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From Training to Practice

Lessons from Clinical Mentorship for Sustained PHC Delivery in Kano State

LEARNING BRIEF | AUGUST 2026

EXECUTIVE SUMMARY

Between 2024 and 2026, the Gates Foundation-funded, Pathfinder-led Task Shifting and Task Sharing (TSTS) initiative supported 222 primary healthcare facilities across Kaduna and Kano States to strengthen the capacity of frontline health workers and improve the delivery of maternal, newborn, and child health services. From October 2025 to June 2026, 26 clinical mentors supported 145 primary healthcare facilities across 26 LGAs, delivering 1,159 mentoring visits, comprising 619 one-on-one and 540 group sessions. Mentorship focused on identified gaps across ANC, labor and delivery, PPH prevention and management, newborn care, postpartum family planning, and other essential PHC services. Competency assessments showed progressive improvement across the mentorship cycle, while service delivery indicators also showed changes across selected areas.

A key finding was the extent to which facility needs extended beyond the planned curriculum. 827 sessions addressed needs outside the originally planned scope, demonstrating the importance of designing mentorship models with sufficient flexibility to respond to context-specific gaps while maintaining core standards. The experience also highlighted the importance of government ownership, competent mentors, evidence-informed planning, peer learning, and integration with existing health system structures for sustainability. This brief documents the Kano clinical mentorship experience, the changes observed, and the lessons for designing and institutionalizing sustainable mentorship approaches within routine primary healthcare systems.

THE CHALLENGE

Task Shifting Task Sharing (TSTS) was introduced in Kano State to address persistent human resources for health constraints affecting the availability and quality of primary healthcare services, particularly maternal, newborn, and child health.[1] The approach aimed to expand access to essential services by enabling trained frontline providers, including community health extension workers (CHEWs) and junior community health extension workers (JCHEWs), to safely deliver selected life-saving interventions. However, adopting a policy and providing training do not automatically translate into improved clinical practice. Three critical constraints stood between what providers were taught and what happened in routine service delivery.

01 Training alone may not be sufficient to change clinical practice

While training can strengthen knowledge and skills, frontline providers may require continued coaching, guided practice, supportive feedback, and reinforcement to translate learning into routine clinical practice. This is particularly important for complex and time-sensitive interventions such as postpartum hemorrhage (PPH) prevention and management. [2]

02 Frontline providers often have limited access to continuous professional support.

Without regular opportunities for workplace-based learning, supportive feedback, and practical coaching, competency gaps may remain unidentified or unaddressed. This creates a need for support that takes place within the service delivery environment, where gaps can be identified through direct observation and addressed in real time.

03 An expanded scope of practice raises the stakes for quality and safety

As CHEWs and JCHEWs take on selected clinical responsibilities under the TSTS policy, there is a corresponding need to ensure that they are adequately supported to apply new skills safely, consistently, and in accordance with approved clinical standards.[1]

Clinical mentorship was positioned as the mechanism to address these gaps by providing structured, workplace-based support that connected training to routine service delivery. Through practical coaching, direct observation, demonstrations, feedback, and guided problem-solving, mentorship served as a bridge between what providers were taught and what they were able to apply in real clinical settings.

THE TSTS MENTORSHIP APPROACH

Mentors selected through the State, not around it

The request for mentors was routed formally through the Kano State Ministry of Health (SMOH), and candidates were drawn from the state's existing pool of trainers, building on capacity the State already owned. Candidates applied, sat a competency test that determined shortlisting, and 26 mentors were selected and assigned across local government areas (LGAs). Eligibility required a qualified nurse or midwife, resident in the LGA they would serve, prior experience in PPH management, and strong maternal health competency. The residency requirement mattered as much as the clinical one: proximity made frequent, short-notice mentoring affordable.

Prepared to teach, not only to practice

Mentors took a five-day refresher covering both clinical content (basic emergency obstetric and newborn care (BEmONC) competencies, labor monitoring, PPH prevention and management, postpartum family planning, newborn care) and mentoring methodology: facilitation, adult learning principles, demonstrations, role play, and case-based methods. Pre- and post-tests confirmed readiness. A one-day orientation then standardized understanding of roles, reporting requirements, and documentation tools. Work plans were built directly from identified Objective Structured Clinical Examination (OSCE) gaps, so deployment targeted observed deficits rather than a generic curriculum.

Delivered inside the service environment

The model was facility-based and primarily one-on-one: regular coaching, hands-on support, case-based guidance and real-time feedback within the mentee's own workplace, so learning did not interrupt care and could be applied immediately. Group and peer learning sessions added teamwork and shared problem-solving, and review meetings turned field experience into corrective action. Mentors also documented gaps, supported facility action planning, and escalated system constraints upward, making mentorship a feedback channel into the health system as well as a clinical intervention.

> *We don't just go there and hijack their routine. We observe what they do, and where we feel they are going wrong we systematically intervene without even allowing the clients to realize we are doing it. Then we sit with them, we bring the areas we felt need to be corrected, we discuss, and we prepare solutions.*
>
> — **Clinical Mentor, Kano State**

Measured through a standard tool package

Six instruments standardized delivery and monitoring across all sites, backed by quarterly coaching assessments of mentees and supportive supervision of mentors.

Tool	What it made visible
Coaching Log Form	Each session mentor observations, feedback, and identified challenges were documented.
Task Log Form	Number and type of PPH management tasks performed by each mentee per month; skills actually used, not just taught.
Clinical Assessment Tool	Mentee competence observed during live service delivery.
OSCE Assessment Tool	Practical skill level and the specific gaps requiring follow-up.
Feedback Forms	Mentor views on mentee progress, and mentee views on the quality of mentoring.
Coaching Quality Assessment Tool	The quality of the mentoring itself, feeding supportive supervision.

Table 1: The six-instrument mentorship tool package and what each instrument made visible

Anchored in State systems

The project engaged the SMOH, the State Primary Healthcare Management Board (SPHCB), the Hospital Management Board (HMB), and other ministries, departments and agencies(MDAs) from the outset; supported revitalization of the Human Resources for Health (HRH) Working Group; worked through the Reproductive, Materna, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH+N) coordination platform; established a state steering mechanism; and secured reflection of TSTS priorities in the State's Annual Operational Plan. State monitoring and evaluation (M&E) officers oversaw data collection and maternal, newborn, and child health (MNCH) coordinators coordinated mentorship across their LGAs. Facilities were selected against agreed criteria of service delivery need, workforce gaps, and readiness.

EVIDENCE OF CHANGE

Data and methods

Data presented in this section covers the implementation period from October 2025 to June 2026. Implementation data on mentoring visits, coaching sessions, and areas of focus were drawn from program records. Mentee competency data were drawn from three competency assessments conducted during the coaching period and analyzed to assess changes in overall and domain-level performance. Selected service delivery indicators were drawn from routine District Health Information System (DHIS2) data, while PPH task frequency and OSCE competency scores were drawn from program data.

Results are presented as evidence of contribution rather than attribution to mentorship alone. Mentorship was implemented alongside training, supportive supervision, commodity support, and state coordination activities, which may also have contributed to the observed changes.

What was delivered

From October 2025 to June 2026, 26 competency-screened mentors, drawn from the state trainer pool, reached 145 facilities with 1,159 mentoring visits total: 619 one-on-one coaching sessions and 540 group coaching sessions.

As Figure 1 shows, coaching concentrated on labor and delivery and antenatal care, reflecting the program's emphasis on core maternal health competencies. Family planning was also a major focus. Fewer sessions addressed data management and referral systems. The distribution suggests that mentoring responded primarily to clinical care needs while also providing opportunities to strengthen lower-frequency areas such as referral and data use.

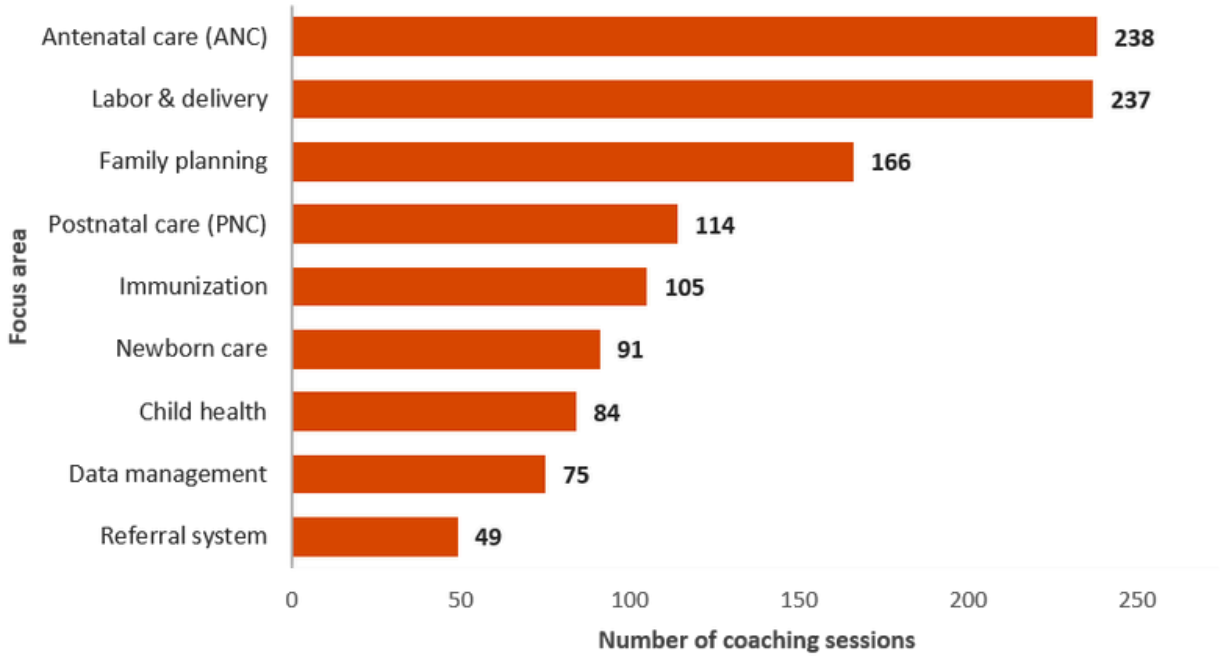


Figure 1. Coaching and mentoring sessions by focus Areas, October 2025- June 2026

What changed

The proportion of assessed mentees meeting the 80% competency threshold also increased: **95 of 145 records (65.5%) met or exceeded the threshold at the first assessment**, compared with 145 of 145 records (100%) at the third. This represents a substantial shift toward consistently high competency performance among assessed mentees.

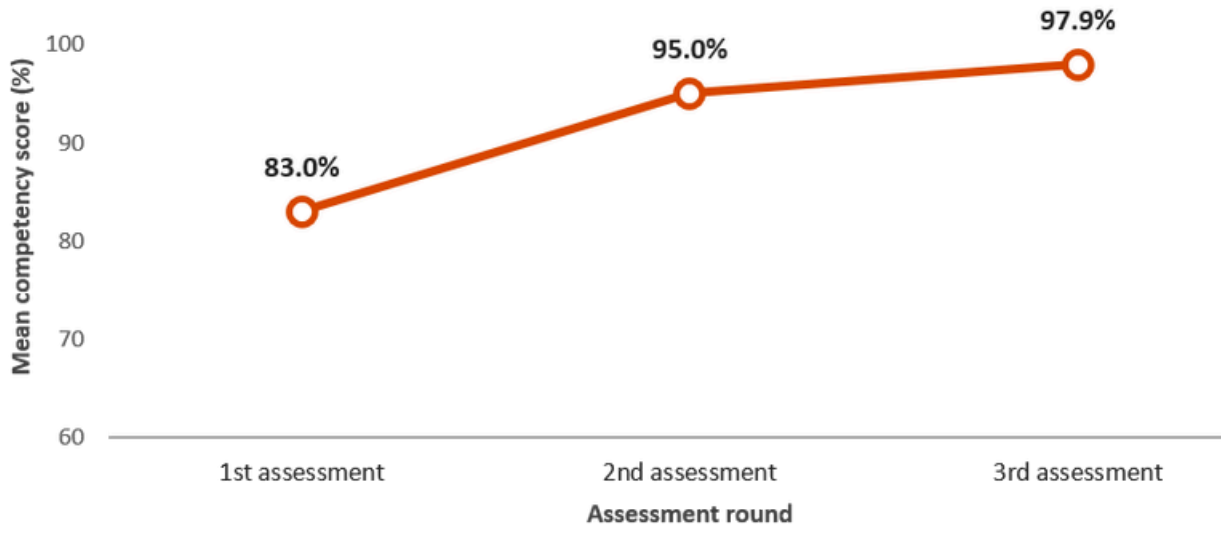


Figure 2. Change in mean overall competency score across three assessments

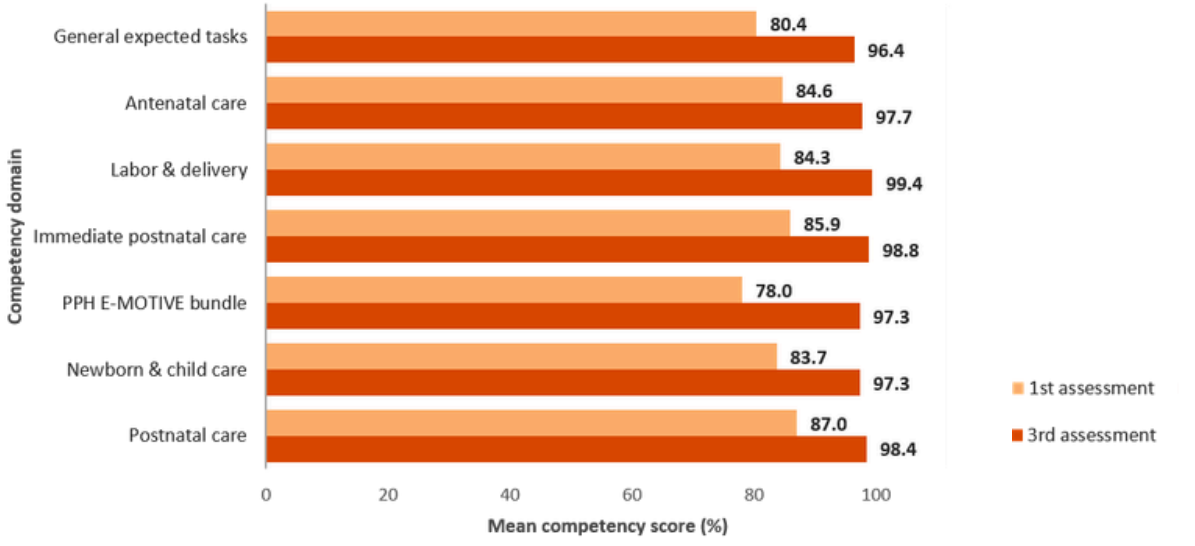


Figure 3. Mean competency score by domain, first and third assessments

Improvement was broad-based across the seven competency domains (Figure 3). The largest gains were in the PPH E-MOTIVE bundle — early detection and treatment of PPH using uterine massage, oxytocic drugs, tranexamic acid, intravenous fluids, examination, and escalation — at +19.3 percentage points, followed by general expected tasks (+16.0), labor and delivery (+15.1), and newborn and child care (+13.6). By the third assessment, mean performance exceeded 96% in every domain, suggesting that improvement was broad rather than confined to a single clinical area.

> *Before the mentorship, we used to refer many complicated maternal cases because we lacked the confidence and practical skills to manage them. Today, after the training and mentorship, we are able to assess, stabilize, and manage conditions such as postpartum hemorrhage and other obstetric emergencies with greater confidence.*
>
> — **Binta Ahmed, Mentee, PHC Muhammad Gauyama, Kano State**

Mentees' Experience of Coaching

The coaching quality assessment showed strong reported uptake of the mentoring approach. All respondents (100%) reported improved confidence after coaching, 99.4% reported applying their learning in daily activities within the quarter, 98.1% reported receiving feedback, and 94.8% reported using guidelines or job aids.

These findings complement the competency results. Together, they suggest that mentees not only demonstrated higher competency over time but also found the coaching relevant, practical, and applicable within their routine work.

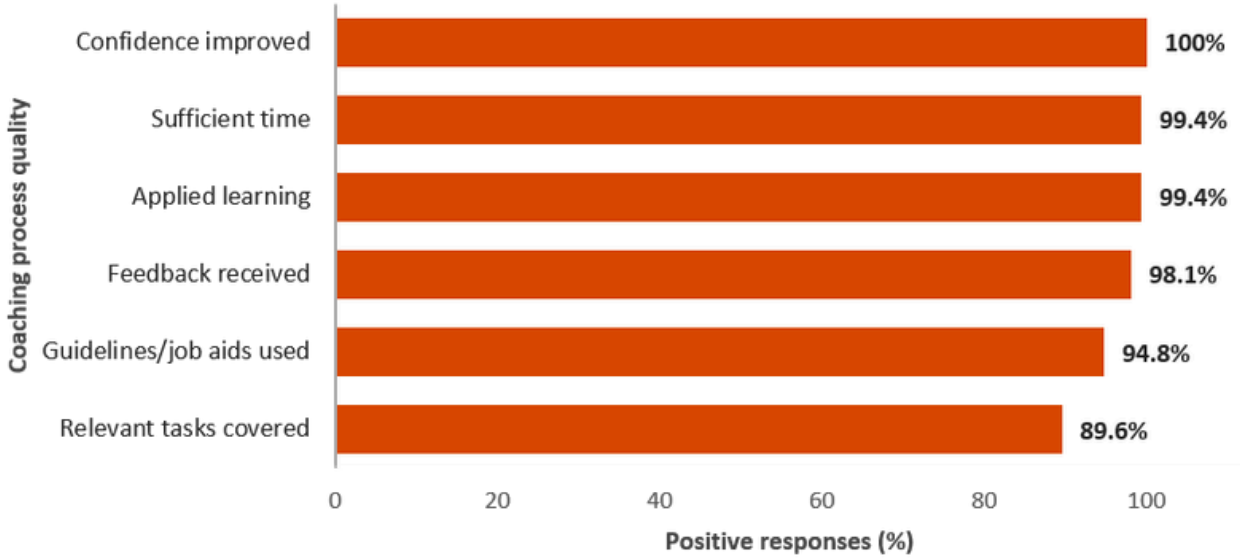


Figure 4: Mentee-reported coaching quality, single round assessment.

> *Before the mentorship, some of the procedures we carried out were based on routine practice rather than current evidence. The mentors corrected many of these practices and provided continuous on-site coaching that has greatly improved the quality of care in our facility.*
>
> — **Esther Fashola, Mentee, PHC Rahama, Kano State**

Changes in selected service delivery indicators

Changes in selected service delivery indicators were mixed across the implementation period (Table 2). Skilled birth attendance, postnatal care within 72 hours, Labor Care Guide use, postpartum family planning uptake, OSCE competency, and PPH tasks performed per mentee all increased between baseline and endline. ANC 4+ attendance declined, while reported uterotonic use in the third stage of labor remained at 100%.

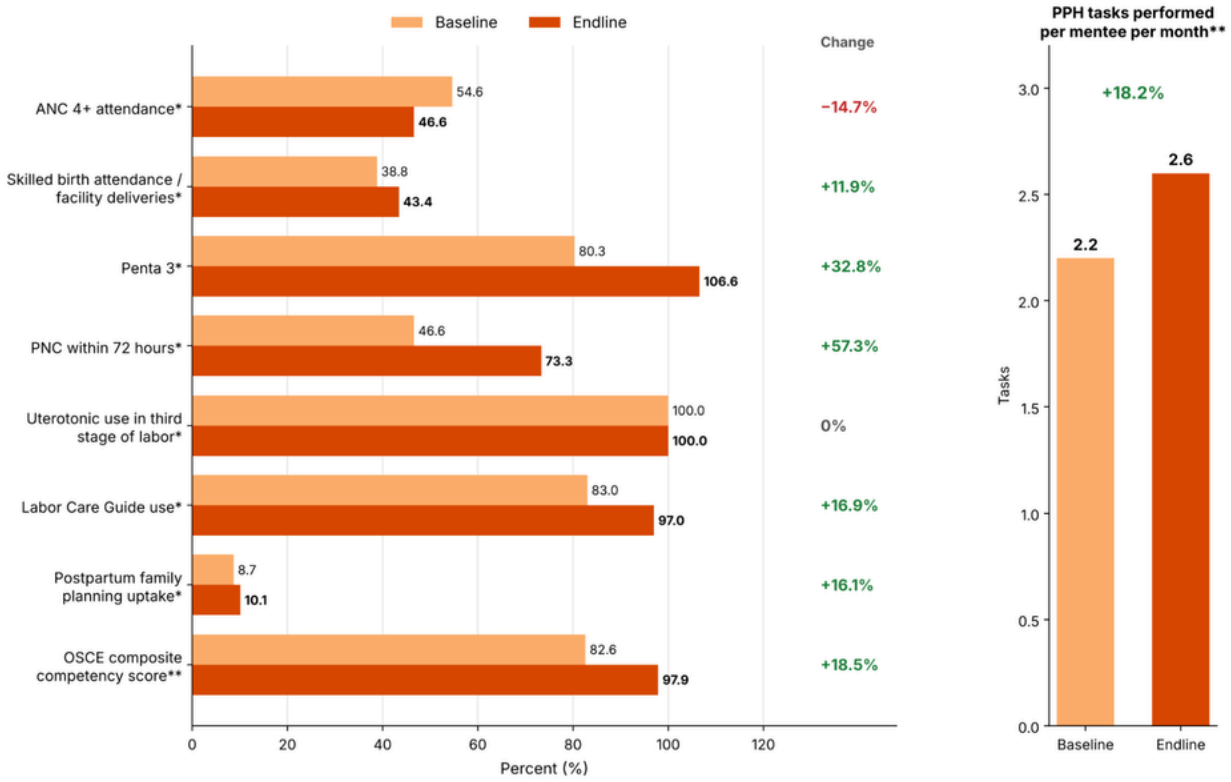


*Figure 5: Selected service delivery indicators, baseline to endline, Data Source.*DHIS2 and **Program Data*



HCW during the 8 days TSTS training

KEY LESSONS

The Kano experience generated several lessons about how facility-based clinical mentorship can be designed, delivered, and institutionalized within the health system. These lessons extend beyond the technical content of mentorship and highlight the importance of government ownership, mentor selection and preparation, evidence-informed targeting, flexibility, and the wider service-delivery environment.

01 Government ownership is fundamental to sustaining mentorship

The mentorship model was designed as a health system function rather than a standalone project activity. Early engagement with the State Ministry of Health (SMOH), State Primary Health Care Management Board (SPHCB), and Hospital Management Board (HMB) created shared ownership, while working through the revived HRH Working Group and the RMNCAH+N platform helped reduce duplication and clarify accountability.

A critical step was integrating mentorship into the state's Annual Operational Plan, creating a pathway for government to allocate resources to continue the approach beyond project support. This demonstrates that sustainability planning needs to begin during implementation, rather than being treated as a closeout activity.

> *"The high-level state stakeholders buy into the idea of TSTS completely — there is a willingness to work together and see results. There was a review meeting with the DG of the State Primary Healthcare Board aimed at increasing health care workers across facilities, and there will be a financial budget for the mentors to increase the facilities and the number of CHEWs across the state.*
>
> — **HRH/TSTS Focal Person, Kano State**

Future mentorship programs should establish government ownership, institutional structures, and financing pathways from the earliest stages of implementation.

02 Who mentors matters as much as how they mentor

The selection and preparation of mentors influenced the credibility and effectiveness of the model. Drawing mentors from the state trainer pool reinforced both technical credibility and government ownership. Competency testing provided an additional quality safeguard by assessing mentors' technical knowledge rather than relying on nomination alone.

Requiring mentors to be based within the LGAs they served also enabled more consistent engagement with facilities. Rather than functioning as periodic external trainers, mentors could build ongoing relationships with mentees and respond to facility-level needs as they emerged. Therefore, mentorship programs should use transparent, competency-based selection criteria and prioritize mentors who can provide sustained, locally accessible support.



Group mentorship session with mentee and other healthcare workers in PHC Rimin Gado, Kano

03 Clinical expertise does not automatically translate into mentoring ability

Effective clinical mentorship requires two distinct competencies: the ability to perform a clinical skill correctly and the ability to teach, observe, provide feedback, and support another provider to perform that skill in a busy service environment.

The mentor refresher therefore focused not only on clinical competencies but also on mentoring and teaching skills. This distinction is important because technically strong clinicians may require additional preparation to become effective mentors. Hence, mentor preparation should deliberately build both clinical competence and the skills required to facilitate workplace learning.

04 Mentorship is more effective when it responds to measured gaps

The use of OSCE results in developing individual and facility work plans shifted mentorship from generic curriculum delivery toward targeted remediation. Assessment results gave mentors and mentees a shared, evidence-based understanding of the competencies requiring improvement and helped concentrate limited mentoring time where it was most needed.

Standardized tools, including the Task Log, also made progress more visible by documenting whether skills addressed during mentorship were subsequently practiced. Competency assessment should precede mentorship planning, with mentoring priorities periodically updated based on evidence from assessments, supervision, and service data.

05 A defined core with flexibility is more responsive than a rigid mentorship package

Facility-based mentorship generated demand beyond the competencies originally anticipated in the core curriculum. The **1,307 mentorship and coaching sessions delivered** demonstrate the scale of engagement and the extent to which facilities used mentorship as a platform for addressing practical service-delivery challenges.

The experience suggests that off-plan requests should not automatically be treated as implementation drift. They can provide valuable intelligence about unmet learning and service-delivery needs. However, these requests should be systematically documented and analyzed so that recurring needs can inform future training and program design. It is critical that mentorship packages establish a clearly defined core while deliberately allowing flexibility to respond to facility-specific needs. Topics addressed outside the core package should be tracked as a source of learning and program intelligence.

06 Workplace mentorship can create a multiplier effect through peer transfer

Mentorship did not remain limited to interactions between designated mentors and directly mentored providers. As individual providers gained competence and confidence, they began supporting colleagues within their facilities, extending the reach of the intervention to staff who had not participated directly in mentorship sessions.

Evidence that nearly half of facilities also sought support outside scheduled sessions further suggests that mentorship became a source of ongoing professional support rather than a series of isolated training events. Mentorship programs should intentionally encourage peer-to-peer transfer and create mechanisms for competent providers to share skills with colleagues. This can help shift mentorship from a project-supported activity toward a routine facility-level practice.

07 Mentorship can identify and escalate system constraints, but cannot resolve them alone

Improvements in clinical competence are influenced by the wider health system environment. Mentees identified transportation and timely referral of women with obstetric complications as ongoing challenges. Mentorship could strengthen providers' ability to recognize complications, stabilize patients, and initiate referrals, but it could not eliminate transport or referral-system constraints outside the facility.

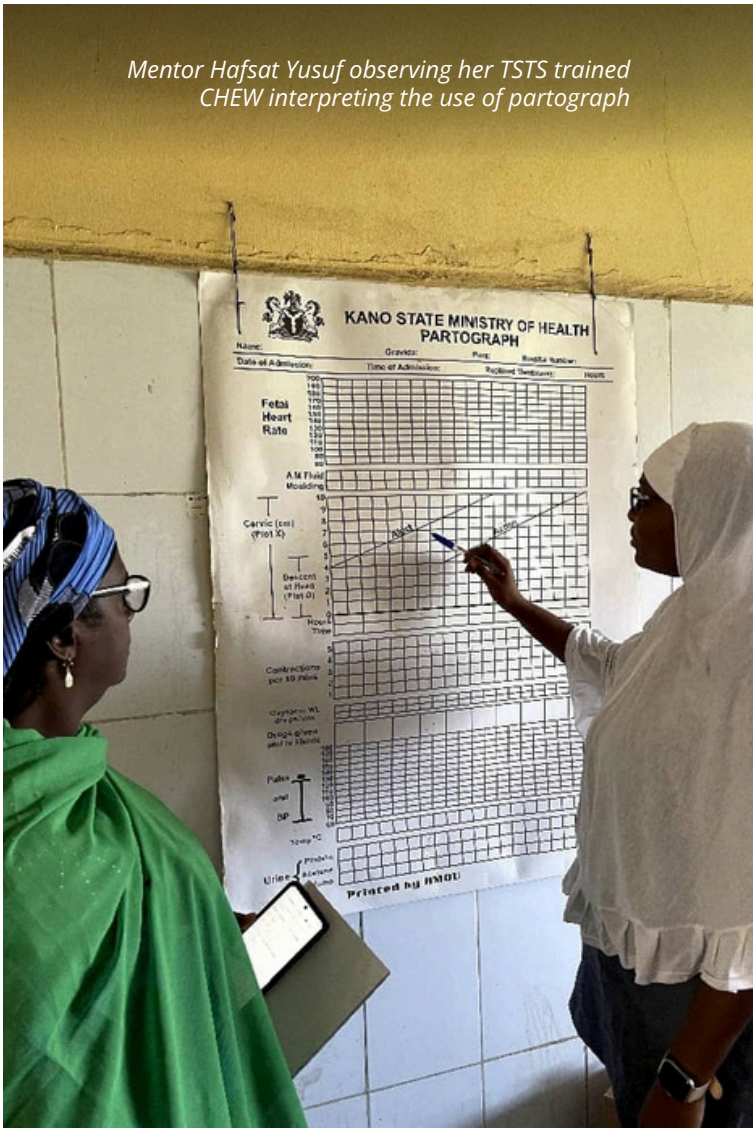
Similarly, mentorship surfaced gaps in essential equipment, commodities, and supplies. While some facilities and MNCH coordinators advocated to facility management and local authorities for additional resources, the ability of providers to apply newly acquired skills remained constrained where essential resources were unavailable.

> *"Following the mentorship visits, we advocated to our facility management and local authorities for the provision of essential equipment and supplies. We are pleased that some of these requests have already received support.*
>
> — **MNCH Coordinator, Kano State**

Staff transfers present another potential sustainability risk. When trained or mentored providers are moved to other facilities, the originating facility may lose part of the capacity built through the intervention and replacement staff may require additional support.



Mentee giving healthtalk at ANC Clinic.



Mentor Hafsat Yusuf observing her TSTS trained CHEW interpreting the use of partograph

IMPLICATIONS FOR SCALE AND SUSTAINABILITY

Effective clinical mentorship depends on the quality of the mentoring sessions themselves. Sustainability requires government ownership and financing; effectiveness requires competent and well-prepared mentors; relevance requires evidence-informed targeting and flexibility; and institutionalization depends on peer learning and integration into routine health system structures. At the same time, mentorship cannot compensate for weaknesses in referral systems, transportation, commodities, equipment, or workforce stability. These constraints should be identified through routine mentorship and linked to the appropriate health system actors for action.

Future mentorship programs should therefore be designed as institutionalized quality improvement mechanisms, with clear government ownership, competency-based mentor selection, evidence-informed work planning, flexible delivery, routine documentation, peer learning, and formal pathways for escalating broader health system constraints.

The elements most readily integrated into routine systems are those that build on existing state structures and resources: mentors drawn from the state trainer pool and residents in their LGAs, peer mentorship within facilities, and oversight through existing coordination platforms. These should form the core of the transition and scale-up approach.

What should be institutionalized

- Mentorship as part of routine supportive supervision and quality improvement, rather than as a parallel project activity.
- The mentor register, selection criteria, and competency screening, maintained by SPHCB to support continuity and future mentor deployment.
- The six-tool mentorship package as state instruments, with routine coaching assessment and competency reassessment integrated into the state's quality improvement processes.
- Dedicated mentorship line items within the Annual Operational Plan and state health budget to support continuity beyond project financing.

What should be adopted before scale-up

- Build flexibility into the mentoring package. The 827 sessions delivered outside the originally planned scope demonstrate the need for a defined flexible component that allows mentors to respond to facility-level needs while maintaining core standards.
- Formalize peer mentorship within facilities by identifying named facility focal persons and incorporating peer learning into routine supervision and mentorship processes.
- Link mentorship to a minimum commodity and equipment standard, because providers need the necessary supplies and equipment to apply and retain the skills developed through mentorship.
- Establish a clear escalation pathway for system constraints, so issues identified through mentorship, including referral, transportation, commodity, equipment, and staffing gaps, are documented and referred to the appropriate state or LGA actors for action.

KEY RECOMMENDATIONS

What we learned	What we recommend
Government ownership is fundamental to sustaining mentorship	Institutionalize mentorship within routine supportive supervision and quality improvement, and line-item it in the Annual Operational Plan and state health budget before transition.
Who mentors matters as much as how they mentor	Retain competency screening and LGA-residency criteria, and hand the mentor register and selection process to SPHCB.
Clinical expertise does not automatically translate into mentoring ability	Keep the refresher-plus-orientation sequence and adult learning methods as the state standard for all mentor preparation.
Mentorship is more effective when it responds to measured gaps	Set each mentoring cycle's priorities from OSCE results and routine service data, and repeat assessment quarterly.
A defined core with flexibility beats a rigid package	Design a defined core with deliberate flexible time, and log off-plan topics so the curriculum evolves with demand.
Workplace mentorship creates a multiplier effect through peer transfer	Formalize peer mentorship with named facility focal persons and a simple internal coaching log.
Mentorship can escalate system constraints but not resolve them alone	Embed mentorship within broader quality improvement and health systems strengthening, with clear pathways for escalating constraints that cannot be resolved at the point of care — including a policy agreed with SMOH and SPHCB that mentored staff remain in post for a defined minimum period.

CONCLUSION

The experience in Kano shows that clinical mentorship can be a disciplined, technically robust, and operationally practical strategy for improving frontline clinical performance — provided it is embedded in government systems rather than layered on top of them. The model was strengthened by transparent mentor selection, defined criteria, deliberate preparation, workplace-based delivery, standardized tools, and routine supportive supervision, moving coherently from advocacy through field mentoring to sustainability planning. Its early results show both scale and responsiveness: 26 mentors, 145 facilities, 1,159 visits, and demand for support well beyond the original scope. Clinical mentorship should therefore be understood not only as a workforce development strategy, but as the practical mechanism that gives task shifting and task sharing policy effect at the point of care — and as something Kano State is now positioned to own.

PHOTO GALLERY



TSTS Mentors and Technical Partners During Pause and reflect session in Kano



Hand over of Calibrated drapes to the Kano State Primary Healthcare Management Board



Fundal Height Measurement by a TSTS Mentee

Reference

1. Federal Ministry of Health. (2014). Task-shifting and task-sharing policy for essential health care services in Nigeria. https://www.policyvault.africa/wp-content/uploads/policy/NGA104.pdf
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The Task-Shifting/Sharing initiative, implemented in partnership with Impact Catalysts and state governments, strengthens primary health care services in Kaduna and Kano and seeks to improve health workforce distribution and service quality in rural and underserved areas. The initiative takes a holistic strategy to supporting current health systems and personnel, providing high-quality, sustainable, and gender-responsive health care for all.

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