

Institutionalizing Catchment-Based Clinical Mentorship and Supportive Supervision in Ethiopia

Improving Family Planning and Comprehensive Abortion Care Service Provision



Background

Demographic and health survey data for Ethiopia show significant progress has been made in improving the modern contraceptive prevalence rate (mCPR) from 27% in 2011 to 41% in 2019 and reducing maternal mortality from 676 per 100,000 live births in 2011 to 412 per 100,000 live births in 2016. However, a full range of family planning (FP) and abortion services is not readily available to women due to a shortage of skilled providers. Improving health worker competency is critical to enhancing access to quality FP and abortion care services. Clinical mentorship is one mechanism used to sustain high-quality clinical competency in resource-constrained settings.

In 2014, the Ethiopian Ministry of Health (MOH) started a Catchment Based Clinical Mentorship (CBCM) program in reproductive, maternal, newborn, and child health (RMNCH). National guidelines for RMNCH CBCM were developed in 2019, aiming to advance healthcare provider competency in quality maternal and child health service delivery. The guidelines defined CBCM as a

clinical mentoring strategy where both mentors and mentees work in health facilities that have direct referral linkage within a catchment. Clinical mentoring is a practical capacity building strategy where experienced clinicians provide professional support to or teach less experienced healthcare providers. (MOH 2019)

The frequency and length of mentoring visits to facilities vary depending on personal, clinical, and health system factors, including resource availability. Evidence from South Africa's Department of Health (2011) recommends intensive support (one to four face-to-face contacts in addition to virtual communication) in the first month and fewer subsequent visits. Particularly if transport and accommodation are a major challenge, a longer mentoring visit, e.g., for one week, may be more efficient than having the mentor travel to the primary healthcare facility on multiple separate occasions. National RMNCH CBCM guidelines (MOH 2019) recommend that one cycle of mentoring consist of one visit per month for three to six months—depending on logistics, resources, services targeted, and the provider needs identified during initial assessment—and that each visit should last no more than five working days.

This technical brief describes program design and assessment of clinical mentorship implemented by EngenderHealth, discussing key achievements, successes, lessons learned, and challenges in implementing the EngenderHealth-supported CBCM and supportive supervision (CBCM-SS) model, which uses a health systems strengthening approach to improve access to and quality of FP and comprehensive abortion care (CAC) services.

Project Overview

Through the Family Planning by Choice project (FPbC) and the Access to Better Reproductive Health Initiative (ABRI), EngenderHealth has provided technical assistance to the MOH in Ethiopia to scale a CBCM-SS initiative. CBCM-SS supports goals of the MOH and Regional Health Bureaus (RHBS) to improve the quality, equity, choice, and financing for FP and CAC services. EngenderHealth provided technical assistance to the MOH to improve standards and tools and build national capacity to institutionalize and scale up CBCM-SS across eight regions and two city administrations. FPbC



supported a three-level training and mentorship structure across eight regions/city administrations, namely Amhara, Dire Dawa, Harari, Sidama, SNNP, and the three developing regions of Afar, Benishangul-Gumuz, and Somali. ABRI supported mentorship at the primary health center (HC) level in these same regions, with the exception of Somali, as well as in Oromia region and Addis Ababa city administration. The initiative worked closely with RHBs and was implemented in partnership with tertiary (university teaching) hospitals as well as referral, general, and primary hospitals.

EngenderHealth CBCM-SS Model

The EngenderHealth CBCM-SS model (see Figure 1) is designed in alignment with Ethiopia's three-tier health service delivery system. The primary tier of the Ethiopian health system consists of primary healthcare units (PHCUs)—each comprised of five HCs, which in turn each have five satellite health posts—and district-level primary hospitals. Secondary level services are provided by zonal or regional level referral or general hospitals, and tertiary services by specialized (university teaching) hospitals. CBCM-SS aims to build on existing government institutional capacity and catchment-based referral networks in order to extend clinical mentorship and supportive supervision to the most decentralized level of healthcare service delivery. Specifically, CBCM-SS is designed to develop a core trainer-mentor pool for FP—including long-acting reversible contraceptives (LARC), post-partum family planning (PPFP), and CAC—at tertiary and secondary level hospitals to cascade training, mentorship, and clinical audit to health facilities in their respective catchment areas. Senior level obstetrician-gynecologists and midwives working at tertiary hospitals mentor more junior level obstetrician-gynecologists, midwives, nurses, and integrated emergency surgical officers employed at secondary level hospitals; these secondary level mentees in turn mentor early career nurses and midwives working in primary level HCs, creating a cascade of shared expertise and strengthened skills.

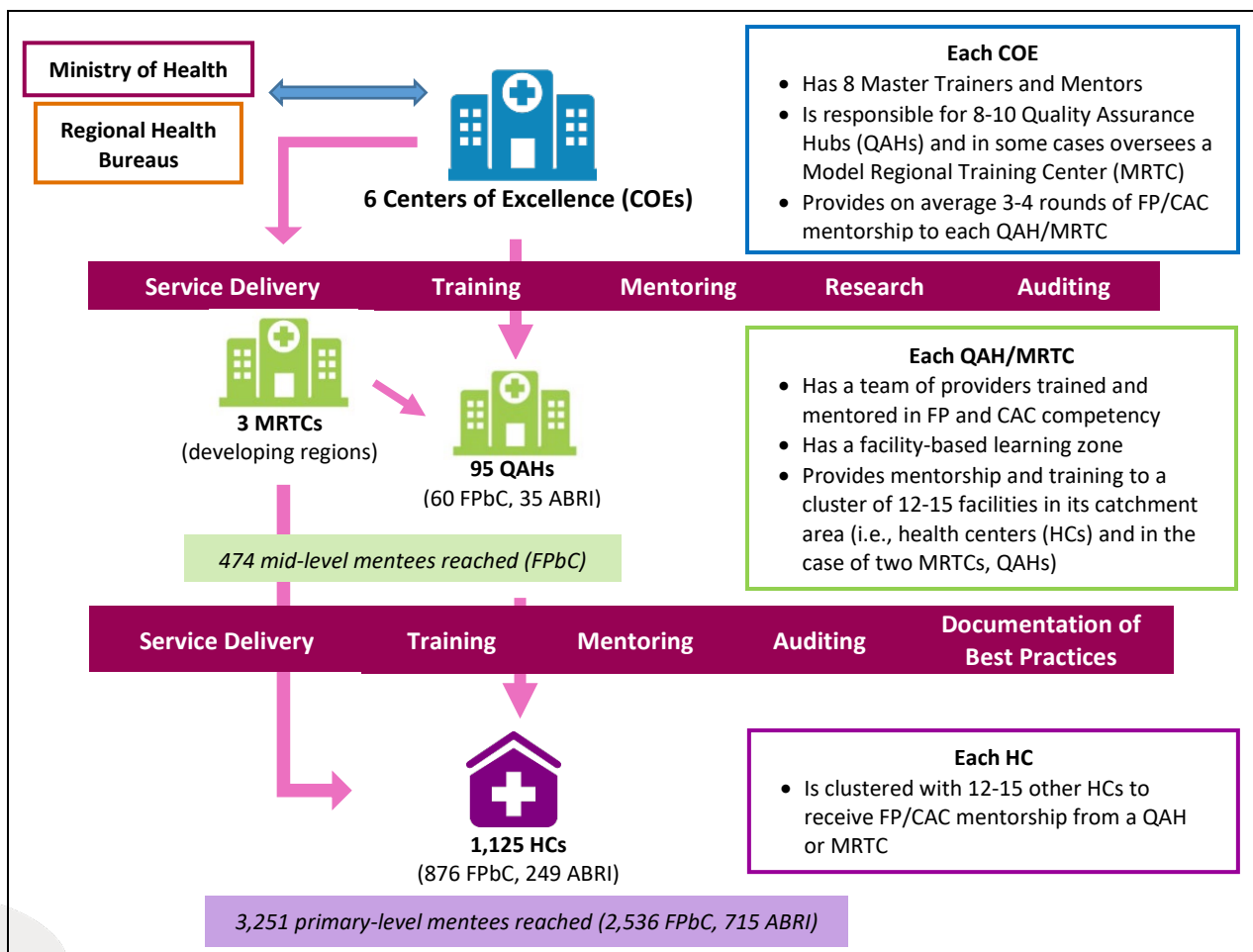
The CBCM-SS model prioritizes university teaching hospitals to serve as Centers of Excellence (COEs) in **S**ervice provision, **M**entoring, clinical **A**udit, **R**esearch, and **T**raining (SMART functions). COEs serve as regional training and resource centers for facilities in their catchment area and undertake operational research on FP and CAC that informs policy and practice, supporting regions by generating evidence on local barriers. In each of the project's three developing regions, where there are no tertiary level hospitals, the project identified a referral or general hospital to serve as a Model Regional Training Center (MRTC), whose capacity for mentoring is supported and overseen by a nearby COE. In addition, the Dire Dawa city administration, with strong urban infrastructure and relatively compact scale, was clustered under the adjacent Harari region's COE catchment.

To build training and mentoring capacity across health system levels, COEs collaborate with RHBs and, where applicable, MRTCs to build the capacity of the next tier of the health service delivery system—the general hospital, or where one does not exist, the primary hospital—to serve as Quality Assurance Hubs (QAHs). QAHs are capable of providing quality services on their own and cascading in-service training, clinical mentorship, and audit to PHCUs—specifically, HCs. Due to structural gaps and catchment logistics in the developing regions, MRTCs mentor QAHs and/or HCs, depending on local capacities, situations, and needs.

Through the CBCM-SS initiative to date, EngenderHealth through FPbC has supported the MOH to build the capacity of six university teaching hospitals to serve as COEs for SMART functions, and has

institutionalized the CBCM-SS initiative at 63 referral, general, or primary hospitals (3 MRTCs and 60 QAHs), including establishment of training centers/learning zones within the facilities. Each of the six COEs trained a team of eight master trainers/mentors, and each of those COE master trainer teams, in turn, trained, mentored, and supervised a more junior team at 8-10 QAHs in its catchment cluster. Some COEs also trained, mentored, and supervised one of the three MRTCs, two of which then mentored on average five QAHs in their respective developing regions. Altogether, COE clinical mentorship at MRTCs and QAHs reached 474 secondary level mentees under FPbC. Two of the MRTCs and all QAHs, in turn, trained, mentored, and supervised FP and CAC providers at on average 12 to 15 HCs in their catchment areas, for a combined reach of 2,536 primary level mentees across 876 HCs. Thus, under FPbC, a total of 3,010 secondary and primary level providers received CBCM-SS. Through ABRI, 715 healthcare providers across 249 HCs received clinical mentorship from 35 QAH hospitals over the last two years.

Figure 1. Catchment-Based Clinical Mentorship and Supportive Supervision Model



In line with national RMNCH CBCM guidelines and under the leadership of the MOH, EngenderHealth developed a mentor's guide to standardize RMNCH clinical mentoring and facilitate the initiative's operation. The guide recommends a mentorship visit once per month in the first three months; every two months for the subsequent six months; and every three months for an additional year until the mentee graduates. If there are inadequate cases/clients for learning at the healthcare facility, the mentee attaches to the mentor's facility for one full week every two months over the same time period. This level of mentoring is similar to national guidelines, but in practice mentees demonstrated competency to graduate after on average 3-4 CBCM-SS visits. After demonstrating competency and graduating, the provider is ready to become a mentor themselves—peer mentoring incoming staff if they are employed at an HC, or if they are employed at a QAH, joining the trainer-mentor team to mentor HCs in the catchment.



** Photo credit: Rabirra Promotion/EngenderHealth
Implant service provision by mentees in Injibara Health Center along with their mentors from Injibara Hospital QAH, Amhara region.*

Methods

From April-May 2021, EngenderHealth conducted a mixed methods assessment to review and document experiences implementing CBCM-SS between 2019 and 2021. Concurrent quantitative and qualitative approaches combined the use of a desk review, qualitative and quantitative interviews, and service statistics.

The desk review focused on FPbC and ABRI project documents, guidelines and standards of practice, needs assessments, intervention plans, periodic reports, documentation of lessons learned, and additional literature. The study accessed the government health information system (DHIS2) to analyze service data from intervention (health facilities supported by CBCM-SS) and non-intervention sites for further enrichment and validation of desk review findings.

The qualitative portion of the assessment included key informant interviews and focus group discussions (FGDs). The study enrolled 14 MOH and EngenderHealth representatives engaged in the CBCM-SS initiative through COEs, QAHS, RHBs, and *woreda* (district) health offices to serve as key informants. The study conducted two focus group discussions with provider-mentees. The study used a purposeful sampling approach to identify respondents, administering a series of questions exploring the effectiveness of CBCM in enhancing provider capacity to provide FP, offer CAC, and initiate quality improvement, as well as what worked well, challenges, and lessons learned. Questions were administered in Amharic, and transcription, including direct quotes, was performed in English. COVID-19 prevention measures were followed while conducting all interviews. Thematic analysis was employed to analyze the qualitative findings.

Study teams administered survey questions to gather quantitative data on 166 FP mentees' perceptions of their competencies in FP service provision after they engaged in CBCM. The study team also compared mentees' competency scores assessed by their mentors at the first meeting (pre-CBCM) and after at least two mentorship visits (post-CBCM), with descriptive statistics computed after quantitative data analysis in SPSS.

Key Findings

Quantitative Results

The study team recruited respondents (n=166) working in seven representative program regions, most commonly in Amhara (44.6%), SNNP (22.3%), Sidama (16.3%), and Afar (10.2%). The remaining 6.6% of respondents worked in Benishangul-Gumuz, Dire Dawa, and Somali. The majority of respondents were female (65.1%), and most respondents were employed as midwives (78.3%), with 18.7% employed as clinical nurses and 3% as health officers. In terms of work experience, 51.6% of respondents had 1-5 years of experience, 35.2% had 6-10, and the remaining respondents (13.2%) had 11 or more. Most respondents reported having received two (45.2%) or three (50%) mentorship visits.

Mentees responded to a series of survey statements related to CBCM, according to a four-point Likert scale (1-strongly disagree, 2-disagree, 3-agree, and 4-strongly agree). Responses were recoded into



* Photo credit: Gedefaw Amenu/EngenderHealth
Mentee knowledge assessment in Loko Health Center, Sidama region.

“More health professionals developed skills for provision of LARC and abortion care. Family planning counseling has improved much in the region because of the mentoring. Referrals for these services, mainly CAC, have significantly dropped. Women presenting with incomplete abortion declined.”

MCH head at RHB, developing region

dichotomous variables to illustrate agreement or disagreement. Results are shown in Table 1 below.

Overall, participant responses demonstrated positive perceptions of the CBCM-SS initiative. Over 90% of respondents agreed that CBCM-SS had improved their skills and should be recommended to others. While just over two-thirds of respondents reported being able to provide LARC before the mentorship, those reporting the ability to insert IUDs and implants without

supervision after CBCM-SS showed an increase of about 20%. The survey also indicated that more than 90% of the mentees strongly agreed that their mentors were fully committed to supporting them.

Areas where respondents had less agreement involved the number and interval of mentorship visits, which in part reflects some of the logistical challenges discussed further below. Additionally, while most respondents agreed that the mentoring program was not a burden, with efficient sessions that taught useful skills, methodology limitations prevented gathering additional insights from those who did disagree with these statements. In complement to the survey results, based on reflection throughout implementation, the project recognized logistical and approach constraints, addressing some during project implementation and recommending others for consideration in future efforts in order to further improve the clinical mentorship experience for all (see Success Factors, Lessons Learned, and Challenges, below).

Table 1. Perceptions of the Mentorship Program

Selected Variables	Agree/Strongly Agree (%, n=166)
I would recommend the mentorship program to my colleagues.	95.8
The clinical mentorship program has improved my skills in providing contraceptive services.	94.0
My mentors were fully committed to supporting me in acquiring the skills I need to provide contraceptive services.	93.4
I can insert IUDs without supervision now.	91.4
Because of the CBCM, my facility is capable of providing a full range of contraceptive services.	89.2
I can insert implants without supervision now.	87.8
The mentorship program was not a burden for me.	83.7
I would regret if I had not been given the chance for the mentorship.	79.5
My mentors used the time effectively so that I learned skills.	75.9
Before the mentorship, I was able to provide long-acting reversible contraceptives (LARC).	68.7
The number of mentorship visits was sufficient to develop skills.	59.0
The time interval between mentorship visits was appropriate.	54.8

Analysis of provider-mentees' competency scores assessed by the mentor prior to and after the mentorship program showed an overall increase in competency over time, with few differences by gender or profession. The average competency score before the mentorship was 64.4 (range 30-92), and the average score after the mentorship was 86.5 (range 50-100).

Achievements of CBCM-SS

The CBCM-SS initiative has demonstrated several achievements related to the competency of healthcare providers, initiation and uptake of services, and quality of service.

Enhanced Competency of Providers

The CBCM-SS initiative improved healthcare provider skills in delivering LARC and CAC services. The mentees' perception survey, competency scores, key informants, FGD participants, and program documents were all consistent in this regard. Key informants also reiterated that mentorship improved mentee competence, confidence, and motivation. Knowing they would receive necessary skills and logistics support through CBCM-SS made provider-mentees enthusiastic to serve clients.

“The program has produced not only competent but also committed service providers. I have seen providers carry an IUD in their pocket, so they don't have to look for it when they need it.”

Participant from COE

Initiation of FP and CAC Services

Qualitative assessment data indicated that despite having providers trained in FP and CAC, most HCs had not initiated service provision in these areas. CBCM-SS specifically trained providers to initiate FP and CAC services, helping providers refresh their skills and obtain confidence to begin FP and CAC service provision. The assessment's competency survey supported these findings, indicating that the CBCM-SS initiative boosted the range of contraceptive services offered.

Informants from QAH hospitals indicated that CAC service initiation at the HC level had resulted in a reduction in unnecessary referrals, mainly for incomplete abortion care, compared with before the mentorship program. CBCM-SS introduced both LARC methods such as IUDs as well as safe abortion care services (e.g., in the Somali region), whereas clients requiring those services before the mentorship initiative had been referred to neighboring cities.

“Clinical mentorship has left providers without any excuses. Those who claim they had received the training but lost the skills and those who stopped working at the FP clinic for a long time and so were not providing LARC services have no reasons not to serve clients now. Some even stopped complaining about lack of supplies, as mentors brought some essential items for these services.”

Participant from RHB

A key informant from the MOH reported that the number of CAC service delivery points throughout Ethiopia increased from 1,950 in 2018 to 2,400 in 2020, with 450 facilities having initiated CAC services during that timeframe. Likewise, the FPbC end of project report (2021) indicates the initiation of CAC and PFP services in 178 HCs, 15 QAHs, and 3 COEs as a result of CBCM-SS.

Enhanced Uptake of FP Services

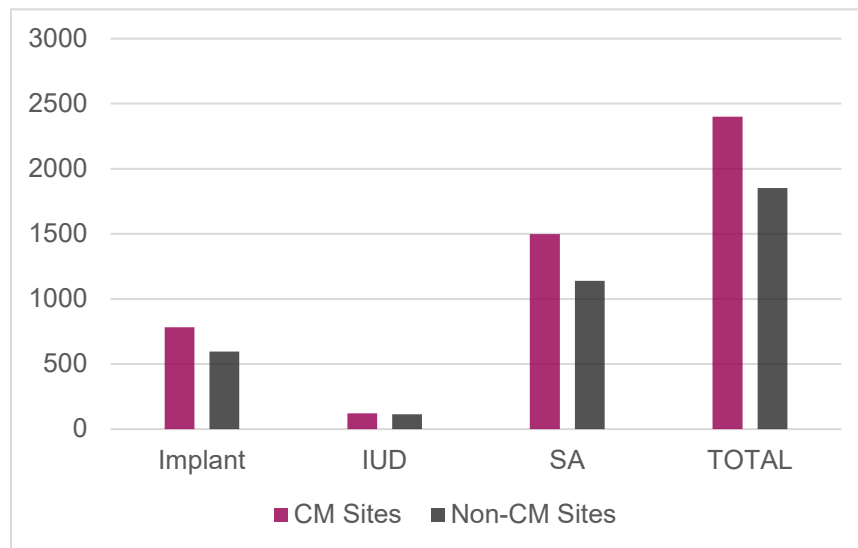
Most key informants and FGD participants noticed significant increases in both FP and CAC service uptake. In particular, key informants from COEs indicated increased uptake of FP services, including post-partum IUD, as well as second trimester abortion. Improvements in service provision and quality were also documented by a January 2021 EngenderHealth internal assessment.

“We have been tracking progress on service statistics, and there is a noticeable increase in clients using FP and CAC services.”

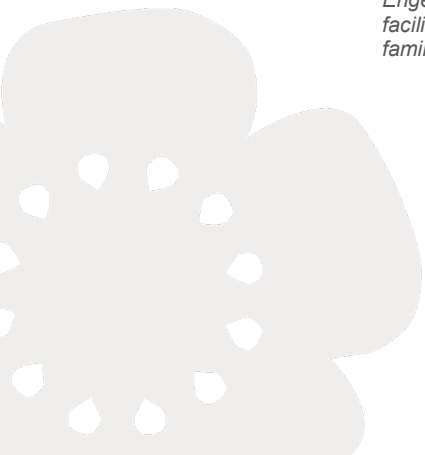
FGD participant (HC mentee)

As Figure 3 shows below, HCs supported with clinical mentorship (“CM sites,” n=482) served more clients per month on average than HCs without the CBCM-SS initiative (“Non-CM sites,” n=482). On a monthly average basis, facilities with CBCM-SS support provided 185 more women with an implant, six more women with an IUD, and 358 more women with short-acting methods than HCs who did not receive CBCM-SS support.

Figure 3. FP Service Uptake in CM and non-CM Areas



EngenderHealth analysis of service data spanning July 2019 to April 2021, from 482 facilities that received CBCM-SS support and 482 that did not, showed higher uptake of family planning services in catchment areas with clinical mentorship.



Improved Quality of Service

Mentorship has also played a critical role in improving quality of care, not only contributing to service uptake but providing the conditions for clients to switch from short acting to LARC methods. This shift was noted in particular by key informants from FPbC developing regions of Afar, Benishangul-Gumuz, and Somali. This finding was confirmed by FGD participants and parallels another achievement noted by EngenderHealth regarding enhanced quality in terms of client comfort—namely through availing separate rooms to offer quality counseling and to perform procedures.

Mentorship has also improved quality of care regarding client privacy and confidentiality, and in turn, satisfaction. The FPbC end of project report (2021) indicated that 332 HCs arranged for separate FP and CAC rooms.

“There was a significant number of clients who switched methods, and the method mix was becoming diverse because of better counseling practices. Clients who had been using Depo for a long time switched to implants after we took time counseling them.”

FGD participant, SNNP region

Success Factors

The assessment identified three key success factors for an effective clinical mentorship program.

1) **Conducting a needs assessment.** FPbC initially conducted needs assessments at the COE, QAH, and HC levels and identified the gaps preventing these facilities from cascading clinical mentorship from the COE and QAH levels. It also assessed facility readiness in terms of basic infrastructure, equipment, and availability of trained health workers and management support. Before initiation of the clinical mentorship program, EngenderHealth also documented the knowledge and skills of both mentors and mentees.

The findings were used both to tailor clinical mentorship and trainings to the needs of mentees as well as to ensure readiness of facilities for the mentorship program.

“On our first visit, we conducted a needs assessment. We checked whether the facilities were ready to provide CAC and FP services, if there were active trained providers and essential supplies and equipment. We measured knowledge and skills of providers and service quality. This has made our support focused and need-based.”

Mentor at QAH

2) **Linking clinical mentorship with supportive supervision.** Linking CBCM with SS made mentorship more impactful. Supportive supervision was meant to complement provider-mentees' skill development by addressing both immediate and systems-level logistics constraints and administrative issues. Key informants explained that the mentorship program would not have worked if the necessary logistics including equipment and supplies were not available. The FPbC end of project report (2021) indicates the positive outcomes related to addressing facility-level supply interruption brought about

through supportive supervision in Amhara, Harari, and SNNP regions. In FGDs, provider-mentees echoed the positive impacts CBCM-SS was able to have on improving logistics and availability of materials, with mentors helping to address equipment and supply shortages.

3) Integrating Structured On-the-Job Training (SOJT) with CBCM-SS.

Integrating SOJT with mentorship was beneficial for both initiatives. Clinical mentoring builds on basic training, knowledge, and skills; it strengthens competency and confidence using training materials and models, and through support during actual service provision. In clinical mentorship interactions, when a provider-mentee presented with a major gap in basic knowledge and training, the program integrated SOJT. This enabled mentees to receive robust training from their trained peers, staying on-site and on-the-job, contributing to systems strengthening and efficiency while reinforcing learning between mentorship visits. FPbC support of QAH learning zones, including training and insertion materials and models, further strengthened the quality of SOJT. In this way, CBCM-SS amplified the utilization of SOJT. Likewise, SOJT programming produces a pool of recent trainees poised to benefit from reinforcement of those skills through mentorship. Thus, implementing SOJT parallel to mentorship becomes highly productive.

“Peer education through SOJT is something that can be expanded to equip more healthcare providers with the skills for provision of FP and CAC. Mentors are not always there when their mentees need them, but their peers are always available.”

Participant from COE

Lessons Learned

1) **Integrate FP with other RMNCH services.** Integrating CBCM in FP and CAC with other RMNCH services is critical for increasing access and impact. Because the services are interrelated, the same providers can be involved in building confidence and trust across services. For example, FP and CAC can serve as strong entry points for improving other RMNCH services. Facilities (mainly QAHs) were also able to strengthen PFP through integration with antenatal care, leading to fewer referrals and improved management of emergency obstetrics cases.

“We should not have competent providers for only specific maternal health services. Comprehensive RMNCH mentoring, instead of mentoring only for FP and CAC, is the right approach for effectiveness and efficiency.”

Participant from RHB

2) **Cluster mentorship.** Mentorship groups were clustered according to geographic proximity and common referral sites instead of political administration. Such catchment linkage was found to function effectively and efficiently, except where clustering crossed boundaries of developing regions. For example, in Afar and Benishangul-Gumuz, boundary-crossing clusters created significant implementation delays. Alternative clustering approaches should be explored in such situations.

“We clustered facilities geographically based on catchment, looking at how proximity was considered when patients received referrals. This made visits easier for mentors, despite some challenges in developing regions.”

Program Implementer

3) **Use technology.** EngenderHealth introduced CBCM-SS videoconferencing to increase mentor-mentee contact and reinforce in-person mentorship learning and relationships. Because senior obstetrician-gynecologists serving as mentors tend to be busy with academics and clinical work at their home institutions, it proved challenging in some cases to conduct multiple in-person visits for mentorship. The application of communications technology in the CBCM-SS approach facilitated scheduling and contact, although it cannot fully replace face-to-face sessions. Two of the six COEs used videoconference technology to communicate with mentees, not only to consult on cases but also to conduct routine communications, such as meetings.

Furthermore, all COEs and QAHs used the Telegram app to create an innovative group messaging, document sharing, and audio-visual communications channel with their mentee facilities. EngenderHealth internal documentation indicated that such telegram platforms enhance communication, experience sharing, and the referral network between mentee and mentor facilities.

4) **Establish ownership for sustainability.** The CBCM-SS initiative inspired revision of the national RMNCH clinical mentorship guidelines, for which EngenderHealth has provided technical support.

“We know mentoring works: that is why we designated funds for regions. But that funding will be made available only on request. The RHB needs to show interest in implementing the program. The MOH will not transfer funds; instead, [the RHB has] to submit a grant application. In this way, we ensure accountability.”

Key Informant Interview, MOH

The initiative also influenced the MOH to scale up RMNCH mentorship in different regions by allocating resources for RHBs to run CBCM-SS. Some regions are already showing interest in this critical step toward sustaining the mentorship program.

In addition, EngenderHealth supported development of both national and regional costed implementation plans for CBCM-SS. The process actively engaged RHBs with mentor and mentee facilities as a step toward sustaining the initiative through government systems. As a result, all regions and city administrations now have

an annual CBCM-SS plan with a detailed costing for the coming fiscal year (2021/2022). Further advocacy effort is required around allocating adequate budget from government and partners to continue running the program after the project period.

Key informants suggested that the health science student/residency programs at university teaching hospitals could serve as an additional mechanism for sustaining clinical mentorship. In addition to senior faculty and medical providers supporting on-the-job learning of health science students and residents assigned to teaching hospitals and their catchment facilities, mentorship could be formally integrated into those students' experiences and responsibilities. In this way, students/residents would benefit from clinical mentorship and supervision by senior-level teaching hospital staff, and would simultaneously pass along that expertise through their own mentorship of staff at the catchment facility where they are assigned—expanding and sustaining CBCM-SS impact.

“COEs should feel ownership of, institutionalize, and ensure all faculty take part in the mentorship program. The Department of Gynecology and Obstetrics should make mentoring for RMNCH services part of their academic program, so that all members of the department take turns supporting primary hospitals' catchment areas.”

Key Informant Interview, COE

Challenges

1) **High number of mentee facilities.** Under the FPbC CBCM-SS initiative, each QAH covered 12-15 HCs (reduced from an initial cluster of 32), with mentors travelling every two months. These demands on QAH mentors' time made it difficult to support mentees for sustained periods. Even when mentors increased their stay at a facility to two days, time remained short to support mentees in learning required skills, particularly for those with limited formal training. Additionally, lack of cases often meant that mentoring sessions were dominated by simulation rather than practice with clients. Thus on-the-ground logistics created mentorship frequency and intervals that sometimes fell outside of guidelines, which recommend up to five days of mentorship per monthly visit and suggest that mentees attach to the mentor's facility for five days every month in case of low caseload at the home institution.

2) **Lack of adherence to schedule for follow-up visits.** In some cases, mentors deviated from the schedule for follow-up visits, leading to irregular follow-up and some skipped sessions. Moreover, mentors sometimes failed to inform mentees, despite

“We had to be at many health centers to reach out to many mentees; therefore, we could not afford to stay long. Had we been assigned to mentor fewer facilities and fewer health providers, we would have spent as many days as we could so that there would have been a high chance to find cases for mentorship and follow the progress of mentees. We would not have needed to come back to the facility every two months.”

Mentor at QAH

national guidelines around joint scheduling. To help address these issues, FPbC promoted pre-planning of mentorship visits and virtual communications technology, in addition to adjusting downward the number of HCs per QAH/MRTC and continuing to reflect on the most effective catchment definitions. EngenderHealth assessment showed primarily logistical reasons for disruption of scheduled visits, including lack of or delayed funding or transportation and associated dissatisfaction among mentors for delayed reimbursement.

3) **Lack of detailed guidelines on mentees.** According to key informants, some clinical mentorship standard operating procedures and guidelines lack sufficient clarity and detail, for example in defining how many mentees a mentor should engage with during each visit. As another example, national guidelines indicate the characteristics of mentees, but do not outline inclusion criteria in detail. Mentors tended to improvise in good faith and according to local needs and constraints, generally allowing potential mentees to join the program. Despite the knowledge that mentoring cannot replace training, there were provider-mentees involved in the program who lacked sufficient prior training; SOJT was integrated to help address this issue.



** Photo credit: Mahlet Bekele/EngenderHealth
Mentee participates in SOJT in Bona Hospital QAH, Sidama region.*

“There is inconsistency and subjectivity across facilities in involving providers for the mentorship program. Some focused on only those with prior formal training. Others allowed those with no training to take part. A few set criteria like a certain pre-mentorship competency score would be useful to include those with no prior training in the mentorship program. This can be viewed in two ways. If the mentee is motivated and received enough mentoring with good case exposure, they can be as competent as those who pass through formal training. On the other hand, mentorship is meant to reinforce what has been taught in training, focusing on skills. Robust evidence is needed to determine whether those with prior training have higher competency or are easier to coach than those without the training.”

Mentor at QAH

Conclusion

The CBCM-SS model that has been implemented from 2019-2021 in Ethiopia successfully enhanced the skills of provider-mentees to lead the provision of higher quality FP and CAC services. The integration of CBCM with supportive supervision and SOJT made mentorship more impactful, even as challenges and gaps remain to be addressed. The approach strengthened healthcare providers' clinical knowledge, skills, and attitudes to provide quality care competently, confidently, and enthusiastically. CBCM-SS also enhanced the quality of service provision, contributing to increased uptake of FP and CAC services. In addition, CBCM-SS increased the availability of FP and CAC services by supporting newly skilled providers to initiate delivery of these services in facilities where such services were not available before the intervention. However, national guidelines for the mentorship program require additional detail to ensure effective implementation, and suggest that CBCM-SS should address integrated RMNCH services. Additional research is required to further evaluate the impact of CBCM-SS, explore participant experiences to strengthen the clinical mentorship approach for all, and make a comprehensive recommendation.



** Photo credit: Rabilirra Promotion/EngenderHealth
Mentors from Injibara Hospital QAH providing clinical mentorship in Injibara Health Center, Amhara region.*

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* Photo credit: Gedefaw Amenu/EngenderHealth
Mentee providing implant service along with mentor from Aleta Wondo Hospital QAH, Sidama region.

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