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Shukhi Jibon

PATHFINDER

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Beyond Training: Strengthening Bangladesh's Family Planning Workforce by Integrating Mentorship and Supportive Supervision

Since 2019, USAID's Accelerating Universal Access to Family Planning Project, known as Shukhi Jibon in Bangladesh, has partnered with the Ministry of Health and Family Welfare to strengthen the competence, capacity, and confidence of Bangladesh's family planning workforce. Led by Pathfinder International, Shukhi Jibon has leveraged the government's strong commitment to improving the quality of family planning and sexual and reproductive health services to pioneer an Integrated Mentorship and Supportive Supervision model that lays the groundwork for significant improvements in the capacity of health providers across the country.

Challenges

Everyone should have access to skilled, responsive, and respectful health care providers who are ready to deliver high-quality family planning and sexual and reproductive health (SRH) services. Yet, despite the government of Bangladesh's (GOB) strong commitment,[1] Bangladesh's public health system faces significant challenges, including a shortage of qualified providers and available health facility services that meet people's SRH needs.

44.5% of clinics have staff who were never trained on family planning.[2]

There are no formal requirements for continuing medical education for family planning providers.

41% of providers are not aware of guidelines for adolescent and youth services.[3]

67% of facilities are not prepared to provide general family planning services.[4]

Privacy and confidentiality are scarce during service provision.[5]

Nearly **20%** of facilities lack regular supervisory visits.[6]

Efforts to enhance the skills of providers have traditionally emphasized off-site training with little or no on-site post-training support. Supervision systems within the Ministry of Health and Family Welfare (MOH&FW) are complex and require coordination across three health directorates—the Directorate General of Family Planning (DGFP), Directorate General of Health Services (DGHS), and Directorate General of Nursing and Midwifery (DGNM). While both managers and service providers agree that supervision is essential to sustain the delivery of quality services, Bangladesh's current supervision systems are often overburdened, resulting in minimal contact between supervisors and providers and a lack of supervisory follow-up action. In fact, Bangladesh's 4th Health, Population and Nutrition Sector Program (HPNSP) Strategic Implementation Plan identified a lack of supervision and monitoring as one of the main challenges of Bangladesh's family planning program. In many cases, supervision has become synonymous with fault-finding inspection—primarily focused on identifying gaps—rather than promoting joint problem solving among staff and supporting them to arrive at a direction for how to reach goals.

Meanwhile, mentorship is relatively new to Bangladesh's health sector. In recent years, only a limited number of programs have piloted mentorship, and none applied a systematic approach that ensured sustainability. By 2019, no mentorship activity had focused on strengthening Bangladesh's public sector family planning services.

1 Bangladesh's 4th Health, Population and Nutrition Sector Program's (HPNSP) Operational Plans and 2015 Bangladesh Health Workforce Strategy demonstrate the government's commitment to strengthening the capacity and retention of family planning service providers as well as supervision systems.

2 National Institute of Population Research and Training (NIPORT) and ICF, *Bangladesh Health Facility Survey 2017*. NIPORT, ACPR, and ICF (Dhaka, Bangladesh: 2019).

3 Pathfinder International, *Assessment of Family Planning Service Delivery at Selected Public Health Facilities in Bangladesh*, Pathfinder/Shukhi Jibon (Dhaka, Bangladesh: 2019).

4–6 Pathfinder, *Assessment of Family Planning Service Delivery*, 2019.

Response

In response to these challenges and findings from Shukhi Jibon's landscape assessments,[7] and in alignment with GOB priorities, Shukhi Jibon leveraged Pathfinder's global experience[8] to strengthen supportive supervision and integrate mentorship within the MOH&FW's existing supervision structures to systematically improve the capability of Bangladesh's public-sector health workforce. Shukhi Jibon recognized that while mentorship and supportive supervision are distinct, they do have overlapping functions (see Figure 1), and this overlap inspired the project to develop its Integrated Mentorship and Supportive Supervision (M&SS) model to improve the quality of family planning services. Shukhi Jibon's Integrated M&SS model promotes a whole-site approach to improving service quality by fostering an enabling work environment, ensuring effective resource mobilization and facility readiness, and strengthening the systematic capability of the health workforce to resolve challenges efficiently.

FIGURE 1. THE RELATIONSHIP BETWEEN MENTORSHIP AND SUPPORTIVE SUPERVISION*

* *Adapted from "Basics of Clinical Mentoring: Participant Handbook." International Training and Education Center for Health (I-TECH)*

DEFINITIONS

CLINICAL MENTORSHIP[9]

Driven by the mentee with the primary aim to build their capacity and self-reliance, mentorship is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes.

SUPPORTIVE SUPERVISION[10]

A process that focuses on the entire health facility and all its health workers, supportive supervision promotes quality at all levels of the health system by strengthening relationships within the system, identifying and resolving problems; optimizing the allocation of resources; and promoting high standards, teamwork, and better two-way communication.

7 Shukhi Jibon conducted multiple assessments to identify opportunities to strengthen the capacity of Bangladesh's family planning workforce, including a *Training Needs Assessment, Assessment of Family Planning Service Delivery*, and a *Landscape Analysis: Integrating Mentorship and Supportive Supervision in Family Planning*, which revealed widespread enthusiasm for the inclusion of mentorship within Bangladesh's family planning program as a compliment to supportive supervision.

8 In Bangladesh, in 2017, Pathfinder piloted a mentorship program under the USAID-funded NGO Health Services Delivery Project. In addition, Pathfinder has conducted mentorship programs in Burkina Faso, Mozambique, Pakistan, and Tanzania.

9 Pathfinder International, *Mentorship: Standard Operating Procedure* (Washington: 2022) 27.

10 Pathfinder International, *Supportive Supervision Standard Operating Procedure* (Washington: 2021) 8.

Approach

Shukhi Jibon is the first project in Bangladesh to strengthen the capacity of public-sector family planning service providers by integrating mentorship into the government's existing service delivery supervision system. Ultimately, the project aimed to achieve the following objectives: (1) strengthen supportive supervision within Bangladesh's family planning program; (2) introduce mentorship for family planning service providers within the public sector; and (3) improve the quality of family planning services.

Shukhi Jibon's Integrated M&SS model was intended to support the MOH&FW to increase Bangladesh's qualified family planning workforce through the following strategies: (a) provide on-the-job support, including post-training reinforcement and follow-up, to family planning service providers and health facility managers; (b) enhance the capacity and readiness of facilities to provide family planning services at the required standards of quality; (c) strengthen accountability mechanisms; (d) foster an enabling work environment for providers that increases their motivation, growth, and leadership; (e) ensure respectful care for clients, including the provision of appropriate contraceptive method-mix information; and (f) create opportunities to challenge harmful gender norms, promote positions of influence for women, and address gender imbalance and power inequities.

Addressing gender inequality

While women comprise a significant proportion of the health workforce in Bangladesh, particularly in lower-level cadres, fewer women are in decision-making or leadership positions. Findings from Shukhi Jibon's M&SS landscape analysis revealed that many female managers and providers feel that health facility infrastructures are "not gender-friendly," citing issues such as inadequate availability of female toilets and breastfeeding corners, as well as a lack of privacy. Among service providers, the distinction between the concepts of "sex" and "gender" was not clear, and most managers reported never receiving training on gender concepts. Managers also claimed to lack awareness of appropriate referral services for individuals experiencing gender-based violence.

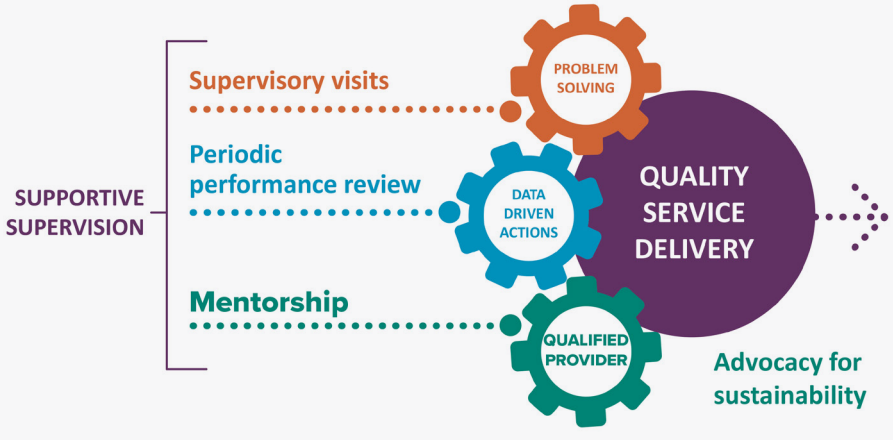
Recognizing that existing gender and power imbalances inherent in supervisor-supervisee and mentor-mentee relationships must be closely monitored, Shukhi Jibon strove to integrate a gender-transformative[11] approach into its M&SS activities. The project worked to create an enabling environment within M&SS that increases providers' competencies in delivering gender-sensitive family planning services[12] and advances outcomes consistent with gender equality and female empowerment.

Creating change through local partnerships

Shukhi Jibon's M&SS efforts have required strong collaboration across several MOH&FW structures, including DGHS, DGFP, DGNM, National Institute of Population Research and Training (NIPORT), and the University of Dhaka, as well as other stakeholders within and outside of the MOH&FW, such as the Clinical Services and Quality Improvement Team (FPCS-QIT) and Quality Improvement Committees (QICs). Prior to implementation, Shukhi Jibon organized regional workshops with district-level managers and service providers from the MOH&FW to identify key themes related to M&SS. Shukhi Jibon also supported the development of a national-level M&SS Working Group with representatives from Pathfinder/ Shukhi Jibon, relevant government agencies, donor agencies, and development partners to co-design and agree upon a robust Integrated M&SS Theory of Change.

Shukhi Jibon's M&SS Theory of Change (see Figure 2) prioritizes the development of qualified service providers , who are essential drivers of strong health systems and quality care. Mentorship, applied as a tool for supportive supervision, can increase competency of service providers and generate in-depth data within the health system. Mentorship works in synergy with other supportive supervision approaches—supervisory visits and periodic performance reviews of providers and health facilities—to promote problem identification and problem solving through data-driven actions. Taken together, Shukhi Jibon's Integrated M&SS model ultimately results in the delivery of quality services, with supportive supervision advancing advocacy for sustainability.

FIGURE 2. THEORY OF CHANGE: INTEGRATED M&SS MODEL



11 Gender-transformative activities foster critical examination of gender norms and dynamics, and proactively seek solutions to challenge and address inequitable dynamics by empowering women, men, girls, and boys.

12 Provider competencies include using gender-sensitive communication, promoting individual agency, supporting legal rights and status related to family planning, engaging men and boys as partners and users, facilitating positive couple's communication and cooperative decision making, and appropriately addressing and responding to a context of gender-based violence.

Developing integrated M&SS tools and resources

In collaboration with the national M&SS Working Group and technical review committee, Shukhi Jibon developed integrated M&SS training manuals (available in English and Bangla) and job aids that focus on common skills required for both mentorship and supportive supervision. The project also made the following available to the public sector:

- Mentorship checklists for assessing providers' skills[13]
- Supportive supervision checklist[14] for assessing facility readiness, observing mentees' and supervisees' service delivery, and recording their performance
- M&SS Action Plan Handbook, including a Root Cause Analysis[15] tool that supports SMART action planning
- Digital Mentorship Application to support the monitoring of mentorship data and mentees' learning processes
- Client eligibility screening checklists[16]
- Anatomical models for clinical skills practice
- Consent forms[17] for use during the provision of injectables, long-acting reversible contraceptive methods (LARCs), and permanent methods

Piloting a Digital Mentorship Application

Building upon Pathfinder's previous experience of creating and testing digital mentorship tools in other countries, Shukhi Jibon developed a custom, android-based mentorship application designed for the Bangladesh context. Consisting of a mobile interface for public-sector mentors and mentees, as well as a website for management of the platform and visualization of data, the application allows users to (1) record observations using digitized checklists during mentorship sessions; (2) quickly view data from a previous mentorship session to plan, conduct, and organize future sessions; (3) track action planning and follow-up; and (4) communicate mentorship progress and growth plan of supervisees. The application was pilot tested and refined during implementation, and Shukhi Jibon is now providing necessary technical support to transfer the system to DGFP.

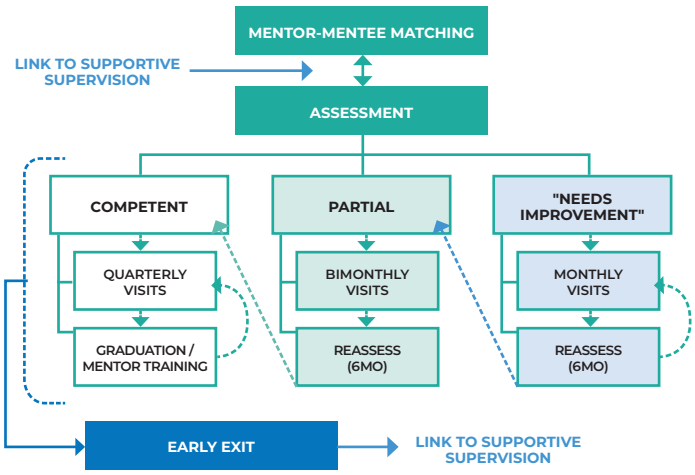
94% of the users surveyed said the digital mentorship application was helpful. Users reported that it was useful to have checklists digitized and handy. One mentee respondent said, *"I can see which important points I have missed during my previous session, which I can later address in my next service to the same or another client. As a result, I can now provide quality service to clients."*

Advancing to mentee graduation

Within the mentorship process (see Figure 3), after a mentor has received training, service providers are selected and invited to serve as mentees. Each mentor is paired with up to five mentees (pairing is made with the approval from district managers). Before mentorship sessions begin, a mentor conducts SWOT (***s***trengths, ***w***eaknesses, ***o***pportunities, and ***t***hreats) analyses of mentees, creating individual mentee profiles. Next, the mentor and mentees meet for an on-site mentorship session, during which the mentor assesses the mentee's skills using DGFP competency checklists at baseline. Mentees' skills may be categorized as "competent" (≥80% score), "partially competent" (60%–80% score), or "needs improvement" (<60% score). Based on a mentee's assessment score, a plan for the focus and frequency of future mentorship sessions is developed. Mentoring frequency depends on numerous factors, such as geographic location, program priorities, identified needs, competency level of mentee, and mentor-mentee availability. Mentorship sessions may be conducted monthly for mentees who need more intensive support or quarterly for those who require less frequent support to advance their skills. Ultimately, after achieving the full, desired competency score in skills agreed upon by the program, a mentee will "graduate" from the mentorship process. At this point, a competent, graduated mentee may seek approval to train to become a mentor, while their mentor may move on to support other providers. At any stage, a mentee or mentor may opt for an early exit from the program.

Each point in the mentorship process—from pairing to graduation to when a provider is recommended be trained as a mentor—is linked to the supervision system. However, while mentorship follows an intensive process for graduation, a similar process does not exist for supportive supervision. This is because supervision is a continuous administrative process and core activity of the health system, whereas mentorship is a targeted, time-bound intervention.

FIGURE 3. MENTORSHIP AND GRADUATION PROCESS



13 Shukhi Jibon adapted checklists on family planning methods from the Bangladesh's National Family Planning Manual to observe and score service providers' skills.

14 The supportive supervision checklist, developed by FPCS-QIT of the Clinical Contraception Services Delivery Program, was used by GOB supervisors with support from Shukhi Jibon.

15 According to WHO, Root Cause Analysis is "a defined process that seeks to explore all of the possible factors associated with an incident by asking what happened, why it happened and what can be done to prevent it from happening again."

16 Through Shukhi Jibon's M&SS activities, use of these checklists from DGFP increased significantly—from 66% at baseline to 87% at endline.

17 As a result of M&SS, the availability and providers' completion of these consent forms from DGFP increased—from 77% at baseline to 84% at endline.

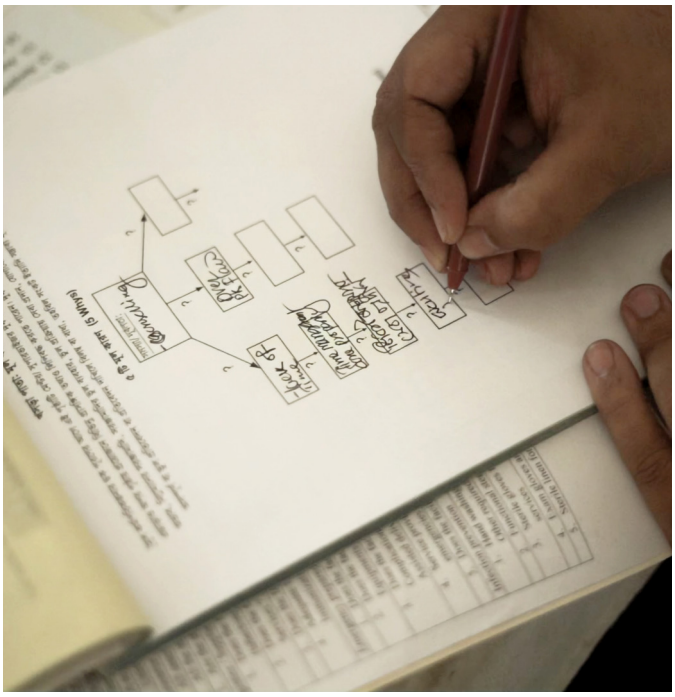
Implementation

From 2019 to 2023, Shukhi Jibon implemented M&SS activities across four divisions—Dhaka, Mymensingh, Sylhet, and Chattogram. While M&SS trainings were conducted in 32 districts and more than 260 upazilas (subdistricts), most intensive implementation focused on 16 districts and 27 upazilas—home to more than 4 million eligible couples.[18] To date, Shukhi Jibon has supported M&SS activities at a total of 544 health facilities across all levels of the health system, from community-level satellite clinics to specialized hospitals and national-level training institutes.

FIGURE 4: IMPLEMENTATION PROCESS

Preparatory Phase

- Consultative workshop
- Landscape analysis
- M&SS Working Group formation
- Curriculum development for M&SS
- Master training of trainers (ToT) on M&SS
- Piloting draft M&SS manuals



A mentor completing Root Cause Analysis to identify appropriate solutions to an issue.
Photo: K.M. Munmun Hafiz

Implementation Phase

- ToT on M&SS
- Orientation on M&SS
- Cascade training on M&SS
- District approval of mentor-mentee pairing with M&SS action plan
- 1st mentorship meeting between mentor and mentee
- Baseline assessment through mentorship session
- Mentorship sessions *(monthly to quarterly)*
- Supervisory visits *(quarterly to annually)*
- Training on Digital Mentorship Application
- Digital Mentorship Application piloting
- Graduation/completion of mentorship
- District M&SS progress review meetings *(quarterly to bi-annually)*
- M&SS Working Group meetings *(quarterly or as needed)*
- Refresher trainings *(bi-annually to annually)*

18 "Eligible couple" is defined by the GOB as a currently-married couple in union where the wife is of reproductive age—between ages 14 and 45.

Working across all levels of the health system

To ensure sustainability, Shukhi Jibon engaged members of the public-sector workforce as mentors in consultation with local stakeholders. The project worked with the MOH&FW to select national and divisional managers, technical supervisors, and experienced service providers from DGHS, DGFP, and DGNM to be trained as master mentors. These master mentors subsequently trained mentors at the district and upazila levels. For more details on the selection criteria of mentors, mentees, and supportive supervisors, see Figure 5.

FIGURE 5: SELECTION CRITERIA

Supportive Supervisor

- Serves as supervisor currently (by default)
- Is referred by supervisor
- Has completed related training and/or has experience on supervision

Mentor

- Is referred by managers
- Has good past professional records (performance volume and quality)

Mentee

- Is a trained family planning service provider
- Is willing to be mentored
- Is Identified by mentor and/or supervisor

Mentorship sessions, scheduled by the mentor and mentee(s), included skills observation and assessment, on-the-job training, demonstration, technical knowledge update, problem identification of mentee through Root Cause Analysis and joint problem solving by SMART (***s***pecific, ***m***easurable, ***a***ttainable, ***r***elevant, and ***t***ime-bound) action plan development. These periodic sessions, held monthly to quarterly, covered a range of topics, including all contraceptive methods offered by the GOB as well as maternal health and infection prevention. During the COVID-19 pandemic, on-site mentorship sessions transitioned to virtual sessions, leveraging platforms, such as WhatsApp, Zoom, Facebook Messenger, to expand mentees virtual knowledge and conduct question-and-answer sessions.

Shukhi Jibon also supported quarterly supportive supervision visits, which increased health facility compliance with protocols and the availability of essential supplies. Supervisors also took a SMART approach to problem solving and action planning. This approach improved coordination within facilities and among DGFP and DGHS partners, leading to increased facility readiness and more efficient use of resources. M&SS enabled district and upazila (subdistrict) managers to analyze data and review the quality of family planning services by examining contraceptive discontinuation rates, side effects, complications management, and removal trends.

Implementation challenges

- The attrition of mentors was difficult to manage. When mentors exited the project, they did so for various reasons—most commonly transfer and retirement. Immediate replacement was rarely possible given the project's limited scope related to geographical reach, training, and human resources.
- Like mentorship programs all over the world, the project encountered challenges related to resource constraints, e.g., providers' limited time for an intensive mentoring visit during busy work hours. Prioritizing mentorship was a challenge for many GOB mentors given other competing priorities of their jobs.
- M&SS activities were conducted during the COVID-19 pandemic, when DGHS providers were largely unavailable, given their need to prioritize COVID-19-related duties and work at COVID-19 hospitals. On-site movement was restricted during this period, which also inhibited in-person M&SS.
- Attaining certain skills, such as the provision of LARC and permanent methods, was difficult in facilities with lower caseloads. With limited numbers of clients seeking these services, mentors had limited opportunity for clinical observation and coaching, and mentees had limited opportunities to practice their skills.
- While the development of Shukhi JIbon's Digital Mentorship Application ultimately helped improve data quality, M&SS implementation began with paper-based data collection tools. The reluctance of mentors and mentees to capture and store data for further analysis also contributed to initial sub-optimal data quality and quantity.
- Providers and other staff were often uncomfortable being observed, observing others, and documenting observation of themselves or of mentees/supervisees. Mentors and supervisors were sensitive about documenting constructive feedback or errors in their observations of mentees/supervisees. Some were hesitant to prepare documented action plans due to concerns that these could later be used against them for administrative actions if problems or capacity gaps were not resolved.

Results

In Shukhi Jibon's 16 intensive M&SS implementation districts,[19] 157 doctors and 52 mid-level providers[20] were trained as mentors (73.1% female and 26.9% male). Mentees comprised doctors (34), mid-level providers (416), and community health workers (68),[21] of whom 92% female and 8% male.

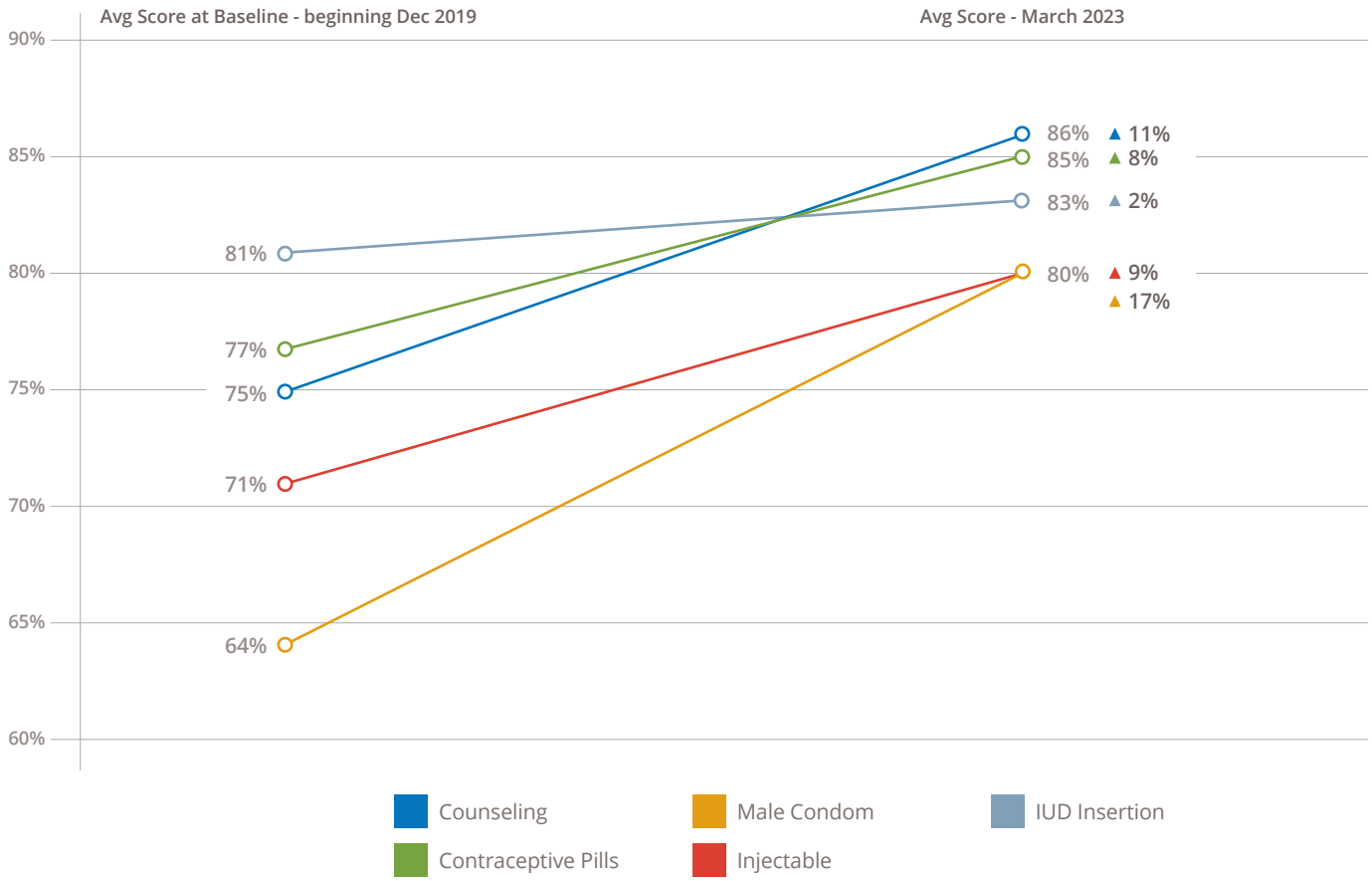
A total of 1,098 mentorship sessions were conducted (924 sessions were conducted onsite, and 174 sessions were conducted virtually). A total of 1,031 supportive supervision visits were conducted at the union and community level, upazila level, and secondary level.[22]

Analysis performed on data generated from the project's mentorship and supervision checklists, in conjunction with feedback obtained from mentors, mentees, and supervisors revealed the following results:

Providers' skills enhanced

During mentorship sessions, providers demonstrated improved competency in several skills, including family planning counseling, male condom provision, injectable provision, contraceptive pill provision, and IUD insertion.

FIGURE 6. CHANGE IN PROVIDER COMPETENCY SCORES AFTER MENTORSHIP



19 Districts include Dhaka, Faridpur, Rajbari, Shariatpur, Mymensigh, Jamalpur, Netrokona, Sylhet, Sunamganj, Moulvibazar, Chattogram, Rangamati, Cox's Bazar, Bandarban, Cumilla, and Feni.

20 This includes nurses, midwives, Family Welfare Visitors, Assistant Family Welfare Officers, and Sub-assistant Community Medical Officers.

21 This includes Family Planning Inspectors, Family Welfare Assistants, Health Assistants, and Health Inspectors.

22 Union and community level includes union health and family welfare centers, rural dispensaries, satellite clinics, and community clinics; upazila level includes upazila health complexes and the FP Sadar Clinic; and secondary level includes district hospitals and maternal and child welfare centers.

On average, service providers' competency levels increased. A closer look at providers' competency related to the provision of contraceptive pills (see TABLE 1) shows that, at baseline, about two-thirds (61%) of service providers scored below 80%. After mentorship, 66% scored above 80%.

TABLE 1. PROVIDER CONTRACEPTIVE PILL SCORE BETWEEN BASELINE AND ENDLINE BY COMPETENCY LEVEL

Competency level score (n = 41)	Dec 2019 (Baseline)	March 2023 (Endline)
Below 60%	10%	0%
60%–80%	51%	34%
Above 80%	39%	66%

Mentees identified improvements

94% of mentees surveyed reported that their service provision skills have improved. All attribute this improvement to M&SS.

83% of mentees reported using checklists more than they did before.

88% of mentees reported using necessary job aid more than they did before.

88% of mentees reported maintaining privacy during service provision more than they did before.

94% of mentees report treating their clients with more respect than before.

92% of the supervisors, mentors, and mentees reported that, as a result of mentorship, they are now providing more gender-responsive care.[23]

"I can see my weak point from the previous session. [M&SS] helps increase quality of service."

–Mentor, Family Welfare Visitor, Maternal and Child Welfare Center (MCWC)

"My experience is positive … My mentee now provides quality service by using all job aids and supplies. I observe her using the checklist or app, then discuss about her lacks and gaps. I develop action plan by analyzing the root causes. Also, I asked for other service providers' presence during sessions so that they can learn too, so no gap will be created when one mentee is absent or gets transferred. Also, I discuss about previous sessions findings with the mentee."

–Mentor, Medical Officer - Clinic, MCWC

"Earlier, I did not focus so much on counseling and communications, but as a result of this training and through the guidance of my mentor, I take these matters seriously … allowing clients to speak openly and creating an environment in which they are interested in speaking on their own."

–Mentee, Sub-Assistant Community Medical Officer, Union Health and Family Welfare Center (UH&FWC)

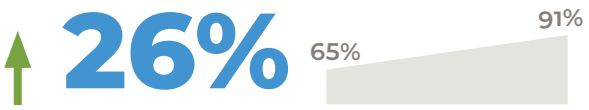
"I need to increase my self-confidence because I need to provide on-job training to my mentee, identify her mistakes, mentor her according to the checklists. For that, I also need to study the checklists. To ensure my mentee provides quality services, I need to develop my own skills. Thus mentorship is contributing in my skill development as well."

–Mentor, Medical Officer - Clinic, MCWC

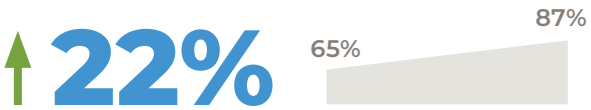
23 Gender-response care includes the following skills: using gender sensitive language and help clients to make informed decision, ensuring privacy during service provision, gaining awareness of reproductive rights related to family planning services, remaining alert for possible gender-based violence and providing necessary support if needed, encouraging men as client, engaging partner of female client, engaging client and her partner to make informed decision as a couple.

Facility readiness improved

Regular supportive supervision and enhanced coordination with facilities and among DGFP and DGHS has contributed to increased facility readiness. Now more facilities are equipped and prepared to meet the needs of family planning clients. An analysis of family planning quality improvement monitoring data showed the following increases:

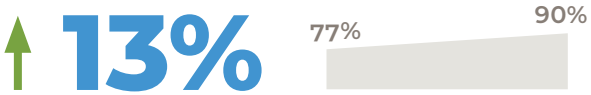


Service registers for adolescent health are available

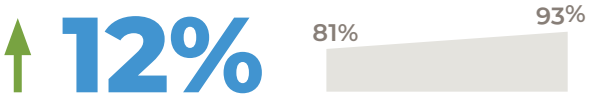


Checklists for FP methods are available

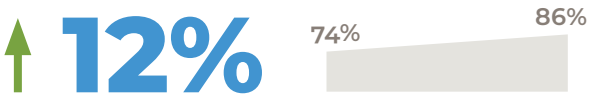
Checklists for screening clients for FP methods are used



Functional sterilization (autoclaving) is available

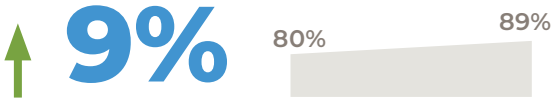


Consent forms for LARC and PM are available



Supplies for infection prevention practices are available

Sterile gloves for providing LARC and PM services and maternal health services are available



National FP Manual is available

"Previously, in the absence of regular supervision, it was not possible to provide proper guidelines... As a result, [providers] didn't have clarity and focus. But [after the M&SS training] ... everything could be managed much better."

–Mentor, Medical Officer - Clinical Contraception

Conclusion and Recommendations

Shukhi Jibon's M&SS model shows that by seizing opportunities to build an integrated M&SS approach upon Bangladesh's existing supervision structure, the public health sector can take critical steps toward increasing provider and facility performance to deliver higher quality family planning and SRH services.

The project recommends the following strategies to institutionalize the integrated M&SS model in Bangladesh:

1. Ensure frequent follow-up to increase interaction between mentors and mentees, improve mentees' skills, and help identify mentees' ongoing needs.
2. Skilled human resources are critical. Program attrition due to the transfer of a mentor or mentee is a missed opportunity. Consider engaging the mentor at their new workplace with new mentees and train new mentees to fill attrition gaps.
3. Mentorship should be a time-bound activity. Programs should focus on the graduation of competent mentees. In program areas with high attrition, programs may focus on enlisting mentees with higher competencies who can be graduated more quickly and then trained as new mentors.
4. For mentorship programs to be effective, large amounts of complex data must be collected and analyzed for decision making. Deploying Shukhi Jibon's Digital M&SS Application for new mentorship programs can help meet data accuracy and analysis needs and provide users with readily available job aids and learning resources to simplify their work.
5. While clinical mentoring is essential for improving service providers' competency—their skills, attitude, and practice—integrated M&SS should also focus on nonclinical skills, such as report writing and record keeping to further strengthen the public health system.
6. It is important to reiterate to all stakeholders that the M&SS model promotes collaboration, learning, and adaptation instead of criticism, performance appraisal, or retribution to foster a nonjudgmental and facilitative environment for continuous quality improvement.
7. Include Shukhi Jibon's Integrated M&SS model in the 5th Health, Population and Nutrition Sector program with necessary budgetary allocation for scale-up, including travel and daily allowances for mentors and mentees.

Suggested citation
Accelerating Universal Access to Family Planning/Shukhi Jibon Project, *Beyond Training: Strengthening Bangladesh's Family Planning Workforce by Integrating Mentorship and Supportive Supervision* (Dhaka: Pathfinder International, 2023).

COVER: Skill observation during a mentorship session. Photo: K.M. Munmun Hafiz

Authors
Ituki Chakma, Senior Technical Advisor - Family Planning Services
Pathfinder International - Bangladesh

Maren Vespia, Strategic Communications
Pathfinder International - Bangladesh

Contributors

Md. Mahbub ul Alam, Project Director, Shukhi Jibon
Country Director, Pathfinder International - Bangladesh

Dr. Shahina Sultana, M&SS Manager
Pathfinder International - Bangladesh

Anupama Islam Nisho, Data Analyst
Pathfinder International - Bangladesh

Fatema Begum, M&SS and Family Planning Coordinator
Pathfinder International - Bangladesh

Motahara Islam Tania, M&SS and Family Planning Coordinator
Pathfinder International - Bangladesh

Saiful Hasan; Monitoring, Evaluation, and Learning Manager
Pathfinder International - Bangladesh

Liaquat Ali, Monitoring, Evaluation, and Learning Specialist
Pathfinder International - Bangladesh

Sungida Ferdous, M&SS Coordinator
Pathfinder International - Bangladesh

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Pathfinder International - USA
9 Galen St, Watertown, MA 02472, USA | +1 617 924 7200

Pathfinder International - Bangladesh
Shezad Palace, 5th floor, 32 Gulshan Avenue North C/A,
Dhaka – 1212, Bangladesh | +880-1770294834

pathfinder.org | @pathfinderInt:

Training alone is not enough to improve health workers' confidence and competency to provide quality health services. To improve the capacity of Bangladesh's family planning workforce, Shukhi Jibon's Integrated Mentorship and Supportive Supervision (M&SS) model points the way forward. M&SS is a pillar of Shukhi Jibon's overarching goal to increase the use of voluntary family planning and sexual and reproductive health services by ensuring that all people can receive high-quality health care from skilled, responsive, and respectful providers.

"This M&SS approach should be included in the Government's regular activities, because the project might come to an end, or the district might be dropped off from the project. But if [M&SS] is part of the government program, there will be continuity and an increase in our quality of care."

—Mentor, Medical Officer - Maternal and Child Health and Family Planning, Upazila

"Not only family planning—if M&SS is applied in surgery, orthopedics, gynecology, or other services, I think everyone will be more interested to work and enjoy their work. It will be good if M&SS is started in all departments."

—Mentee, Senior Staff Nurse/Certified Midwife, District Hospital

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