PATHFINDER

Implementation of a Clinical Mentorship Program in Mozambique

PATHFINDER INTERNATIONAL TECHNICAL BRIEF | JULY 2021

Photo: Kendra Hebert

Integrated Family Planning Project, 2019. A nurse trained by IFPP stands with Pathfinder clinical mentor Victoria Mubai.

Abstract

Mozambique's pregnancy-related mortality ratio is one of the highest in Southern Africa at 443 deaths per 100,000 live births and a total fertility rate of 5.4 children per woman.[1] Family planning (FP) can prevent up to 32% of maternal deaths and 10% of child deaths globally.[2] Yet health systems challenges, traditional beliefs, misconceptions, poor access to services, challenging policy environments, and low funding commitments have hindered FP uptake in Mozambique, where unmet need for FP is high: 23% of all women who want to space or limit pregnancy lack access to modern contraception.[3] To improve FP access, Pathfinder International implemented the USAID Integrated Family Planning Program (IFPP, 2016-2021) in partnership with N'weti, Abt Associates, and Population Services International (PSI). This technical brief documents IFPP's implementation of a mentorship program to improve the quality of FP services in supported districts and share lessons learned and recommendations for replication, adaptation, and scale-up of the mentorship approach.

Background

The National Health System provides almost 95% of health care in Mozambique but reaches less than 60% of the population.[4] The majority (70%) of the population reside in rural areas; only one-third have access to a health facility within 60 minutes walking distance of their homes, and 12.5% have no access to care.[5] In 2012, Mozambique made a Family Planning 2020 commitment to provide community-level FP services, strengthen health facilities to offer universal access to FP information and services, and increase the modern contraceptive prevalence rate (mCPR) from 11.3% in 2011 to 34% by 2020.

1. "MOZAMBIQUE COUNTRY QUICKSTATS." DEMOGRAPHIC AND HEALTH SURVEYS. ACCESSED FEBRUARY 23, 2021. HTTPS://DHSPROGRAM.COM/COUNTRIES/COUNTRY-MAIN.CFM?CTRY_ID=61.
2. CLELAND, JOHN, STAN BERNSTEIN, ALEX EZEH, ANIBAL FAUNDES, ANNA GLASIER, AND JOLENE INNIS. "FAMILY PLANNING: THE UNFINISHED AGENDA." THE LANCET 368, NO. 9549 (NOVEMBER 2006): 1810–27. HTTPS://DOI.ORG/10.1016/S0140-6736(06)69480-4.
3. "MOZAMBIQUE: COMMITMENT MAKER SINCE 2012." FAMILY PLANNING 2020. ACCESSED JANUARY 13, 2021. HTTP://WWW.FAMILYPLANNING2020.ORG/MOZAMBIQUE.
4. VISSER-VALFREY, M, AND MB UMARJI. "SECTOR BUDGET SUPPORT IN PRACTICE CASE STUDY HEALTH SECTOR IN MOZAMBIQUE." LONDON, UK AND OXFORD, UK: OVERSEAS DEVELOPMENT INSTITUTE AND MOKORO, 2010.
5. ANJOS LUIS, ANTÓNIO DOS, AND PEDRO CABRAL. "GEOGRAPHIC ACCESSIBILITY TO PRIMARY HEALTHCARE CENTERS IN MOZAMBIQUE." INTERNATIONAL JOURNAL FOR EQUITY IN HEALTH 15, NO. 1 (DECEMBER 2016): 173. HTTPS://DOI.ORG/10.1186/S12939-016-0455-0.

The USAID Integrated Family Planning Program (IFPP, 2016-2021)

IFPP aimed to increase Mozambique's mCPR by generating new FP users, diversifying the chosen method mix based on quality comprehensive counseling and service provision, and strengthening family planning and reproductive health (FP/RH) systems. IFPP reached women with high unmet need, namely postpartum women; women living with HIV; adolescents, including orphans and vulnerable children; medium- and high-parity women; and postabortion women. IFPP covered two provinces—Nampula (mCPR 22%) and Sofala (mCPR 14%)[6]—and implemented activities in all 36 districts within these provinces, covering an estimated population of 8,018,168 in 2019.[7] In partnership with the Ministry of Health (MOH), the Provincial Health Directorate (DPS) and District Health Welfare and Women Directorate (SDSMAS), IFPP supported 411 peripheral health facilities to increase access to quality FP/RH counseling and services by expanding the method mix, strategically integrating FP with other services—for example, HIV testing and treatment, nutrition, and immunization—and improving the quality and youth-friendliness of contraceptive services.

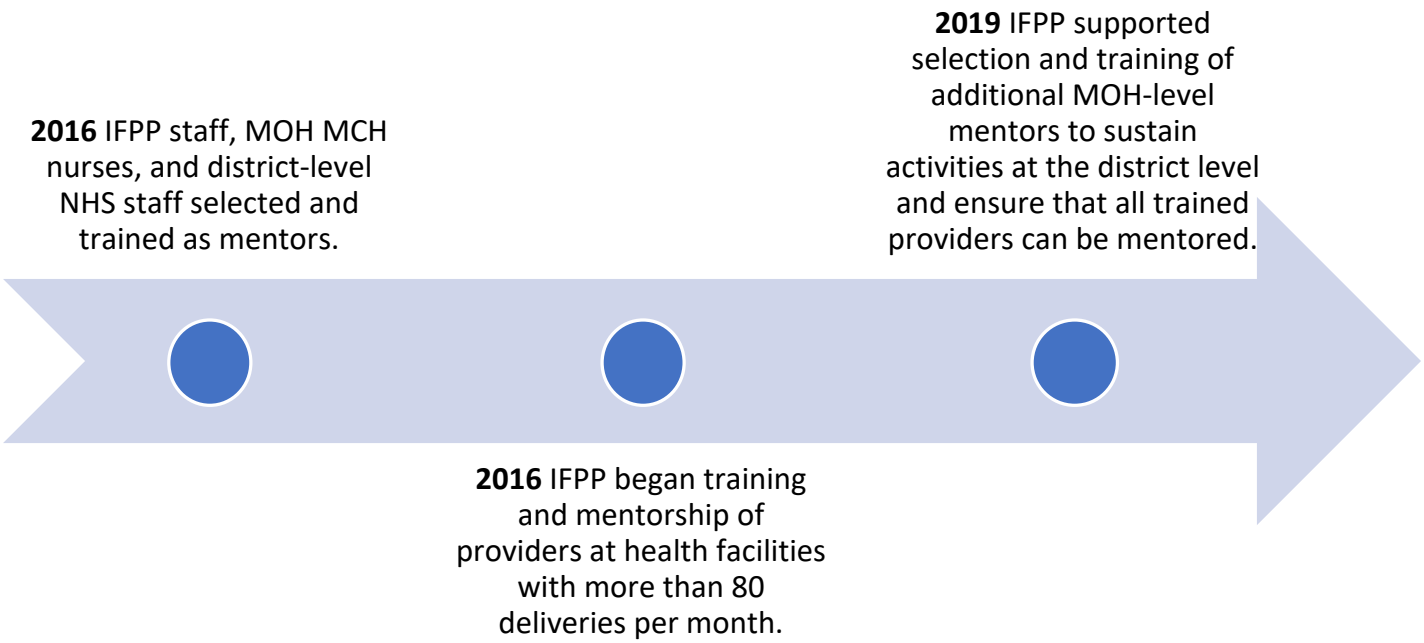
Pathfinder's decades of experience strengthening the capacity of health care providers around the world has demonstrated that training alone is often insufficient to transfer the knowledge, skills, and confidence necessary to improve the quality of health services. While training and supportive supervision are important to improve quality of services and ensure adherence to proper protocols within a health facility, mentorship provides ongoing on-the-job skills-building opportunities for providers through regular contact, assessment of abilities, reflection, and constructive feedback. Mentors facilitate continuous quality improvement by helping providers build on foundational knowledge and skills gained during training. This brief documents IFPP's implementation of a mentorship program to improve the quality of FP/RH services in the project area.

Implementation

Pathfinder was the first organization to introduce mentorship within FP/RH services offered in Mozambique's health system. The goals of the mentorship approach were to reinforce the skills and techniques learned during training and to sustainably improve facility-level service quality and provision of the full range of available methods. The primary objective of mentoring in IFPP was to guarantee that health providers trained by the project were regularly engaged and supported to achieve and maintain clinical competency and service quality. The secondary objective was to cultivate institutional engagement and ownership among health-facility management and staff to remove barriers to uptake of FP services. Experienced IFPP staff, district-level NHS maternal and child health (MCH) nurses, and MOH MCH nurses selected by the provincial directors were trained as mentors. These mentors helped mentees gain professional knowledge, skills, and confidence in a shared area of practice through direct observation of service provision using the National FP Quality Standards and supplementary on-the-job training.

IFPP's mentorship model consisted of a series of visits, the first of which took place within 10 days of the initial training. A subsequent visit was scheduled for approximately 25 days after the clinical training and another approximately 46 days after training. Visits thereafter were scheduled depending on the findings of the early visits with a goal of reaching each facility with trained health providers once a quarter, if possible. Visits focused on FP counseling, implant insertion and removal, and interval and postpartum IUD (PPIUD) insertion and removal. IFPP envisioned that mentors would do the following:

FIGURE 1: IFPP Mentorship Model



6. MINISTÉRIO DA SAÚDE- MISAU, INSTITUTO NACIONAL DE ESTATÍSTICA - INE, AND ICF. 2018. INQUÉRITO DE INDICADORES DE IMUNIZAÇÃO, MALÁRIA E HIV/SIDA EM MOÇAMBIQUE - IMASIDA, 2015. MAPUTO/MOÇAMBIQUE: MISAU/MOÇAMBIQUE, INE, AND ICF.
7. "MOZAMBIQUE." CITY POPULATION. ACCESSED JANUARY 13, 2021. HTTPS://WWW.CITYPOPULATION.DE/EN/MOZAMBIQUE/CITIES/.

• Provide practical knowledge and skills-building support;

• Assist in providing services and making referrals for more complicated issues; and

• Supplement on-site mentorship with provision of technical assistance and other support via WhatsApp and other remote communication platforms.

Performance

Reach and Effect of Mentoring on Clinical Competency

IFPP used both quantitative and qualitative methods to document implementation and assess the effect of the mentorship approach. To measure its reach, the project tracked the proportion of health facilities with at least one eligible provider trained, the proportion of facilities with all eligible providers trained, the number of eligible providers who had received at least one mentorship visit, and the number of eligible providers who had received a mentorship visit for each method or technique of focus (counseling; insertion and removal of IUD, PPIUD, and implants; and provision of injectable contraceptives). The project also employed pre- and post-training testing as well as post-mentoring visit checklists to measure provider knowledge, attitudes, and clinical skills.

Over the duration of IFPP, 4,755 health providers (3,031 women and 1,724 men)—mostly MCH nurses and clinical officers—in Sofala and Nampula provinces were trained. In 402 of the 411 total health facilities in the project area (98%), at least one health provider received FP training; in 301 facilities (73%), all health providers were trained. The nine health facilities where no one was trained were linked with the penitentiary system or the Catholic Church and did not allow provider training.

After the first mentoring visit, 309 more providers met standards for insertion and removal of implants, 122 more for IUD, and 100 more for PPIUD than after training alone. This means that approximately 1 in 10 providers would not have achieved clinical competence after training alone but did so with post-training mentorship. Most providers (97% of those mentored in implant provision, 93% of those mentored in IUD provision, and 95% of those mentored in PPIUD provision) achieved clinical competence as indicated by the checklists completed at the end of mentorship visits (Figure 2).

Perceived Benefits of Mentoring on Quality of Family Planning Provision

In July 2020, IFPP conducted a qualitative study to assess provider perceptions of the effects of the project's mentorship approach. To document successes, constraints, and lessons learned, a research consultant did 69 semi-structured interviews in Angoche and Nacarôa districts in Nampula province with providers who were trained and mentored; providers who were trained but

FIGURE 2: Proportion of mentored providers that achieved clinical competence, by mentorship type

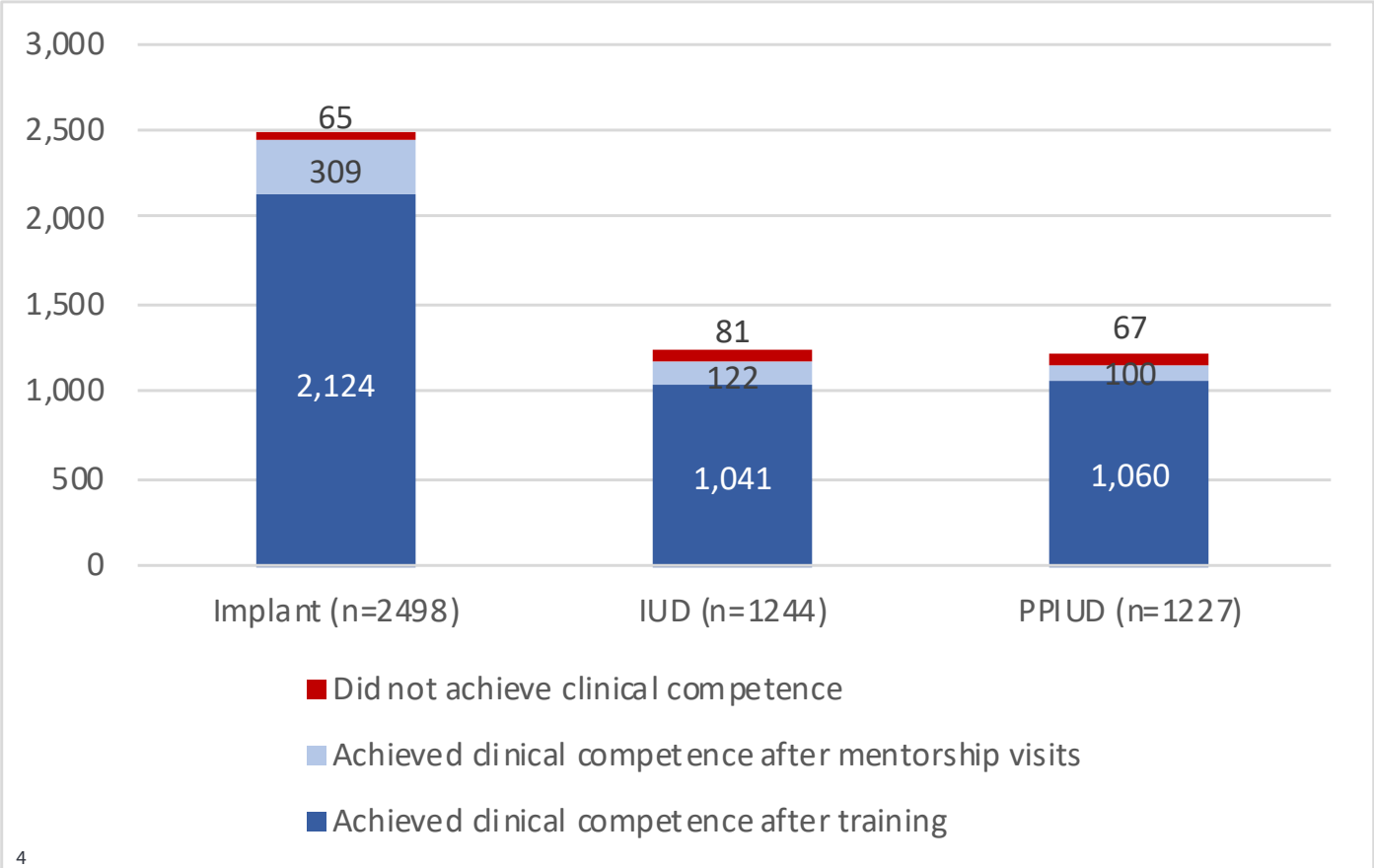


Photo: Kendra Hebert

IFPP home health visit.

"I consider the mentoring to be very important, because when a person is overwhelmed with responsibilities, human error can occur without the person even realizing it... With mentoring, the person can learn from mistakes and look out for similar errors in the future."

- Clinical officer, Natire Health Center

not yet mentored; MCH officers of select health units; and IFPP officers and district coordinators who served as mentors. Sixteen of these interviews were conducted with providers who were mentored on implant provision and focused solely on the mentorship experience. The other interviews focused more broadly on IFPP's integration of contraception into a range of other health services, including primary health care, HIV, MCH, and mobile outreach. Learnings from these interviews will strengthen future implementation of FP/RH mentorship.

IFPP's assessment revealed clear differences in skill level in FP provision between providers who were both trained and mentored and those were trained but who were transferred to another health facility or left the health system before they could be mentored. Those who were mentored were more motivated to offer FP services and more skilled in FP counseling and provision of long-acting reversible contraceptives (LARCs) due to the follow-up and technical assistance they received. They described the mentoring as useful because it allowed them to observe, practice, and improve contraceptive insertion and removal techniques with the support of their mentor and to offer these methods with greater skill, confidence, and safety. Providers emphasized that mentoring not only improved their skills but also helped them correct procedural mistakes and reduce error. On the other hand, those who were not mentored reported feeling less informed, supported, motivated, or confident in managing LARC provision safely and easily than those who were mentored.

Photo: Kendra Hebert

A community dialogue, where participants discuss family planning.

Almost all interview participants reported confidence in their ability to insert and remove LARCs including, Jadelle, Implanon, and IUD, asserting that their training and mentorship provided them with the skills they needed. Some participants mentioned that despite a high level of confidence, they could not practice the technique because it is not carried out at their facility. When these providers were able to accompany a patient to the higher-level facility, some could observe and even practice the technique successfully. These instances presented opportunities to develop a rotating approach that invited personnel from different facilities to attend insertions and removals for in-service training and refresher training. This not only helped to ensure that everyone had an opportunity to practice, but it also helped mitigate the impact of staff turnover in a specific health unit or service sector.

Lessons Learned and Recommendations

IFPP's comparative analysis of the experiences of providers who were trained and mentored and those who were trained but not mentored showed the value of mentoring in evaluating the technical skills of providers, providing practical demonstration of method provision, and offering constructive feedback. Even providers who were initially skeptical of mentoring saw after participating that it motivated them to improve the quality of their services and ensured timely sharing and practice of new approaches and techniques. Several lessons and recommendations emerged from the evaluation findings.

Differentiate mentoring from supervision.

While providers understood that the purpose of mentoring was in-service support for specific activities, most referred to mentoring as "supervision" and noted a focus on observation, book completion, stock control and availability, verification of proper procedures, and alignment of implementation with training. At their first visit, mentors should define mentoring as a skills-building exercise so that providers understand the purpose.

Ensure quarterly visits and continuous follow-up with trained and mentored providers.

While providers were to be mentored for all contraceptive methods, lack of eligible women at the time of the mentorship visits hindered the process. Because of this variability, duration of mentoring visits ranged from 30 minutes to several hours.

Furthermore, mentees who worked at facilities that did not offer LARCs had to visit higher-level facilities to practice techniques with their mentors, posing potential delays and inconveniences. Providers cited the need for more regular, frequent mentoring visits.

Improve the mobile application used to document the mentoring visits.

The app did not always work properly and therefore disrupted the flow of the visit, posing a time-management challenge. A district coordinator reported, "While I am already finishing the process, or even sometimes while I'm even almost in the middle of finishing the process, the application closes, and I have to go back to square one...It's disturbing, because I have to refill the same form two or three times... This also takes up the time of the provider." Some mentors used a paper checklist and later transferred the data to the app, but this also took time. Improving the functionality of the app will improve efficiency and morale.

Improve communication with the health units about mentor visits and providers to be mentored.

Partners supporting IFPP had no control over the mobility of staff within the health system. At times, high mobility of health providers, combined with limited communication, affected planning when providers targeted for engagement were no longer in the health system.

Mentor providers who have not yet been mentored to improve their technical skills.

The approximately 20% annual turnover rate of MOH providers meant that each year, one-fifth of the trained providers leave, and new ones arrive in need of training and mentoring. Therefore, mentorship is never finished, and a government-led team should be trained and readily available to support and mentor new staff beyond the close of IFPP.

Create useful information sharing mechanisms and success stories among health unit providers.

Using regular district meetings to share updates on provider performance during mentoring visits, as well as creating a user-friendly dashboard to share real-time data on provider performance with district managers, can help ensure that successes are celebrated and that additional follow-up is done with providers who need more support.

"[Mentoring] is a good method that I hope will happen more...because we learn a lot from it.... It is also a good way for us to stay updated and fit."

- Clinical Officer, Nhachere Health Center

Conclusion

IFPP trained thousands of providers but training alone achieves limited results. After training, some providers needed additional practice to achieve competency in the counseling and contraceptive insertion and removal techniques they learned. Mentorship improved their skills, abilities, and confidence in FP provision. Moving beyond traditional training and supportive supervision to provide mentorship supports continuous quality improvement by helping to assess provider ability and improve provider skills to offer quality services. Mentorship builds on the foundation laid by training, ensuring that providers are knowledgeable, skilled, experienced, confident, and motivated. Mentoring offers an opportunity to implement and institutionalize a structured mechanism for tracking provider skills and improvement. IFPP's lessons can be applied to strengthen the mentorship model and meet contextual challenges as they arise. The MOH should consider scaling up and institutionalizing mentorship in Mozambique as a strategy to ensure continuous quality improvement and increase provision and uptake of voluntary FP, particularly LARCs. As a step in this direction, FP/RH mentorship is currently being scaled up to Maputo City and Maputo, Manica, Tete, and Zambézia provinces. Technical-working-group discussions about embedding and streamlining mentorship as a national tool to be used in tandem with the National Supervision Checklist and National FP Quality Standards are ongoing.

Contributors: Dr. Pritha Biswas, Dr. Mohamad (Bram) Brooks, Elizabeth Futrell, Kendra Hebert, Ana Jacinto, Riaz Mobaracaly, Dr. Jean Jose Nzau Mvuezolo, Dr. Adalgisa Ronda, Dr. Luc Van der VekeN

The USAID Integrating Family Planning Program is a five-year activity implemented by Pathfinder International, N'weti, Abt Associates, and Population Services International (PSI).

Photo Credit, Cover: USAID Integrated Family Planning Project 2019. Community facilitators, Pathfinder trained providers, and Pathfinder's clinical mentor for Nhamatanda, Angélico Camata (Kendra Hebert)

9 Galen St, Watertown, MA 02472, USA | +1 617 924 7200
email: technical@pathfinder.org

pathfinder.org | @pathfinderInt:

Pathfinder International in Mozambique
Rue Eça de Querois #135
Bairro da Coop, Cidade de Maputo
Maputo, Mozambique | +1 617 924 7200

PATHFINDER

USAID
FROM THE AMERICAN PEOPLE