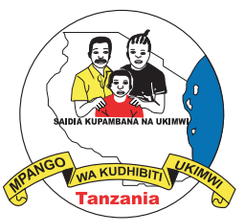
THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

A MANUAL FOR COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING ON HIV AND AIDS HEALTH SERVICES



NATIONAL AIDS CONTROL PROGRAMME (NACP)
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Preface

Supportive supervision is recognised as critical part of human resource management for the delivery of quality health care services. It is especially important for HIV and AIDS related health services, as the scope and the coverage of the services are rapidly expanding. In addition, health care workers are being asked to take on new and complex roles at a rapid pace, while continuing to provide the comprehensive health care services to the populations they serve. Furthermore, there are numerous new interventions for HIV and AIDS prevention, that need to be integrated into ongoing general health service. The new interventions include, HIV Testing and Counselling (HTC), Prevention of Mother to Child Transmission (PMTCT), Home-based Care, management of Opportunistic Infections (OI), Anti-retroviral Therapy (ART), Syndromic Management of Sexually Transmitted Infections (STIs), laboratory tests for HIV diagnosis and monitoring patient on ART, OI diagnosis and, management of Tuberculosis and HIV co-infection, medical male circumcision for HIV prevention. In this regard, the importance of supportive supervision and mentoring at all levels, cannot be overemphasised for the delivery of quality HIV and AIDS health services.

With the Health Sector Reform, the management of health care services in Tanzania, has been decentralised from the central to the regional and district levels. Supervision is supposed to take place at all levels i.e. the national, regional, council and health facility levels.

Supervision from the central level has been conducted by programme leaders and partners in a vertical manner, based on the interventions being implemented. This has resulted into a wide variation between one partner and another, from region to region and district to district. Furthermore, supportive supervision for ensuring the quality of HIV and AIDS health services, has been a challenge due to limited implementation capacity. Mentorship is a system of practical training and consultation, that fosters the ongoing professional development in order to yield sustainable high-quality clinical care outcomes. It should be recognised as part of the continuum education, that is required to create competent health care providers. In Tanzania, however, it is still a new concept and implemented by a few partner organisations, with limited capacity.

Both supportive supervision and mentoring are complementary activities, that are both necessary to build a continuum of care and support. World Health Organisation (WHO) recommends that, the two activities shall be conducted by different teams in a synergetic manner.

As HIV and AIDS health services in Tanzania are decentralised to district hospitals, health centres and dispensaries, supervisors need to take up expanded roles and responsibilities. At the same time, skilful and experienced practitioners at national and regional levels, need to be capacitated as mentors to provide clinical/technical support to less skilled health practitioners, to ensure that quality services are provided at facility level.

This manual is therefore a milestone for the MOHSW, for improving the supervision and setting up of the national mentoring system and standardising the two activities. The manual accompanied with appropriate tools is for use by managers, programmers, implementers and evaluators of supportive supervision and mentoring system. The manual can be also used by health service providers to self-assess their services. The manual could be also a reference material for pre-service and in-service training. It complements the National Supportive Supervision Guidelines for Quality Health Care Services (MOHSW, 2008), the National Guidelines for Quality Improvement of HIV and

AIDS Services (MOHSW, 2009) and the National Essential Health Sector HIV and AIDS Interventions Package (MOHSW, 2010), and other standard operating procedures, that have been produced and disseminated by the MOHSW.

The manual addresses key HIV and AIDS health services. It should be recognised as a "living document", that needs to be reviewed and revised as challenges and new approaches/interventions are emerging continuously in the field of HIV and AIDS. I therefore urge all users of the manual, to provide a feedback, to address the emerging needs and to further improve the current version.

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Acknowledgments

Development of the Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services, had two phases. The first phase was, a situation analysis for the supportive supervision and mentoring in HIV and AIDS health services, and the second one was, the development and pre-test of the manual and the tools. This manual with accompanied tools, is a product of the collaborative efforts of many individuals and organisations.

The Ministry of Health and Social Welfare (MOHSW), would like to express its sincere and profound appreciation, to the Japan International Cooperation Agency (JICA), for the generous financial and technical support. The appreciation also goes to the World Health Organisation (WHO) and the Centre for Disease Control (CDC) for their financial and technical contributions.

The process of drafting this manual, was facilitated by a team of consultants from I-TECH, that included Dr. F. M. Magari and Mr. T. Charles. The Ministry commends them for a job well-done.

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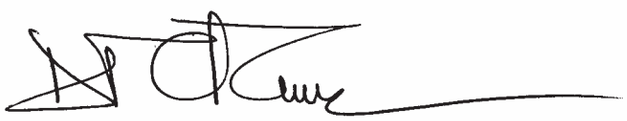
Finally, as it is not possible to mention by name, all those who contributed to development of this manual, I wish to acknowledge the contribution in one way or another of every expert who participated in the entire process of preparing the manual and its tools.



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Acronyms

A&B	Abstinence and Being Faithful
AIDS	Acquired Immunodeficiency Syndrome
AMO	Assistant Medical Officer
ART	Antiretroviral Therapy
ARVs	Antiretroviral drugs
BCC	Behaviour Change Communication
CBO	Community Based Organization
CCHP	Comprehensive Council Health Plan
CDC	Center for Disease Control and Prevention
CHMT	Council Health Management Teams
CTC	Care and Treatment Clinic
DACC	District AIDS Control Coordinator
DED	District Executive Director
DMO	District Medical Officer
DNA PCR	Deoxyribonucleic Acid Polymerase Chain Reaction
DRCHCo	District Reproductive and Child Health Coordinator
EGPAF	Elizabeth Glazier Paediatric AIDS Foundation
EID	Early Infant Diagnosis
FBO	Faith Based Organization
FEFO	First Expired First Out
FHI	Family Health International
FP	Family Planning
HBC	Home Based Care
HCWs	Health Care Workers
HF	Health Facility
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
ICAP	International Centre for AIDS Care and Treatment Program
IEC	Information, Education and Communication
IMAI	Integrated Management of Adult and Adolescent Illness
IPT	Isoniazid Preventive Therapy
I-TECH	International Training & Education Center on Health
ITN	Insecticide Treated Net
JICA	Japan International Cooperation Agency
MCH	Maternal and Child Health
MO	Medical Officer
MOHSW	Ministry of Health and Social Welfare

M&E	Monitoring and Evaluation
NACP	National AIDS Control Programme
NEHSHIP	National Essential Health Sector HIV and AIDS Interventions Package
NGO	Non Governmental Organization
NMSF	National Multi-Sectoral Strategic Framework for HIV/AIDS
OIs	Opportunistic infections
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPP	Public – Private Partnership
QA	Quality Assurance
QI	Quality Improvement
RACC	Regional AIDS Control Coordinator
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RRCHCo	Regional Reproductive and Child Health Coordinator
RTIs	Reproductive Tract Infections
SOC	Standards of Care
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TB/HIV	Tuberculosis and HIV Co-infection
TFDA	Tanzania Food and Drug Authority
THIS	Tanzania HIV and AIDS Indicator Survey
THMIS	Tanzania HIV AND AIDS and Malaria Indicator Survey
UNAIDS	United Nations Joint AIDS Programme
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
VHWs	Village Health Workers
WHO	World Health Organization
ZHRCs	Zonal Health Resource Centres

Chapter 1: Background

1.1 HIV Epidemic in Tanzania

Since the first cases of Acquired Immunodeficiency Syndrome (AIDS) in Tanzania were reported in 1983, AIDS has evolved into an epidemic. The mainland Tanzania faces a generalized human immunodeficiency virus (HIV) and AIDS epidemic, with an estimated 5.8% of the mainland population aged 15-49 infected with HIV. The prevalence is higher among women than men (6.8 and 4.7%), according to the 2007-08 Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS). Compared with HIV prevalence data from the 2003-04 Tanzania HIV Indicator Survey, there has been a slight decrease (one percentage point) in overall prevalence of HIV among adults from 7 % in 2003-04.

It is particularly encouraging to note that the decline in HIV infection among the youth aged 15-19 was from 2 percent in 2003-04 to 1 percent in 2007-08. There are large variations in HIV prevalence by region. The highest HIV prevalence rate is found in Iringa region (15.7%), followed by Dar es Salaam (9.3%) and Mbeya (9.2%). Regions on the Mainland with the lowest HIV prevalence are Arusha, Kigoma, Kilimanjaro and Manyara (less than 2 % each). There continues to be a significant difference in the prevalence among urban and rural areas of the Mainland, 9.1% and 4.8% respectively.

According to HIV/AIDS/STI Surveillance Report No.21 (MOHSW, 2009), overall, 1.4 million Tanzanians (1,300,000 adults and 110,000 children) are living with HIV infection, in a total population of 41 million. The social, economic, and environmental impact of the pandemic is sorely felt as an estimated 140,000 Tanzanians have perished, leaving behind as estimated 2.5 million orphans and vulnerable children, representing approximately 10-12% of all Tanzanian children. Close to 85% of HIV transmission in Tanzania occurs through heterosexual contacts, less than 6% through mother-to-child transmission, and less than 1% through blood transfusion.

1.2 National Response to the HIV Epidemic

Between 1986 and 2002, the National Response was coordinated through successive short and medium term plans under the leadership of the National AIDS Control Programme (NACP) of the Ministry of Health. In 2001, an Act of Parliament established the Tanzanian Commission for AIDS (TACAIDS) to lead the multi-sectoral national response under the Prime Minister's Office. In November of the same year, the National Policy on HIV/AIDS was developed and approved by the Parliament. In January 2003, the National Multi-Sectoral Strategic Framework for HIV/AIDS (NMSF) was approved.

The Care and Treatment Plan was developed in 2003 and subsequently approved in 2004. With funding mainly from the Government of Tanzania, the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR), HIV care and treatment services have been rolled out to 700,000 patients out of whom 300,000 are on antiretroviral therapy (ART) as of March 2010. This can be attributed to the increased access to ART, HIV testing and counselling (HTC), prevention of mother to child transmission (PMTCT) services and the impact of the National Testing Campaign in 2007.

Various documents such as NMSF, Health Sector HIV and AIDS Strategic Plan (HSHSP), in addition to aligning with the National Vision and Strategies also aligned with international commitments and goals. These include the Millennium Development Goals (MDGs)[1] which, among things, focused on combating HIV/AIDS by 2015; the United Nations General Assembly Special Session

[1] The Millennium Development Goals are a United Nations initiative where heads of state promised "eradicate poverty, promote human dignity and equality and achieve peace, democracy and environmental sustainability at the beginning of the millennium." In order to achieve this, eight MDGS were developed for 2015 including the "combating of HIV/AIDS and other diseases".

(UNGASS)[2] Declaration of commitment and the recognition of the basic right of comprehensive HIV prevention, care, treatment and support services to all who need it. This was reinforced by the UNAIDS 'brainchild' of Universal Access[3] to comprehensive Prevention, Care, Treatment and Support Services by setting what later turned to be ambitious target of all by end of 2010. The target is far from being met but periodic reviews and reports keep countries focused.

1.3 HIV and AIDS Interventions

The National Essential Health Sector HIV and AIDS Interventions Package (NEHSHIP) describes all HIV and AIDS interventions, services and activities to be provided at all levels of the health care system in Tanzania. The interventions fall into the three categories as follows:

a) Prevention of HIV Transmission
Prevention of Mother to Child Transmission (PMTCT), Sexually Transmitted Infections (STI) and Reproductive Tract Infections (RTI), Male Circumcision, Safe Blood, Workplace Interventions, Youth Friendly services and Positive Prevention.

b) HIV Treatment, Care and Support
Antiretroviral Therapy (ART), Tuberculosis (TB)/HIV collaborative and Community and Home Based Care (HBC) services.

c) Cross Cutting Services
Diagnostic (laboratory and imaging), Pharmaceutical services, HIV Testing and Counselling (HTC: Voluntary or Client and Provider Initiated, Home Based testing), Stigma and Discrimination reduction, Condom programming and Nutrition support and Information, Education and Communication (IEC)/Behaviour Change Communication.

In this document, however, the focus is on the following key interventions/services including their Monitoring and Evaluation (M&E) and IEC components: PMTCT, STIs/RTIs, ART, TB/HIV, HBC, laboratory and pharmaceutical services and HTC.

1.4 Health Care Delivery System in Tanzania

The Mainland Tanzania is divided into 21 administrative regions and 113 districts with 133 Councils. There are a total of 10,342 villages (MOHSW, 2009). Tanzania has adapted a decentralized system of Government including health services. Figure 1 depicts the structure of the health care system organized in a pyramidal pattern as per experts' recommendations way back in 1993.

According to the structure, a dispensary is the lowest formal health system structure, caters for 6,000 to 10,000 people and may serve one or more villages. Service provision is limited to managing common illnesses as outpatients on one hand and health preventive/ promotion services on the other. Currently there are 4,679 dispensaries.

A health centre, on the other hand, caters for approximately 50,000-100,000 people residing in one administrative division. Apart from the outpatient and preventive/promotion services, a health centre also provides inpatient services with 24 beds medical ward for female and male, obstetrics theatre and diagnostic services.

Each administrative district is served by a district hospital. There are 55 public owned district hospitals and 13 Faith Based Organizations (FBO) owned designated district hospitals and 86 other hospitals at first referral level (owned by Government, parastatal and private sector). District hospitals

[2] UNGASS is the United Nations General Assembly Special Session on HIV/AIDS. Biannually, Tanzania reports to UNGASS on a series on indicators to show progress in reaching the agreed goals.

[3] Universal Access is the new UNAIDS theme of ensuring everyone who needs to access services related to HIV and AIDS across the themes of prevention, care and treatment and impact mitigation.

form an integral part of the PHC system. They provide clinical services to inpatients and outpatients referred from primary health facilities and other hospitals within the district. District hospitals may differ in size and bed capacity but are generally capable of managing common medical, obstetric, paediatric and surgical emergencies.

Regional Hospitals are designated health facilities, forming the secondary referral level in the pyramid. There are 18 regional hospitals providing specialized clinical services which are better equipped and staffed (have one or more specialist doctors). Plans are underway to ensure that all regions have specialists in the major clinical disciplines: surgery, medicine, obstetrics and gynaecology, and paediatrics.

Referral Hospitals are tertiary-level multi-specialist hospitals. There are four hospitals i.e. Muhimbili National Hospital (MNH) and Mbeya, Bugando and Kilimanjaro Christian Medical Centre (KCMC) referral/consultant hospitals. Of the four, the MNH offers services of a wider range much more specialized. Patients who may not be adequately managed at these hospitals are referred outside Tanzania.

Specialized hospitals offer specialist services of one kind: MOI for orthopaedics and traumatology, ORCI for cancer, Mirembe for mental health and Kibong'oto for tuberculosis.

The MOHSW is gearing itself to improving staffing and the health system in general as a way of improving access and quality. Primary Health Services Development Programme (MOHSW, 2007) was developed to accelerate the provision of primary health care services for all by 2012. The main areas of focus are on strengthening the health systems, rehabilitation, human resource development, the referral system, increase health sector financing and improve the provision of medicines, equipment and supplies. Through this programme each village in the country will have a dispensary and each ward a health centre. The implementation of this ambitious programme has already started.

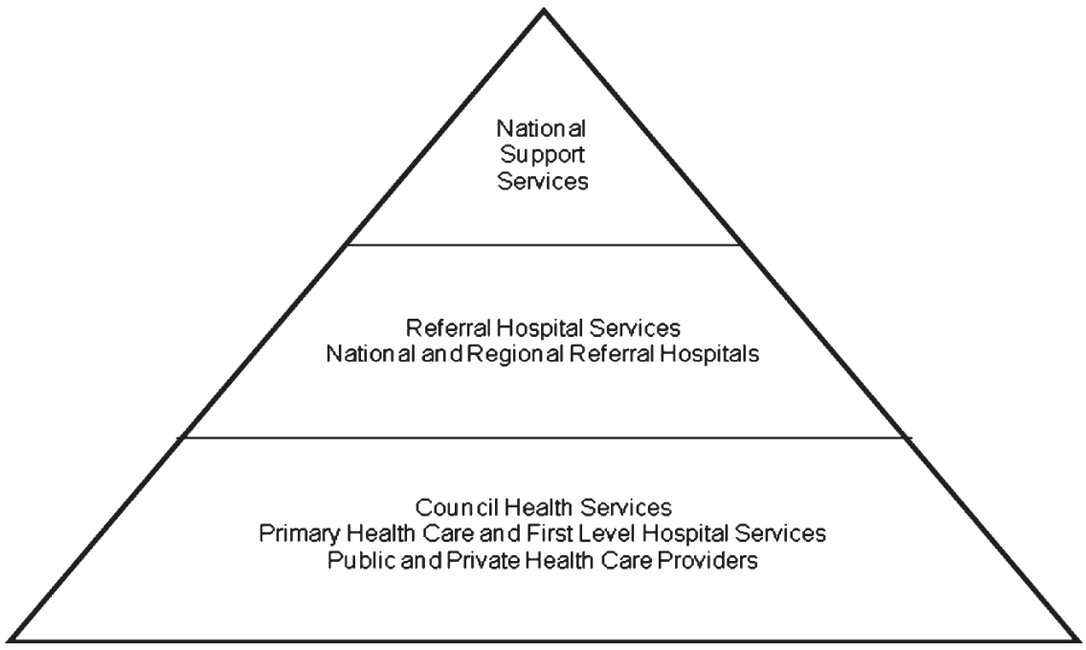

Figure 1. Health Services Structure in Tanzania (MOHSW, 2009)

1.5 Situation Analysis of Supportive Supervision and Mentoring in Tanzania

The National AIDS Control Programme (NACP) with the support of Japan International Cooperation Agency (JICA) and International Training & Education Center on Health (I-TECH) conducted a situation analysis on supportive supervision and mentoring in Tanzania between June and August, 2009 (MOHSW, 2009). The overall objective was to assess the status of supportive supervision and mentoring activities with respect to HIV and AIDS health services at all levels. Information on supportive supervision and mentoring was collected from the national, regional, district and health facility levels. The study population included programme managers, focal persons for HIV and AIDS interventions and partners at national, regional, district and facility levels. Four regions were selected by NACP based on the reporting rates of HIV Care and Treatment and Voluntary Counselling and Testing (VCT) services. These were Mtwara, Iringa, Kigoma and Manyara. In addition, data was collected from corresponding referral hospitals i.e. Muhimbili National Hospital and Mbeya Referral Hospital. Rombo and Monduli districts in Kilimanjaro and Arusha regions respectively were included in the study because of their experience in implementing mentoring activities.

1.5.1 Summary of Findings:

The findings are grouped into providers, tools and documents, implementation capacity of supervisors and mentors, knowledge and perception of health care workers, achievements, challenges and key recommendations.

Actors currently involved in supportive supervision and mentoring of HIV and AIDS health services:
At the national level supportive supervision is vertically provided by programme administrators and partners while at the regional and district levels, it is done by Regional Health Management Teams (RHMTs), Council Health Management Teams (CHMTs) and focal persons of HIV related health services. A formal mentoring programme is not yet in place but some care and treatment partners such as EGPAF, AIDS Relief and ICAP have taken the initiative to provide mentoring services in their respective regions. There are not clear guidelines on supervision such as frequency, tasks to be accomplished and mechanisms for follow up on recommendations. Actual practice varies from one HIV intervention to another and from one implementing partner to the other. Similarly, mentoring practice lacked clear guidance.

Tools and documents used in supportive supervision and mentoring:
Differences were observed in tools/checklists and documents used in supportive supervision and mentoring. Some Programme staff, RHMTs, CHMTs and Partners adopted the national supportive supervision checklists while others made modifications of checklists to suit their needs.

***Implementation capacity of supervisors and mentors*:**
Although some partners in Kigoma and Mtwara were providing 'some' supervision-related training, most of the supervisors had not been formally trained nor were NACP staff. In the case of clinical mentoring, ICAP and EGPAF took initiatives to prepare the clinical mentors. In fact, EGPAF has a 5-day district clinical mentors training package.

Knowledge and perception of supervisees and mentees on prior supportive supervision and mentoring:
Very few Health Care Workers (HCWs) stated that supportive supervision involved transfer of knowledge (18.8%), motivation (8.0%), performance feedback (23.2%) and sharing new development (18.8%). The majority of supervisees interviewed (83.9%) however perceived that supportive supervision will be helpful in building their capacity, motivating and improving their confidence. At Rombo, where EGPAF has been providing support in clinical mentoring for a considerable period of time, Care and Treatment Clinic (CTC) - based HCWs reported that mentoring helped them acquire knowledge and build their skills and confidence to improve their clinical practice.

Achievements in supportive supervision and mentoring:
Achievements reported by the HIV and AIDS leads in supportive supervision include timely reporting, improved supplies management, improved patient management and partners' adherence to national HIV guidelines. HCWs reported improvements in VCT services, filling of registers, availability of supplies and report writing. In addition, HCWs from Rombo and Iringa reported improved clinical performance due to mentoring. It was also stated by the district mentors that clinical mentoring led to reduced referral of patients and facilitated the initiation of ART in children at lower level facilities.

Challenges in providing supportive supervision and mentoring:
Some of the challenges included:

- Lack of a standardized approach to supportive supervision and mentoring,
- Lack of adequate and reliable financial resources,
- Lack of guidelines on mentoring,
- Shortage of human, financial and time resources,
- Lack of technical skills and work overload among HCWs, and
- Vertical, uncoordinated intervention-specific supervisory activities.

1.5.2 Key Recommendations:

The key recommendations included:

- Develop a national manual and tools on comprehensive supportive supervision and mentoring to guide implementation of supportive supervision and mentoring to cover all HIV and AIDS health services at all levels of the entire health care delivery system;
- Adopt effective comprehensive supportive supervision and mentoring approaches and establish supervisory and mentoring teams at national, regional and district levels;
- Develop a standardised national training package on supportive supervision and mentoring for HIV and AIDS health services;
- Institute a long-term capacity development programme for practicing supervisors and mentors and newly recruited HCWs through formal and on-the-job training. To facilitate this, there is a need for a standardised training package for mentors and supervisors;
- Ensure the sustainability of supervisory and mentoring activities by advocating for the activities to be planned (and budgeted for) at all levels of the health care delivery system. The two key ministries (PMORALG and MOHSW) should take the lead;
- Continually pursue innovative ways (e.g. MMAM) to address the HRH crisis;
- Put in place a quality improvement (QI) system in line with the national guidelines;
- Introduce an efficient and regular monitoring and evaluation system for supervision and mentoring activities; and
- Document and share good practices with various stakeholders at various forums (in- and out of the country).

NB: The full version of the Situational Analysis Report on Supportive Supervision and Mentoring in Tanzania is available at the NACP website.

Chapter 2: Introduction to the Manual

2.1 Rationale

Reviews of intervention studies in low and middle income countries suggest that the simple dissemination of written guidelines is often ineffective, that formal and informal training, supervision and audit with feedback is generally effective, and that multifaceted interventions might be more effective than single interventions although few interventions have been evaluated with rigorous cost-effectiveness trials. For decades it was assumed that poor performance was simply due to lack of knowledge and skills. As a result, most interventions concentrated on training, which has had mixed and sometimes disappointing long-term results. We need to go beyond the old paradigm that most performance problems can be solved by training alone.

Supervision as an intervention deserves special attention due to the following reasons: 1) It can improve performance, at least in the short term; 2) If correctly done, it could be a mechanism for providing professional development, improving health workers' job satisfaction, and increasing motivation; 3) Although often dysfunctional, supervision systems are ubiquitous; 4) With decentralisation, district supervisors are increasingly the only human contact between health workers in remote villages and the rest of the formal health system; 5) Most policymakers and managers already think supportive supervision is valuable (Rome A.K. et al., 2005). The main challenges for supervision are improving quality, increasing the time supervisors actually spend with health workers, and measuring its cost-effectiveness. These challenges, however, are large. Too often supervisors lack skills, useful tools and transportation and are burdened with administrative duties.

In the area of HIV and AIDS, rapid increase of patients in need of comprehensive HIV services in the early 2000s was the major driving force behind the re-focus of major global and local priorities. The UNGASS Declaration of Commitment that advocated and established targets for each member country for provision of HIV quality and comprehensive prevention, care, treatment and support services to all who need the services came into being in October 2001.

The Ministry of Health and Social Welfare (MOHSW) was not far behind the global agendas as the first National Care and Treatment Plan was operational by 2004 with a major focus on expanding HIV Care and Treatment services to meet the ever rising demand. Since then, many health care workers (HCWs) were trained in HIV and AIDS interventions such as HTC, PMTCT, Home-based Care, management of Opportunistic Infections (OIs), ART, Syndromic Management of STIs, laboratory tests for HIV diagnosis, OI diagnosis and monitoring patient on ART, management of Tuberculosis and HIV co-infection. All these HIV and AIDS health services require to be integrated into ongoing health service delivery. HCWs have been asked to take on new and complex roles at a rapid pace while continuing to provide the comprehensive health care services to the populations they serve.

Strengthening supportive supervision with introduction of mentoring therefore are gaining more recognition than ever as critical part of human resource management for the delivery of quality health care services especially in HIV and AIDS. In this regard, comprehensive supportive supervision combined with mentorship programme for both administrative and technical support to health facilities at all levels shall be established for delivery of quality HIV and AIDS health services.

However, in Tanzania, supervision has generally been erratic, vertical and unlinked. Supervisors have limited capacity to comprehensively cover both technical and administrative issues while mentoring is quite a new concept and practiced by only a few partner organizations for HIV care and treatment services with limited coverage. Therefore, performance- and resource-related problems at the health facilities remain unsolved.

Supportive supervision and mentoring are supposed to be complementary activities that are both necessary to build a continuum of care and support. Supervisors need to have comprehensive managerial and administrative knowledge and skills while mentors need to be practitioners and experienced in a specific service/intervention area.

The primary driving force that motivated the MOHSW/NACP to develop a manual and tools for comprehensive supportive supervision and mentoring was therefore as follows: 1) rapid scale up of HIV prevention, care, treatment and support services; 2) challenges of providing comprehensive and quality services; 3) critical shortage of skilled and experienced HCWs; 4) task-shift of specialized and highly technical care of HIV patients to lower cadre of HCWs. A standardized way of conducting and developing capacity in comprehensive supportive supervision and mentoring, which is appropriate and applicable in a resource-constrained setting like Tanzania, has become a critical need.

2.2 Purpose of the Manual

The purpose of this manual is to standardize the approach to supportive supervision and mentoring process and activities in HIV and AIDS health services. This manual will complement the National Supportive Supervision Guidelines for Quality Health Care Services (MOHSW, 2008), the National Guidelines for Quality Improvement of HIV and AIDS Services (MOHSW, 2009) and the National Essential Health Sector HIV and AIDS Interventions Package (MOHSW, 2010), as well as intervention specific guidelines and Standard Operating Procedures (SOPs).

2.3 Objectives

The objectives of this manual are to:

- Provide a standardized definition of supportive supervision and mentoring;
- Provide a rationale for a standardized approach to comprehensive supportive supervision and mentoring in Tanzania;
- Provide guidance on planning and implementation of comprehensive supportive supervision and mentoring activities for HIV and AIDS health services; and
- Provide strategies for bringing about synergy between supportive supervision and mentoring activities.

2.4 Target Audience of the Manual

The target audience of this manual includes:

1) Programme managers, administrators from public and private sectors and partners who implement HIV and AIDS health services in Tanzania;
2) Supervisors and mentors who are responsible for HIV and AIDS health services at national, regional, council and health facility levels; and
3) Trainers who provide in-service and pre-service training to health care workers.

Chapter 3: Concept of Supportive Supervision and Mentoring

3.1 Overview of Supportive Supervision

By definition, supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, optimizing the allocation of resources, promoting high standards, team work and better two-way communication (Marquez and Kean 2002). The MOHSW supportive supervision guidelines similarly describe supportive supervision as a "process which promotes quality outcomes by strengthening communication, identifying and solving problem, facilitating team work, and providing leadership and support to empower health providers to monitor and improve their own performance." Supportive supervision involves directing and supporting health care workers in order to enhance their skills, knowledge and abilities with the goal of improving health outcomes for the patients they manage. It is an ongoing relationship between health care workers and their supervisors.

Some of the benefits of supportive supervision as described in the MOHSW supportive supervision guideline draft (2008) include: helping service providers to achieve work objectives by improving their performance, ensuring uniformity to set standards, identifying problems and solving them in a timely manner, making a follow-up on decisions reached during previous supervision visit, identifying staff needs and providing opportunities for personal development and reinforcing administrative and technical link between high and lower levels

3.2 Traditional Supervision vs. Supportive Supervision

Although the traditional approach to doing supervisory visits is effective to some extent, it also has several shortcomings. For example, the supervisors leaned more towards facility inspection rather than guidance for problem-solving to improve performance. Supportive supervision promotes sustainable and efficient programme management through interactive communication, as well as performance planning and monitoring. Table 1 below highlights some of the differences between traditional supervision and supportive supervision.

Table 1: Comparison of Traditional and Supportive Supervision (Adapted from Marquez and Kean, 2002)

Action	Traditional supervision	Supportive supervision
Who performs supervision	External supervisors designated by the service delivery organization	External supervisors designated by the service delivery organization; staff from other facilities; colleagues from the same facility (internal supervision); facility health committee; community health committees; staff themselves through self-assessment
When supervision happens	During periodic visits by external supervisors	Continuously: during routine work; team meetings; and visits by external supervisors

What happens during supervision encounters	Inspection of facility; review of records and supplies; supervisor makes most of the decisions; reactive problem-solving by supervisor; little feedback or discussion of supervisor observations	Observation of performance and comparison to standards; provision of corrective and supportive feedback on performance; discussion with clients; provision of technical updates or guidelines; onsite training; use of data and client input to identify opportunities for improvement; joint problem solving; follow-up on previously identified problems
What happens after supervision encounters	No or irregular follow-up	Actions and decisions recorded; ongoing monitoring of weak areas and improvements; follow-up on prior visits and problems

3.3 Overview of Mentoring

Mentoring describes a process conducted by a mentor to a mentee in order to help the mentee to do a job more effectively. Mentoring can be conducted to all interventions but when applied in the clinical setting it is referred to as "clinical" mentoring.

According to the WHO, mentoring is a "system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. Mentors need to be experienced, practising clinicians in their own right, with strong teaching skills" (WHO, 2006).

The WHO further lists the objectives of mentoring as:

- Supporting decentralized delivery of HIV care, antiretroviral therapy and prevention with high-quality care at all levels;
- Supporting the application of classroom learning to clinical care;
- Maintaining and progressively improving the quality of clinical care;
- Building the capacity of first-level health care workers (health centre staff) and second-level health care workers (district hospital staff) to manage unfamiliar or complicated cases such as antiretroviral therapy toxicity, immune reconstitution inflammatory syndrome, complicated HIV/TB cases, treatment of children or pregnant women or referring them when appropriate; and
- Improving the motivation of health care workers by providing effective technical support.

3.4 How Supportive Supervision and Mentoring Overlap

Although supportive supervision and mentoring are two very different approaches, there are areas in which they overlap as indicated in Figure 2.

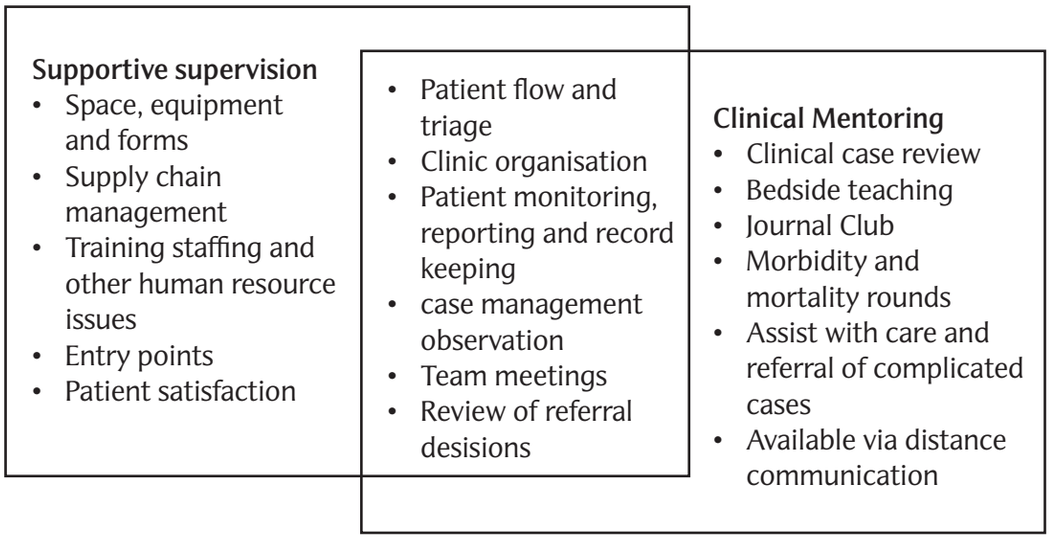

Figure 2: Relationship between Supportive Supervision and Mentoring

Adapted from: WHO Recommendations for Clinical Mentoring to Support Scale-Up of HIV Care, Antiretroviral Therapy and Prevention in Resource-Constrained Settings

While mentoring and supportive supervision have several areas of overlap, each requires different skills and should be undertaken by different, but complementary teams. Whereas mentoring mostly targets individual clinicians or small groups supportive supervision provides an excellent opportunity for follow-up training, to improve overall performance and solve other systemic problems that contribute to poor service delivery. Mentors need to be very experienced and practicing individuals while supportive supervisors can be trained management staff.

At the clinic level, effective patient care requires that both mentors and supervisors monitor clinic activities such as patient flow and triage, clinic organization, patient monitoring, record-keeping, case management, team meetings, and review of referral decisions. As such it is important for these two systems to work together to maximize the effectiveness of each and to avoid duplication of efforts.

Chapter 4: Setting up a National Supportive Supervision System

In order to set up the national supportive supervision system, it is important to define attributes, competencies and training of supervisors as well as resources needed and items to be covered during supervision.

4.1 Attributes of a Supervisor

A supervisor should have the following attributes:

- Familiar with health care system;
- Familiar with the HIV and AIDS health services to be provided at each level of health system, which are stipulated in the National Essential Health Sector Intervention Package;
- Ability to address both administrative and programmatic issues and needs in HIV and AIDS health services;
- Committed, responsible and have strong interpersonal skills;
- Ability to train, motivate and support supervisees; and
- Flexible, respectful and hard working attitude.

4.2 Core Competencies of a Supervisor

As per MOHSW National Supervision Guidelines, the supervisor should have attained the following competencies:

- Conceptual skills: ability to listen, probe and analyze situations, problems and formulate solutions;
- Sufficient knowledge about comprehensive HIV and AIDS health services and health system;
- Ability to coach, train and convey information to others and learn from them;
- Sufficient knowledge of concept of quality improvement (QI) including supportive supervision and mentoring and the use of national guidelines and SOPs:
- Deep understanding of the roles and responsibilities of both supervisors and mentors and align oneself with mentors; and
- Ability to provide and receive feedbacks after each visit and write reports.

4.3 Training of Supervisors

Since HCWs in managerial positions at national, regional, district and facility levels are supervisors by the nature of their positions, they require training in order to make them effective supervisors. Their training should be based on a standardized training curriculum which should cover the following topics:

- Basic concept of quality, quality improvement (QI) and quality assurance (QA);
- Purpose of conducting supportive supervision;
- Key items to be covered during supervision;
- Communication and coaching skills;
- Roles and responsibilities of both supervisors and mentors;

- Practical of conducting supportive supervision including the use of tools, forms, charts and registers used in the HIV and AIDS health services; and
- Monitoring and evaluation of supportive supervision.

4.4 Resources Needed for Supportive Supervision

The main resources required are:

- Reliable transport;
- Adequate time for preparation, travel, field visit, reporting and follow-up activities ;
- Travelling allowances;
- Supportive supervision tools and stationery;
- Supportive supervision manual and the latest HIV intervention guidelines and SOPs;
- Monitoring and Evaluation tools; and
- Support for periodic review meetings.

4.5 Issues/Areas to be covered during Supportive Supervision

Issues/areas to be covered differ depending on the level of supervision. The first list is targeting Regional and Council Health Management Teams (R/CHMTs), the second one is for Zonal Health Resource Centres (ZHRCs) and the third one is for health facilities.

4.5.1 Issues/Areas to be covered during Supportive Supervision to R/CHMTs:

Patient care:

- Coverage of HIV and AIDS health services in a given region or district
- Referral system and linkages to care and support
- Policies, Guidelines, SOPs, Job aids , Manuals and IEC materials
- Quality improvement initiatives, if any.

Health infrastructure:

- Facility and equipment
- Utilities such as water, electricity and communication facilities
- Auditory and visual privacy

Human resources for health:

- Staff adequacy, availability of staff trained
- Training and staff needs
- Short and long term paln

Logistics and resource management:

- Availability and adequacy of medicines, lab reagents and other commodities
- Availability of reliable transport
- Sources and management of funds
- Implementation status of Comprehensive Council Health Plan (CCHP) and regional annual plans

Monitoring and Evaluation:

- Records and documentation system
- Patient records, registers/forms
- Data management

4.5.2 Issues/Areas to be covered during Supportive Supervision to ZHRCs:

- Incorporation of HIV and AIDS trainings and activities in their short, medium and long-term plans;
- Resource mobilization for successful implementation of planned activities;
- HIV and AIDS trainings conducted;
- Availability of and adherence to HIV and AIDS related policies, guidelines, SOPs and training materials; and
- Overall capacity (technical skills, financial and other resources) to support RHMTs, CHMTs and training institutions in their zones.

4.5.3 Issues/Areas to be covered during Supportive Supervision of Health Facilities

For each intervention, specific issues to be addressed during supportive supervision are as follows:

Category 1: Prevention Services

Prevention of Mother to Child Transmission of HIV (PMTCT)

- Availability and utilization of recent PMTCT guidelines and SOPs
- Availability of PMTCT services at Reproductive and Child Health (RCH) clinics
- Coverage of pregnant women tested and given results including their partners
  - Enrolment of all pregnant HIV positive women into CTC within one month of first antenatal visit
  - Availability of efficacious regimen for HIV positive pregnant women and exposed babies
- Adequately equipped labour ward
- Status of HIV positive pregnant women with CD4 test done
  - Provision of Cotrimoxazole prophylaxis to HIV exposed babies from the age of 4 weeks
  - Access to HIV Early Infant Diagnosis (DNA PCR) and transportation of Dried Blood Spot (DBS) samples
- Linkage of HIV-positive women to CTC
- Data management and utilization
- Follow-up on status of HIV exposed babies
- Counselling support for infant feeding
- Male involvement in PMTCT services
- Family planning services
- Availability and use of TB screening tool

Management of STIs/RTIs

- Availability of STI/RTI guidelines and protocols/flow charts for management of STIs/RTIs
- Inventory of staff trained in STI/RTI case management
- Provision of PITC services
- Syphilis screening at ANC during the first visit
- Availability of essential STI/RTI drugs (1st and 2nd line)
- Availability of penile and/or pelvic models and their use
- Condom availability (both male and female)
- Contact tracing
- Availability and use of IEC materials
- Availability of essential equipment and commodities (see annex for checklist)

- Availability of recording and reporting tools for STI/RTI services
- Data Management – recording, analysis, utilization, reporting and record keeping
- Availability of reagents for syphilis screening
- Challenges in providing STI/RTI services in HIV era

Category 2: Treatment, Care and Support Services

HIV Care and Treatment

- Availability and utilization of latest National Guidelines for the management of HIV and AIDS
- Availability of reporting forms and registers
- CD4 testing to all pre-ART and ART patients in every six months
- Adherence assessment of all ART patients at every visit
- All patients on ART return to clinic for follow-up within one month of starting ART
- Cotrimoxazole prophylaxis given to all eligible HIV patients
- Screening for TB among PLHIV
- Provision of Isoniazid Preventive Therapy (IPT) to HIV clients who are free from active TB
- Availability of Post Exposure Prophylaxis for HCWs and community
- Magnitude of missed appointments and loss to follow up
- Magnitude of treatment adverse effects and treatment failure
- Screen for unmet family planning demand and proper referral
- Referrals made to HBC

TB and HIV

- Availability and utilization of TB/HIV guidelines, and protocols
- TB/HIV burden
- Status of HIV testing among patients with TB (DCT)
- Availability and use of national TB screening tool
- Status of TB screening among PLHIV
- Provision of Cotrimoxazole prophylaxis to TB/HIV patients
- Data management and utilization
- Availability of IEC materials specific for TB/HIV
- Referral and linkage of TB/HIV co-infection
- Infection control

Home Based Care

- Availability of palliative care including pain management
- Provision of adherence counselling and support services to patients on ART adherence to medication
- Patients' adherence to schedules of visits to the CTC
- Effectiveness of referral systems i.e. referral of PLHIV to CTC, TB, RCH and Family Planning (FP), and social and legal services
- Availability and use of recording and reporting tools (check the registers/forms for completion and accuracy)
- Positive health, dignity and prevention services such as condoms, Insecticide Treated Nets (ITN), safe water and male circumcision

- Care for the carers – for members of support groups through meetings, training, provision of incentives etc
- PLHIV involvement and participation through membership to support groups, providing services in CTC, compiling lists of contact persons in different health facilities, linking patients to services etc
- Male involvement and participation: their participation in caring for patients, accessing HIV test, in PMTCT in couples testing and counselling and in home/family testing and counselling
- Training of HBC providers – number of trainings conducted in a given period
- Challenges of implementing HBC and how they are addressed

Category 3: Cross Cutting Services

HIV Testing and Counselling

- Availability of VCT and PITC guidelines, SOPs, protocols (including QA protocols) and job aids
- Availability/status of HTC services
- Status and trend of testing and receiving HIV test results among patients
- Status of testing and counselling to couples and under 18 years
- Status of male involvement
- Referral to CTC and other services
- Status of counselling rooms
- Availability of condoms, penile and/or pelvic models and their use
- TB screening in HTC
- Availability of IEC specific for HTC
- Data management

Laboratory Services

- Availability of SOPs, algorithms, Waste Management Manual and Quality Assurance Manual
- Management of laboratory supplies including HIV tests
- Availability of machines and reagents for CD4 Count, Full Blood Picture and Biochemical Analysis
- Availability of biochemistry and haematology equipment and reagents

Pharmaceutical services

- Availability and adequacy of medicines and medical supplies Storage of medicines
- Tracking system (including verification of Expiry date before receiving supplies)
- Record keeping and inventory
- Staffing and training
- Adverse drug reaction reporting

Information, Education and Communication (IEC)

- Availability and use of IEC materials
- IEC materials given to patients/clients
- HCWs trained in Abstinence and Being Faithful (A&B)
- HCWs trained on IEC/Behaviour Change Communication (BCC)
- Availability of guidelines on A&B

- Recording in the Ledger book IEC materials received and distributed
- Display of IEC materials
- Periodic exit interview with patients/clients on IEC materials
- Conducting social/community sensitization meetings
- Locally developed IEC materials

Monitoring and Evaluation (Recording and Reporting)

- Availability and adequacy of recording and reporting tools for each intervention
- Ordering of the tools (Stock of the forms)
- Correctness and completeness of recording - If all the variables in the forms/registers are correctly and completely filled
- Management –How the data forms/registers are filed and stored
- Level specific clarity on recording and reporting and roles and responsibilities
- Data use – level-specific dissemination of reports/data
- Data flow from health facility to national level
- Feedback on data quality, data recording, data backup, reporting and analysis

NB: The list may be reviewed and updated as and when required and other interventions which are not covered in this manual shall be added.

Chapter 5: Structure and Function of the National Supportive Supervision System

This chapter describes the structure of the national supportive supervision system and presents the functions of each of the structural levels at national, regional, district, health facility and community.

5.1 National Level

At the national level, a supportive supervision team for HIV and AIDS health services will be composed of 2-4 members including programme leads, partners and co-opted members trained in comprehensive supportive supervision.

The team will conduct supportive supervision at the regional level, targeting RHMTs, national and referral/special hospitals and ZHRCs. The visits shall be twice a year and each visit will take five working days. From time to time when it is required, the team may also visit a few selected lower level health facilities. Several teams shall be formed and trained to be able to provide the service across the country.

The team shall pay a courtesy call to the Regional Administrative Secretary (RAS) for briefing at the start of the visit and de-briefing at the end of the visit. While at RHMT level, the team reviews progress reports, finance management and implementation of regional annual plans and CCHPs. The team also reviews the activities of the regional Quality Improvement (QI) team and share the debriefing report. In addition, the team reviews reports of supportive supervision to CHMTs.

The team may also accompany the RHMT conducting supportive supervision to one or two selected districts for capacity building of the RHMT.

At national and referral/special hospitals, the team spends at least two days providing supportive supervision to all HIV and AIDS health services in respect to infrastructure, equipment and forms, supply chain management, patient and provider satisfaction, training and staffing and other human resources issues. The team also looks into patient flow and triage, clinic organization, patient monitoring, record-keeping and reporting, team meetings and challenges.

When the team visit a ZHRC, the main interest shall be in looking at availability of National HIV and AIDS documents, their capacity and plan in supporting regions and districts on HIV and AIDS-related trainings and the ability to develop IEC materials to meet local needs.

5.2 Regional Level

Supportive supervision at the regional level shall be conducted by RHMTs and co-opted members and partners. They provide supportive supervision to the regional hospital and CHMTs every quarter. The team shall pay courtesy calls to the District Executive Director (DED) for briefing at the beginning of the visit. The regional team shall also review the activities of the QI team

The RHMT shall conduct supportive supervision to the regional hospital for one day and provide feedback on the next day in areas related to infrastructure, latest guidelines, equipment and forms, supply chain management, patient flow and triage and clinic organization. Other areas include patient satisfaction, patient monitoring, record keeping and reporting, team meetings, linkages,

financial, managerial, training and staffing and other human resources issues and challenges. At the end of the visit, the team shall debrief the Regional Hospital Management Team.

At CHMTs, the regional team will be involved in providing supportive supervision in areas related to supply chain management, HIV-related reports, infrastructure, latest guidelines, equipment and supplies, human resources management, Public – Private Partnership (PPP) implementation, implementation of CCHP and supportive supervision of the CHMT for the implementation of their CCHP especially those related to HIV and AIDS health services.

In addition to supervising CHMT, the team may accompany CHMTs conducting supportive supervision to a few selected health facilities for follow up and capacity building. The regional team is expected to spend about 3-4 days at district level. At the end of the visit, the team will debrief the CHMT and DED.

5.3 District Level

A team of supportive supervision on HIV and AIDS health services at the district level consists of 2-4 members from CHMT and co-opted members, HIV focal persons and partners. The team targets health management teams of District Hospital and other health facilities under the CHMT (hospitals, health centres, dispensaries, pharmacies, and laboratory).

The team shall visit the Ward Executive Officer for a briefing. The team is expected to conduct the visit quarterly and spend a full day especially at the hospital level and at least half a day at health centre and dispensary level.

Since the implementation of many HIV and AIDS health services occurs at this level, the district hospital will require one full day visit. Therefore the supervision team will focus on infrastructure, supply chain management, equipment and supplies and human resources. The team will also concentrate on HIV and AIDS health service delivery in line with national guidelines and SOPs, Public Private Partnership (PPP) implementation, patient flow and triage, clinic organization and team meetings. Other supervision areas will include patient satisfaction, community linkages, patient monitoring and record-keeping and reporting, managerial and financial management.

5.4 Internal Supportive Supervision

Supportive supervision at a health care facility shall be internal in nature and it shall be conducted by the facility health management team members including the in-charges of the health facilities and the QI team, if any. This team is responsible for setting and monitoring quality of care standards and assuring that guidelines and SOPs are disseminated to staff and followed. The team is also responsible for supporting and motivating providers; training and recognition; forming and building teams and promoting team-based approaches to problem-solving; fostering trust and open communication; and collecting and using data for decision-making.

The team shall supervise all relevant units in the facility providing HIV and AIDS health services and all its health care workers. The team shall also discuss and promote the utilization of SOPs and look at infrastructure especially space issues, equipment and forms, supply chain management, patient monitoring and record-keeping and reporting, financial management, and supply chain management. Other areas of interest are human resources, HIV service delivery based on guidelines, patient satisfaction, training needs as well as referral systems and community linkages. The team shall be responsible to make follow-up actions recommended by district supervisors and mentors.

At this level, the team will also supervise inventory, patient flow and triage, clinic organization and team meetings. The health facility in-charge will be responsible to ensure that all agreed action points are implemented.

5.5 Supportive Supervision at the Community Level

The health facility in-charge and the relevant focal persons will ensure that supportive supervision is provided at the community level .This will be conducted on a monthly basis or as need arises. The team will pay a courtesy call to the Village Executive Officer during such a visit.

Community–based health care programmes and workers such as Village Health Workers (VHWs), Peer Educators, and HBC providers will be supervised. Supportive supervision will be on SOPs, equipment and supplies, HIV service delivery based on guidelines, patient satisfaction, training needs, referral systems and community linkages.

Chapter 6: Supportive Supervision Process

This chapter describes supportive supervision process which includes planning, getting started, conducting supportive supervision, giving feedback, wrap up and report writing. It also gives details on the roles and responsibilities of the supervisors at different stages as presented in Table 2.

Table2: Stages and Specific Tasks in Conducting Supportive Supervision

Stages	Tasks to be Performed
Planning stage	• Identify sites/health facilities to be supervised and develop a route plan. • Inform the relevant authorities and supervisees on the dates, team composition, time, objectives of the visit and support needed. • Take note of: o All the vital information about the supervision sites/health facilities such as types of HIV and AIDS health services and the capacity; o All the strengths and limitations regarding the supervision site/ health facility performance in delivery of HIV and AIDS health services; and o Important supervision site/health facility issues, action points already known/reported if any. • Arrange logistics (refer to 4.4). • Organize a preparatory team meeting the preceding day.
Getting started	• Pay a courtesy call to the relevant authority according to the level of supervision (refer to chapter 5). o Introduce yourself and the team o Objectives o Sites to be visited o Debriefing date At the supervision site/ health facility: • Establish rapport - always start by greeting and introducing yourself and the rest of the team to the supervisees; • Tell the in-charge and supervisees the purpose of the visit. Let the supervisees introduce and listen in a relaxed manner but attentive and avoid interruption; • Explain the whole supportive supervision plan e.g. supervisee to be met, time to be spent, feedback session etc.; • Avoid making promises and be honest; and • Use communication skills to encourage active participation.

Conducting supportive supervision	• Show respect and patience throughout the supervisory visit. • Allow time for staff to complete any consultations underway and for any hand over. • Review the previous action points and status of implementation. • Observe and gather information using the checklist. • Listen to their problems and challenges. • Address and follow up on problem areas. • Provide corrective and supportive feedback on performance. • In case a procedure is performed incorrectly, demonstrate the correct procedure and ask for return demonstration. • If there is a need, liaise with mentors. • Update supervisees on new guidelines and information. • Give on-the-job training on new techniques and approaches if required.
Immediate feedback	• Once you are done with supervision, find a conducive environment with appropriate privacy to give feedback. • Use positive feedback, when performance is good; and constructive feedback, when performance needs improvement. • Start with those areas they are doing well followed by those where there are problems. • Focus on systems and processes, the performance or action, not on the person. • Discuss previous action points which were not implemented and include them in the new action plan. • Outline areas needing improvement and guide them to come up with corrective actions and time line. Link the behaviour to programme goals e.g. “If we don’t get the reports on time, the patient on treatment numbers will be out of date by the time we get them back. Then we won’t be able to use the information to improve our patients’ services.” • Listen attentively, with encouragement and open mind believing that everyone has good contributions to make. Give a chance to the supervisee to respond. • Invite the supervisee to give you feedback and questions. You may ask: o How did the process go? o What things did you find helpful? o What are some things that you didn’t like, or were not helpful to you? o Are there things you want help with which we did not address today?

Wrap up	During wrap up, the following points should be discussed/considered: • Share new information, such as guidelines and training opportunities; • Share some observations/findings made such as data recording and reporting; • Summarize the specific aspects that require change or improvement, discuss/review and agree on what needs to be done and how. • Identify areas of strengths including specific aspects of care going well and commend them appropriately. • Identify areas that need improvement/strengthening and agree on the action plan using a joint problem solving approach; • Set aside adequate time for supervisees' questions; • Identify persons responsible to solve the identified action points and problem areas; • Share with staff as a group the supervisor's general impressions on what is going well and what needs further improvement based on the supervisor's findings; • When ready to leave, thank the supervisees and others.
Report writing and follow up action	• Use the report writing format to document the visit including action and follow up plans • Disseminate the report to the relevant levels including the supervision site/ health facility • Share the information on the identified gaps with mentors

Chapter 7: Setting up a National Mentoring System

In order to set up the national mentoring system, it is important to define attributes, competencies and training of mentors as well as resources needed and items to be covered during mentoring.

7.1 Attributes of a Mentor

For effective mentorship, a HCW requires the following attributes:

- Be knowledgeable, skilled and experienced in a specific HIV and AIDS intervention/service area;
- Be approachable and accessible with good interpersonal communication skills;
- Be actively practicing/providing the specific HIV and AIDS intervention/service;
- Be familiar with the country's health system, common illness, the context of the disease, likely patient reactions and outcomes and appropriate language;
- Be willing, committed and available to provide technical assistance to less experienced HCWs; and
- Be a nurse, clinician, pharmacist, laboratory technologist or any other practitioner in the specific HIV intervention/service with the abovementioned attributes.

7.2 Competencies of a Mentor

The core competencies of the mentor can be divided into two major categories: first, mastery of technical knowledge and skills and secondly, effective mentoring techniques and communication skills

7.2.1 Mastery of Technical Knowledge and Skills to Provide Quality of HIV Care:

- Working knowledge of the specific area of essential package of care for a given HIV and AIDS health service; and
- Ability to help mentees improve knowledge, skills and confidence to provide HIV and AIDS health service accurately, consistently and independently.

7.2.2 Effective Mentoring Techniques and Coaching Skills:

- Ability to utilize effective mentoring techniques and coaching and communication skills to transfer or impart the mentor's knowledge/skills to the mentee;
- Establish an effective learning environment as part of a mentoring visit;
- Help the mentee and the patient to feel at ease and comfortable at each other;
- From time to time, share with the mentee teaching tips or clinical management suggestions in the presence of mentee and patient;
- Ensure that communication flows appropriately in three directions between mentee-client, mentor-mentee, client-mentor; and
- Use a variety of mentoring techniques such as bedside teaching, demonstration and clinical case review/discussions at several avenues including grand rounds.

7.3 Training of Mentors

In order to ensure that mentors are well-prepared and familiar with their work, it is important to cover the following key components in training:

- Basic concepts of HIV and AIDS health services, national policies, guidelines and any relevant SOPs;
- Basic concepts of mentoring and supportive supervision;
- Roles and responsibilities of mentors;
- Basic knowledge on QI;
- Coaching skills including interactive communication and relationship building;
- Mentoring methods;
- Mentoring tools;
- How their work complements or relates to supervisors; and
- Synergy between supportive supervision and mentoring.

7.4 Resources Needed for Implementing Mentoring

Mentorship recognizes the importance of capacity development, continuing education, adult learning, and support for HCWs and the long term sustainability and well being of both the personnel and health care system. This initiative needs stakeholders to mobilize resources for its implementation. The resources needed are similar to supportive supervision and include:

- Reliable allocated transport (can also be shared with supervision team);
- Adequate time for mentors' preparation, travel, field visit, reporting and follow up activities ;
- Allowances for the mentors;
- Stationery;
- Tools/checklists for mentoring;
- Current HIV intervention guidelines;
- Monitoring and Evaluation tools;
- Communication support: radio call, airtime, landline, e-mail or internet access; and
- Support for periodic mentors' review meetings

7.5 Issues/Areas to be covered during Mentoring

The following HIV and AIDS health services areas will be covered by different mentors according to their specific areas of expertise.

Category 1: Prevention Services

Prevention of Mother to Child Transmission of HIV Services

- HIV education, counselling and testing
- History taking and physical examination, including WHO staging
- Information on testing family members
- Laboratory test including CD4 count
- STI screening and management
- TB Screening
- ARV prophylaxis or treatment
- Counselling on infant feeding, family planning and prevention
- Adherence counselling and assessment
- Appointment systems, tracking and tracing defaulters including linkages and referral to other supportive services
- Disclosure counselling and partner involvement
- Management of HIV exposed children
- Maternity (Labour and delivery), delivery practices and standard precautions
- Early Infant Diagnosis

Management of STIs and RTIs

- History taking, clinical examination
- Use of flow charts in making diagnosis and management of STIs/RTIs
- HIV education, counselling and testing including risk assessment and reduction plan. Emphasize on four guiding principles: compliance, condom use, counselling and confidentiality.
- Condom demonstration (male and female)
- Utilization of partner notification card and management of sexual partners
- Case recording in STI register
- Blood collection for syphilis screening.
- STI monthly reports for completeness, correctness and timeliness.
- Referral and linkages

Category 2: Treatment, Care and Support Services

HIV Care and Treatment Services

- Initial assessment of newly diagnosed HIV patient
- Lab tests ordered for assessment/monitoring disease progression
- Prevention and management of opportunistic infections (OIs) including TB
- Management of HIV in infants and children including use of first and second line ARV
- Management of HIV in adults and adolescents including use of first and second line ARVs
- Adherence counselling and assessment
- Management of complications like immune reconstitution inflammatory syndrome, adverse effects of ARV
- Management of HIV in pregnancy
- Patient appointment systems, tracking and tracing defaulters including linkages and referral to other supportive services
- Documentation and communication
- Coordination and leadership

TB and HIV Services

- Prevention, screening, diagnosis and management of TB and HIV co-infection
- Linkages and referral mechanisms between TB clinics and CTC.
- Observe an assessment of a TB/HIV infected patient
- Observe initiation of ART and other interventions
- Interpret x-rays
- Start Cotrimoxazole prophylaxis
- Use of the TB screening questionnaire
- Use of Paediatric Score Chart for children
- Demonstrate TB infection control and universal precautions
- Demonstrate measures for HIV prevention
- Manage side effects of ART and anti TB drugs
- Monitor clients on TB and ARV treatment.
- Assess IPT usage

Home Based Cares Services

- Caring model process (Assessment ,plan, implementation and evaluation)
- Disclosure to family members
- Access to prophylactic drugs
- Adherence counselling
- Nutrition counselling
- Information on home-based HIV counselling and testing
- Infection prevention and control at home settings
- Positive prevention
- Referral linkages and networking

Category 3: Cross cutting Services

HIV Testing and Counselling Services

- Client/patient flow in VCT and PITC
- Pre-test counselling or information given
- National HIV testing algorithm
- Family counselling
- Post test counselling, disclosure counselling and partner notification
- Risk assessment and reduction plan
- Couples counselling, for concordant and discordant couples
- Guiding principles (3 Cs: Counselling, Consent, and confidentiality)
- Positive prevention
- TB screening
- Infection prevention measures
- Linkages and referral systems/mechanisms into care and treatment and other supportive services
- Paediatric HIV testing & counselling

Laboratory Services

- Sample testing
- Quality assurance
- Equipment service
- Sample transportation
- Observe standard precautions
- Records management
- Laboratory Information systems

Pharmaceutical Services

- Paediatric formulation
- Dispensing
- Adherence assessment and counselling
- Defaulter tracing
- Anti-Retro Viral (ARVs) and OIs medicines storage
- Inventory management

- Adverse drug reactions reporting
- Quantification

Monitoring and Evaluation (Recording and Reporting)

The M&E officers and mentors will mentor HCWs on data management focusing on the following areas:

- Ordering of the tools – use of routinely collected data to order stock of the forms
- Recording- discuss each and every variable in the form/register to help mentees understand the correct entry
- Reporting – discuss each indicator, numerator and denominator and how to count each from the register/form; how to compute for percentages
- Management of filled forms/registers – filing system and archiving data
- Data use – interpretation of indicators, data/indicators presentation in graphs, tables, trend lines, use of data for management and decision-making (e.g. estimates of drug requirements and supplies, who is utilizing and not utilizing services)
- Data Flow – rationale for timely reporting to the higher level
- Feedback – identified strengths, area of improvement and best practices and feed back to the mentees
- Database management – if computer-based database system is available, (hardware management, software management, anti-virus management, internet connectivity, data entry, generation of reports, data analysis and data backup)

Chapter 8: Structure and Functions of the National Mentoring System

This chapter describes the structure of the national mentoring system. It also presents the functions of each of the structural levels at National, Regional, District, Health Facility and Community.

8.1 National Level

At the national level, mentoring activities shall be done by a pool of national mentors identified, trained and coordinated by NACP. The NACP shall provide coordination and guidance on mentoring to all regional coordinators, disseminate this manual "A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services" to regions, keep track of an inventory/ database of experts who serve as national mentors in different HIV and AIDS health services of each region, develop a monitoring and evaluation framework of mentoring activities, identify and empower mentors of mentors and ensure continuous mentor training. The NACP shall also develop the activity calendar and hold national synergy meetings involving the mentors, the supervisors and other key stakeholders. The national mentors' primary responsibility is mentoring regional mentors.

8.2 Regional Level

RHMTs shall oversee and coordinate the implementation of mentoring activities at regional level. Their main responsibilities include disseminating this manual to districts, identifying mentorship needs at the regional level, creating a team of regional mentors, coordinating district mentoring activities and communicating with NACP for facilitation/guidance and technical backstopping. Other responsibilities are to increase pool of mentors in the region, implement M&E of mentoring activities and identify potential mentors during trainings. In addition, the RHMT shall develop activity calendar, organize joint meetings between supportive supervision and mentoring teams and conduct visits to regional and district hospitals to observe mentoring activities.

8.3 District Level

CHMTs shall oversee the implementation of mentoring activities at district level and coordinate mentoring activities. CHMTs shall identify mentorship needs at the district level; coordinate mentors and mentoring activities in the district; assess/evaluate mentor and performance; select mentors; review mentor's work plan; coordinate and hold joint meeting between supportive supervision and mentoring teams; and create and keep an inventory of district mentors. CHMTs shall be also responsible for monitoring and evaluation of the mentorship programme and shall disseminate monitoring and evaluation results to district, regional, national levels and other stakeholders including partners from time to time.

District mentors target mentees in district hospitals, health centres, dispensaries, FBOs, NGOs, parastatal organizations and other private owned health facilities.

Mentors perform their activities through a number of methods such as clinical case review, bedside teaching, journal club (especially internal), morbidity and mortality rounds, distance clinical support (telephonically, emails, sms), joint meetings, health facility visits, review of reports, follow up using agreed tools and feedback of mentees. The technical assistance provided shall be documented using the mentoring tools and the report shall be properly filed at the facility and shared with CHMT and other stakeholders. For better results, mentorship ought to be well planned, scheduled,

fully implemented and periodically monitored and evaluated. The mentoring activities shall be conducted as needed.

8.4 Health Care Facility and Community Levels

Mentorship within the health facility is a cost effective and sustainable approach for quality improvement of the services. Therefore, mentors are encouraged to provide mentorship to staff providing HIV and AIDS health services at their own facilities. Their activities are similar to those of mentors at district level and they will use the same methods. The health facility mentors shall also be responsible for mentoring community based care providers.

Chapter 9: Mentoring Process

This chapter describes the mentoring process, the frequency and the methods of conducting mentorship.

9.1 Process of Mentoring

Table 4 summarises the mentoring process.

Table 3: The Mentoring Process and Tasks Performed in Each Stage

Stage/Process	Tasks to be Performed
Pre-mentoring planning	• Orient the health facility management and mentees to the upcoming mentorship initiative, which should cover the process and the expected outcome of mentorship • Obtain permission from appropriate authorities • Logistics 9 (refer to 7.4) • Plan and communicate with mentee about arrival date and time
Arrival at mentoring site	• Greet site authorities and staff • If time allows, tour health facility to get a sense of how services are provided
Establish a warm mentoring climate	• Introduce yourself to your mentee • Establish a warm relationship with mentee and health facility staff. Make your mentee feel comfortable and at ease.
Arriving at a mentoring agreement with mentee	• Explain goal of mentoring (to share knowledge skills, to help mentee's professional development, to provide best services) • Ask mentee if there are areas that he/she especially wants to work on, or has had difficulty with • Explain the mentoring process and how you like to mentor
Review records	• Review records e.g. registers or client file. Mentee to summarize background information Identify a few issues to discuss with the mentee
Establishing warm care environment for client/patient	• Mentee should introduce the mentor to client/patient. Make the client/patient to feel comfortable, that both of you will attend the client/patient together.
Begin client/ patient care encounter with mentee	• Mentee should start providing the service as he/she normally would • Mentor's role at this point is to OBSERVE. Do not interrupt the mentee at this early stage • Mentor should be attentive to what the mentee and patient are saying

Identifying teaching moments	• Teaching moments occur when 1) mentor has identified something to contribute or teach during client/patient care encounter, and 2) the timing is appropriate to do so • Content that mentors may wish to contribute include: o Follow-up questions supplementing knowledge base: Demonstrating a procedure; o Model communication skills; and o Suggest alternative management approach. • Timing for teaching moments: o Mentors need to be mindful of WHEN and HOW they chip in; and o Avoid long, extended discussion with the mentee. Mentors need to be mindful of what is and is not appropriate to discuss in front of the client/patient. Look for an opportunity to have a private conversation with mentees, especially when providing constructive feedback to mentee.
Client/Patient education and instruction	• Communicating instructions to client/patient is an opportunity to educate him/her and can also be an indirect way to educate the mentee
Between clients/ patients	• The private time you have with a mentee between clients/patients is an ideal time for targeted, focused teaching • This can be an opportunity for the mentor to: o Reinforce key teaching points from earlier service provision session; and o Answer mentee's questions.
Next client/patient	• Process repeats • Mentee could feel more confident • Mentor could allow mentee to do most of the activities • Mentor shall review and assess performance

Post mentoring feedback session	• After all the clients/patients have been attended to, find a quiet and ideally private place for a feedback session with the mentee • Ask the mentee: "how did the session go for you?" "What did you like" and "what did you learn?" • Provide feedback to mentee, utilizing principles of providing effective feedback (discussed in chapter 6): o Start with positive, encouraging feedback. (things that you observed the mentee doing well); and o Then, identify areas you feel the mentee should work on. Be specific and concrete. Conclude feedback with encouraging remarks, restate positive things that the mentee is doing. Encourage the mentee to keep working on self improvement. • Ask the mentee to give you feedback. Examples of how to do this include asking the following questions: o How did the mentoring session go for you? o What things did you especially like? What was particularly useful for you? o What are some things that you didn't like, or was not as helpful to you? o Are there issues that we did not cover today? Are there things you want help with which we did not address today?
Planning the way forward	• At the end of the feedback session, make a plan with the mentee about next steps for continued professional growth. Agree on things the mentee will: o Work on after this mentoring session; and o Try to teach or support on a future mentoring visit. • Identify a means of communication between mentor and mentee between mentoring sessions o Invite mentee to call you (the mentor) with any questions that may come up between mentoring visits • Identify other ways that mentor can support mentee between mentoring visits o Does the mentee need job aids? Were there questions/ issues that came up today which the mentor did not have the answer to? Identify issues or questions that the mentor will look up (from other colleagues, senior mentors, internet, etc). Identify how the mentor will share what she/he learns with the mentee. o Plan the next mentoring session: When? o Prioritizing the issues for the next mentoring session

Documentation	• Mentors should document all mentoring visits made: who was mentored, what was mentored, what methodologies were used, number of clients/patients seen together • Mentors should document the mentee's performance. This allows mentors to track mentee's improvement in specific areas. • Mentor should use a checklist to keep track of what you have mentored/taught, and what has not been addressed. Make a reminder to yourself to look for ways to introduce topics that have not yet come up.

9.2 Duration and Frequency

Mentors should conduct initial visit to health facilities in order to establish the needs and demands. Mentoring needs at the health facility will likely diminish in terms and duration as the health facility staff gradually gains experience and acquire skills. However, mentoring should be continued for as long as it is required. Remember that mentoring is an ongoing knowledge and skill transfer from mentor to mentee.

Mentors initially need to spend at least two days at the hospital level and one day at lower level health facility and mentor intensely, then the staff needs time to practice and implement. Mentoring leads to capacity building of health facility staff, and should be reflected in improved service delivery and improved outcomes.

It is expected that a health facility will eventually 'mature' and be capable of delivering quality services independently. This is referred to facility graduation /maturity. Site maturity is measured by health staff clinical competencies and quality service provision. In the first 6 months, a facility needs to be intensively mentored and then in the subsequent 6 months this can be decreased both in frequency of visits and number of days that the mentor stays at the facility and eventually can be based on demand by the facility needs as per agreement by mentee and mentor. With time, mentees will become mentors themselves and can mentor other site staff and may be capacitated to mentor lower level staff.

9.3 Mentoring Methodologies

There are certain guiding principles and concrete techniques that can help a prospective mentor to begin mastering the skills of mentoring. Some of these methods are discussed below using mentoring perspective:

9.3.1 Identifying Teaching Moments

A "teaching moment" is any opportunity that comes up for a mentor to share insights, knowledge, or skills with a mentee. In addition, a teaching moment requires proper timing (for example, interrupting a client/patient while she is talking to impart a teaching point is inappropriate).

Tips for identifying clinical or knowledge gaps (potential teaching moments):

<u>During file review before patient encounter</u>: As you (the mentor) review the patient file with the mentee before the patient encounter, you should ask yourself: what do I think needs to be done medically, based on the file review (examples: repeat CD4 count? assessment of medication toxicity? follow-up issues from previous visit?) Ask the mentee what she/he thinks are the priority issues to

address today. A difference of opinion, or something which the mentee forgot or has overlooked, is an opportunity for a teaching moment.

During initial client/patient encounter, observe how the mentee interacts with the client/patient. If the mentor has suggestions for improving the establishment of a warm client/patient care environment, the mentor can model how this is done. Modelling effective care behaviour is a powerful way to teach.

During history-gathering: Listen closely to what questions the mentee is asking of the client/patient. If there is something that the mentee overlooks which the mentor feels is important, this can be a teaching moment.

During physical examination: Mentors can demonstrate how to perform a physical exam, and how to utilize physical examination findings to assist with clinical management decisions.

During formulation of management plan: Mentors can help mentees to formulate an optimal management plan. This is an opportunity for mentor and mentee to discuss the case.

During client/patient instructions and education: Mentors can model how to communicate client/patient instructions. This is an opportunity to educate the client/patient, but also a chance to educate the mentee discreetly.

9.3.2 Bedside Teaching

Bedside teaching is a powerful and effective means of teaching. It is especially useful for:

- Demonstrating physical findings and physical manifestations of various disease processes;
- Modelling compassionate patient care and effective communication skills;
- Combining history, physical exam, and laboratory/radiographic/other data in clinical decision-making and formulating a treatment plan (with patient participation and input); and
- Providing an opportunity for mentees to practice physical exam or procedural skills under the supervision/guidance of an experienced provider.

9.3.3 One-on-One Case Management Observation

This refers to the process of observing a mentee as she/he provides health services. The mentor provides guidance and shares his/her experience with the mentee. Most of the mentoring that occurs involves one-on-one observation.

9.3.4 Review of Patient Monitoring Data

Providing care for any chronic disease involves careful monitoring to ensure treatment efficacy, and to identify treatment-associated toxicities and side effects. In HIV care, some of the monitoring data to pay close attention to include:

- CD4 count within one month of enrolment, and every 6 months;
- Vital sign trends, especially weight (note: this is especially important in children!);
- Growth chart and developmental milestones in children;
- Baseline investigation;
- Screening for tuberculosis; and
- Safety monitoring e.g. Haemoglobin for patients on AZT (zidovudine) and Rash and hepatotoxicity for patients on NNRTI.

9.3.5 Documentation Review

Careful documentation in cards, registers, patient files and other records is essential for the successful operation of HIV and AIDS health services. Therefore, assisting mentees in developing good documentation practices can be a significant contribution a mentor makes to the clinical operations at a site. Though this task falls in the overlap between mentoring and supportive supervision, mentors have an opportunity to observe mentees in actual clinical practice, and can make suggestions regarding documentation in real-time. A good way to do this is through modelling; a mentor can model how he/she would chart in a thorough yet also time efficient manner. Mentors can also discuss what essential/important things to document are and which are less important.

9.3.6 Clinical Case Discussion

Clinical case discussion refers to teaching that is based on a clinical case, rather than a lecture based on a certain topic. Clinical case discussions are an especially powerful way to teach clinical decision-making skills, and promote active discussion from participants.

Case discussions are especially vivid and memorable if they are based on a patient who was seen by both mentor and mentee. Other clinical staff at the mentoring site can also attend a clinical case discussion, even if they did not see the patient in question.

Clinical case discussions are best conducted using a blackboard, flip chart, or pencil and paper. The mentor should think of her/himself not as a lecturer, but as a facilitator of discussion. The mentor/facilitator can and should pause frequently to ask the audience questions like “anything else you would have asked the patient?” “What physical findings would you look for?” “What tests do you want to order?” “What do you think is the problem?”

Begin a clinical case discussion with a brief case summary. It is often helpful to ask the mentee to summarize the case. Information covered in the case summary should include:

- Basic information about patient (age, sex, CD4 count, major co-morbidities);
- Main complaint (if any);
- History (pertinent positives, negatives).
- Vital signs;
- Physical exam findings (pertinent);
- Laboratory and radiographic findings;
- Generating a problem list;
- Assessment and discussion around each problem/issue identified;
- Differential diagnoses and diagnostic approach; and
- Management plan with input from different members of the healthcare team.

9.3.7 Clinical Team Meetings

Clinical team meetings are opportunities to bring together all members of a clinical site, to discuss issues relating to patient care, promote continuous quality improvement at the health facility, and for staff to provide support for each other. The spirit of a clinical team meeting is to foster exchange of ideas and perspectives among different cadres and components of the healthcare team. Furthermore, the provision of HIV care exerts a psychological burden on all members of the healthcare team. Having a means to share the triumphs, as well as the challenges, of providing HIV care services can help to prevent burnout among staff.

Clinical team meetings can serve as a forum*:*

- For various clinical team members to share what is going well in the clinic;
- To share what is not going well, and to brainstorm for ways to improve the problem area with input from different members of the team;
- To provide clinical updates that are important for all staff;
- For healthcare staff to provide support for each other, particularly around the psychological burden of providing care for medically-ill patients, including children, and death. This can help to prevent burnout among healthcare providers; and
- To promote continuous quality improvement at the health facility.

Chapter 10: Synergy between Supportive Supervision and Mentoring

As explained in the preceding chapters, supportive supervision and mentoring are conducted by different teams though they are complementary and synergistic. This chapter describes the mechanisms of bringing about synergy between the two at national, regional, district, and health facility levels.

10.1 Synergy at National Level

At the national level the supervisors, partners, mentors, and the national QI team are the key players creating synergy between supportive supervision and mentoring. Although supportive supervision and mentoring activities will be carried out at different times in a year, the teams should meet at least twice a year to share experiences, challenges and lessons learned. At NACP, the reports shall be tabled during the technical and management meetings. The national sub-committee meetings should also discuss supportive supervision and mentoring reports as a standing agenda item. The same agenda should also be discussed during the biannual MOHSW stakeholders' coordination forum.

Issues for discussion may include:

- Key findings during supportive supervision and mentoring;
- Lessons learned and best practices in supportive supervision and mentoring;
- Challenges identified during supportive supervision and mentoring and action taken;
- Further action recommended to improve service delivery/patient care;
- Action plan; and
- Monitoring and evaluation plans

This level will also have the responsibility to develop a monitoring and evaluation framework. In addition, supportive supervision and mentoring reports will be kept at the NACP library and shared folders in computers for easy access.

10.2 Synergy at Regional Level

Similarly at the regional level, RHMT, Regional AIDS Control Coordinator (RACC) and other co-opted members, regional supervisors and mentors, regional QI teams, and partners will be the key players to bring synergy between supportive supervision and mentoring activities. They will also implement the monitoring and evaluation framework for supportive supervision and mentoring. At this level, the teams will meet on a quarterly basis or may use biannual primary healthcare meetings, regional hospital boards and other regional health related meetings to discuss the following issues:

- Key findings from supportive supervision and mentoring;
- Lessons learned and best practices in supportive supervision and mentoring;
- Challenges identified during supportive supervision and mentoring and action taken;
- Further action recommended to improve service delivery/patient care;
- Action plan; and
- Plans for monitoring and evaluation.

The RHMT meetings will be used to discuss the outcome of supportive supervision and mentoring visits. RHMTs will need to identify a place to keep the reports where supervisors, mentors, QI teams, HCWs, and partners can easily access. Synergy related decisions should be shared with the Regional Commissioner and the RAS.

10.3 Synergy at the District Level

Synergy at the district level will be similar to that of the regional level. The key players at this level are the CHMT, District AIDS Control Coordinator (DACC) and other co-opted members, district supervisors and mentors, council QI teams and partners. The teams will meet on a monthly basis using existing forums like CHMT meetings, hospital governing committee meetings, council health service board meetings, and the standing committee on HIV and AIDS. Issues for discussion will be similar to those listed under the regional level. The decisions from the synergy meetings should be shared with the District Commissioner and the DED.

10.4 Synergy at the Health Facility Level

At the facility level, the key players will include the facility in-charge, health facility management team, the facility QI team and in-house mentors. The teams will meet during health facility governing committees to discuss issues identified through supportive supervision and mentoring and take appropriate actions. The teams meet on a monthly basis to discuss:

- Key findings which arise during supportive supervision and mentoring;
- Lessons learned and best practices in supportive supervision and mentoring;
- Challenges identified during supportive supervision and mentoring and action taken;
- Further action recommended to improve service delivery/patient care;
- Action plan.

10.5 Resources Needed for Synergy Meetings

The main resources required are:

- Travelling allowances;
- Supportive supervision and mentoring reports;
- Stationeries;
- A projector and a laptop computer; and
- Refreshments.

Chapter 11: Monitoring and Evaluation of Supportive Supervision and Mentoring System

Mentoring, supportive supervision, and quality improvement are different but related and complementary functions – all with the overarching aim of expanding and improving clinical services, especially at the Primary Health Care (PHC) HF level. Yet these are not stand-alone functions. For example, the implementation and evaluation of a mentoring programme requires close coordination with the supportive supervision team. Clinical and clinical systems gaps identified by mentors (from direct observation of actual clinical practice, as opposed to deduce from chart reviews) can be fed back to the supportive supervision and QI teams for ongoing support and strengthening. Therefore monitoring and evaluation of supportive supervision and mentoring activities should occur at all levels by the National Programme Leads and Coordinators, RHMTs and CHMTs as well as partners.

Activities should include:

- Baseline information collection;
- Review of written reports from supervisors/mentors – whom, where, on what, when, SS or mentoring, (check against the plan);
- Feedback from supervisees and mentees on supervisors and mentors' performance;
- Reports of meetings between supervisors and mentors;
- Use of comprehensive SS/M manual by supervisors and mentors;
- Periodical assessment of supervisors and mentors; and
- Simple evaluation to investigate: change in HCW performance, utilization of services, client exit interview, observation of clinical practice, stocks of drugs and supplies, timely and accurate reporting and data utilisation.

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Annex 1: Framework

ANNEX 1. FRAMEWORK OF COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING (SS&M) FOR HIV AND AIDS HEALTH SERVICES

		Who	Target	What	Where	When	How	Required Resources	Gap/Challenges in comprehensive SS&M
SS	**National**	Programme Leads, Partners, National Supervisors and Trainers-Facilitators Size of team: 2 to 4 persons	RAS	Courtesy call and feedback	Regional offices	During national level visits	Briefing and debriefing		
			RHMTs	-Coverage of services -Referral system and linkages -Policies, guidelines &SOPs -Health infrustructure -Human resources -Logistics & resource management -Progress reports & implementation of annual plan -Supervision on CCHP, SS to CHMTs, guidance on SS and Mentoring -Monitoring and Evaluation (M&E)	Regional level	Twice a year each visit 5 working days	-Using a national comprehensive SS tools, guidelines and protocols. -Reviewing previous action plans -Interviews, feedback meetings, joint meetings -Desk review of reports and records	Human resources, funds, transport, stationery, report format, SS calendar, guidelines, policies, circulars, comprehensive SS tool	Transport, funds, guidelines , availability of supervisors/ supervisees, time & capacity of supervisors
			National, referral and specialised hospitals	-Infrastructure, equipment and forms, supply chain mgt, -Training and staffing and HR issues, Patient satisfaction. -Mgt and patient flow and triage -Clinic organization -Patient monitoring and record-keeping -Team meetings, -Availability of guidelines, protocols & SOPs	National and Referral hospitals and selected health facilities		-Using a national comprehensive SS tools, guidelines and protocols. -Reviewing previous action plans -Interviews, feedback meetings, joint meetings -Desk review of reports and records -Entry & exit interview reports -Site visits		Transport, funds, guidelines , availability of supervisors/ supervisees, time & capacity of supervisors
			Zonal Health Resource centres	-Incorporation of HIV and AIDS trainings & activities in their plans; -Resource mobilizationHIV and AIDS trainings conducted; -Policies, guidelines, SOPs and training materials; and -Capacity to support RHMTs, CHMTs and training institutions in their zones	Zonal Health Resource Centre within the catchment area		-Using a national comprehensive SS tools, guidelines and protocols. -Reviewing previous action plans -Interviews, feedback meetings, joint meetings -Desk review of reports and records		Transport, funds, guidelines , availability of supervisors/ supervisees, time & capacity of supervisors

SS	**Regional**	RHMT and Co-opted members, Partners, RMAC	DED	Courtesy call and feedback	District offices	During regional level visits	Briefing and debriefing		
			Regional Hospital	-Infrastructure, equipment and forms, supply chain mgt, -Training and staffing and HR issues, Patient satisfaction. -Mgt and patient flow and triage -Clinic organization -Patient monitoring and record-keeping -Team meetings, -Availability of guidelines, protocols & SOPs	Regional hospital	Quarterly	-Using a national comprehensive SS tools, guidelines and protocols. -Reviewing previous action plans -Interviews, feedback meetings, joint meetings -Desk review of reports and records -Entry & exit interview reports -Site visits	Human resources, funds, transport, stationery, report format, SS calendar, guidelines, policies, circulars, comprehensive SS tool	
			CHMT	-Supply chain management; -Equipment & supplies; -Human resources management -PPP implementation, Implementation of CCHP, -Review, analyse & comment on CCHP and RRHP -Feedbacks to the Councils as well as to the Central level. -Facilitate the identification of training needs of Council health staff -SS of CHMT supervising district (incl. designated) hospitals	Regional hospital, randomly selected health facilities		-Using a national comprehensive SS tools, guidelines and protocols. -Reviewing previous action plans, -Interviews, FGD, Observations, register reviews, exit interviews, feedback meetings -Joint meetings; -Desk review of reports and records; -Entry & exit interview reports; -Site visits	Human resources, funds, transport, stationery, report format, SS calendar, guidelines, policies, circulars, checklist	Transport, funds, guidelines , availability of supervisors/ supervisees and time; capacity of supervisors
SS	**Council**	CHMT and Focal Persons and partners. Size of team: 4-6 persons CHMT and Co-opted members, Partners	HMT, Health Centre staff, Dispensary staff District Hospital Councilor, WEO Health facilities (pharmacies, Laboratory, public and private)	-Infrastructure; -Supply chain management; -Equipment & supplies; -Human resources -Service delivery based on guidelines -PPP implementation; -Patient flow & triage; -Clinic organization -Team meetingspatient satisfaction. -Management & implementation of HIV programmes' activities, -Patient flow and triage -Clinic organization, -Patient monitoring and record-keeping, -Team meetings, -Financial management	District hospital, NGO & Private? Hospitals, health centres and dispensaries	Quarterly visits	-Using a national comprehensive SS tools, guidelines and protocols. -Reviewing previous action plans -Interviews, feedback meetings, joint meetings -Desk review of reports and records -Entry & exit interview reports -Site visits	Human resources, funds, transport, stationery, report format, SS calendar, guidelines, policies, circulars, checklist	Transport, funds, guidelines , availability of supervisors/ supervisees and time

SS	**Health Facility (internal SS)**	HMT, in-charge of health facilities	VEO	Courtesy call and feedback	Village Level	Each visit	Briefing & debriefing		
			Hospital departments, Health care workers, both GOT, Private and FBO	-Infrastructure; -Supply chain management; -Equipment & supplies; -Human resources -Service delivery based on guidelines -PPP implementation; -Patient flow & triage; -Clinic organization -Team meetingspatient satisfaction. -Management & implementation of HIV programmes' activities, -Patient flow and triage -Clinic organization, -Patient monitoring and record-keeping, -Team meetings, -Financial management	Within the facility	Monthly, 1or 2 days (depending on the size of the facility)	-Using a national comprehensive SS tools, guidelines and protocols. -Reviewing previous action plans -Feedback meetings & joint meetings -Report compilation and analysis and use -Exit interview -Review inventory; -Review referral	Human resources, stationery, tools, report format & SS calendar Checklist Guidelines;	
			Community-based health workers eg, VHW, PEs, TBAs, THs, HBC	-Guidelines & SOPs -Equipment & supplies; -Service delivery based on guidelines; -Patient satisfaction; -Training needs; -Referral systems and community linkages;	Onsite	Monthly	-Using a national comprehensive SS tools, guidelines and protocols. -Reviewing previous action plans -Feedback meetings & joint meetings -Report compilation and analysis and use -Review inventory; -Review referral	Human resources, stationery, tools, report format & SS calendar Checklist Guidelines;	

Mentoring	**National**	National Coordinator, pool of master mentors	Regional coordinator, Mentors	-Continuous mentor training -Dissemination of SS/M manual to regions -Coordinate and provide guidance on Mentoring -Keep track of an inventory/database of experts who serve as mentors in different areas of each region -Develop a monitoring and evaluation (M&E) framework of Mentoring -Identify and empower mentors of mentors	Regional level	Throughout	-Develop activity calendar -Joint meetings -Regional visits -Coordination	Transport Funds policies & circulars -Manual & tools Training package	Mentoring TOT may be needed at this level
	Regional	Regional Coordinator/RACC	District mentors; Regional hospital mentors	-Dissemination of SS&M manual to districts -Identification of mentorship needs in the regional level -Identify potential mentors and creating a team of mentors -Coordination of district mentoring activities -Increase pool of mentors in the districts -Communication with national coordinator -With Council Level, implement M&E of mentoring	District level	Throughout	-Develop activity calendar -Joint meetings -Regional hospital & District visits -Coordination	SS/M manual Mentoring calendar Guidelines, circulars, Job aids, SOPs and precepting tools - Training Funds Training materials	Coordinating Mentors at Regional and National referral hospitals Selection of mentors?

Mentoring	**Council**	District Coordinator/ DACC	Mentors	-Identification of mentorship needs in the district level -Coordination mentoring activities among districts; -Assessments/evaluation of mentoring performance -Assessment/evaluation of sites performance -Select DMs using an agreed selection criteria -In collaboration with the RHMTs implement the M&E program -Increase pool of mentors in the districts, -Facilitate mentorship visits -Review mentor's workplan -Coordination between SS and needs for mentoring	Health facilities with mentoring programmes	Quarterly	-Develop activity calendar -Joint meetings with mentors -Facility visits -Coordination between SS and needs for mentoring -Review of reports, assess mentor & mentee performance, exit interviews -Follow up using agreed tools and feedback of mentees	-SS/M manual -Mentoring calendar -Guidelines, circulars, Job aids, SOPs and precepting tools -Training Funds Training materials	
		District mentors	Mentees (all interventions) in district, FBO and Private Hospitals, Health Centres and Dispensaries	-Patient flow and triage, -Clinic organization, -Patient monitoring and record keeping, -Review patient mgt, -Clinical team meetings, -Review of referral decisions, -Clinical case review, -Care and referral of complicated cases,	All health facilities in the district. Mentor has relationship with specific sites	As needed (more frequent (2x per month) in beginning phases, less frequent as site matures) -budget for monthly 1-2 days duration	-Clinical case review, -Bedside teaching -Journal club (especially internal), -Morbidity and mortality rounds, -Distance clinical support-telephonically, emails, sms, -Joint meetings -Facility visits -Review of reports -Follow up using agreed tools and feedback of mentees	Funds, transport, stationery, SS&M tools, report format, SS&M workplan, guidelines, policies, circulars, Job aids, SOPs and precepting tools, workplan	Transport, funds, guidelines, availability of mentors/ mentees, time; capacity of mentors
	Health Facility (internal mentoring) Hospitals	In-house Mentors (same as District Mentors)	Mentees (staff providing services in all interventions) HCWs at their facilities	-Patient flow and triage, -Clinic organization, -Patient monitoring and record keeping, -Review patient mgt, -Clinical team meetings, -Review of referral decisions, -Clinical case review, -Care and referral of complicated cases,	At own site	As needed	-Clinical case review, -Bedside teaching, -Journal club (especially in hospitals), -Morbidity and mortality rounds -Macro & Microskills; -Demonstration -Individual coaching -Precepting -Observation -Joint review of records and patients	Stationery, SS/M manual & tools, report format and mentoring workplan, Job aids, SOPs and precepting tools, Guidelines & checklists	Need a team of Mentors that will have relationship with HCWs in Facilities;

Synergy	**National**	National supervisors, mentors and QI team	National Supervisors, mentors and QI Team	-Sharing and discussing experiences/reports from SS&M visits. -Coordinate and provide guidance on SS&M -Develop a M&E framework of SS&M -Information sharing and archiving	NACP & National and Referral hospitals	Twice a year	National feedback meetings after each visit, through National C&T Sub-committee meetings (Standing Agenda)	No addition resources needed	Sharing reports, lack of time, convening joint meetings, action points implementation (follow up assignment)
	Regional	Regional Supervisors and Mentors and QI Focal persons	Regional Supervisors and Mentors and QI Focal persons	-Sharing and discussing experiences/reports from SS&M visits. -Coordinate and provide guidance on SS&M -Oversee implementation of the M&E framework of SS&M -Information sharing and archiving	Regional level	Quarterly	Through quarterly RHMT/CHMT meetings	No addition resources needed	Sharing reports, lack of time, convening joint meetings, action points implementation (follow up assignment)
	Council	District coordinator/ CHMT, Partners and mentors	District coordinator/ CHMT, Partners and mentors	-Sharing and discussing experiences/reports from SS&M visits. -Coordinate and provide guidance on SS&M -Oversee implementation of the M&E framework of SS&M -Information sharing and archiving	District	quarterly	Through CHMT meetings, council health service board meetings, standing committee on HIV/AIDS	No additional resources needed	How to implement action points
	Health Facility (Internal)	HMT, in-charge of health facilities and in house clinical mentors	HMT, in-charge of health facilities and in house clinical mentors	-Meetings for discussing and solving issues raised through SS&M -Implement the action points agreed during SS&M visits -Implement the M&E framework -Information sharing and archiving	Within the facility	Monthly	Team meetings	No addition resources needed	Time to conduct team meetings, implentation of action points

Annex 2: Roles and Responsibilities of the Regional Health Management Team (RHMT)

The RHMT is charged with the responsibility of overseeing the management of health services in a region. It is the team that advises the Regional Secretariat on matters related to ensuring improvement and maintenance of the health status of the population within the region through advice on the overall planning, implementation, delivery, monitoring and evaluation of quality health care within the region. The team is there to ensure that health related planning and interventions are therefore conducted in an integrated and holistic manner to involve all stakeholders and resources within the region (MOHSW 2008).

The roles and responsibilities of the RHMT are summarized below:

- Develop and execute 5 year strategic plan for RHMT, annual regional plans and strategies for RHMT
- Advise the Regional Secretariat on promoting and improving health related interventions across the region in order to improve and sustain the health status of the population within the region.
- Advise and provide technical backstopping to the Council Health Management Teams (CHMT) in their roles and responsibilities to plan and deliver quality health care services within their areas of jurisdiction
    - Technical back stopping for CHMTs for planning and reporting.
    - Support CHMTs to develop health centre and dispensaries plans
        - Advice on construction and rehabilitation of health facilities
        - Assess the distribution of health facilities within the councils in order to avoid duplications and promote use of existing FBO facilities
        - Monitor the distribution of and construction of additional health facilities within the councils to ensure equity of access and efficient use of available resources which includes existing health facilities
        - Monitor the staffing and equipping of all health facilities
    - Support CHMTs on financial and material resource management
    - Supportive supervision of the CHMT for the implementation of their CCHP
    - Review, analyse and comment CCHP and RRHP and give feedbacks to the Councils as well as to the Central level.
    - Facilitate the identification of training needs of Council health staff
    - Technical and clinical supervision of district (incl. designated) hospitals
    - Monitor the equitable distribution of medicines, medical supplies and equipment among the councils
    - Support CHMTs in managing health financing options that ensure sustainability and equity in health services provision (NHIF, CHF, exemption & waiver, use of funds collected at health facilities level)

- Advise Local Government Authorities (LGAs) directly and provide technical backstopping to the CHMTs on the correct and timely implementation of national policies, guidelines, and standards for both public and private health service providers within the LGAs

- Monitor advice and ensure that delivery of quality health care services is conducted within the frameworks of accessibility, affordability, equity and gender mainstreaming within all LGAs.
- Provide the necessary input requirements for effective planning and delivery of health services such as accurate data, new information and capacity development of CHMT members and all Health service providers in public and private facilities

The RHMT shall comprise of technically qualified and sufficiently experienced team members, who will, on a day to day basis ensure that they operate as a cohesive unit with clear and unambiguous roles and responsibilities towards a common vision and mission for their region. They will operate towards meeting the overall targets of their joint annual regional health plan and budget in supporting LGAs to deliver quality health services and advising the Regional Secretariat on all health matters pertaining to the health status of the region's population and health services delivered.

The health and health related services include all those services delivered by public and private providers in all mobile centres, dispensaries, health centres and hospitals. Their responsibility extends to include NGOs, CBOs, pharmacies and drug sellers, maternity and nursing homes, radiological, laboratory and dental services.

This level of operation is the extension of functions of Ministry of Health and Social Welfare (MOHSW) and Prime Minister's Office-Regional Administration and Local Government (PMO-RALG).

1. Develop and operationalise RHMT plans and strategies annually from the 5 year strategic plan
2. Disseminate and support the translation of the policies, strategies and guidelines of the MOHSW / PMO-RALG by CHMTs
3. Support an appropriate environment for private sector development
    - Make sure that the Voluntary Agencies and other private sector providers are registered according to the procedures
    - Resolve any dispute or misunderstanding that arises between CHMTs and the private health service providers
    - Advocate for PPP and organize PPP meetings
4. Coordinate services in the Region
    - Advise for equitable distribution of all resources (NGO, vertical initiatives, and others) between the councils.
5. Support Human resource management
    - Strengthen HRH management
    - Support LGAs to develop innovative and creative retention and incentive schemes for the staff
    - Identify and collate LGAs and Regional Referral Hospital training needs, use them in planning, and submit to zonal training centers and other relevant authorities
    - Conduct Monitoring and evaluation, Collect and compilation of data from the councils
    - Analyze data collected
    - Report and feed back to councils and central level
    - Conduct operational research
6. Ensure the quality of services at all health and social welfare facilities.
7. Facilitate emergency and disaster preparedness and response

- Facilitate the establishment of Council Emergency and Disaster Preparedness Response Unit
- Assist the councils in the planning and logistic

8. Support and backstop Regional Referral Hospital
    - Support Regional Hospital to develop the hospital plan
    - Mobilize resources to provide technical back stopping for the management and clinical services
    - Facilitate capacity development in interpretation of policies, guidelines.
    - Support quality improvement of the hospital services
    - Conduct clinical and managerial supervision of the Regional Referral Hospital.
9. Instituting network system
10. Conduct innovative supervision

Source: MOHSW and PMORALG: Functions of Regional Health Management System (August 2008)