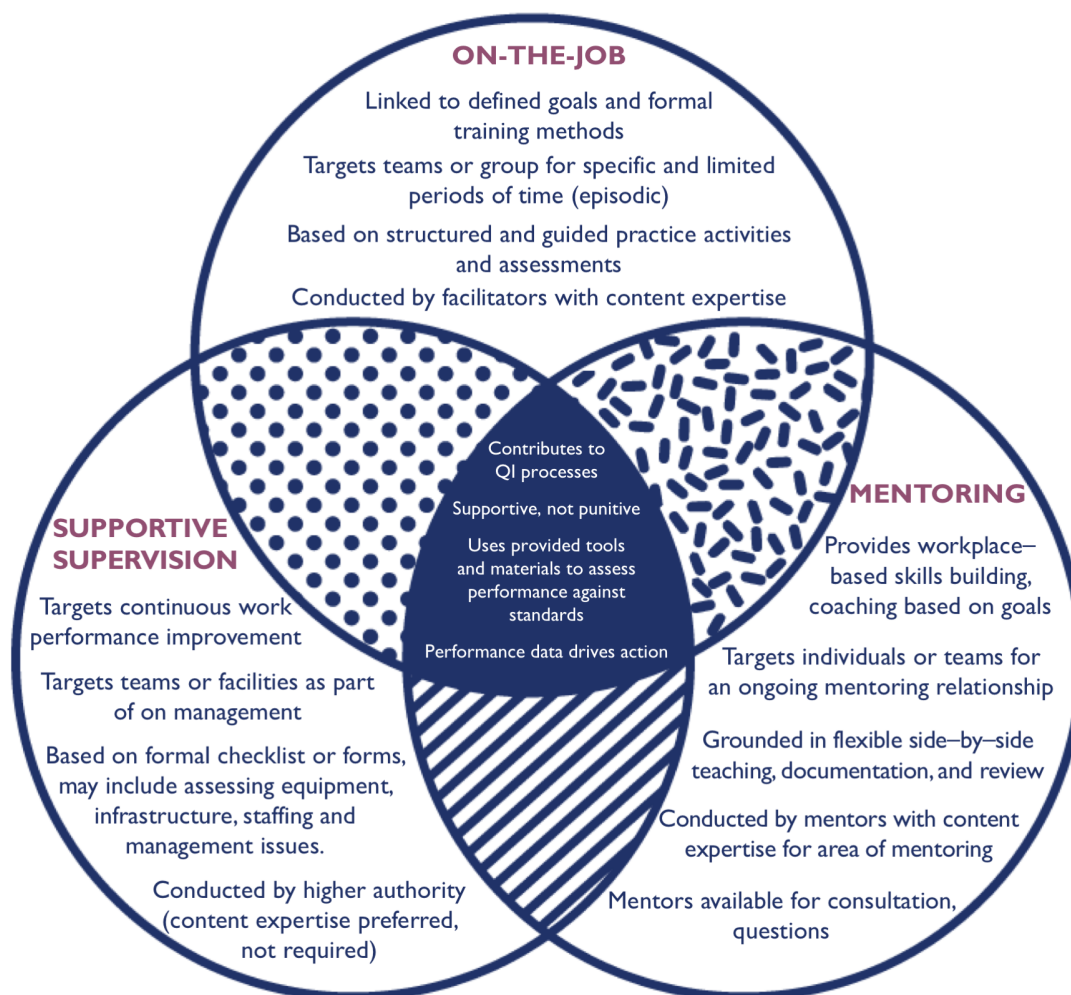
Characteristics of Mentoring Interventions

In November 2017, after the TWG had agreed on an MCSP-specific definition of mentoring, 21 of the 23 MCSP survey respondents validated the MCSP data to ensure consistency with the mentoring definitions in their programs. Using findings from the survey and takeaways from the targeted literature review, the TWG extrapolated the following characteristics of mentoring interventions to help inform future and ongoing programming:

- **Suitable for multiple technical areas:** The literature addressed a range of technical areas, from HIV to non-communicable diseases and palliative care. Schwerdtle, Morphet, and Hall (2017) suggest that mentoring is well suited to protocol-driven primary health care areas (such as integrated management of childhood illness, maternal and child health, and HIV) and for settings where training and development opportunities are limited. MCSP's country program survey showed that many programs use mentoring for HCD across multiple technical areas. On average, mentoring was implemented in at least six technical areas (maternal, newborn, and child health; family planning; water and sanitation; nutrition; immunization; and malaria) targeting different health workers and/or using specific mentors for specific content areas.

- **Three general models:** In the literature, as well as in MCSP country programs, mentoring interventions typically fit into one of the three models outlined in Table 2. These models are adapted from the WHO's recommended clinical mentoring models.

- **Mentor training and preparation:** Most mentor training and preparation includes technical or content-specific skills as well as competencies such as interpersonal communication, feedback, coaching, teaching, and/or using observation checklists for assessments. More than half of MCSP country programs reported that mentors received some combination of technically focused and mentoring-specific capacity-building.

Table 2. Mentoring Models

Facility Level: Internal Mentor	Facility Level: External (Visiting) Mentor	Community-Level Mentor
A current staff member with the required subject matter expertise is identified, trained, and prepared to act as a mentor. This is sometimes called "peer-to-peer" mentoring. Internal mentoring is less costly and easier to implement than other approaches, but providing adequate time for staff to mentor others and the perception of the mentor as a colleague, not an expert, are challenges with this approach.	An external mentor is an expert assigned to a facility or workplace for a specific period of time. The mentor may be a ministry of health staff member, a professional association member, a supervisor or representative from a local district health management team, or a representative from a vertical program. This person may be dedicated, incentivized, and supported for this role over a limited period. Working with an expert with dedicated time is a benefit of this approach, but significant resources are required to recruit and support their mentoring efforts. A variation on this approach is the use of multidisciplinary teams to provide a wider range of support.	The literature on community-level mentoring is limited but increasing, as is MCSP experience. This type of mentoring can involve either an internal or an external mentor. Engaging the local health center staff (often nurses or nurse-midwives) or experienced community-based health workers as mentors is common to several community-focused programs. Community-based mentoring may be part of follow-up after training or may supplement supportive supervision efforts. Common attributes include providing mentoring to health care workers in the communities while they work, including short skill-building sessions, sometimes for groups or teams, or (as in Ethiopia) in-person meetings for case peer review and discussions. Common challenges include funding for travel and releasing staff for mentoring activities.

- **Interactions:** Mentoring approaches are evolving as mentors use both in-person and virtual methods to support mentees. Approximately two-thirds of MCSP country program respondents stated that their mentors and mentees have both one-to-one and one-to-group interactions. Increasingly, MCSP country programs are also employing virtual mentoring methods (e.g., mobile, SMS, social media) to complement in-person approaches. In Nigeria and Laos, for example, MCSP country programs use SMS and WhatsApp as virtual methods of communication between mentors and mentees. This increases the regularity of mentor-mentee interactions, strengthens relationships, and enables real-time support.

- **Frequency and duration:** The appropriate frequency and duration of mentoring interactions depends on the complexity and criticality of the skill or topic of focus. Schwerdtle, Morphet, and Hall (2017) found that the typical intensity of visits in the programs they reviewed was 1–3 days, on a monthly interval. MCSP country programs showed high variability. Nearly half of MCSP country program respondents noted that mentoring visits occurred monthly, with the remaining respondents stating that mentoring occurred quarterly, weekly, or daily. Half of all MCSP country program respondents said that in-person mentoring lasted for 4 hours or less, and several stated that the frequency and duration depended on the technical area.

- **Incentives:** The literature reviewed did not critically examine incentives or support provided to mentors. The WHO clinical mentoring recommendations suggest that programs should budget for the following costs: salary support, travel expenses, communication support, cell coverage, Internet access, coordination, scheduling, and logistics, among other payments. Among MCSP country programs, half of respondents said that mentors received a per diem for their efforts, nearly half stated that mentors were paid/hired staff, and nearly half said that they reimbursed mentors for travel expenses.

- **Institutionalizing mentoring:** The literature reviewed did not address the topic of institutionalization or sustainability for mentoring approaches, but the WHO recommendations for clinical mentoring suggest that clinical mentors should be part of the existing health system. WHO also suggests that

mentors practice in a referral facility where they can mentor others who refer clients to their facility (WHO 2006). Integrating mentorship duties into a mentor's normal practice is essential for uptake and sustainability. MCSP country programs reported having seven different types of mentors (including ministry of health staff, senior health workers, supervisors, peer health workers, external mentors, MCSP staff, and hired counterparts). They did not all see a need to embed these individuals in the health system. Other methods of institutionalization include coordinating with national or subnational ministries of health, supporting development of a mentoring policy, and engaging with pre-service institutions to introduce the approach in early education.

Conclusion and Key Considerations

In conclusion, mentoring approaches vary based on the local context and systems. In conclusion, mentoring approaches vary based on the local context and systems but should adhere to key principles. Evidence to support mentoring is limited, but encouraging, although programs implementing mentoring almost always combine it with other HCD strategies such as supportive supervision or on-the-job training. Although there is no prescriptive guidance for designing and implementing mentoring for HCD, consideration of the following questions will help MCSP country programs plan and execute their mentoring interventions:

- **What are the overall quality and/or performance improvement goals of your program, and what role does mentoring play?** Before introducing a new form of HCD, you should identify current performance goals and map existing interventions to avoid overlap and ensure a clear purpose for each HCD approach (pre-service education, in-service training, and supportive supervision, in coordination with quality improvement). Mentoring can be one aspect of a systemic performance and/or quality improvement intervention. Country programs can determine which model of mentoring and which combination of approaches will be most feasible and sustainable based on the country context, existing efforts, and program needs. As indicated in the literature and in MCSP practice, mentoring should be linked with other interventions for human capacity development. It can also contribute to meaningful post-training follow-up.

- **What existing system can you build upon?** WHO guidance suggests that mentoring should be institutionalized within the existing health system and processes. Identifying current national structures and systems to strengthen and support is preferable to a short-term solution. From the beginning, actively engaging national leadership and existing systems is critical. Determining the existing systems and aligning mentoring efforts to support them will help ensure sustainability.

- **How will you select your mentors?** Mentor selection criteria are important and should include some of the following: subject matter expertise; active practice in the focus area; strong interpersonal, leadership, and communication skills; and a good reputation among peers or other professionals. In MCSP programs, mentors are often district or program managers, health care providers from the ministry of health, and/or MCSP staff. Some MCSP programs (e.g., Rwanda and Nigeria) use representatives of professional associations as well.

- **How will you train and prepare your mentors?** Most mentor training includes an evaluation and confirmation of technical or clinical proficiency in the area in which they will be mentoring others. Mentoring skills (sometimes considered "soft skills") such as communication, feedback, coaching, clinical teaching, active listening, and using observation checklists for assessments are important and should not be overlooked. Specific guidance on quality improvement and the links between mentoring and supportive supervision may also be valuable. In some cases, new mentors can learn mentorship competencies through training that is similar to clinical skills training, including provision of information, simulation of skills with peers, onsite practice under observation, and certification.

- **How will you incentivize and support mentors?** MCSP programs most commonly use travel and per diem support as incentives for serving as mentors. A smaller sample of programs pay mentors for their work. A common challenge for mentors is making sure they have allocated sufficient time for mentoring. Programs can provide service delivery backup coverage for mentors and release mentors from other work duties. Dedicated mentors with adequate support are less likely to face work overload and burnout. A variety of mechanisms are used to provide ongoing support for mentors, including a mobile social

media platform to encourage social learning and structured support calls or meetings. Providing continuing education units, as some countries do for preceptors who train pre-service education students, is an incentive that should be explored. Planning for incentives and adequate support for mentors is an essential part of institutionalizing the approach.

- **What is the appropriate ratio of mentors to mentees?** The majority of MCSP programs surveyed, as well as the programs represented in the literature review, have one-to-one, one-to-two, one-to-team, or team-to-team mentoring. Schwerdtle, Morphet, and Hall (2017) noted that, in the studies they reviewed, the ratio of mentors to mentees was often unclear and sometimes consisted of one mentor per facility. The ability to provide tailored support to multiple staff within a team or unit is one of the attributes of mentoring. Mentees and mentors are paired and assigned based on the goals of the mentoring approach.

- **What is the competency focus?** What problem, new competency, or reinforced skill is your program trying to address via mentoring? Is mentoring the most efficient approach for this issue? Determine the focus of the mentoring program. Often this is a technical or clinical competence to deliver direct health services. To a lesser extent, mentoring programs address management skills, such as use of data for decision-making, efficient resource allocation, supply chain management, or management of community-based immunization programs. If mentoring is part of a formal on-the-job approach, informal coaching or demonstration of mastery of the skills might also be worthwhile.

- **How frequently and for what duration will mentoring occur?** Determine the appropriate frequency and duration of mentoring based on the context and goals. What is the timeframe within which mentoring will occur? How often and for what length of time will mentoring interactions take place? The most common frequency represented in the survey and literature was monthly visits or activities, with the duration ranging from 4 hours or less to 2 days spent within the workplace.

- **How can technology support mentoring implementation?** In some cases, virtual mentoring approaches work to improve skills and communication among mentors and mentees. Virtual mentoring approaches include SMS reminders or quizzes, WhatsApp direct or group messages, and voice calls to respond to questions and address learning needs. Common software functionality to support virtual mentoring includes the ability to track a mentee's self-assessment or learning goals, a mechanism enabling the mentee to pose questions and receive responses, and a place for mentors to provide feedback and host discussions. Software should be responsive to program requirements, affordable and accessible, and consistent with other systems currently in use in the country or location.

- **How will facility or workplace leadership be engaged in supporting mentoring?** When implementing mentoring, the support and active engagement of the workplace leadership and administration is critical. How will the intervention provide ongoing support and staff time and effort for mentoring activities? In many MCSP mentoring programs, engaging workplace leadership and administration is one of the first steps in implementing mentoring activities. Leadership and administration support enables the release of staff for time spent on mentoring, adjustment of work schedules, required client permissions, and client confidentiality and privacy. Engagement with leadership also ensures linkages with ongoing supervisory or quality improvement systems and efforts.

- **How will you monitor and use mentoring data?** The collection, organization, and analysis of mentoring data are important for continuous learning and adaptation. WHO recommendations for clinical mentoring suggest reporting on basic output indicators regarding mentoring visits and encounters. However, in the past decade, it has become important to collect outcome indicators such as changes in provider behaviors, compliance with protocols and guidelines, and even changes in client outcomes. Commonly collected data include the following: number of virtual and in-person encounters, skills observed or supported, pre- and post-learning outcomes, compliance with standards and guidelines, and certification in clinical skills. There is great variation in the way programs document and use data related to mentoring, and the literature reveals no standard tools or approaches. Most MCSP country programs use some form of action, learning, or mentoring plan with mentees. Several MCSP programs use software applications, such as CommCare or Medic Mobile, to track virtual or mobile support. Software programs already in use by the ministry or partners should receive preference when identifying solutions.

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