Mentoring Evidence and Country Experiences
MCSP Mentoring Brief Summarizes Findings from Literature, MCSP Programming

Information Sources

- Targeted literature review: 17 relevant articles, sources
- Internal survey responses from 23 MCSP country programs
- Country case studies
- TWG inputs

Validation Process

1. Definition and principles prepared
2. TWG revision and iteration
3. MCSP internal validation, refinement
4. TWG review and sign off
5. USAID inputs, revisions
Common Themes Emerged About Use of Mentoring for HDC

• Linked to other approaches
• Combined with more flexible, facility-based training
• Interactions are 1:1 or 1:team, in-person and virtual
• Monthly or quarterly, 1-3 days in duration
• Incentives: per diem for T&T, or paid positions
• Institutionalized embedding with existing systems
• Reducing absenteeism is often a benefit
• Evidence is promising (yet limited)
Mentoring for Human Capacity Development
Implementation Principles and Guidance

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www.mcsprogram.org

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 mentor learning享誉, a revised and validated process for MCSP country
Mentorship Capacity Building in Rwanda

Dr Stephen Mutwiwa, MCSP Chief of Party, Rwanda
MCSP Rwanda: integrated HCD to strengthen quality delivery of high-impact interventions

Approach
- **Integrated**, facility-based, low-dose, high frequency training and mentoring
- Focus on performance improvement for HBB/ENC, IMCI, BEmONC, FP

Outputs
- MCSP trained 1,952 providers using LDHF and 3,157 providers received mentorship
- Improvements in health provider knowledge, skills, and competency
- Improvements in key health outcomes
MCSP Rwanda mentorship approaches

- Professional Associations to District Hospitals
- District Hospital Mentors to Health Centers
- HC to Community Health Workers
Rwanda HCD conceptual framework

Continuous capacity building of mentors

- Selection process of Mentors
  - Identification
  - Training
  - Validation

- Implementation of mentorship
  - Mentoring visits
  - 1-2 visits/month
  - Coordination meetings
  - Mentee assessments

- Improved clinical skills, knowledge and competencies

Skills & competencies assessment for providers

Monitoring and evaluation

Improved health outcomes
Rwanda Results (FP)

PPFP Uptake: phase I (4 districts) vs phase II (6 additional districts)

Q1 FY16 Q2 FY16 Q3 FY16 Q4 FY16 Q1 FY17

PPFP Uptake 4 priority districts

PPFP Uptake 6 additional districts
Station Teaser....
Mentorship Capacity Building in Lao PDR

Dr Keokedthong Phongsavan M.D. Deputy head of OB/GYN Setthathirath Hospital, Vientiane, Lao
Helen Catton Program Manager MCSP, Luang Prabang, Lao
Lao PDR Background

For 23 years, there was no midwifery education (1986-2009).

In 2009 there were only 100 midwives left in the country.

Problems ➔
- Rapid training of young, inexperienced midwives who lack skills, confidence and support
- Many sent to remote health centers without oversight, support or opportunity for continuous professional education

Solution ➔
- In-facility mentorship to fill this gap
**Intervention: In-facility mentoring**

**Mentoring: A model of in-service professional development (CPD) and supportive supervision**

**Institutionalized in the facility**

- **Trainer mentor**
  - *Provincial and district*

- **District mentors**
  - *4 in every district hospital, Inter-district quarterly visits*

- **Health center midwives**
  - *Quarterly on-site practice in district hospital, On-site follow-up in Health Centers*

**Leadership engagement and support: Provincial and district level**

- **Quarterly review meetings**
- **QI Facility action plans**
Outcomes

• Mentoring skills and clinical skills of mentors improved and maintained (2 years)
• Clinical skills of provincial and district mentees improved overall but inconsistent over time (2 years)
• Health center midwives show faster improvement and consistent skill development (1 year)
• Leadership engagement and support is essential
• Recognition is important for maintaining motivation of mentors and mentees
Station Teaser...
For more information, please visit www.mcsprogram.org

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