Mentoring Toolkit

Mentoring Job Aide
The booklet you are currently reading all hand-outs of the SAMU ToT-M, i.e. one-pager flash)cards (reminders) on key concept of mentoring, teaching or communication.

Training of Trainers-Mentors
SAMU can organise a training of your team in your project. Requests can be addressed to your SAMU Focal Point.

SAMU Website
You will find several tools (including mentee & mentor handbooks) as actual Word or Excel documents in the Resources section on samumsf.org

The ‘Clinical’ Mentoring programme Guide
The booklet sets a frame for projects willing to implement mentorship activities.

Mentoring MIO Support
This framework is sometimes easier to digest after a quick briefing. All questions and request for support can be addressed via your SAMU Focal Point.
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Clinical Mentoring – Programmatic Overview

1. Mentoring Definition
2. The MSF-MoH Partnership
3. Mentoring vs Supervision
4. Challenges of Mentoring Programmes
5. Success Factors of a Mentoring Programme
6. The Mentoring Programme Framework
7. Skills-set of Effective Mentors
Mentoring - Definition

“Mentoring is a personal learning relationship outside of hierarchies and operations. A mentor (an experienced person) allows a mentee (a less experienced person) to gain and develop knowledge, abilities, and maturity in a specific position or a professional area that they share.”

“Long-term relationship between a technical senior and his junior in which skills can be developed and in which results can measured by competencies gained by all parties (mentor, mentee & organisation)“

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**MENTOR**
- Confidential
- Respectful
- Non Hierarchical

**MENTEE**
- Recognizes her/his Technical Need
- Attitude

**RELATIONSHIP**
- Mutual Agreement

**Objective = Learning Experience**
- Long Term
- Development of competence

**Technical Expertise & Experience**
- Teaching skills
- Communication Skills / Attitude
In several contexts, MSF chooses to partner up with other actors (usually the Ministry of Health) in order to:
- support quality of existing services
- implement new activities.

This approach aims at:
- increasing access to healthcare with fewer expert MSF staff
- Increase the quality of support by providing handover solutions
- foster sustainability by providing handover solutions

Each partnership is a project on its own, going through several phases. Each phase will require presence of different staff, and with various intensity.

**Mentoring is only ONE of various possible approaches to staff capacity-building.**
Mentoring vs Supervision & Supportive Supervision

<table>
<thead>
<tr>
<th>Supervision</th>
<th>Supportive supervision</th>
<th>Mentoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>Project activities &amp; outcomes, Evaluation in order to reach targets</td>
<td>Individual learning and growth relevant to project outcomes</td>
</tr>
<tr>
<td>Main Focus</td>
<td>The activity, facility performance, HR management</td>
<td>Development of competence by individual people to achieve programme objectives</td>
</tr>
<tr>
<td>Professional background?</td>
<td>Usually common but not necessarily</td>
<td>Usually common but not necessarily</td>
</tr>
<tr>
<td>Relationship</td>
<td>Hierarchical</td>
<td>Hierarchical, depends on quality of the interaction</td>
</tr>
<tr>
<td>Nature of contract?</td>
<td>Legal contractual relationship</td>
<td>Legal contractual relationship (work contract)</td>
</tr>
<tr>
<td>Tools used</td>
<td>Project Log-frame, Checklists</td>
<td>Facility dashboards, Checklists</td>
</tr>
</tbody>
</table>

Supportive Supervision Activities
(activities potentially performed by mentors with acceptable impact on confidentiality/legitimacy)

- Feedback on Facility Performance (Dashboard)
- Reporting
- IPC
- Equipment & forms supply
- Stock-out monitoring
- Staffing & other HR management
- Patient satisfaction
- Finance (running costs, payment by performance)
- Patient flow and triage
- Clinic organization
- Case management observation
- Group (classroom) trainings
- Journal club
- Team meetings
- Review of referral decisions
- Support Patient monitoring & record-keeping
- Confidential Individual Feedback
- Clinical case review
- Bedside teaching (consultation, ward rounds)
- Morbidity and mortality rounds
- Assist with care & referral of complicated cases
- Patient-centered data collection
- Facility aggregated data collection
- Data analysis
- Line-list of patients-of-interest production

Role and responsibilities of each cadre might overlap, so they need to be clearly defined. It depends on capacity of the staff, and the impact it could have on the mentoring relationship (and if you have any doubts, refer to the definition of mentoring).
### Historical challenges in running mentoring programmes (& possible solutions)

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Possible Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absenteeism / lack of commitment (late...)</td>
<td>Well-defined structured programme in defined modules</td>
</tr>
<tr>
<td>Poor motivation</td>
<td>Personal benefit by having the mentoring programme accredited for CPD points</td>
</tr>
<tr>
<td>Resentment</td>
<td>Careful selection of the correct mentees by the clinic managers</td>
</tr>
<tr>
<td>Substitution b/o absenteeism of non-mentees</td>
<td>Clear understanding at the outset of the programme</td>
</tr>
<tr>
<td>Overall lack of buy-in and general poor motivation by staff at all levels in the programme</td>
<td>Maintain confidentiality of M-M relationship – create safe space</td>
</tr>
<tr>
<td>Competing priorities</td>
<td>Pre- and post-course MCQ tests to assess baseline knowledge and to identify these gaps</td>
</tr>
<tr>
<td>Staff turnover</td>
<td>Poor baseline knowledge by mentees</td>
</tr>
<tr>
<td></td>
<td>Well-structured trainings on the key clinical topics identified in the needs analysis</td>
</tr>
<tr>
<td>Mentees unhappy with their mentor</td>
<td>Clear understanding at the outset of the programme</td>
</tr>
<tr>
<td></td>
<td>Careful matching of the mentees to mentors by MSF and MoH managers</td>
</tr>
<tr>
<td></td>
<td>Good flagging system &amp; mediation process</td>
</tr>
</tbody>
</table>

### External factors

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Possible Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict with other mentoring programs</td>
<td>Stakeholders Analysis - Identify these as the outset &amp;</td>
</tr>
<tr>
<td>Competing / Interactions with other actors</td>
<td>Prior discussion - negotiate a mutually beneficial path through this</td>
</tr>
<tr>
<td>Stock-outs of medicines, lab tests</td>
<td>Context monitoring</td>
</tr>
<tr>
<td>Strike in the healthcare system / Intrusion of issues related to politics</td>
<td>Context monitoring &amp; E-Prep</td>
</tr>
<tr>
<td>Competing priorities (natural disaster, outbreak...)</td>
<td>Context monitoring &amp; E-Prep</td>
</tr>
</tbody>
</table>

### Challenges | Possible Solutions

- **Lack of mentoring skills**: Structured weekly meetings for communication, support
- **Lack of Technical Knowledge**: Exchanges with other mentors, sharing experiences
- **Lack of Technical Knowledge**: Training of Mentors (ToT-M)
- **Reluctance to admit gaps**: Initial training during programme preparatory phase + regular refreshers
- **Reluctance to admit gaps**: Appointment of a manager of the programme (mentors supervisor)
- **Demotivation**: Formative supervision
- **Socio-cultural Differences**: Clear initial understanding of the mentoring programme & Job Description
- **Socio-cultural Differences**: Develop communication skills & pre-empt discussion with mentee
- **Socio-cultural Differences**: Local recruitment of culturally-appropriate mentors
Success Factors of a Mentoring Programme

- Recognition and accreditation of the programme by the national health authorities
- When this factor is possible, it considerably reduces the obstacles often encountered in the implementation of the programme
- As a halfway measure, certification is usually highly valued by participants.
- Certificate of competence should include a clear set of min. standards

Accreditation

- MSF/MoH at the director level (Agreement Protocols (MoUs))
- MSF/MoH at the clinic and hospital level
- Mentors supervisors: at the level of the in-charges of health facilities, department heads
- mentor/mentee (clarify each person's roles and duties, confidentiality, mediation process)

Formalisation by contract

- Skilled, legitimate and recognised in their profession
- Skilled and sensitive to learners' questions: communication skills
- Skilled in teaching adults in small groups (alternatively, willing to develop them)

Selection & training of mentors

- Identification of medical needs to cover (needs analysis, operational objectives to achieve for the project)
- Development of mentoring programme objectives and learning objectives to be achieved for each medical topic covered.
- Development of the various sequences of the programme and their duration
- Consider providing additional staff to substitute for the mentor while s/he is being mentored (increases the likelihood of support from the rest of the clinic)

Programme planning & structuring

- Define a communication strategy for the mentoring programme to formalise the activity of mentoring and make it official and transparent.
- It should be differentiated from other activities. It should be known and understood by all players involved.
- To wrap-up this communication process, plan opening and concluding phases for the programme involving supervisors, mentors, mentees and management.

Prior communication w/ all stakeholders

- Share results
- Feedback on process
- Use Dashboard to facilitate communication

Briefing of stakeholders

- Support & willingness displayed by all players involved (mutual willingness) at the management and coordination levels of the project.
- MSF: support and involvement of leadership (Medco, PMR, FieldCo)
- MSF/MoH programme directors and health centre supervisors

Support & involvement of leadership

- Develop a monitoring and evaluation system based on four levels
- MENTEE: Evaluate the development of his/her knowledge and skills
- RELATIONSHIP: Monitor the development and conditions of the mentor/mentee relationship
- MENTOR: Training, evaluation and support of his/her activities
- IMPACT: Evaluate the impact of the mentoring action on the medical objectives of the MSF project

M&E
Mentoring Programme – Operational Framework

**NEEDS ANALYSIS**
Healthcare Needs
Training Needs

**DESIGN**
Identify Target
Learning Objectives
Select Mentors
Agreement

**FOLLOW-UP**
Continue monitoring programme indicators
Less intensive visits or Q? new cycle

**EVALUATION**
Indiv. achievements
Impact on programme objective

**IMPLEMENTATION**
Opening & Closure
Conduct classroom & on-the-job sessions

**DEVELOPMENT**
Session Plans
Training material
Teaching/Job Aids

**ADAPTATION**
As with anything, monitoring of the activities should help identifying issues for future adaptation of the programme. M&E does not stop with the last training session – long-term competence and impact on patients’ health should continue beyond intensive MSF presence in a facility.

**LEARNING OBJECTIVES**

**SELECTING MENTORS**
Being a mentor requires more than being a good clinician/counselor, so the selection is paramount (see page below)

**AWARDING CERTIFICATES**
The most important question really is: “What do mentees want to get out of the process?” Certificates are usually an incentive valued by most, but this should be adapted to the context

**CAPACITY-BUILDING**
The proposed framework favors short classroom didactic trainings followed by a series of on-the-job companionship. The succession of these sessions favours back-and-forth between theory and practice, inherent to incremental growth.

**NEEDS ANALYSIS**
Training is not the answer to everything. It will not improve access to care if there is a lack of HRH, drugs stock-outs etc. This phase is critical to successful Programme

**STRUCTURING CURRICULUM**
These steps are meant to ensure the programme is meaningful to mentees, i.e. be useful and used in their daily practice

**FORMALIZATION BY CONTRACT**
During the process, MoUs (at higher level) & then individual mentoring agreement formalize commitments to the programme

**DEVELOPING TRAINING MATERIAL**
Might be time-consuming in order to ensure interactive sessions. It could require some support from referents (people conversant with either content or pedagogy)
Skill-set of Effective Mentors

Ideal mentors are expert peers, matching mentees in culture and qualifications. As a peer, you should also be able to rely on a 3-pronged skill-set:

**Technical expertise & experience**
- Competent at her/his job (clinician/counsellor)
- Knowledgeable in her/his field
- Experienced in he/his field
- Conversant with guidelines & SOPs
- Problem-solving capacity (in patient management)

**Communication skills**
- Motivated (wanting to be a mentor)
- Non-Judgemental, respectful
- Empathetic
- Good listener - Active listening
- Capacity to give constructive feedback, positive
- Challenging, asking questions
- Accessible, trustworthy
- Patient
- Confident but with ego kept under control...

**Teaching skills**
- Conversant with adult learning principles
- Designing learning objectives
- Comfortable speaking to a group of people
- Group management skills
- Time management skills
- Some IT skills
Didactic Teaching for HCW in the work place

1. The Competency Cascade
2. Training strategies
3. Principles of Adult Learning
4. Designing Learning Objectives
5. Preparing the Content of a teaching session
6. Choosing an Instructional Method
7. The Pedagogical Triangle
8. How to use PowerPoint effectively
**COMPETENCY CASCADE**

*Competence* (or skill) is an individual mobilizing a certain number of personal resources (capacities), in a working environment, in a given context, in order to perform (or to reach objectives).

**KEY**
- ▲: Identified gap
- ▲: Baseline situation
- ▲: Expected situation

**PEDAGOGY**

**TRANSFER**

**EFFECTS**

In a training situation

In the workplace
Training Activities & Development of Competence

Training activities limited to a classroom are an illusion when it comes to developing competence. Strategies to develop competence should involve activities in the 3 fields, and ideally across them. Some conditions are critical in fostering the translation of knowledge into competence and ultimately facility performance:

<table>
<thead>
<tr>
<th>Pedagogy Conditions contributing to acquisition of new knowledge</th>
<th>Transfer Conditions contributing to translate knowledge into competence:</th>
<th>Effects Conditions for adequate measuring of team performances:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Trained facilitators (‘Professionals’)</td>
<td>▪ Involve the ‘hierarchy’ and support formative supervision</td>
<td>▪ Measure a baseline performance</td>
</tr>
<tr>
<td>▪ Coherence between content (what is offered) of the training and actual needs (what is required), taking baseline knowledge into account</td>
<td>▪ Involve both learner and her/his supervisor in setting realistic and measurable objectives as training follow-up</td>
<td>▪ Objectives are ste clearly and know to all</td>
</tr>
<tr>
<td>▪ Practical trainings, including exercises or applications close to field conditions and identified issues (create links between theory and reality)</td>
<td>▪ Ensure necessary resources (drugs, diagnostic tests, budget...) to implement knowledge into daily practice are available</td>
<td>▪ Objectives are realistic and measurable (‘FARM’)</td>
</tr>
<tr>
<td>▪ Create an environment conducive to learning (group management, ‘safe space’, logistics)</td>
<td>▪ Shorten as much as possible delay between theoretical training and practical exposure.</td>
<td>▪ Capacity-building includes all key staff members of the facility/project</td>
</tr>
<tr>
<td>▪ Enforce criteria to select appropriate target group (the right people at the right time)</td>
<td>▪ Propose alternative opportunities for support in the workplace (e.g. mentoring)</td>
<td>Measuring the impact of training activities (e.g. mentoring) objectives at project level is complex because of the multitude of factors contributing to it</td>
</tr>
<tr>
<td>▪ Motivation of participants and their involvement in their own development</td>
<td>When the context is not conducive (lack of resources, external constrains), individuals won’t be able to develop the full potential of competence. It could even be worse and lead them to underperform (“incompetence”)</td>
<td></td>
</tr>
</tbody>
</table>

Post-training continuity and support during transfer of knowledge into competence is paramount (verging on non-negotiable) if the aim for individual to be ‘more competent’.
# Principles of Adult Learning

*“People remember better what they discover, experience, analyse and discuss than what they just hear”*

<table>
<thead>
<tr>
<th>KEY FEATURE</th>
<th>MATCHING METHODOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B</strong> Adults like to <strong>BUILD</strong> on existing knowledge</td>
<td>Know what they already know, and design content to add to this. The trainer knowing this beforehand conveys respect and value to the participants</td>
</tr>
<tr>
<td><strong>R</strong> Adults like to be <strong>RESPECTED</strong> and valued for the experience they already have</td>
<td>Ask questions early on to establish this. It both informs you and gives them a sense of being understood and valued. Acknowledge them for their existing skills and knowledge, even if not relevant to this training</td>
</tr>
<tr>
<td><strong>A</strong> Adults like to <strong>APPLY</strong> learning to real life experience</td>
<td>Training must be geared to have immediate practical application. Trainings have to be <strong>MEANINGFUL</strong>.</td>
</tr>
<tr>
<td><strong>I</strong> Adults like to be <strong>INVOLVED</strong> in the learning process</td>
<td>Choose ways of learning that maximise participants engagement</td>
</tr>
<tr>
<td><strong>N</strong> Adults learn best when the training meets an identified practical <strong>NEED</strong></td>
<td>Orientate the training towards the felt needs of the participants.</td>
</tr>
<tr>
<td><strong>S</strong> Adults enjoy <strong>SHARED</strong> learning experiences</td>
<td>Create opportunities for sharing of experiences so that participants learn from each other as well</td>
</tr>
<tr>
<td><strong>F</strong> Adults have concerns about being made to look <strong>FOOLISH</strong></td>
<td>During training, everybody can make MISTAKES. Trainees need to feel secure. A mistake is a ‘gift’ / an opportunity for the trainer! It tells the trainer how the trainee may benefit from the training. Be careful with the exercises that you ask them to do. Leave the more exposing exercises till later in the course when participants are feeling safer with each other</td>
</tr>
<tr>
<td><strong>G</strong> Be a “<strong>Guide on the side</strong>” rather than a “<strong>sage on the stage</strong>”</td>
<td>Adult learners usually work best in an atmosphere of mutual learning, rather than a “teacher knows all” environment. Adults in training are expecting FEEDBACK. This enables the mentee to evaluate her/his work when compared to standard practice. Create opportunities for constructive exchange and feedback</td>
</tr>
</tbody>
</table>
Designing Learning Objectives

What is a Learning Objective?

‘What a trainee needs to be able to do at the end of a training period’ Aim:

- For the training to be centred around the trainee rather than on the trainer or the content
- For the competence to be defined along an activity that is performed in the professional setting
- Time necessary to reach a learning objective is essential. Several sessions may be required to reach a learning objective. When professional competencies are concerned, a theoretical session often require a practical application of the knowledge at the workplace.

The 4 components of a specific objective

- The **task** expressed through a verb (see list)
- The **content** specifies the task being done.
- The **condition/ circumstances**: describes the circumstances under which the task is being performed.
- The **criteria**: defines the minimum standard the trainee needs to reach.

The 5 quality criteria of a good specific objective:

**FEASIBLE**: Can we achieve the learning objectives in the available time and available means? If not, either don’t start the training or set the bar lower.

**ACCURATE**: the objective is a communication tool: Will anyone reading it be clear on exactly what is going to be achieved? Is there any room for interpretation or confusion?

**RELEVANT**: Is it useful in the particular setting in which the learning is going to be implemented? (e.g. available lab tests, organization of healthcare...)

**OBSERVABLE & MEASURABLE** = Evaluation. Would someone be able to observe the outcome of the learning objective? The specificity of the active verb and of the criteria will make the objective measurable.

Specific Learning Objectives are categorized in 3 domains:

- **Knowledge, (intellectual skills), e.g.** Name the priority groups for active HIV screening, List 5 high risk factors to developing active TB disease, Explain the I-M-B model to behavioural changes.
- **Practical Skills** (applying knowledge, procedures = motor skills) e.g. perform an i.m. crapeomycin injection, Read a CrAg LFA test result, performs an enhanced adherence counselling session.
- **Attitude (behavioural aka interpersonal skills)** e.g. reassure patient with positive HIV test, encourages patient who presents with side-effects to DR-TB treatment, preforms EAC session in an empowering fashion.

3 Types of objectives:

<table>
<thead>
<tr>
<th>Type</th>
<th>In a mentoring Programme</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Objective</strong></td>
<td>Objective of the whole mentoring programme – relates to operational objective of the project</td>
<td>Improve the quality of care of advanced HIV patients management in Eshowe</td>
</tr>
<tr>
<td><strong>Intermediate Objectives</strong></td>
<td>Objective of a week of mentoring</td>
<td>Manage a high viral load result in patients with CD4 &lt; 200</td>
</tr>
<tr>
<td><strong>Specific Objectives</strong></td>
<td>Objectives of a single teaching or mentoring session</td>
<td>1. Define virological failure according to MSF guidelines</td>
</tr>
<tr>
<td></td>
<td>Detail steps required to reach the intermediate objective</td>
<td>2. Communicates high viral load result in a supportive manner</td>
</tr>
</tbody>
</table>

- A general Objective will be reached through several Intermediate objectives AND an intermediate objective contains several specific objectives.
- A training depends mostly on its specific (and intermediate) objectives: their accuracy makes a training very pragmatic.
How to Prepare the Content of a Teaching Session

**SEQUENCE FOR PREPARATION**

**SESSION PHASES**

- CALL
- THEORY
- PRACTICE (Exercise)

**QUESTION**

- What will draw them into wanting to achieve the learning objectives?
  - What can you spark to make them FEEL like learning?

- What do the participants need to learn in order to succeed in the practice session?

- What do you want the participants to be able to DO at the end of the session?

**TIPS**

- To teach as little as a finger, you have to know as much as an arm

  **BUT**

  Too much information kills information

  Instructional Method is to be chosen after content is identified

  - This is linked directly to the learning objectives
  - Choose exercises that are as close to real life as possible (e.g. case study, role play...)
  - Starting with the practice avoids presentations that are too theoretical and are not applicable in the field

  - Joke, story, video clip...
  - In line with the topic
  - That draws on emotion, humor ...

  **KEY MESSAGES**

  Must be learnt = Max 3 to 5/session

  Interesting to learn, but mostly unnecessary details = can be referenced, found in facilitator’s notes

  Useful to learn = on slides, in handout
Instructional Methods

Adapted to the audience
- Adults (learning principles)
- Number of participants
- Education
- Pre-existing knowledge

Adapted to the context
- Classroom
- Consultation room
- Distance learning

Type of Learning Objective
- Knowledge
- Applied Skills
- Attitude / Behaviour

Teaching Aids
= resources used to make the content more attractive, structured. Mostly visual aids contribute to complement a talk and use several ways of learning (they are not a method in themselves, except for the use of video as a means of auto-confrontation)

Examples:
- Board (Black / White)
- Flip-chart
- Meta-plan
- PowerPoint
- Photos / video
- Audio
- Accessories
- Models
- Simulator

Puzzle
Role Play
Simulation
Bed-side teaching (accompanying trainees in their workplace)

File Review
Case Study

Snowball

Group Brainstorming

Plenary Brainstorming

Conference / presentation

Knowledge
- Philips 6/6
- 3 Bus Stops
- M.I.G.G.
- Debate
- Puzzle

Applied Skills

Attitude / Behaviour

Level of Participants’ Involvement

Time available for
- Preparation of the session
- Carrying out the session
The Pedagogical Triangle - Dominant behaviours toward training

How do we position ourselves in a training, as a trainer? How do we see participants? What is our relationship with the topic that we are going to cover?

**Trainer dominant**
= “sage on the stage”

The trainer:
- Is making the show
- Sends his/her message only
- Talks more than 50% of the time
- Talks to the topic (i.e. to the slides), not to the audience

→ Patronising approach

**Group dominant**

- Self-group management
- People left to to identify their own learning needs & achievements
- Loose focus,
- No key messages
- No regulation of outcomes
- No clear feedback

**Well Balanced Triangle**
= “Guide on the side”

- Complementary approach between inputs from the group and inputs from trainers
- Better chance to assess trainees’ experiences and needs
- Use and build the session on people experiences
- Adult learning principles can apply (audience is involved, they can share...)

**IF YOU (trainer) TALK MORE THAN 40% OF THE TIME... ...YOU MAY NOT BE IN A TRAINING! 😊**
Using PowerPoint as a Visual Aid Effectively

Three parts to a presentation

- **1. Slides**
  - Keep slides simple & concise
  - Slides should re-enforce words not repeat them

- **2. Your notes**
  - There is no need for anyone to die of cervical cancer when such easy screening tests are available to prevent it

- **3. Handouts**

4 Tips on Slide Design

Avoid ‘distractions’ & Use catch-phrases (‘slogans’)

- **1. Message to noise ratio**
  - There is no need for anyone to die of cervical cancer when such easy screening tests are available to prevent it
  - VS
  - Nobody ever needs to die...

**Power of Pictures: Pics remembered > words**

- **2. Picture superiority**
  - Is it TENS or SJS ??
  - This can manifest in mucous membrane changes
  - Look for:
    1. Conjunctivitis
    2. Ulcers - lips or mouth
    3. Genital lesions
  - VS
  - TENS or SJS ?? Look for:

Contrast

- **3. Contrast**
  - Lab tests are important in the diagnosis of DRESS syndrome
  - VS
  - Repeating similar elements throughout the presentation (e.g. design format)

Repeating similar elements throughout the presentation (e.g. design format)

YouTube links for amusing additional input about PowerPoint
[https://www.youtube.com/watch?v=KbSPFFYxx3o&ab_channel=DonMcMillan](https://www.youtube.com/watch?v=KbSPFFYxx3o&ab_channel=DonMcMillan)
[https://www.youtube.com/watch?v=lwpI1Lm6dFo](https://www.youtube.com/watch?v=lwpI1Lm6dFo)

People can’t listen and read at the same time

Content: Key figures

- **1 MESSAGE**
  - Per slide

- **Maximum 6 ELEMENTS**
  - per slide

“Avoid slide-uments”

YouTube links for amusing additional input about PowerPoint

[https://www.youtube.com/watch?v=KbSPFFYxx3o&ab_channel=DonMcMillan](https://www.youtube.com/watch?v=KbSPFFYxx3o&ab_channel=DonMcMillan)
[https://www.youtube.com/watch?v=lwpI1Lm6dFo](https://www.youtube.com/watch?v=lwpI1Lm6dFo)
Clinical Mentoring Techniques

1. Organizing a Mentoring Visit
2. Instructional methods for teaching at the work-place
3. Aspects of side-by-side teaching
4. Role Modelling – 4 Steps to Active Observation
5. The 1 minute preceptor
6. Identifying learning opportunities in IPD
7. The ward round as an effective learning moment
MSF’s model of care for patients with chronic diseases relies on a multidisciplinary approach.

**Modelling interactions** & interdependence of clinicians / counselors / pharmacist / lab / M&E is an important part of the ‘informal’ skills imparted during mentoring sessions

- **Tip:** Organize joint visits & training sessions, involving different team members/cadres, it will also help with logistics.

**Steps of a mentoring day**

1. **Preparation**
2. **Session**
3. **Debriefing (Feedback)**
4. **Action Points for next session**

**How much time spent with a mentee?**

- The mentee-mentor relationship is the vehicle for competence development → Make sure mentors have the time to foster it.
  
  **Tip:** initial contacts with a mentee should be allowed 4 to 6 hours /week. (i.e. +/- 1 hour of classroom training + 4 hours of individual side-by-side teaching)

- The ultimate goal of mentoring is competence, and thus the mentee’s autonomy, daily presence of mentors during mentee’s professional activities is not to be recommended.

**Team Work**

- The mentee-mentor relationship is the vehicle for competence development → Make sure mentors have the time to foster it.

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**MSF’s model of care for patients with chronic diseases relies on a multidisciplinary approach.**

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# Teaching in the work-place – instructional methods

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<tr>
<th>Method</th>
<th>Side-by-side Mentoring</th>
<th>Case Study</th>
<th>File Reviews</th>
</tr>
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<tbody>
<tr>
<td><strong>Working alongside the mentee in clinic/ward</strong></td>
<td>A scenario is presented to mentees, followed by a discussion/questions about how to characterize, describe, and/or act on the situation in the scenario</td>
<td>Files of patients with known clinical problems are drawn to be studied by the mentee as the content of the learning experience</td>
<td><strong>Preparation for patients coming on a particular day so that the mentee is well prepared to discuss and manage the patient’s condition</strong></td>
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<td><strong>Mentor either observes, supports, or models practices. Alternatively the mentor and mentee alternate duties of seeing patients</strong></td>
<td><strong>Can be used incorporated into a regular clinical meeting in a facility or a project, in a classroom or a consultation room, with groups or individual learners.</strong></td>
<td><strong>Guarantees real-life example of this condition can be produced whenever needed just by drawing the file, even when a clinical condition is less frequently seen</strong></td>
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<td><strong>Mentees do not feel like they are being watched, but rather supported by a colleague</strong></td>
<td><strong>An opportunity to apply new skills and knowledge to a simulated “real-life” situation.</strong></td>
<td><strong>Several of the same condition can be seen sequentially so as to consolidate learning on a particular subject</strong></td>
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<td><strong>Visits are more comprehensive and thorough and should allow for better care to be provided</strong></td>
<td><strong>Allows exploration of various strategies to address complex issues</strong></td>
<td><strong>Where more lengthy technical discussion needs to happen for which the presence of the patient can be avoided (e.g. the management of the high viral load or renal dysfunction)</strong></td>
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<td><strong>When mentees are quite new to the job, patients may be seen more quickly.</strong></td>
<td><strong>Enables the learner to develop analytic, problem-solving, and critical thinking skills</strong></td>
<td><strong>If the content of the file review is an error to be learnt from, something best not discussed in front of the patient (morbidity and or mortality)</strong></td>
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<td><strong>Mentor can observe mentee at work and identify and address challenges</strong></td>
<td><strong>When prepared by the trainee, it enables to practice synthesizing relevant information.</strong></td>
<td><strong>Preparation for patients coming on a particular day so that the mentee is well prepared to discuss and manage the patient’s condition</strong></td>
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<td><strong>Allows for learning in all 3 domains: knowledge/applied skills/attitude (behaviour)</strong></td>
<td><strong>Allows health care workers to share complex situations and to learn from how their colleagues treated patients</strong></td>
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## Merits

- **Ethics: patient’s well-being cannot be at risk.**
- **Depends on the number of patients. Rare conditions limit opportunities for learning.**
- **Usually consultations take more time (might increase resentment)**

## Limitations

- **Limited to knowledge and applying knowledge (e.g. applying an algorithm). Not adapted to test practical procedures. Can give rise to ethical debates, but does not allow to test attitude or relational skills.**
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- **Highly dependent on the quality of documentation of consultations / filing of results / access to files...**

## Tips

- **Agree in advance how the mentor will behave during the session (silent observation, intervening in specific moments, role-modelling...)**
- **Inform the patient of the mentor’s presence and get his/her consent beforehand**
- **Checklist may be useful (should be agreed with the mentee beforehand)**
- **Patient centred: keep the patient’s Feelings, Expectations & Fears in mind (FER)**
- **Mentor or mentee can think aloud in order to demonstrate thinking process**

## Collect file references relevant for specific topics as you go (consultations / mentoring sessions / mentees’ questions (file numbers or make copies)

## The M&E team usually can extract lists of patients (e.g. paediatric cases with high VL, TB patients with sputum results & no outcome...)

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**Case Study**

- **Can be used incorporated into a regular clinical meeting in a facility or a project, in a classroom or a consultation room, with groups or individual learners.**
- **An opportunity to apply new skills and knowledge to a simulated “real-life” situation.**
- **Allows exploration of various strategies to address complex issues**
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## File Reviews

- **Files of patients with known clinical problems are drawn to be studied by the mentee as the content of the learning experience**
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Role Modelling

- Active Observation by mentee
  - See Role Modelling Tips

  **Benefits:**
  - Useful when working with mentees unexperienced in the field
  - Helpful in establishing mentor as a legitimate professional (clinician/counsellors)

  **Limitations:**
  - Risk of substituting, overtaking the mentee’s space & responsibilities
  - Leads to disengagement
  - Possibly ending in absenteeism

  **Tips:**
  - Make the unconscious conscious
  - Think aloud & use 4 steps for active observation by mentee

Transition

Work side-by-side

- Active Observation by mentor
  - See The 1-minute Preceptor

  **Benefits:**
  - Useful to assess mentee’s needs - early on
  - Useful to assess mentee’s competence (assess achievements) and level of self-confidence (autonomy) - later on

  **Limitations:**
  - Possible questioning of mentor’s legitimacy
  - Possible resentment for not ‘pitching in’

  **Tips:**
  - Use Observation grids to make your observation process active & structured
  - Use the 1-minute-preceptor microskills
Role Modelling – 4 steps to Active Observation

**01**
**PREPARATION FOR ACTIVE OBSERVATION**
(prior to observation)

1. Describe to the mentee what I intend to do and naming the competence
2. Explain the connection between the mentee’s need and what I am about to do
3. Draw mentee’s attention to useful knowledge, skills & attitudes in relation to what I am about to demonstrate
4. Provide mentee with specific instruction for observation

**02**
**MAKING THE UNCONSCIOUS CONSCIOUS**
(during the observation)

1. Draw attention and highlight the demonstrated competence
2. Comment on interventions I succeeded, and if applicable, to those that more complicated and/or problematic or did not provoke the expected outcome.

**03**
**REFLECTION & ABSTRACTION**
(post-observation)

1. Discuss what the mentee has understood based on her/his observations
2. Analyze with the mentee what was demonstrated, the impact and issues

**04**
**TRANSLATING INSIGHT INTO PRINCIPLES**
→ BEHAVIOR CHANGE

1. Discuss with mentee concrete options for her/him to master and implement what I demonstrated in her/his future practice
2. Check with mentee if s/he has any questions and make sure they are answered
3. Ask the mentee to state 1-2 key messages s/he takes home from this observation.

Adapted from L. Cote et al., in Pédagogie Médicale

= to be a source of inspiration because of one’s behavior as a professional.

It has to be INTENTIONSAL and EXPLICIT to enhance the mentee’s learning.
The 1-minute Preceptor - diagnosing clinical reasoning

01 Get a Commitment
Ask mentee to articulate his/her own diagnosis & plan
e.g.: “Can you tell me what is the most likely diagnostic?”
Avoid prompting or suggesting a diagnosis or treatment plan at this point

02 Probe for Supporting Evidence
Ask to explain her-/him-self
e.g.: “What elements do you consider support your diagnosis?”
Avoid questions that rely on memory, e.g. “What is the differential diagnosis for...?”

03 Reinforce what was done well
Positive feedback will encourage desirable behaviours
e.g.: “You conducted a proper history taking...”

04 Correct mistakes
Point out any errors & propose alternative solutions
e.g.: “Did you know that tuberculosis could also...”

05 Teach a general rule
Try to find a teaching point that can be applied to other situations
e.g.: “Evaluation of a clinical issue should always include...”

06 Conclusion
Define actions to be taken & individual responsibilities
e.g.: “So in this case, let’s plan for...”

One-Minute Preceptor
= a framework around which teacher-student conversations can be built

This sequence fosters learner ownership of the clinical problem
+ allows you to both: identify gaps in the learner’s knowledge & focus teaching appropriately to learner needs.
Opportunities for learning in the Hospital

Many interventions are considered fundamental to increase the quality of care in IPD. Most should contribute to staff’s continued medical education. For both these reasons, we should aim at implementing as many of the following as possible in partner IPDs (supported through ‘mentoring’ programs)

<table>
<thead>
<tr>
<th>#</th>
<th>Activity</th>
<th>Patients Benefit</th>
<th>Learning Opportunity</th>
<th>Frequency?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>WARD ROUNDS</strong> (systematic review of all patients on the ward)</td>
<td>See ad hoc handout (page below)</td>
<td>Discuss complex cases thoroughly</td>
<td>Daily</td>
</tr>
<tr>
<td>2</td>
<td><strong>SELECTED PATIENT REVIEW</strong> (‘Contre-tour’)</td>
<td>Review clinical status and adapt treatment of sickest or newly admitted patients</td>
<td>Discus complex cases thoroughly</td>
<td>Ad hoc (daily)</td>
</tr>
<tr>
<td>3</td>
<td><strong>MORTALITY REVIEWS</strong> (standardized review of deaths)</td>
<td>Identify gaps in patients management</td>
<td>▪ Critical Analysis</td>
<td>1 – 2 x / month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Reinforce awareness of SOPs</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>IPC WARD ROUNDS</strong>: review indication of invasive medical devices (ivs, urine catheter, mobility...)</td>
<td>▪ Prevent hospital-acquired infections</td>
<td>Reinforce awareness of SOPs</td>
<td>2x / week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Foster autonomy &amp; quicker recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>ANTIBIOTIC STEWARDSHIP WARD ROUNDS</strong>: review indications, route of administration and duration of all anti-infectious treatment</td>
<td>▪ Reduce exposure to unnecessary medication or invasive devices (iv)</td>
<td>▪ Question ‘usual’ practices</td>
<td>1x / week</td>
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<tr>
<td></td>
<td></td>
<td>▪ Contribute to antibiotic ‘preservation’</td>
<td>▪ Expand on clinicians’ curative toolkit</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>MULTI-DISCIPLINARY TEAM MEETINGS</strong> (Nurses + doctors + pharmacist + counsellors + ... when applicable)</td>
<td>Optimize the department’s ways of working and keep it patient-centered (information flow, roles &amp; responsibilities)</td>
<td>‘Behavioral’ learning objectives on empowering all cadres to foster quality of care</td>
<td>Min. 1 x / month</td>
</tr>
<tr>
<td>7</td>
<td><strong>CONTINUED MEDICAL EDUCATION SESSIONS</strong> (training session, journal club...)</td>
<td>Indirect (via capacity-building of staff)</td>
<td>Foster reflection on practices through more theoretical perspectives</td>
<td>Min. 1x / month</td>
</tr>
</tbody>
</table>
The Ward Round

How?

Patient Care 1

Training 2

What is being done at the bedside?
1. **Introduce patient** to the team + ensures patients dignity is respected
2. **State Aims**: 'situation, background, assessment, recommendation' (SBAR) structure → discuss clinical scenario
3. **Review**: review clinical status & care according to assigned tasks
4. **Goal setting**: leader will summarise the plan for the patient
5. **Educational opportunity**: highlight educational point if appropriate

Rules:
1. **Patient-centered**: introduce patient to team & team to patient, involve patient in discussion, mind patient’s Feelings, Expectations & Fears
2. **Enhance communication**: Quiet environment, Small group size, Disruptive discussions kept for later
3. **Interactive**: All involved (various staff AND patient)
4. **Prepared**: Time slot scheduled for all parties, All necessary medical records & equipment are readily available

What should be taught?
1. ‘**How to do it**’ – ‘**How not to do it**’: How to take a history / How to examine / Ordering tests / What to prescribe / How to prescribe
2. **Problem analysis**: Clinical reasoning / Interpreting test results
3. **Use of best evidence**
4. **Communication skills**: Empathy / How to explain illness / Privacy / Dignity / Respect for patients / Equality / Honesty
5. **Defensible documentation**
6. **Organisation skills**: Planning ahead / Time management / Prioritisation
7. **Ethics**
8. **Teamwork**

TIP
If there are too many participants or too many patients, start with a ‘sitting’ ward round in the medical office, then attend patients in the people directly responsible for their care. Bedside mentoring can target specific patients at another time.
Communication Skills in Mentoring

1. What is Communication?
2. Active Listening
3. Giving Constructive Feedback
4. Building a Mentoring Relationship
5. Ending a Mentoring Relationship
**Communication – Basic Concepts**

**Def.** The exchanging of information by speaking, writing, or using some other medium - The successful conveying or sharing of ideas and feelings.

**Nonverbal Communication**

- **How:** through the use of
  - Body language (facial expressions, gaze, gestures, posture)
  - Tone of voice
  - Physical environment (distance,
- **AIM:** convey emotions or norms.
  - Express emotions
  - Express interpersonal attitudes
  - To accompany speech in managing the cues of interaction between speakers and listeners
  - Self-presentation of one's personality
  - Rituals (greetings)
- **Check-out:** used in art and rituals accompanied with verbal communication.

![Diagram of communication process](image-url)
DON’Ts
Avoid distractions, like phone calls/text messages, other people, (note that this is a factor related to the environment in which you are holding a conversation)
Avoid barriers such as crossing arms, having a desk in between...
Facial expressions such as Frowning, Paperwork (mitigation: if using a checklist or taking notes, discuss and agree on it with the mentee prior to mentoring session)

DOs
Make eye contact
Face-to-face, Lean in (mirror attitude)
Demonstrate interest in what is being said e.g. nodding
Smiling
Choose your position in room carefully (not in the center and not too removed: discuss it with mentee)

Active Listening
= Using verbal and non-verbal language we actively display to communicate that we are really listening.
- Is an essential component of good communication.
- Often, instead of truly listening to what the other person is saying, we’re thinking about what our response will be to what they’re saying, or what we want to say next, or something else entirely.

1. Non-Verbal Communication

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| Avoid barriers such as crossing arms, having a desk in between... |   |
| Facial expressions such as Frowning, Paperwork (mitigation: if using a checklist or taking notes, discuss and agree on it with the mentee prior to mentoring session) |   |

2. Reflective listening
= The process of verbally “reflecting” back what someone has expressed:
- Helps the mentor verbally check whether s/he understands what the mentee expresses, whether verbally or non-verbally, content or emotions that transpire
- Helps the mentee feel understood and respected as a health care worker

Tips on reflective listening
confirm that you have understood the mentee by using statements such as:
- “So you feel like there’s not enough time to do a complete physical exam.”
- “It sounds like you’re concerned about this patient’s ability to adhere to treatment.”
- “You’re wondering if this patient should be started on an ART regimen.”
Note that these statements include the word “you,” which emphasizes that the active listening and This helps to check for understanding

Avoid
Offering similar personal anecdote

Offering a solution
Why? questions

3. Summarising
= Process of synthesizing and stating what a mentee has said in order to capture key concerns and issues
Use summarizing:
- To check that you have understood the mentee’s story or issue
- When changing topics, closing discussion, or clarifying something
- To collect your thoughts
- To show the mentee that you have heard and respect his/her point of view
Sometimes you can use it to close down a conversation that is going on for too long – it clarifies that you have understood without hurting the person by stopping them abruptly
Giving Constructive Feedback

**Golden Rule during consultation**

**PATIENT FIRST**
If taking the lead or giving feedback during a consultation keep in mind the patient’s:

- Feelings
- Expectations about the disease
- Fears & treatment

= EMPATHY

---

**Feedback goes both ways:** remember to ask your mentee for feedback as well, and be open to receiving it!

---

**Make it a positive experience**

Before giving feedback make sure you remind yourself why you are doing it. The reason for giving feedback is to improve the situation or performance. You won't accomplish that by being harsh, critical, or offensive.

1. Ask permission and identify that you are giving feedback. Examples:
   - “Can I give you some feedback on that follow-up patient visit?”
   - “I’d like to provide some feedback on what I observed during my visit today.”

2. Ask the person how they feel they performed and listen actively.

3. Give feedback in a 4-points sequence:
   - **Constructive Feedback**: Make it a positive experience
   - **Choose your timing**
   - **Be Specific**

---

**Choose the best time and place to do it**

You can provide feedback any time: during the clinic visit, immediately afterwards, or after you leave the clinic premises.

But, don’t wait too long to give feedback. The closer the feedback is to the actual event, the more likely the mentee will remember the teaching point.

Remember the mentoring relationship remains confidential: when giving feedback, do so in private.

- Certain feedback need to be given more urgently:
  - If the patient’s well-being/health is at risk
  - If the mentee is doing something in error or omitting a very important step during the visit.

- If you provide feedback during a patient encounter:
  - Do not alarm the mentee or patient. Put them both at ease.
  - Be very calm and patient as you explain your recommendation.

---

**Do More**

**Do Less**

**Stop**
Giving Constructive Feedback - 2

Be Specific

→ Specific observations:

✓ You are stating your own observations:
   - Use the first person: “I think,” “I saw,” “I noticed.”
   - Limit your focus: discuss maximum 3 issues (or the mentee might feel attacked/demoralized)
   - Feedback should address what a person did, not your interpretation of his or her motivation or reason for it. State facts, not opinions.
     ✓ Action: “You skipped several sections of the counselling script.”

✗ Interpretation: “You skipped several sections of the counselling script. I know you want to finish because it’s almost lunch time, but…”
   ▪ Don’t use second-hand observations, don’t give feedback based on rumours
   ▪ Don’t be judgmental or use labels. Avoid words like “lazy,” “careless,” or “forgetful.”
   ▪ Don’t exaggerate. Avoid terms such as “you always” or “you never.”

→ Specific suggestions

Make sure you both know what needs to be done to improve the situation. The main message should be that you care and want to help the person grow and develop.

When making suggestions for improvement, use statements like, “You may want to consider…” or “Another option is….”

Leave plenty of time for the mentee to ask questions and respond to what you’ve said.

S
Situation
• when”, “where” – situation you are referring to
  • e.g. “This morning during the first consultation…”

B
Behaviour
• you…” – the behaviour you observed that needs to be adapted

I
Impact
• “I…” – how it affected you or others

Be Specific

Commentary: The page provides guidelines on giving constructive feedback. It emphasizes the importance of being specific in observations, avoiding interpretations, and focusing on actions rather than motivations. Specific suggestions are also given to help improve the situation. The diagram illustrates the Situation-Behaviour-Impact (SBI) model for giving feedback, ensuring clarity and effectiveness.
**Building a Mentoring Relationship – 1st Meeting**

Mentor & mentee explore if they can work together through the following 4 steps:

---

### 1. Identify foundations of a good relationship

**Aim:** Establish mutual respect through alignment of values

- Non-judgemental & respectful
  - Honesty
  - Transparency
  - Confidentiality
- Safe learning environment,
  - Be ready to try out new things (and take ‘risks’)
  - It is OK to make mistakes
  - No hiding issues, no false excuses
- Engage in the relationship
  - Mutual commitment = shared responsibility
  - Both can learn from it
  - Communicate issues simply & with respect
- Be prepared for training sessions, (read notes from previous session...)
- Punctuality

---

### 2. Clarify Expectations – clearly & early

- Define the aim of the relationship
- Define commitments
  - Talk logistics:
    - Best timing for group teaching, for side-by-side work
    - Space (where is it going to take place?)
  - Establish respective roles & responsibilities
  - Explain conditions (time & effort) necessary to complete programme successfully
- Define mutually expected behaviours
  - Define lines of communication in times of disagreement
  - Don’t expect the mentee to adhere to unwritten & unspoken commitments considered obvious by the mentor.

---

### 3. Identify potential barriers

Explore possible socio-cultural barriers to a trustful, balanced relationship between mentor & mentee e.g.: difference in

- gender
- age
- qualification
- language

---

### 4. Mentoring Agreement

Document & formalizing the discussion through a written agreement → refer to it if issues arise’
## Ending a mentoring Relationship

Mentorships aren't meant to last forever. Ending the mentoring partnership well is important in ensuring that mentoring pairs transition from a Mentoring relationship to a strong collegial relationship.

### 1. Plan for the cessation of an ‘intensive’ relationship

- Ensure that you both (mentee & mentor) are aware of when the final meeting will occur well before it does (e.g. Start talking about it around the third-to-last session)
- Set aside the whole of the last session for reflecting on the process and relationship and how you feel it went

### 2. Reflect on Achievements

- Reflect upon what you both have accomplished and what you have learned as a result of the mentoring → celebrate your successes and the goals you have achieved
- Discuss outstanding issues → explore plans for the mentee to overcome them on her/his own

Note: this is different from formalizing the end of the program and the acknowledgement of acquired knowledge and competence via a certificate.

### 3. Reflect on the Process & Relationship

It is important to discuss what went well and what you both gained from the experience. Consider the objectives that you discussed in your first mentoring meeting (refer to the mentoring agreement).

**Your experience as a mentee / mentor**

- What were the most beneficial aspects of the mentoring program for you?
- What aspects of the program could be improved?

### 4. Discuss future of the relationship

- Agree what your contact will be in the future (e.g. future CME meetings...)
- Thank your mentor/mentee for their time, effort
M&E Tools

1. Mentee’s Hanbook
2. Mentoring Team Tools
3. Creating a mentoring dashboard for Quality Improvement
4. Use of mentoring M&E tools – timeline
5. Preparing a Knowledge Assessment
6. Tips on writing MCQs
Mentoring – Monitoring Tools

- Anonymous when captured into DB / reported on
- Used for individual purpose (certificate)
- Can contribute to proxy indicators in availability of services

Mentorship Agreement:
The success of a mentoring programme depends significantly on the quality of the relationship between the mentor and mentee. The foundations for this relationship are therefore agreed upon during the opening phase, and formalized through the agreement.

Pre/post-training evaluation (of knowledge). Test performed at the beginning and end of the programme, aligned with the objectives. (MCQs, script convergence questions...)

Attendance as basic evaluation of mentees’ commitment to the programme

Mentoring observation grid enables the mentor to measure the mentee’s ability to apply his/her knowledge to real working situations (competence).
- Initial evaluation at the beginning (baseline)
- + review regularly after training & mentoring

Assessment of the relationship:
Planning a mid-term interview is recommended to evaluate the progress made and set objectives for the period to come, both in the area of meeting the learning objectives and in the relationship between the mentor and mentee. The final evaluation taken as feedback for improving future activities.

NB: it relies on empowerment of mentees from the beginning of the program.
Mentoring – Monitoring Tools (2)

• Mostly for HR development purposes
• Not meant to be captures individually or systematically (minutes from team meetings should suffice)

Mentor self-evaluation to help mentors take a critical look at their own practices – identifying areas for change and improvement. Used to prepare mentors’ meetings. (Its use will decrease over time in an experienced team)

Mentorship – Monitoring Tools (2)

• @ facility-level = process indicators (direct ‘impact’ of capacity-building)
• @ patient level = outcome indicators (indirect ‘impact’)

Impact

Programmatic Indicators connecting the objectives of the mentoring programme and their contribution to the operational objectives of the project. It is quality-improvement activity of its own that evaluates the whole partnership.

At Facility level = PROCESS INDICATORS

- Availability of services
- Good quality services
- Free through MoH

On patients’ Health = OUTCOME INDICATORS

- Patients are detected
- Started on treatment
- Adequate monitoring
- Retained into care

Evaluation & Safe learning environment

Mentees who feel constantly under hierarchical supervision often tend to remain silent about their perceived weaknesses, which are areas for improvement.

Mentees in a healthy, supportive mentoring relationship tend to be more confident. They more openly show their strengths and ‘weaknesses’. They display better understanding of the purpose of their medical training.
Mentoring Dashboard for Quality Improvement

**PROCESS INDICATORS** depict performance of a facility in providing good quality (decentralized, free...) services. Intuitively, process indicators would depend more directly on mentoring activities (mostly related to providers’ activities)

**Availability**
- Clinicians & PS &...
- are trained
- No absenteeism
- Triage with (NCD / TB) screening is implemented
- Lab tests are available

**Good Quality**
- Mentees reach satisfactory level / performance
- Adequate drugs are prescribed
- Lab tests results are acted upon

**Through MoH**
- No staff under MSF incentive
- No medication stock-out
- Supply of pharmacy & lab taken over by MoH

**OUTCOME INDICATORS** are the most relevant when assessing if a projects reaches its objective when measured through routinely collected data. The impact of the mentoring programme on outcome indicators is more **indirect** (depend on patients accessing the services, their adherence to the care ...)

**4. Reporting Timeline**

**MSF / Project timeline**
- **MSF**
- **Project timeline**
- **Quarterly Reports**
  - Feedback to stakeholders (facilities and other MoH / partners, MSF)
  - On implementation progress & community Health outcomes **DASHBOARDS**
- **Closing of Cycle**
  - Feedback from & to stakeholders (facilities and other MoH / partners, MSF)
  - On individual learning achievements, implementation progress & community Health outcomes
  - **CERTIFICATES & DASHBOARDS**

**Partner’s timeline**
- **End of Module 1**
- **End of Cycle 1**

**REPORTING**

All individual ‘indicators’ should remain as confidential as possible i.e. not included in any facility performance evaluation.

For programmatic use, they can be collated in a database (e.g. coded). It can then be used in its aggregated form to show trends.

**2. Choose Indicators to be shared with Partners**

**3. Choose Reporting Format**

**LogFrame**
- **MSF-only**
- **Annual report?**

**Dashboard**
- Relevant indicators for facility
- Print facility-centered one to show evolution
- Debrief on comparative achievements quarterly

**Alternative (visually- / user-friendly) formats**
- In order to aggregate data (confidentiality)
- For quarterly debriefing
- Consider if relevant
Use of M&E tools - timeline

**Module 0 OPENING**

- Pre-test knowledge
- Initial evaluation of competencies
- Mentee logbook

**Thematic week 1**

- Training session 1
  - Presentation 1
- Mentoring at work
  - Observation 1

**Thematic week 2**

- Training session 2
  - Presentation 2
- Mentoring at work
  - Observation 2

**Thematic week 12**

- Patient file review

**CLOSURE process**

- Final evaluation of competencies

**Technical training**

**M&E Mentee competencies**

- Initial agreement
  - Mentor/mentee
- Attendance form
  - presence/absence
- Attendance form
  - presence/absence
- Intermediate feedback form
  - Mentor/Mentee

**M&E Inter-personal relationships**

- ToT mentoring
  - Mentors
- Logbook
  - Mentor
- Weekly follow-up meeting
  - Mentors
- Self-evaluation
  - Mentors

**Mentors SUPPORT**

- Initial joint clinic needs assessment
  - MSF/MoH clinic
- Key indicators - project logframe

**M&E Impact on project outcomes**

- Registers
- Sitrep
- Project dashboard

- Final joint clinic evaluation
- Final feedback form
  - Mentor/Mentee
  - Final

- Conclusion
  - Recommendations
  - Mentors

- Post test knowledge

- eg SAMU HIV/TB (5d)
Preparing meaningful pre- & post-tests (Knowledge Assessment)

- Assessments can be summative and/or formative
- Content of assessment reflects learning objectives

Define assessment needs
- Step 1: Review training learning objectives
- Step 2: Consider learner characteristics
- Step 3: Differentiate content for Basic Sciences and Clinical MCQ items

MCQs

**Merits**
- Versatile tool, can assess:
  - Prompted factual recall
  - Comprehension of text/graphics/data
  - Analysis/Deductive reasoning
- Time and cost effective
- Test important domains
- Tough testing in a safe environment
- Excellent sampling

**Limits**
- Cannot assess effectively:
  - Unprompted recall
  - Organization of thoughts/work
  - Articulate explanation/opinion

MCQs

**Alternative Question Formats (to MCQs)**
- Extended matching items
- Short Answer Questions
- Script-Concordance Items
- Structured essays

Why & When to Test?

- **Prior to training**
  - Baseline to show improvement (M&E)
  - Learning needs

- **Post-training (= summative)**
  - Have the trainees reached minimum standards?
  - Have trainees progressed thanks to training? (from pre-test, provided it is the same test)

- **Test-enhanced learning (= formative)**
  - Retrieval improves storage strength, enhancing overall memory
  - If stakes are low

Script Convergence items

Good to assess clinical reasoning
Tips on Multiple Choices Questionnaires

MCQs
✓ Can assess more than simple recall if based on cases
✓ Are more effective if well constructed

**Stem**
- Provide only meaningful & relevant information
- Use clear and concise language
- Give bare details and do not summarize
- Avoid using negatives (e.g., not, never…)

**Question**
- Write a question for the one-best-answer (e.g. which is abnormal /most likely?)
- Do NOT use incomplete statements or opinions
- Be specific
- Confirm answer to lead-in can be found from stem
- Avoid frequency terms (usually, often)

**Options**
- Write the key (the one best answer) first
- Provide only plausible & significantly different distracters
- Use common student errors
- Avoid obvious wrong options
- Keep option length the same

‘Good’ = plausible
- CM = common student mistakes, a recurrent misconception about topic
- TG = too general option, that is too broad to answer the question
- TS = too specific option, option focuses on one detail in stem
- OT = off topic, option misses the answer completely

‘Bad’
- Same information is repeated in all the options
- Negative options (not, never, none, only)
- Tedious text copied incorrectly from text that seems familiar, but is wrong
- “All” or “none” of the above