FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPA MINISTRY OF HEALTH

GUIDELINE FOR HIV CARE/ART CLINICAL MENTORING IN ETHIOPIA

November 2018

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Table of Contents

Foreword i

Acknowledgements ii

Acronyms and abbreviations iii

1. INTRODUCTION iv

1.1. Background 1

1.2. Rationale and Significance of Clinical Mentoring 2

1.2.1 Decentralization 2

1.2.2 Task sharing 2

1.2.3 Sustainability 3

2. GOAL, OBJECTIVES AND TARGET AUDIENCE 4

2.1. Goal 5

2.2. Objectives 5

2.3. Target Audience 5

3. Concepts of Clinical Mentoring in HIV Care 6

3.1. Definition of Clinical Mentoring in HIV Care Context 7

3.2. Clinical Mentoring as Continuing Education 7

3.3. Clinical Mentoring versus Supportive Supervision 8

4. SELECTION AND TRAINING OF CLINICAL MENTOR 10

4.1. Selection of clinical mentors 11

4.2. Selection criteria for facilities that can provide mentorship 12

4.3. Training of clinical mentors 12

4.4. Mentee competency assessment 12

5. Developing a national system of clinical mentoring for decentralized HIV care/ART 14

5.1. Introduction 15

5.2. Organization of the clinical mentoring practice 15

5.2.1 Establishing clinical mentoring team 17

5.2.2 Multi-Disciplinary Team (MDT) 17

5.2.3 Organization of HIV related services

5.3. Planning Clinical Mentoring at Different Levels 19

5.4. Management and coordination of clinical mentoring 21

6. Approaches and Tools for Clinical Mentoring 27

6.1. Site visits by mentors 28

6.1.1 One-on-one case management observation 30

6.1.2 Review of patient monitoring formats 31

6.1.3 Clinical case discussions 31

6.2. Mentoring by telephone 32

7. Monitoring and evaluation of clinical mentoring program 34

8. Annex 39

Foreword

Achieving and maintaining standard quality of care in the view of decentralization of HIV prevention, care and treatment services is very crucial. Ensuring access to HIV prevention, care and treatment services across the nation could be challenging in the context of limited human resources. One of the strategies the country has been using to respond to the human resource constraints of HIV interventions is task-sharing. However, we have to maintain the quality of HIV services while performing task-sharing activities in the health facilities. Even though many factors govern HIV care service quality, a well-designed and coordinated clinical mentoring program is taken as an immediate option of interventions to achieve and maintain the desired quality of HIV care/ART.

It is evident that clinical mentoring was extensively practiced by different stakeholders in the country during the scale up of HIV/AIDS programs. Currently however, the government is integrating clinical mentoring services into the existing health care system so that regional health bureaus take the primary responsibility to coordinate and implement. FMOH has also recently revised the national consolidated guidelines for HIV prevention, care and treatment based on recent national and global evidences and recommendations. Revision of this guideline thus became crucial to institutionalize the key changes and assure the implementation of the new recommendations. Therefore, the National Clinical Mentoring guideline is revised through consultation and active involvement of key stakeholders.

It is our hope that health care providers and program managers will benefit from this guideline during provision of HIV prevention, care and treatment services and provision of clinical mentoring support.

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Acronyms and abbreviations

Acquired Immunodeficiency Syndrome	AIDS
Antenatal Care	ANC
Antiretroviral Therapy	ART
Antiretroviral	ARV
Ethiopia public health institute	EPHI
Federal HIV/AIDS Prevention and Control Office	FHAPCO
Federal Ministry of Health	FMoH
Health Centre	HC
HIV Counseling and Testing	HCT
Health Extension Workers	HEW
Human Immunodeficiency Virus	HIV
Health Officer	HO
HIV Testing Service	HTS
Maternal, Newborn and Child Health	MNCH
Medical Doctor	MD
Multidisciplinary HIV/AIDS Team	MDT
Monitoring and evaluation	M&E
Memorandum of understanding	MOU
Non-Governmental organization	NGO
Opportunistic infections	OI
Out-patient department	OPD
Pharmaceutical fund and supply agency	PFSA
People living with HIV	PLHIV
Prevention of mother to child transmission of HIV	PMTCT
Regional HIV/AIDS Prevention and Control Office	RHAPCO
Regional Health Bureau	RHB
Tuberculosis	TB
Technical Working Group	TWG
United Nations	UN
Voluntary Counseling and Testing	VCT
World Health Organization	WHO

1 INTRODUCTION

1.1. Background

The first evidence of HIV epidemic in Ethiopia was detected in 1984. Since then, AIDS has claimed the lives of millions and has left behind hundreds of thousands of orphans. The government of Ethiopia took several steps in preventing further disease spread by increasing accessibility to HIV care, treatment and support for persons living with HIV. According to 2016 EDHS estimate, the adult HIV prevalence for 2018 is 0.9% of which 2.9% is urban and 0.4% is rural. The 2016 EDHS also showed that the HIV prevalence varies from region to region ranging from 0.1% in Somali to 4.8% in Gambella. According to HIV Related Estimates and Projections for Ethiopia by EPHI in 2018 the estimated number of people living with HIV is 610,335, of which 56,515 are children and 379,251 are female. The number of people who are in need of ART are the same since 'Treat all' is adopted by Ethiopia since 2016.

Fee based ART service was started in July 2003 in selected referral hospitals. Then the free ART service followed in 2005.Recently ART service is available in more than 1,224 health facilities of which around 909 are health centers. The country rolled out ART services using public health approach which include decentralization of HIV care and treatment services to health centers from only hospital based to health centers. The decentralized management has contributed for the fast move of ART scale-up in all regions. The task sharing strategy that FMoH employed contributed for the efficient use of limited trained health workers in the scale up of ART services. The country has been progressing well in light of the three 90s. At the end of 2017, 78 % of estimated PLHIV knew their status of which 71% are on treatment. Nearly Fifty percent of Patients accessed treatments have had their viral load tested and the viral suppression rate (third 90) is 88%.

The national clinical mentoring program has evolved since the scale-up of ART program. Initially clinical mentoring was directly implemented by international partners. Since the end of 2014 however, RHBs have been directly implementing clinical mentoring program with technical and financial support from development partners. Moreover, the country adopted various global recommendations in the prevention and treatment of HIV since this guideline was published three years ago. In order to incorporate the new changes, and improve the quality gaps observed in the program, revision of this guideline became crucial.

1.2. Rationale and Significance of Clinical Mentoring

1.2.1 Decentralization

Ethiopia adopted public health approach for the decentralization of the HIV care and ART services across the country. This approach envisages use of simplified and decentralized systems that can maximize the role of primary health care and community-led care. For the programs that aim to decentralize the HIV care and ART services, public health approach necessitates using standardized and simplified treatment guidelines that can realistically be administered by less trained professional health care workers and nonprofessional community members. Furthermore, ensuring the quality of care across all levels of the health care delivery system require an on-going capacity building of the health care workers through well designed clinical mentorship scheme.

Decentralizing HIV care and treatment is linked with the national Health Network Model which is crucial for effective prevention, building ART pipeline, ensuring the continuum of care and quality service. With the decentralization of HIV care and ART to the health center level, the Health Network Model has to be effectively used through transferring out patients from hospitals to health centers and strengthening sample transfer from health centers to hospitals and regional laboratories. However, it is critical to remember that the Health Network Model is not specific to HIV/AIDS services, and the implementation strategies need to strengthen the health system, reach the community and bring the system wide effect.

1.2.2 Task sharing

In response to the human resource challenges in scaling up of HIV prevention, care and treatment, FMoH has been working in concordance with the approach of task sharing. Task sharing is the name given to the process of building capacity of less specialized health workers. When there is shortage of medical doctors, qualified health officers and nurses could prescribe and dispense ART. Further, community workers can potentially deliver a wide range of HIV services (adherence support, tracing and linking lost to follow-up cases, etc.) thus freeing the time of qualified health officers and nurses.

Task sharing is being implemented with the aim of improving the overall quality of care. The need for rapid expansion of HIV care and ART services in the context of task sharing needs transfer of knowledge and skills to the health workers including the new cadres in the primary health care system. The capacity building of these health care workers has to be reinforced and strengthened through well-organized clinical mentorship and planned supportive supervision. Effective on-site, and off-site clinical mentoring provided through skilled input by case consultation or case review, or consultation by phone can provide the necessary support to health care workers in the primary health facilities. This can potentially improve the quality of ART outcomes and minimize the complications of antiretroviral therapy associated with treatment failure.

1.2.3 Sustainability

Sustainability of a public health intervention depends much on crafting a doable framework which is well aligned with the existing health system. That is why clinical mentoring program activities should be part of the annual plans, review meeting agenda and performance evaluation criteria in RHBs. Implementing partners will continue to support financially and technically. However, the direction of FMoH is to integrate the clinical mentoring into the routine health system throughout the country. One of the objectives of the transition strategy was to support integration of clinical mentoring in the health system. A cascaded approach to mentoring of mentors per levels of the health system as well as strengthening of internal (peer) mentoring within a facility needs to be an integral part of the clinical mentoring program to ensure sustainability.

2

GOAL, OBJECTIVES AND TARGET AUDIENCE

2.1. Goal

To provide high quality and sustainable comprehensive HIV prevention, care and treatment services in health centers and hospitals.

2.2. Objectives

- To ensure the integration of clinical mentoring into the health system.
- To equip HIV service providers with the capacity to provide comprehensive, standard quality and sustainable HIV care and treatment services in all health facilities.
- To improve health worker motivation by providing clear guidance and continued learning.
- To enhance the team spirit and network between health facilities.

2.3. Target Audience

This guideline is intended for:

- Health workers providing and receiving clinical mentoring on HIV prevention, care and treatment.
- Policy makers and HIV program managers at all levels of the health system and all partners working on HIV.
- Trainers on clinical mentoring and comprehensive HIV prevention care and treatment services

3 CONCEPTS OF CLINICAL MENTORING IN HIV CARE

3.1. Definition of Clinical Mentoring in HIV Care Context

WHO defines clinical mentoring as, "Clinical mentorship is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes." The mentor, who often, but not necessarily, works in the same organization or field as the mentee, achieves this by listening and talking in confidence to the mentee."

A clinical mentoring occurs during on-site visits as well as via ongoing phone and email consultation. Clinical mentors need to be experienced, currently practicing clinicians in their own right, with strong teaching skills. Mentoring has to be a voluntary contracted relationship. This is crucial component of definition of mentoring. The two parties meaning the mentoring facilities and mentored facilities enter into a contract and agree on the set of clear goals. Also it has to be a planned program designed to fulfill the policy and strategic objectives.

3.2. Clinical Mentoring as Continuing Education

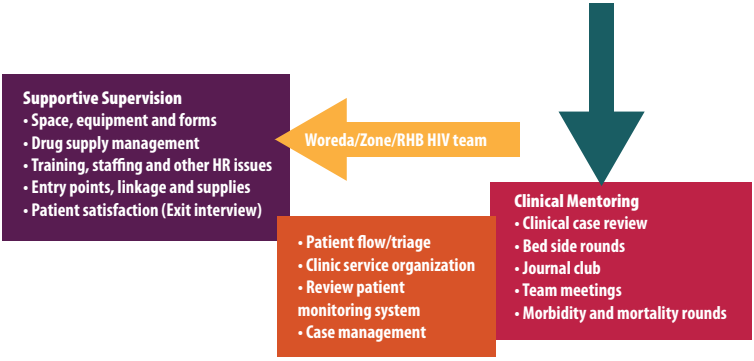
Mentoring should be seen as part of the continuum of education required to create competent health care providers. It should be integrated with and immediately follow initial training. Training without follow up mentorship is considered as incomplete in task sharing. Initial in-service training should be case based and participatory, based on the principles of adult learning. Mentoring starts at the point where the initial training ends and is taking place where health care workers manage patients.

With the principles of adult learning one needs to practice the concept of dialogue (interaction between mentor and mentee), supportive atmosphere (a comfortable environment which facilitates learning process and encouragement of cooperative communication between mentors and mentee and among each other). Adults respond to contribute more to learning which is active, experience based, skill seeking, real life centered, self-directing and task centered. Clinical mentors must be trained and versed with basic pedagogical skills in order for the process to be a successful platform of developing the knowledge and skills of health care workers. The training manual addresses this concept in depth.

3.3. Clinical Mentoring versus Supportive Supervision

Supportive supervision is a management function planned and carried out in order to guide, support and assist health workers in carrying out their assigned tasks. It involves on job transfer of knowledge and skills between the supervisor and the supervised through opening of administrative and technical communication channel. Supportive supervision is one of the most critical components of system capacity building in the process of decentralizing comprehensive HIV prevention, care and treatment. Supportive supervision aims at improving the quality of HIV care and treatment service delivery through joint observation, discussion, and direct problem solving, mentoring and learning from each of the topics observed and discussed and planning the way forward.

Figure 1: Differences and overlapping features of Clinical mentoring and supportive supervision.



Although clinical mentoring and supportive supervision overlap considerably, the activities are different enough to warrant implementation by different teams.

Clinical mentoring focuses on professional development of health care workers; clinical mentors need to be experienced and practicing clinicians among other things. Supportive supervision to HIV care/ART services is implemented by Woreda, Zone, Regional or Federal supervisory and management teams, often having fulltime administrative duties and do not have the time, qualification and experience to be effective clinical mentors.

Both supportive supervision and clinical mentoring are complementary and are necessary for building the care system. Clinical mentoring should not discount the importance of supportive supervision. As to implementing the two process of strengthening care, clinical mentoring provides opportunities to incorporate supportive supervision activities such as discussing issues including patient flow, workload, and organization of care and treatment services, triage and recording practices.

Clinicians who do not understand or interested to understand the basics of how the clinic or clinical team should function will not be effective as clinical mentors even if they are extremely knowledgeable about managing HIV disease. Without well-organized and functioning clinical service, the individual health care worker's ability of implementing care protocols will be affected.

4

SELECTION AND TRAINING OF CLINICAL MENTOR

The National Clinical Mentoring Guideline defines:

- A clinical mentor is a clinical practitioner (specialist or general practitioner) or a health officer or a nurse currently practicing at the ART clinic, of the mentoring health facilities.
- Pharmacy mentor is a knowledgeable, skillful and experienced pharmacy professional that offers help, guidance and advice to pharmacy professionals in health facilities involving in ART pharmacy service.
- Laboratory mentor as a Laboratory technologist or Laboratory technician practicing in HIV related laboratory services.

4.1. Selection of clinical mentors

Mentors need to be experienced, practicing clinicians in their own right with strong teaching skills. As far as professional back ground is concerned, a clinical mentor needs to be at higher or at least the same level of profession e.g. MD-HO, HO-Nurse, or MD-MD, HO-HO, Nurse-Nurse.

The clinical mentor must be experienced in the overall health service delivery system, the HIV care/ART/PMTCT practice setup, standards and protocols at the health centers/hospitals and possess expert knowledge in the comprehensive HIV prevention, care, treatment including ART.

A health care worker should fulfill the following criteria to be selected as a mentor:

- Currently practicing clinician with clinical proficiency and capacity to make decision
- Minimum of 6 months experience on the ART clinic
- Willingness to mentor other clinicians through on-site visits and telephone/email support
- Ability to facilitate a case discussion
- Adequate training on mentoring, comprehensive HIV/AIDS prevention care and treatment and/ or PMTCT
- Good communication skill and ability to communicate clearly and effectively with staff including provision of constructive, timely, and interactive feedback
- Understanding of the health service delivery system
- Committed to work for a reasonable period as a mentor after training

NB: Selection of Laboratory or pharmacy mentors shall be based on the specific SOPs prepared for laboratory and pharmacy mentoring.

4.2. Selection criteria for facilities that can provide mentorship

In order to be selected as a mentoring facility, Hospitals/Health centers should fulfill the following criteria:

- Conducting regular internal mentorship according to the National clinical mentoring guideline
- Have been providing HIV care and treatment services for at least two years
- Performing better in HIV prevention ,care and treatment
- Have adequate (trained mentor) human resources to participate in clinical mentoring

4.3. Training of clinical mentors

The Nationally standardized training manual should be used to train clinical mentors. Training of clinical mentors should make use of adult teaching principles. It is imperative to use the full range of methods and techniques, as individuals learn differently. Mixed learning techniques should be considered, with the use of audio, video, computer modules and practical attachment. These methods will provide complimentary means of transferring knowledge, attitude, and behaviors where resources are scarce (Human, financial and logistic).

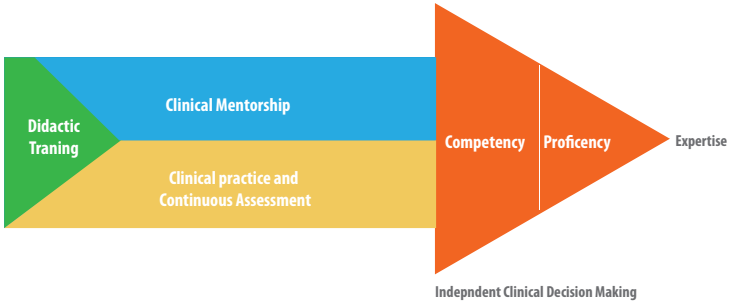
RHB/ZHD may facilitate networking of newly graduated mentors with an experienced one during internal mentoring so that the former will develop the confidence to conduct the mentoring independently as soon as possible.

4.4. Mentee competency assessment

After initial didactic coursework, the health care provider responsible for providing quality care and treatment will be mentored at facility level to help him implement clinical standards. The mentee will be assessed by the clinical mentor throughout the clinical mentoring process. The quality of health care service delivery provided by the mentee could be assessed through records review, interviews and client chart review. Selected Core

competencies may be used to evaluate the mentee's own perception of his/her competence or by the mentor to evaluate performance of the mentee. The mentee should maintain a logbook of patients examined and treated under the guidance of the clinical mentor. A wide variety of patients should be included, varying by age, gender and type of clinic visit.

Figure 2: The process of skill development in clinical practice



- The objective is to measure competency gained through mentorship
- Self-administered questionnaire - mentee self-assessment tool
- Self-awareness (awareness of one's own qualities and limitations) is important for the mentor to deliberate on the process as that of a learning quest
- Mentee Skill/knowledge assessment tool
    - Observation
    - Chart review
    - Elicit feedback

A standardized tool (clinical mentoring tool) accounting for all mentioned competency assessment is provided in the annex.

5

DEVELOPING A NATIONAL SYSTEM OF CLINICAL MENTORING FOR DECENTRALIZED HIV CARE/ART

5.1. Introduction

Clinical mentoring has been intensively implemented since 2006 with its overall goal of better treatment outcomes. The National clinical mentoring program supports implementation of the following strategies:

- Decentralizing HIV/AIDs services,
- Strengthening the district health care system,
- Enabling mid and lower level health care workers through continuing education
- Standardizing& simplifying clinical protocols and SOPs at all levels of health care system
- Ensuring sustainability

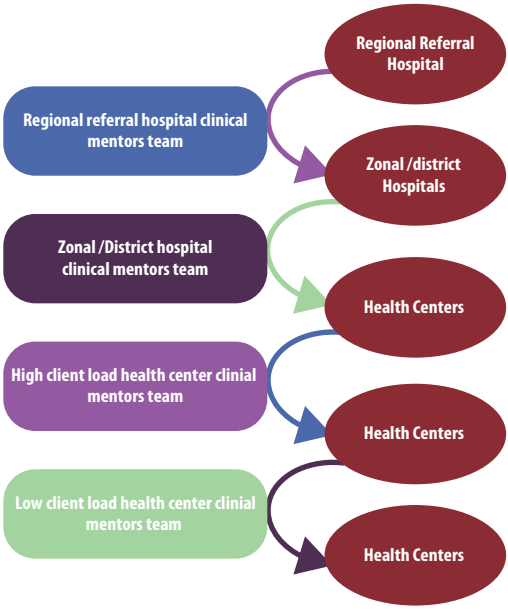
The national clinical mentoring program has contributed to the following achievements:

- Improved access to standard quality HIV Care/ART services
- Improved mentees' Clinical competence
- Improved mentees' habit of consultation (on-site and distant)
- Improved HIV patient monitoring (disease monitoring)
- Improved record keeping practices
- Improved engagement of facility leadership and staff in HIV program quality improvement initiatives
- Improved uptake of HIV testing at key service delivery points
- Improved linkage to care, adherence and retention

5.2. Organization of the clinical mentoring practice

The mentoring modalities could be across the various levels of the health system (like between hospitals and health centers) or within the same level. However, the relationship between the mentor and mentee facility is purely technical with no administrative authority.

Figure 3: The national clinical mentoring framework



Clinical mentoring will be conducted in a cascading approach. Selected and trained clinical mentors from regional referral hospitals will mentor service providers at zonal or district hospitals. Selected and trained clinical mentors of zonal or district hospitals will provide clinical mentoring at health centers in their catchments area. Similarly, selected and trained clinical mentors of high client load health centers will mentor service providers at low client load health centers.

This cascading system will enable to maximally utilize the available expertise with in the system. In addition to the offsite mentoring, clinical mentors will also provide internal mentoring of their facilities regularly.

The mentor health facilities will be selected by respective regional health bureaus with defined criteria and will be given responsibility to provide mentoring to their catchment mentee health facilities on regular basis. The mentoring visits will be conducted according to the guidance provided in these guidelines.

In order to mitigate the effect of limited number of health professionals in the system, trained medical doctors, health officers and nurses will provide clinical mentoring. Doctors can mentor doctors, HO or nurses. While HO can mentor HOs and nurses, and nurses can mentor nurses. Trained expert pharmacists will also provide mentoring for pharmacy personnel working in the ART pharmacy every six months after assessment of need. By expanding the mentoring sources and professional categories, the human resource shortage may be tackled.

5.2.1 Establishing clinical mentoring team

Composition of the clinical mentoring team depends on the chosen modality of mentoring:

1. Routine clinical mentoring: the routine mentoring will be conducted by team of clinicians trained on ART and PMTCT.
2. Special mentoring: In addition to ART/PMTCT clinicians the team may include pharmacy, laboratory, monitoring & evaluation experts.

5.2.2 Multi-Disciplinary Team (MDT)

Involving health workers that provide comprehensive HIV/AIDS service in monitoring the quality of their own activities will enable them to deliver quality services and create sense of ownership of the comprehensive HIV/AIDS services. One of the mechanisms that give health workers the opportunity to monitor implementation of quality comprehensive HIV/AIDS service is establishing MDT and conducting regular meeting.

Members of MDT

- ART physician/health officer/ART nurse
- ART pharmacy technician/druggist
- ART lab technician
- Internal mentor
- PMTCT focal Person
- TB/HIV focal Person
- HTS focal person
- Data clerk
- Case manager/MSG

MDT meeting process

- The ART physician/health officer /ART nurse will chair the MDT meeting and one of the team member will act as secretary of the MDT, and hence he/she takes MDT meeting attendance and minutes and archive the minutes properly at the ART clinic
- Members of the MDT will meet every month, and the meeting will preferably be conducted at the ART clinic
- Clinical mentors will participate in the MDT meetings actively whenever possible, and will encourage MDT members to conduct their meetings regularly
- The Hospital Director/Health Center Head will ensure the MDT meetings are conducted as per their schedule and meeting minutes are properly archived at the ART clinic

Responsibilities of MDT

- Review of the clinical mentor assessment findings and set action items to improve low performances
- Review selected difficult cases to be further discussed with respective mentors
- Organize clinical updates sessions in collaboration with mentors
- Ensure the availability of basic supplies and commodities
- Identify unaddressed major gaps and challenges and present to the facility's management

5.2.3 Organization of HIV related services

The following service units are expected to be available to function in a closely linked integrated system:

- Card room (shared by the whole service)
- Triage area (near the card room or reception)
- Counseling room (adherence counseling is given here)
- ART Clinician room
- VCT room
- Laboratory

- OPDs (under five, adult, TB,STI)
- Dispensing room/pharmacy
- ANC/MCH (PMTCT is component of ANC)
- Data clerk room
- IPDs

The clinical mentor needs to ensure that:

- The MDT meeting is conducted regularly as per the guideline (through checking the minutes)
- All members of the MDT team are present during the meeting (through checking the minutes)
- All the above mentioned service units are available in the facility

5.3. Planning Clinical Mentoring at Different Levels

Clinical mentoring is a major strategy for capacity building aimed at ensuring standard quality HIV care and treatment at all levels of the health system. This requires strong engagement of the leadership at all levels.

The mentoring plan and financing must ensure sustainability of clinical mentoring. Clinical mentoring at each site requires long-term engagement since the professional development is a slow and cumulative process. The fast turnover of staff mandate clinical mentoring to be given to the newly coming members of the clinical team. This makes the process to stay over long period of time at a given facility. The mentors must be trained sufficiently not only in the technical knowledge but also in communication skills to improve their pedagogical capacity. The mentees must receive sufficient training before they embark on mentoring other mentees. The training and mentoring must take into account the needs of the Adherence Counselors as well.

The number of health facilities to be mentored by each mentoring facility may range up to five. The most determining factor is the distance between the two facilities, i.e., the mentee and mentor facilities.

The number of mentors to be recruited, trained and assigned should depend on the number of mentee facilities. Taking into account the frequency of visits as well as social and other leaves, training at least 2 to 3 mentors at each mentor facility would be appropriate. Again the diversification of the categories of professions to provide mentoring must always be taken into account.

Budget

a. Budgeting

i. Individual facilities and local administrations are responsible for including clinical mentoring in all annual plans and budgets.

   1. Identify key supplies needed for clinical mentoring service and make request accordingly.

   2. The management at each health facility should ensure that mentoring activities planned, logistics, and equipment is available.

ii. Woreda/zonal administration should ensure that budgets exist at all facilities and that funds are available (Resource Mobilization).

iii. FMoH needs to ensure efficient and equitable utilization of available resources

b. Logistics

i. Scheduling should be coordinated by hospitals and health centers

ii. Administrative offices (woreda /zonal health/regional health office) should be responsible for the arranging logistics

The budget requirement of mentoring program is for:

- Training of the mentors
- Perdiem and travel expenses: clinical mentors—visit sites (fuel, per-diem, vehicle and its related costs etc.), Communication support: mobile phone/airtime, landline, at the facilities, e-mail, and internet when access is possible.

Since budget demands decision by the policy makers, as indicated in the planning, Woreda/Zonal /Regional office management should work strongly to ensure adequate budget allocation. If there is budget gap an effort should be made to engage partners.

5.4. Management and coordination of clinical mentoring

As any other health sector HIV/AIDS response, clinical mentoring is the responsibility of the health management arm, together with the facility management body. FMoH, FHAPCO, RHBs, zonal/woreda health offices, uniformed services have their specific roles in clinical mentoring. The programs are owned and led by these structures at different levels and

partners have important role of supporting the program technically and financially. The important activities in clinical mentoring include, selecting and training the mentors, and deploying them to facilities.

The roles of partners involved in clinical mentoring of comprehensive HIV care, treatment and prevention must be clearly defined. The support provided by partners could be technical, financial or logistics. The level of partner support could be at Federal or Regional level as long as a well-defined MOU is signed.

Roles and Responsibilities

Each level of the healthcare system maintains a set of responsibilities to ensure clinical mentoring is effectively implemented and institutionalized. Broadly, the Federal Ministry of Health holds responsibility for policy and priority setting, while the Regional and City Administration Health Bureaus hold responsibility for ensuring mentoring activities are effectively carried out in each region. Woreda/Zonal health offices hold responsibility for confirming mentoring activities are included in the annual plan and budget while implementation responsibility belongs to each healthcare facility. Development partners, previously responsible for the bulk of mentoring activities, continue to have a role in supporting the system but must do so in a way that supports the government system, rather than introducing a parallel structure.

The detailed set of responsibilities for each level of the health system is described below.

National/Federal Level

The Federal Ministry of Health and its agencies maintain all national/federal responsibilities for clinical mentoring. The Primary responsibility of clinical mentoring program resides within the Disease Prevention and Control Directorate of FMoH. However, close collaboration with Maternal and child health Directorate as well as other relevant directorates like the Medical Services Directorate is crucial.

The Federal Ministry of Health is responsible to:

1. Coordinate the national clinical mentoring program
2. Ensure that clinical mentoring is implemented across the health system in all regions

3. Make sure that relevant stakeholders including government institutions, development partners, and professional associations carry out the defined roles in clinical mentoring
4. Define policy framework for clinical mentorship
5. Lead national priority setting for clinical mentorship in consultation with stakeholders
6. Develop/review clinical mentoring materials for selected priority areas including guidelines, training materials, and implementation tools.
7. Coordinate training of clinical mentoring trainers for each region in collaboration with relevant stakeholders to ensure that the national clinical mentoring guideline is implemented
8. Monitor the institutionalization of clinical mentoring across the health system through providing necessary support systems including but not limited to availability of:
    * Budget
    * Staffing
    * Transportation
    * Equipment and supplies
    * Relevant information systems
    * Guidelines, training manuals and tools

Regional Level

The Regional/City Administration Health Bureaus are responsible for:

1. Maintaining ownership and leadership of the clinical mentoring program
2. Adapting the national policy framework for use at the regional level
3. Adapting national priority areas to meet regional needs
4. Leading the implementation plan for clinical mentoring, including assigning mentoring relationships between facilities in collaboration with zonal health departments and woreda health offices

5. Ensuring the availability of necessary support systems including but not limited to:
    * Budget
    * Staffing
    * Transportation
    * Equipment and supplies
    * Relevant information systems
    * Guidelines, training manuals and tools
6. Ensuring clinical mentoring is included in the annual/woreda based planning and budgeting processes through support to Zonal and Woreda health offices.
7. Coordinating training for mentors at all levels through engagement with relevant stakeholders including local universities
8. Ensuring feedback from mentoring activities is shared at all levels, including regional leadership, health facilities, and mentors.
9. Monitoring and Evaluation of clinical mentoring program

Zonal Level

1. Ensure ongoing implementation of clinical mentoring program activities
2. Adapt regional clinical mentoring priority areas for zonal requirements
3. Ensure Adequate Resources for mentoring
    * Budget
    * Staffing
    * Transportation
    * Equipment/supplies
    * Information System
    * Guidelines, training manual and tools
4. Participate in setting up the health facility networking for mentoring
5. Support woreda health office in the planning of clinical mentoring activities

6. Support training of mentors
7. Monitoring and Evaluation of the clinical mentoring program

Woreda/Town Health Offices

i. Ensure implementation of clinical mentoring program as scheduled
ii. Ensure Adequate Resources for mentoring in partnership with zonal/ regional leadership
    1. Budget
    2. Staffing
    3. Transportation
    4. Equipment/supplies
    5. Information System
    6. Other
iii. Participate in setting up the health facility network for mentoring(With RHB and Zonal Health Department)
iv. Partner with health facilities to identify mentors and mentees
v. Support health facilities in the planning of clinical mentoring program
vi. Facilitate training of mentors
vii. Monitoring and Evaluation of mentoring program

Regional Referral Hospitals –to mentor nearby health facilities

i. Identify potential mentors for training
ii. Assign mentors
iii. Ensure availability of resources (in collaboration with RHBs/ZHD/ WHOs)
    1. Transportation
    2. Equipment
    3. Per Diems

iv. Provide onsite refresher training opportunities for mentors with in their catchment

v. Consider mentoring roles in staff requirements and rotations

vi. Ensure mentoring is integrated in annual planning, budgeting and routine performance reporting

vii. Conduct internal mentoring within facilities

viii. Reporting mentoring activities to the Zone/Region

Zonal/District Hospitals/Mentor health centers

i. Identify potential mentors

ii. Assign mentors

iii. Make the mentees available as per the schedule

iv. Ensure availability of resources (in partnership with Zonal Health Department)

    1. Transportation
    2. Equipment
    3. Per Diems

v. Provide onsite refresher training opportunities for mentors with in their catchment

vi. Consider mentoring roles in staff requirements and rotations

vii. Ensure mentoring is integrated in annual planning, budgeting and routine performance reporting

viii. Conduct internal mentoring within facilities

ix. Reporting mentoring activities to the Zone/Region

Health facilities receiving clinical mentoring

i. Ensure proper implementation of the mentorship schedule

ii. Make sure mentees are available as per schedule

iii. Closely coordinate training plans with Primary Hospital and woreda health Office

iv. Implement action points of the mentoring visit.

Mentee graduation criteria

As the mentee gains confidence and competence in providing the service, he/she will require less face-to-face interaction with the clinical mentor. It is recommended that the mentee could continue consultation either through phone or e-mail as required. The clinical mentor can determine that the mentee is competent after evaluation of core competencies. If the mentee requires further support, contact sessions should continue.

A. Mentee graduation

A mentee is ready for graduation when the following criteria are fulfilled

* Has received mentorship for at least six consecutive sessions in about 6-9 months, and
* Mentor confirms that mentee has demonstrated required knowledge/skill through progressive evaluation according to standardized criteria. (See annex 8.1)

B. Facility graduation

A given facility is ready for graduation when the following criteria are fulfilled

* Received mentorship at least for one year
* At least two graduated mentees on the specific service areas
* The facility is self-sufficient and conducts internal mentorship
* Demonstrated good coordination and management

NB: Even though, a facility has already been graduated, it can be returned to a mentee facility if it fails to fulfill the above mentioned criteria up on re-evaluation.

6 APPROACHES AND TOOLS FOR CLINICAL MENTORING

6.1. Site visits by mentors

Comprehensive assessment of the need for clinical mentoring should be conducted before initiating the clinical mentoring support. The assessment need to focus on the capacity and professional mix of the facility as well as the quality of services. The clinical mentoring need assessment should also be continued every six months for all health facilities including those which have been graduated.

Clinical mentoring can be on site or off site.

- **Off-site**: when the mentors move from their facility of practice to other treatment site to provide mentoring.
- **On-site mentoring:** when the mentor and mentee are within the same facility. For facilities with adequate number of expertise, onsite mentoring need to be emphasized rather than offsite which is cost effective and will help to assure sustainability.

In a facility that is newly starting ART, site visits by the clinical mentor is important soon after the training of the clinical team. This is the time when the clinical team organizes the HIV care/ART services at the site. The major goals of site visits by the clinical mentor are reinforcing the training and building relationship with the clinical team members.

Each visit will take at least one full day. The mentor may use some or all of the following modalities of clinical mentoring during the visit.

1. One-on-one case management observation;
2. Review patient records and provider documentation of health care (clinic-based records);
3. Clinical case review: people recently initiated on ART, routine and challenging or difficult cases and deaths;
4. Multidisciplinary team meeting to elicit feedback: identifying potential problem areas and issues and recommendations; and

Each mentoring visit activities like who was mentored, for how long, types of cases discussed, findings, recommendations and lessons learned should be documented.

Table 1: Summaries of activities of mentors providing off/onsite mentoring

Parameters	Offsite mentoring	Onsite
Program Planning	Mentor facility and regional health bureaus need to develop detailed annual plan	Facility and region health bureau need to develop annual plan. The health facility will have to take the major responsibility of planning and implementation.
Activity Planning	The mentor need to prepare a detailed activity plan for each facility mentored	The mentor need to plan a detailed annual activity plan
Duration	A minimum of one day	A minimum of one day
Frequency	Every month for the first six months then every 2-3 months	Twice in a month
Reporting	Will report to the head of facility, and nearest health administrative unit(WoHO, ZHD,RHB)	Will report to the head of facility

The onsite mentoring should be monitored and evaluated by the facility quality committee or relevant committees like MDT. It should also be evaluated and supported by program managers at each level.

Sequence of steps in a clinical mentoring visit

Figure 4: Sequence of steps in a clinical mentoring visit

A checklist can be useful to guide the mentors on which steps to focus and which ones to cover during the site visit.

Each step will be accomplished in a standardized fashion and tools of effectiveness in terms of measuring the improvement in knowledge and skills of the mentee and quality of the care to be adapted and applied.

Even though the emphasis for the clinical mentoring support is the ART/PMTCT clinic, the clinician mentors need to oversee the other service units that including the ART pharmacy. For the pharmacy mentoring, in addition to the clinicians oversee, pharmacy experts will mentor twice a year using the pharmacy-mentoring tool.

6.1.1 One-on-one case management observation

Mentor observes the mentee managing a patient and then provides constructive feedback. The approach of giving feedback must be tactful and productive. The different health care professionals and Adherence Counselors in the clinical team are mentored with the same mentor. Therefore, the one-on-one mentoring, in particular giving feedback to each member of the clinical team at the health center, critically takes into account the level of mentee. The mentor should use time wisely. It may not be possible to observe and provide feedback to all clinical team members in the same visit. Therefore, the mentor makes sure to observe everyone in the team over several visits.

There are different kinds of checklists developed for one-on-one mentoring based on the professional category of the mentee. For instance, the checklist intended for clinicians need to consider the following care components:

- To obtain a good medical history
- To perform a comprehensive physical examination
- Initiation/refill of ART drugs
- To ask about possible toxicity from ARV or other drugs;
- To assess adherence to ART and other treatments
- To screen and treat for OIs;
- To review other concomitant medications;
- To assess for prevention practices;
- To educate the patient on relevant issues related to the visit; and
- To perform a quick home or situational assessment to determine others (partner or children) at risk for HIV infection and refer them for VCT, etc.
- To provide client focused care

Standardized tools which support assessment and feedback provision are attached in the annex.

6.1.2 Review of patient monitoring formats

All health facilities use the same documentation and reporting system of the national ART program. There are registers (Pre-ART and ART), intake formats and follow up formats. The mentor is expected to review the charts and registers for two reasons. The first one is to discuss on the management of specific patients with the clinical team or the mentee. The mentor will also discuss on the consistency and completeness of these formats in order to address documentation related knowledge or skill gaps.

The second one is to follow and provide support on the quality of data recording. The mentor randomly selects five patient records to look for recording error and the provision of standard services. The registers are checked to make sure that the information has been correctly transferred from patient record to the registers. Checking the medical recording system may be an overlap with supportive supervision, in particular at the earliest stage of the initiation of the care. However, there is no much problem with the duplication since medical recording requires considerable attention. While checking the medical recording system and providing feedback, the mentor should always develop good relationship and create a sense of trust with the clinical team. The goal of reviewing medical records for the mentor is to better understand how to help and teach the clinical team, not a police or audit medical errors.

6.1.3 Clinical case discussions

The cases selected by the clinical team for discussion include patients newly started with ART and difficult cases. Difficult cases include patients not responding to treatment as expected, children, patients with severe drug adverse effects or intolerance, suspected treatment failure, etc. Actual cases from the facility itself are generally preferable, but some mentors have used prepared cases from other sites.

During case presentations and discussions, the mentor should lead the case discussion in the following fashion:

- Presenting the case with interactive discussion;
- Presenting the results of the physical examination
- Developing a problem list, reviewing clinical reasoning and establishing a diagnostic and management plan
- Emphasizing other areas including patient education, prevention, adherence and counseling; and
- Summarizing learning points.

The medium of communication may be a local language as long as it is mutually understood by both of them. The health worker that leads the team is responsible for case selection, presentation, record keeping on the logbook and discussion according to the format. The mentors make assessment of the discussed cases by looking into the logbook. This assists to recommend the type of case to be selected for the next discussion. Inpatients may also be used and, on occasions, a sort of bedside teaching could be provided.

6.2. Mentoring by telephone

The mentee functions independently between the visits. Yet case management plans can be reviewed with the mentor by telephone. This improves quality of care and reduces the possibility of frequently displacing the mentor from hospital ART clinic. Presentation of cases by telephone and subsequent discussion to reach a management plan decision demands training. The mentors and mentees should be provided with such kind of training. Mobile phones can be used for such purpose. The telephone is much more convenient than the Internet for this purpose since mentor can quickly ask for clarification or additional information from the mentee after case presentation.

The mentor may have to initially call the mentee regularly, to solicit problems, discuss cases and follow up on cases and problems discussed during the previous site visits. The mentee should be encouraged by the mentor to call any time and frequently, although agreement when to call may be arranged.

Other complementary approaches such as call centers, telemedicine may be used to make mentoring effective, sustainable and easily done. Such technologies and approaches retain the mentors at the hospitals where they provide their routine services fulltime. Partners could play important role with this regard. Making broadband Internet access available at the health centers and hospitals would be a cost effective capacity building.

Teleconference and e-mail- Clinical mentorship can also be supported through tele-medicine. Internet based approaches can be effective in certain settings; internet access is increasingly available in facilities and case presentations via web-based sites can be done where there is suitable technology.

Call centers are important elements of mentee support, and all participants in clinical mentorship programs should be encouraged to use those for technical support.

7

MONITORING AND EVALUATION OF CLINICAL MENTORING PROGRAM

The monitoring and evaluation plan for a clinical mentoring program should be geared towards the processes and expected outcomes of the mentoring program as indicated in the preceding chapters.

Among the expected outcomes of clinical mentoring that show improvement of service quality include:

- Health care workers gain knowledge and skills about comprehensive HIV care/ART
- Health care workers improved the quality of HIV service delivery
- A forum of clinical mentors is established which meets regularly and review the overall implementations and outcomes of mentoring
- Improvements are made in the facility operations and systems (patient flow, record keeping, supervision, logistics, etc.)
- Ownership and leadership of the mentoring program and continuous support by the management arms at all levels of the health system

The process of clinical mentoring can be monitored using the following simple indicators:

- Number of site visits per mentor
- Number of mentor hours/month/facility
- Progress of knowledge and skill of mentees across a period of time based on serial preceptors scoring
- Documented mentorship feedback
- Discuss Mentees feedback after each visit:
    - Evaluation of individual mentor
    - Appropriateness of mentor's questions or comments to the mentee concerning technical aspects of the mentee's practice
    - The mentor's questions and phrasing of suggestions to the patient are appropriate in content and time.
- Review of mentor's plan and report(see annexes 8.3 and 8.4.3)
- Periodic mentors' review meetings: a forum of exchange of experiences among mentors.

The above indicators enable to track how well the mentoring system is functioning, but not the effect of clinical mentoring on the quality of HIV care/ART. For this purpose different monitoring indicators could be used. The M&E of mentoring must be linked with the M&E of the overall comprehensive HIV care/ART program of the country. The impact of the mentoring services on the quality of care as well as on the overall accelerated scale up of the HIV care must be monitored with sensitive indicators.

As a rule of thumb the M&E of Clinical mentoring should be integrated with the overall M&E of HIV national program. Various stake holders have different responsibilities as far M&E of clinical mentoring is involved:

Roles of FMOH:

- List out the key tools needed for M and E
- Develop standard M&E tool (checklist, Site visit reporting template with feedback, Evaluation form)
- Receive feedback from RHBs regarding M and E tools and incorporate comments while updating
- Disseminate the key findings, program outputs/outcomes at annual review meeting
- Incorporate mentoring as one component of ISS and review meetings
- Period evaluation of the mentoring program.

Roles of RHBs

- A focal person should be assigned to receive summary reports on administrative and operational issues which require attention of RHB, Regional Lab/EPHI and PFSA.
    - Avail all the necessary recording and reporting tools
    - Take action based on summary of mentorship report. Follow the documentation of feedback given and improvements in the health facilities
- Update the M&E tool based on regional reality/priority areas
- Incorporate mentoring monitoring activities as part of ISS and review meetings
- Disseminate the findings during regional review meeting

Roles of Zonal health department/WoHO

- Incorporate mentoring as one component of ISS and review meetings
- Avail the necessary inputs for mentoring(guideline, formats, tools)
- Monitor and follow implementation of mentoring program related supervision findings

Role of health facilities providing mentorship support

- Select and assign an external mentor based on the selection criteria
- Set schedule for off-site mentoring
- Based on the monthly off-site mentoring schedule exempt the assigned offsite mentors from routine work.
- Provide necessary supports for the mentor like transport arrangement, stationary and others
- Follow implementation of the off-site mentoring as per their schedules
- Ensure off-site mentoring reports are submitted timely and identified gaps are addressed timely
- Ensure summary reports requiring attention of RHB, Regional Laboratory/EPHI, PFSA, ZHD, Town Health Office reports are compiled, submitted to next level and archived

Roles of the mentor

- Develop mentoring action plan and submit timely to RHB and ZHD
- Check for completeness and accuracy of documents required for clinical mentoring
- Monitor the improvement of service deliveries by supporting use of facility level data analysis and decision making
- Prepare mentoring activity report at each visit and timely submission to ZHD/RHB
- Support mentees to use various tools and reporting formats appropriately and timely.
- Check availability of HIV related M&E tools and registers.
- Review the implementation of activities planned during previous visits.
- Provide feedback

Responsibility of the mentee

- Utilize feedbacks for improving quality of service
- Provide feedback on the mentor's activities'
- Identify and prepare difficult cases for discussion with the mentor
- Ensure clean and accurate documentation of HIV related data
- Prepare accurate and timely monthly reports
- Analyze and use data for decision making and quality improvement

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ANNEX

1. CLINICAL MENTORINGTOOL

A. SKILL (PRECEPTER)CHECK LIST FOR HEALTH WORKERS

(N.B: *The mentor should spend at least two-third of his/her stay in conducting one - on- one case management observation*)

Mentee:..... Mentor:..... Date:.....
Facility.....

Qualification ..... Qualification .....

Please summarize the Mentee's demonstrated knowledge and skills using the codes below:

Mentee Competency level assessment category

- **X= not applicable**
- **1 = None:** No demonstrated skills at all or does not perform the task(s) completely .Needs a lot of support
- **2 = Limited:** Mentee demonstrates very limited strengths or skills in this area and needs additional support
- **3 = some:** Mentee demonstrates some ability or skills in this area.
- **4 = Strong:** Mentee demonstrates excellent skills or strengths in this area

Completeness of Mentor's assessment

- **A = Comprehensive assessment–** skill was assessed completely,mentor was able to observe fully.
- **B = Satisfactory assessment–** assessment was satisfactory although mentee›s skill may exceed than observed.
- **C =Partial assessment** .....Observations and scores based on incomplete information.
- **R = Resource limits–**skill or care limitation clearly related to resource limits.

Use the "comments" column to note key observations to be discussed later with the Mentee. In addition, this space should be used to record explanations to why recommended practices were not followed, to describe instances where the provider was particularly effective and/or to note particularly useful advice provided by the Mentor to the Mentee.

Note: Clinical Mentors need to focus on knowledge and skill capacity building of mentees providing care and treatment services using the Preceptor check list (A). The chart abstraction tool (B) is intended to be used to review client charts, registers and oversee service integration/ linkage with other units.

1. Two third of the mentoring time should be used for technical capacity building
2. One third of the mentoring time should be used for chart review and oversee service integration/linkage with other units.

Demonstrated knowledge and skills	Comments	Codes1-4,A- C,R,X
Professional and Interpersonal skills		
Provider is welcoming for the clients(Greets with dignity and respect)		
Briefly describe the purpose of the mentor ship program to the patient(i.e., the mentee need to explain to his/her clients who the mentor is and mentor's purpose)		
Patient centered (listens to patient's ideas and concerns)		
Creates trusting/supportive rapport with the patient (encourages open communication-Uses recommended communication skills to encourage and open the client to tell their stories)		
Timely(doesn't rush patient and doesn't take too much time-provides adequate time to address all concerns as well as does not take unnecessary too much time when it is not needed)		
Treats patient with empathy, dignity and respect (including confidentiality; maintain slows peaking voice)		
Assessment		
Conducts focused and open discussion of medical, social and family history and progress relevant to current complaint including assessment of adherence		
Uses team approach (shares information with adherence counselor, efficient interaction and lack of duplication)		
Conducts adequate physical examination(pertinent in relation to history and current complaints)		
Accuracy of assessment and diagnosis(including WHO staging)		

Patient management and care plan		
ART adherence, tolerance and side effects addressed.		
Appropriate involvement of patient in development of a focused management plan		
Appropriateness of recommended drug treatment(ART and OIs)		
Appropriateness of recommended laboratory tests		
Patient education on sexual and other risk behavior		
Emotional and psycho-social support needs discussed and addressed		
Gave appropriate Referral as required		
Develops appropriate follow up schedule		
Documentation and recording		
Appropriate history and physical examination findings are documented on the respective formats		
Documentations are complete and consistent		
All required formats are updated and complete		

A. Chart Abstraction tool

Activity	Performance(Document percentage for each observation)		Bottle necks (Causes for low performance)	Actions Planed (Mitigations to address the bottle necks	Remarks
ART/PMTCT clinic(Patient chart review: *Draw 3 adult ART and 2 pediatric patient charts randomly and Check for updates and completeness of the following)*	Performed/All charts (%)				
	Adult	Pediatrics			
BMI calculated for adults					
Growth monitoring for children <15yrs of age					
Prevention counselling(Family planning, condom use)					
TB screening					
INH prophylaxis					
CD4 determination done as per the guideline					
Viral load determined as per the guideline					
CPT provision for eligible clients					
WHO Clinical staging/T-staging					
ART initiated for all clients as per the guideline					
Prevention plan(Disclosure, STI, Psychosocial support)					

Check intake form for completeness and updates on index case family testing					
Eligibility for appointment spacing care and whether client is provided ASM.					
Review last three months record on ART register and assess for Completeness and updates					
Review last three months record on Pre-ART register and assess for Completeness and updates					
Review retesting practice by checking recently initiated clients against the retesting register(Draw three newly initiated clients chart)					
Review completeness and consistency of the EAC support on the high viral load register for at least five clients records					

Service integration					
TB clinic: Check the TB-DOTS register for the last three months					
TB patients HIV testing					
Linkage to ART					
CPT initiation					
ARV initiation					
VCT clinic					
Check linkage of HIV +ve clients to ART care (last 1 month) with linkage confirmation mechanisms					
ANC/Labor ward: check the ANC, delivery and integrated MNCH/mother baby pair cohort registers data of the last one months					
HIV testing of all pregnant women					
Provision of ARV prophylaxis to the infant					
DNA PCR testing of the infant					
Review last three months record on mother baby cohort register(Completeness and updates)					

Pharmacy					
Check Stock out of any drugs(ARV,OI drugs)					
Adherence Counselling provided					
Pharmacy records are used and updated(Dispensing register and patient information sheet)					
Laboratory					
Laboratory machines Failure **YES NO**		If **YES** specify which machine			
Stock out of Lab Supplies (sample collection as well as reagents **YES NO**		If **YES** Specify			

Interpretation of performance observation findings: *Poor <50%, Fair=50-75%, Good= 75-90%, Very good >90%*

2. Clinical Mentoring Activities Logbook

This is a tool to document routine mentorship activities at facility level

Types of cases discussed

Major achievements

Gaps identified

Challenges

Actions taken

Recommendation/Planned actions

Mentors name and signature .....

Mentees name and Signature .....

Facility head name and signature .....

Date.....

3. Clinical Mentoring Activities Reporting Template

Activity	Report/observation
Major achievements	
Gaps Identified	
Challenges	
Actions taken	
Recommendation/ Planned actions	

Mentor's Name..... Sign.....

Mentee's Name..... Sign.....

Date.....

NB: Only program related gaps need to be mentioned here and avoid specific mentee related issues.

4. Clinical mentoring implementation monitoring tool: Facility level

Name of Mentor Health Facility.....

Name of Mentee Health Facility .....

Activities		Status	Remark
Number of facilities planned for clinical mentoring in the quarter			
Number of facilities mentored in the quarter			
Number of monthly summary reports received			
Gaps identified	Mentorship training		
	Mentorship related tools		
	HIV commodities (specify)		
	Finance		
	Transportation		
Number of mentoring related JSS	Improved scoring of the preceptor checklist*		
	Verified mentorship Documentation at facilities		
Number of review meetings conducted			
Number of Internal mentorship conducted in the quarter			

**Those, who scored 3 & 4 from the initial lower score.*

5. Clinical mentoring implementation monitoring tool: RHB level

.....Regional Health Bureau

Number of Health Facilities providing Mentorship: Hospitals..... HC.....

Number of Health Facilities receiving Mentorship: Hospitals..... HC.....

Number of available trained mentors in the quarter.....

Evaluation Period: .....

Activities		Status	Remarks
Number of facilities planned for mentorship in the quarter			
Number of facilities mentored in the quarter			
Number of monthly summary reports received			
Gaps identified	Mentorship training		
	Mentorship related tools		
	HIV commodities (specify)		
	Finance		
	Transportation		
Number of mentoring related JSS	Improved scoring of the preceptor checklist*		
	Verified mentorship Documentation at facilities		
Number of review meetings conducted			

**Those, who scored 3 & 4 from the initial lower score.*

6. ART Pharmacy Mentoring Tool
General direction to the mentor:

This checklist is to be filled by the mentor during every mentoringvisit. If an activity is covered during mentoring (i.e. mentored), write YES, otherwise write NO. Write challenges (bottle necks) encountered during the mentoring process and write the assignments given to the mentor and the mentee or to any other party.

Mentee facility: ..... ;WoHO name: .....

Mentee name: ..... ; Mentee mobile: .....

Mentor name: ..... ; Date of mentoring: .....

	Major activities covered during mentoring	Yes / No	Challenges faced	Assignment for mentee or mentor
ART pharmacy service related	Briefly describe the purpose of the mentor ship program to the patient (i.e. What the Mentor is			
	read the prescription correctly (including patient name & age, medicine description, dosage instructions)			
	Ask patients for the goal for ART pharmacy visit			
	Check understanding of HIV/AIDS and ARV therapy			
	Ensure patients readiness and willingness for ARV therapy			
	Discuss importance of lifelong treatment adherence and identify adherence barriers.			
	Suggest possible solutions with the patient to improve adherence			
	Educate patients on the importance of adherence in the prevention of resistance			
	Encourage the use of adherence aids/reminder devices (e.g. alarms).			
	communicate the patient politely and provide proper information (medicine name, dose, frequency and route of administration, medicine handling at home, cautions)			

	Counsel patients/care taker during initiation of ART on potential side effects and how to cope with them.
	Explain medication dosing and how to handle missed doses.
	Advise patients about medication toxicities, how to prevent or control them and when to seek medical assistance.
	Discuss potential drug-drug, drug-food, or drug-alternative medicines interactions
	Ensure patients get drugs with sufficient shelf life for use until next appointment (more attention to clients on ASM)
	Correctly label all ARVs and OI medicines (patient name, medicine description, dose, frequency of administration)
	Provide drug information specific to pregnant and breastfeeding mothers as well as children.
	Counselling on family planning and condom use
	Discuss with patients importance of regular follow-up and scheduled follow-up appointment for refills to assess and identify clinical efficacy or treatment failure and to detect drug related toxicity.
	Involve patients and their families as an active participant in their adherence plan.
	Monitors and supports adherence regularly at each visit (especially in children)
	Assess the patient about their current medications whenever filling a prescription that is new for them.
	Monitor the ART outcomes and potential side effects of ARV medicines.
	Monitor and identify potential drug–drug interactions, and recommend for dose adjustment or prevent co-administration of contraindicated medications.
	Dispense Plumpy nut and Plumpy sup and counsel patients on their proper use.
	Recommend dosage adjustment in renal and hepatic dysfunction.
	Provide information to other healthcare providers about the next regimens to be used after switching or changing of therapy.
	Should educate healthcare team members on ARV drug interactions, and its management

	Participates in the MDT meetings regularly
	Should have excellent coordination with multidisciplinary team to avoid/manage drug interactions or to monitor patients for treatment failure or toxicity.
	Provide information for other healthcare provider on regimen selection, the availability of different options, dosage forms and consult on drug-drug interaction.
	Discuss with professionals on general issues related to treatment failure and potential prevention strategies.
	Uses team approach (shares information with adherence counselor/case managers & data clerks)
	Closely work and collaborate with prescribers in prevention and treatment of OIs.
	Recommend drugs for the prophylaxis and treatment of common OIs.
	Filling the patient information sheet (the yellow sheet) properly for every visit of each patient (check for its availability, completeness for each patient, updating practice and the sequential arrangement)
	If available check for EDT functionality and updating practice
	Check for the completeness of drug dispensing register
	Check for the presence and completeness of monthly consumption summary
	Provide appointment for next visit date

ARV	Continuously avail required medicines for prophylaxis and treatment of OIs.
supply chain related	Ensure that LPV/r suspension is kept in refrigerator.
	(N.B: If unable to refrigerate, use within 60 days. AZT, ABC & NVP suspensions DO NOT need refrigeration)
	Arranging containers/packs/ with labels, expiry dates and manufacturing dates clearly visible in a way to facilitate FEFO.
	Check for Bin Card availability, completeness and updating practice at both ART pharmacy and health facility store.
	Check for RRF (completeness, timeliness, accuracy and chronological filing)
	Check for IFRR (completeness, timeliness, accuracy and chronological filing)
	Check for stock out of 1st line ARV drug (TDF/3TC/EFV)
	Check for stock out of 2nd line ARV drugs (LPV/r)
	Check for stock out of 100mg INH for IPT
	Check for stock out of 300mg INH for IPT
	Check for stock out of Co-trimoxazole for CPT
	Check for stock out of Fluconazole for FPT
	Check for stock out of rapid HIV Test Kits
	Check for stock out of DBS Kits/accessories