Mentoring the Community Health Worker

MCSP/Rwanda Case Study

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Background

Due to the country's mountainous terrain and growing population, community health workers (CHW) have played a critical service delivery role in the Rwandan health system. In 1995, Rwanda established its first systematized CHW Programme to increase access to maternal and child health care and preventative services. The number of CHWs grew from 12,000 in 1995 to 45,011 in 2005, and, by 2013, the government aimed to ensure that each village had three CHWs who would promote and administer reproductive, maternal, newborn, and child health (RMNCH) services.[1]

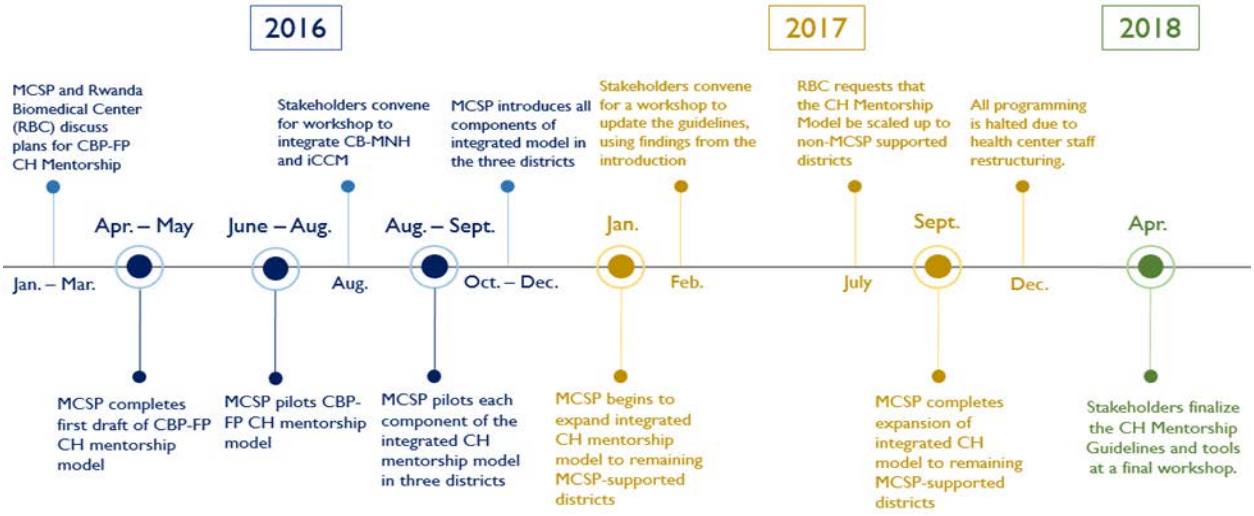
To further strengthen community-based services, the Ministry of Health (MOH)[1] mandated health centers (HC) to provide one-on-one supportive supervision to CHWs under HC purview. Each HC Community Health In-charge was responsible for supervising and mentoring, on average, 105 CHWs per quarter. However, they were only able to support 15-20 CHWs in this time period[2]. The lack of oversight contributed to knowledge gaps about CHW commitment, availability and quality of services, and data accuracy.

MCSP Rwanda aimed to improve and sustain high-quality RMNCH services at the community level by forming a partnership with the MOH/Rwanda Biomedical Center (RBC). Consequently, RBC led the process of developing and implementing the "Community Health (CH) Mentorship Guidelines" for Rwanda with support from MCSP.

[1] National Community Health Strategic Plan (July 2013 – June 2018).

[2] This number was derived from mentorship reports that the HC In-charge of CHW activities shared with MCSP. The Program also confirmed this number through regular supportive supervision visits.

Figure 1. Timeline of key CH Mentorship development and implementation activities



Methodology

Development: Conceptualizing CH mentorship

Design Process

Although proposed by MOH and USAID, CH mentorship was a new concept for the national community health program and RMNCH stakeholders in Rwanda, including MCSP. MCSP deployed an iterative design process to create a CH mentorship framework, guidelines, and orientation materials. The initial stages of the process were exclusively conducted by MCSP and the RBC/Maternal Child and Community Health (MCCH) Desk, with input from technical working group (TWG) members.

Key Design Principles

- **Advocacy and Buy-in:** The Program consulted the MOH/RBC after each step of the process and each iteration of the CH Mentorship Guidelines.
- **Data-driven design:** Gaps analyses and needs assessments were a standard for each iteration of the guidelines. To design the first iteration, MCSP leveraged the Community Health Information System (SIScom) to analyze supervision, service provision, and data gaps at the community level. The review uncovered major challenges, such as lack of adequate strategies to maintain CHWs knowledge and skills. The Program also regularly presented implementation progress and barriers at the RBC CH and Family Planning (FP) sub-TWGs and the broader Maternal and Child Health (MCH) TWG meetings, during which RMNCH stakeholders could brainstorm immediate solutions.
- **Participatory Approach:** MCSP Rwanda engaged 25 CH stakeholders in three development and implementation workshops. Each stakeholder brought a unique perspective that helped address gaps, inadequacies, and needs at each health system interaction point. The inclusiveness also created buy-in and harmonized implementation among stakeholders across the health system.

Piloting Community-Based Provision of FP (CBP-FP)

Initially, MCSP developed the CH Mentorship Guidelines and supporting materials for CBP-FP only and tested the model with 28 mentor candidates in Rwamagana from June to August 2016. Given the successes with CBP-FP in Rwamagana (Box 1), RBC/MCCH and MCSP expanded the CH Mentorship Guidelines to include community-based maternal and newborn health (CB-MNH) and Integrated Community Case Management (iCCM).

Box 1: CBP-FP Mentorship Pilot Findings: Feasibility of supporting CHWs after training

- CHWs should be grouped into small teams that regularly meet health center staff.
- Approximately two HC staff were enough to reach all CHWs in a catchment area per quarter.
- CH In-charges and FP clinical staff fulfilled the role of mentors during field visits and mentored all CHWs within the quarter.
- Field visits were an opportunity to review the entire CBP-FP program, assess service provision, and identify reporting gaps.
- Visits were time-saving – CHWs did not have to travel long distances and the mentors had fewer visits.
- CHWs were happy to host mentorship sessions.
- Field visit costs (transport and lunch) were affordable for the HC.

Introduction: Piloting the integrated CH mentorship guidelines[3]

From August 2016 to December 2016, the Program pretested the usability and feasibility of the integrated CH Mentorship tools in three districts by technical area —Kamonyi (CBP-FP), Ngoma (iCCM), and Rwamagana (CB-MNH). After the model was further refined, the Program introduced the integrated CH Mentorship Guidelines in all ten MCSP-supported districts by September 2017.

1. Mentor Identification

MCSP had not administered strict mentor identification criteria for technical and clinical staff during the CBP-FP pilot in Rwamagana. As a result, many mentor candidates had expertise in facility-based services, but not all were trained on the national community health program components. The revised guidelines required health centers to nominate one technical staff per technical area, in addition to one CH In-charge, who had received formal CH training by RBC/MCCH and implementing partners.

2. Mentor Orientation

The three-month pilot began with a four-day training and mentorship orientation. National-level mentors – MCSP, MOH, and design stakeholders – dedicated two days to review the community-based technical content, such as strategies for FP counseling. This refresher training ensured that mentors had a strong clinical foundation in community-based services. Mentor candidates also received a theoretical orientation on the CH mentorship model and strategies for effective mentorship. The topics included adult learning methodology and introduction to mentorship tools.

3. Mentor Candidacy Confirmation

Candidates completed a CH mentorship visit in his/her village. During the visit, two CH national mentors used the Mentor Observation Checklist to evaluate how the candidate mentors prepared and conducted the visit in accordance to the guidelines. National mentors provided feedback immediately after the session and confirmed candidates that received a score of >85%. CH national mentors, including MCSP, conducted additional practical sessions for candidates that did not score high enough after the first session.

[3] Although referred to as "integrated," CH Mentorship for each technical component happens independently.

The CH national mentors also used the Mentor Candidacy Confirmation phase as an opportunity to test the CH mentorship model design. Each day, the Program and other CH national mentors convened to discuss challenges, successes, and potential improvements to the guidelines.

4. Mentor Follow-up and Validation

The Program led a three-prong approach to follow-up and validate mentors in Rwamagana.

- Conduct follow-up visit with each CH mentor a month after he/she has been confirmed as a candidate. During the follow-up visit, the Program used the Mentor Observation Checklist to evaluate compliance to technical guidelines.
- Perform random field visits throughout the remainder of the Program, focusing specifically on mentors that have not been performing well. During the visit, MCSP used the checklist to evaluate the performance of the mentor. Many mentors improved their skills, but health centers considered replacements for mentors that consistently performed poorly.
- Hold quarterly coordination meetings with all hospital-based CH mentors within the district, during which they share experiences, challenges, etc. The meetings strengthened the bond between mentors and served as a mechanism to provide updates on the general status of CH mentorship.

CH Mentorship Visits

Quick Facts

- Mentors: CH In-charge (1) and health center technical / clinical staff member (1)
- Time Length: Two hours
- Topic: FP, MNH, or iCCM
- Participants: Cohort of 6-9 CHWs
- Location: One CHW home (rotates each quarter)
- Evaluation Tools: Mentee Observation Checklist

Key Components

Service Provision: Two or more CHWs, including one from the location, each provide the planned service to a client while the mentorship group observes.

After-action Review: The mentors facilitate a group discussion in which CHWs evaluate the service provision – successes, gaps, and future improvements.

Refresher Training: The Technical Area In-charge uses anatomic models to demonstrate services, based on the identified gaps.

Documentation: Mentors review the accuracy and completeness of community register data with 1-2 CHWs. CHWs are chosen at random to help hold each accountable for quality data collection.

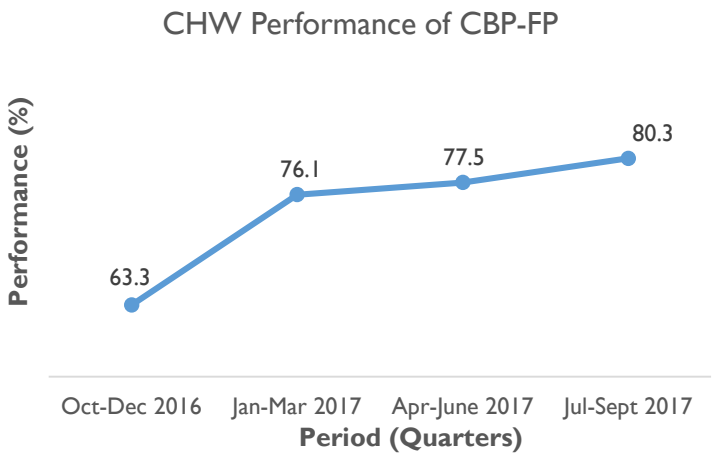
Systems Evaluation: Mentors informally discuss and identify system gaps with CHW, such as stock outs and referral challenges.

The MOH has committed to adopting and leading mentor follow-up and validation in all other districts.

Results

- **Increased % of CHWs reached through CBP-FP CH mentorship:** Between Program Year 3 Quarter 1 (Oct. – Dec. 2016) and Quarter 4 (July – Sept. 2017), the percentage of CHWs reached with mentorship improved from 63.6% to 83.3% in Rwamagana and 13.5% to 55.6% across all 10 MCSP supported districts. This impacted the quality of services and contributed to an increase in the number of clients that using FP services.

Figure 2. CHW performance of CBP-FP across nine districts



- **Improved CHW performance of CBP-FP.** Mentors used the Mentee Observation Checklists to assess CHW performance: preparation, welcoming clients, the way/approach to getting information on client, providing FP methods in respect of technical norms and protocol, filling in data recording tools, managing FP commodities, and closing the session. Results across nine districts showed that CHW performance increased by 17% in one year (Figure 2). These improvements help validate the usefulness of a CH mentorship program.

Lesson Learned and Recommendations

- **The development process requires a clear logic framework and in-depth analysis of needs and potential resource gaps**. To better identify the needs for a scalable model, programmers should account for more intensive stakeholder involvement – workshops and iterative meetings – throughout the development and introduction of an intervention. In Rwanda, the decision to rapidly scale-up CH mentorship limited stakeholder engagement, which resulted in unanticipated costs (e.g., training sessions and field visit per diem), budget constraints, and insufficient human resources for post training follow-up and data documentation. However, to ensure effective programming, MCSP engaged public sector staff from neighboring districts, among other solutions, to introduce CH mentorship in a given district.
- **Data and process documentation support a data-driven approach to development and scale up.** While the Program collected output data (e.g., # of people trained on CH Mentorship) and held review meetings with the TWGs, detailed documentation of the process was very limited due to resource constraints. Stakeholders should invest in immediate documentation of qualitative achievements so that they can continuously assess the effectiveness of the intervention and adapt implementation at each step of the process.
- **To be effectively scalable, the mentorship model must be adjusted according to characteristics (e.g., capacity and size) of each sector.** While the supervisory burden has decreased significantly, CH In-charges that were assigned to larger sectors[4] had an unmanageable number of CHW groups to mentor. Furthermore, MCSP found that the high workload at the facility level limited service providers from also effectively participating in mentorship activities. Mid-implementation, MCSP advocated for more than two trained mentors at the health center to conduct CH mentorship site visit, if needed.

[4] "Each district is divided into sectors, which are further divided into cells and finally into villages, *Imidugudu*." [National Community Health Strategic Plan (July 2013 – June 2018)]. Each village has three CHWs.

- **Evaluating the knowledge and skills of a CHW group during mentorship, rather than of an individual, can encourage teamwork.** The Mentee Observation Checklist and CHW Mentorship Guidelines are currently applied to 1-3 CHWs per group during each mentorship session. The CHW's performance score is extrapolated to the group. Therefore, the group is motivated to identify low-performing CHWs and work together to raise his/her competencies in the technical area, including the use of data collection and reporting tools.

The Unfinished Agenda and Next Steps

Scale Up: Preparing for nation-wide implementation and sustainability

In December 2017, The Rwanda MOH Corporate Services Division/Human Resources Unit combined the CH In-charge and Environmental Officer roles at the health center into one position. The unique duality of this new role has made it difficult for districts to find skilled staff to continue implementation of CH mentorship, leaving many districts with only 6-8 providers per HC who were oriented on mentorship. RBC/MCCH and MCSP agreed to halt scale-up until staffing gaps were filled.

Nonetheless, RBC/MCCH, MCSP, and national CH mentors held a workshop in April 2018 to assess the viability of financing scale up of this approach, especially how to integrate CH mentorship into health facility and district action plans. RBC/MCCH approved the guidelines in August 2018, leading the MOH integrate CB-FP into the Adolescent Sexual and Reproductive Health/FP strategic plan and the Health Sector Strategic Plan IV. Implementation is expected to progress through an e-learning model.

To ensure sustainable scale up of the CH Mentorship Guidelines, the Program recommends that national and local stakeholders prioritize:

- Training new officers on community health services and mentorship. These orientations can mitigate knowledge and service gaps as result of nation-wide staffing changes.
- Creating a practical monitoring and evaluation logic framework, clear theory of change, and specific monitoring indicators.
- Involving district and community level health administrators and management teams when designing the scale up process.
- Including CH mentorship in hospital and health center action plans and budgets so that health care providers can freely implement the approach.
- Equipping health centers and hospitals with the commodities and resources necessary for CH mentorship interventions, such as postpartum family planning.
- Including CH mentorship on daily duties/schedule of facility staff.

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