Summary Book

Comprehensive Supportive Supervision and Mentoring

(CSS&M)

Health Systems Strengthening for HIV and AIDS Services Project

Oct 2014

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Therapy
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CQIT	Council Quality Improvement Team
CSS	Comprehensive Supportive Supervision
CSS&M	Comprehensive Supportive Supervision and Mentoring
DS	District Supervisors
5S	Five S (Sort, Set, Shine, Standardize and Sustain)
HBC	Home Based Care
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMT	Hospital Management Team
HTC	HIV Testing and Counselling
ICT	Information Communication Technology
IPs	Implementing Partners
JICA	Japan International Cooperation Agency
LAB	Laboratory
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Programme
NQIT	National Quality Improvement Team
NS	National Supervisors
PMTCT	Prevention of Mother to Child Transmission
QI	Quality Improvement
QIT	Quality Improvement Team
RHMT	Regional Health Management Team
RQIT	Regional Quality Improvement Team
RS	Regional Supervisors
SOPs	Standard Operating Procedures
SS	Supportive Supervision
STIs/RTIs	Sexually Transmitted Infections and Reproductive Tract Infections
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

1. INTRODUCTION

The Ministry of Health and Social Welfare (MOHSW) through the National AIDS Control Programme (NACP) has implemented a four-year project entitled "Health Systems Strengthening for HIV and AIDS Services Project" since Oct 2010 with support from the Japan International Cooperation Agency (JICA).

One of the focuses of the project was operationalization of comprehensive supportive supervision and mentoring (CSS&M) for HIV and AIDS services in two model regions, i.e., Dodoma and Pwani in utilization of the Manual and Tools developed in 2010. The MOHSW intended to transform intervention-specific supervisions to comprehensive supportive supervision and introduce mentoring to attend intervention-specific clinical needs identified through complement supportive supervision. The idea was in line with the recommendations made by the World Health Organization in 2006[1].

This document is a summary to share the experience in operationalizing CSS&M at the national level and in the two model regions.

2. WHAT WERE THE PROBLEMS IN GENERAL?

In Tanzania, supervision on HIV and AIDS interventions had been conducted by external supervisors of both government and implementing partners for each intervention separately in an uncoordinated manner with different supervision tools. Such intervention-specific supervisions were unlinked and often left some important issues unattended. In addition, supervision depended on the interest of donors. Some interventions were well supported by donors with enough funds to conduct supervision visits while others were not.

Clinical mentoring was introduced to some districts by a few implementing partners (IPs) as a pilot intervention to meet technical needs at health facilities that started to offer Anti-retroviral Therapy (ART). However, their approaches differed from partners to partners. Mentoring was an unpopular concept that was not clearly understood especially in relation to supervision.

3. WHAT SYSTEM DID THE MOHSW WANT TO INSTALL?

The NACP envisioned operationalization of CSS&M as depicted in Figures 1 and 2 in line

[1] WORLD HEALTH ORGANIZATION. (2006) *WHO recommendations for mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained settings*. Geneva: WHO.

with the Tanzania Health System structure.

Supportive supervision shall be comprehensive, covering all HIV and AIDS interventions and support services. The main focus of CSS shall be administrative and programmatic issues. Specific technical issues identified but not attended by supervisors shall be taken up by mentors who are practitioners in specific interventions. Mentoring shall be offered through site visits and ICT communication. Supervisors and mentors need to have meetings to share information and make decisions on actions. This structure shall be established at each level and linked each other from the national level to the community level in line with the national health system[2].

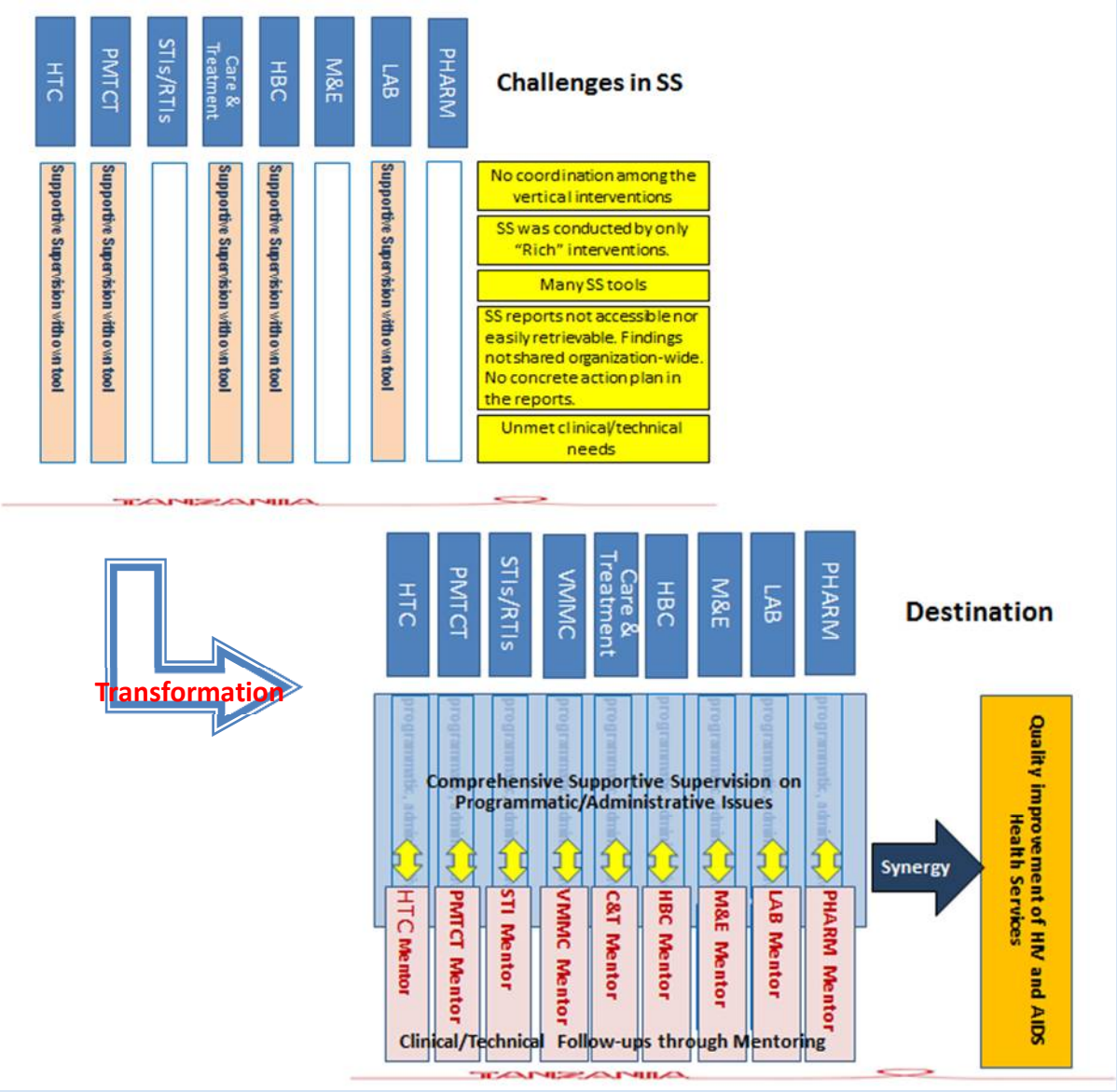


Figure 1: Envisioned Destination of Comprehensive Supportive Supervision and Mentoring

[2] *A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services Second Edition (2014)*

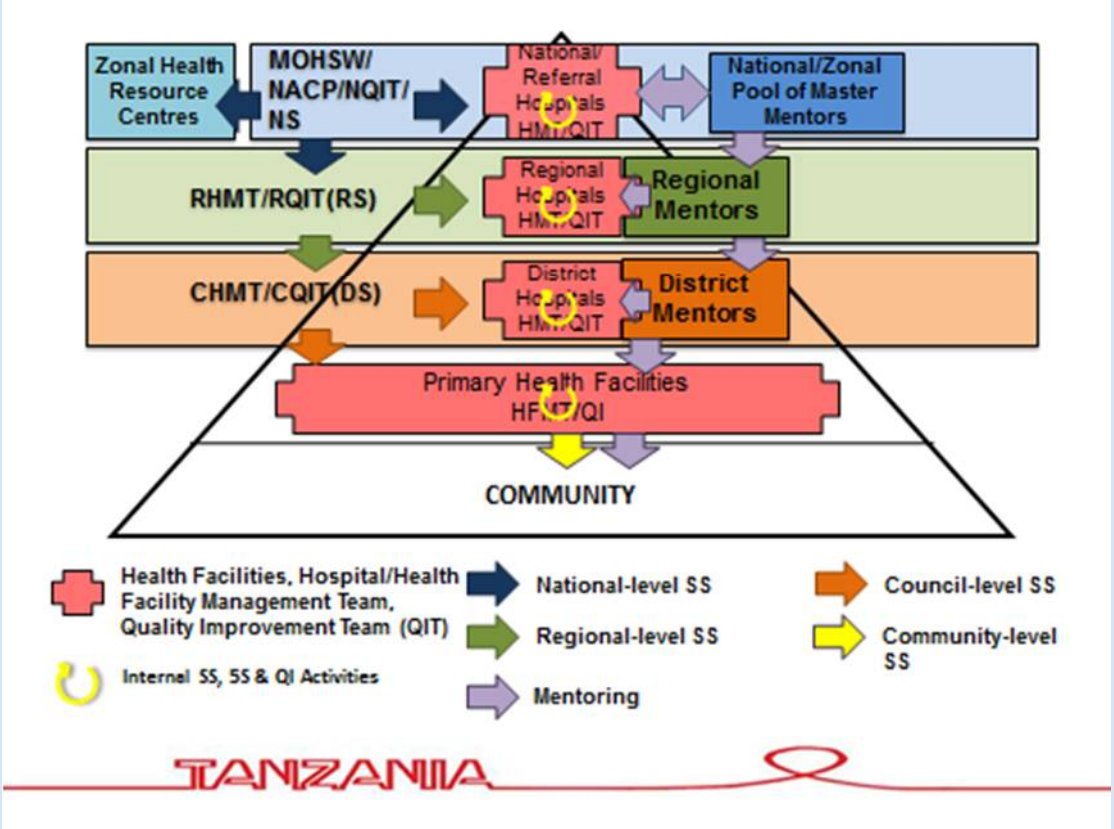


Figure 2: National Health System and Structure of Supportive Supervision and Mentoring

4. HOW WAS THE SITUATION AT THE BEGINNING OF THE PROJECT?

During the period of 2010/11, at the national level, the CSS tool had not been fully utilized although the Manual and Tools for CSS&M had already been published. Supervision to regions was still coordinated, planned and implemented by each vertical intervention team. Supervision reports were kept in an unorganized manner at each Unit of the NACP and the reports were not easily accessible to other unit members of the NACP. Once submitted, the reports had hardly been utilized. Mentoring had not started yet at the national level.

At the regional level, both Regional Health Management Teams (RHMTs) conducted supportive supervision on HIV and AIDS interventions to health facilities and reports were available. However, no reports were available on supportive supervision to Council Health Management Teams (CHMTs), which was one of the primary responsibilities of RHMTs.

The reports described strengths, challenges and recommendations for health facilities. However, action plan with responsible person and timeline for recommended actions was not included. Both regions had not started mentoring yet.

At the council level, all CHMTs in the model regions conducted supportive supervision on

HIV and AIDS interventions to health facilities although they had not started to use the NACP CSS tool for supervision of HIV and AIDS interventions. According to the responses by the CHMTs, 9 out of 13 CHMTs supervised more than 90% of health facilities offering at least one of HIV and AIDS interventions. However, supervision reports covering HIV and AIDS services were hardly accessible. Only 4 out of 13 CHMTs could present their reports for the fiscal year 2010/11. These reports were not health facility specific. A supportive supervision report was a monthly or quarterly summary covering many health facilities. Mentoring activities had been introduced by IPs in some CHMTs although the NACP mentoring tools had never been used yet.

5. WHAT INDICATORS WERE SET TO MONITOR THE LEVEL OF OPERATIONALIZATION OF CSS&M?

5.1. At the national level:

1) One coordinated supportive supervision plan in place.
2) Retrievable documentation rate of CSS in the past one year
   Numerator – Number of CSS reports submitted and archived as shared documents in the past one year
   Denominator – Number of CSS conducted in the past one year
3) Execution rate of mentoring in response to the needs identified and documented by national supervisors in the past one year
   Numerator – Number of mentoring needs attended by national mentors in the past one year
   Denominator – Number of mentoring needs identified and documented by national supervisors in the past one year

5.2. At the regional level:

1) Retrievable documentation rate of supervision covering HIV and AIDS services to both regional hospital and CHMTs in the past one year
   Numerator – Number of retrievable SS reports covering HIV and AIDS services in the past one year
   Denominator – Number of SS visits covering HIV and AIDS to Regional Hospital and CHMTs in the past one year
2) Execution rate of mentoring in response to the needs identified and documented by regional supervisors in the past one year
   Numerator – Number of mentoring needs attended by regional mentors in the past one year

Denominator – Number of mentoring needs identified and documented by regional supervisors in the past one year

5.3. At the council level:

1) Retrievable documentation rate of supervision covering HIV and AIDS to health facilities in the past one year.
   Numerator – Number of health facilities supervised and documented covering HIV and AIDS services in the past one year
   Denominator – Number of health facilities supervised covering HIV and AIDS in the past one year
2) Execution rate of mentoring in response to the needs identified and documented by council supervisors in the past one year
   Numerator – Number of mentoring needs attended by council mentors in the past one year
   Denominator – Number of mentoring needs identified and documented by council supervisors in the past one year

6. WHAT DID THE PROJECT DO?

The project conducted the following activities:

6.1. At the national level

1) Developed a standardized training package for CSS&M in August 2011 to train supervisors and mentors to operationalize CSS&M using the manual and tools at all levels.
2) Trained trainers of the CSS&M training in June 2011 and August 2012
3) Trained national level supervisors and mentors in 2011 and 2012
4) Developed and installed a Web-based CSS&M Archive System in April 2012 to facilitate information sharing among all NACP staff
5) Conducted CSS to Dodoma and Pwani regions and provided OJT to RHMTs and CHMTs in January 2013
6) Conducted workshops to review and revise the CSS&M manual and tools in December 2013
7) Conducted CSS to Dodoma and Pwani regions and provided OJT to RHMTs and CHMTs in January 2014
8) Revised the CSS&M manual and tools during December 2013 – April 2014 to accommodate new HIV/AIDS approaches and CSS&M structure and information flow

(the documents available at http://www.nacp.go.tz/)

9) Conducted a study tour to Zimbabwe to learn supervision and clinical mentoring approaches of Zimbabwe
10) Conducted a National Stakeholders Meeting in August 2014 to share findings from the study tour to Zimbabwe and mentoring good practices by national mentors

6.2. At the regional and council level

1) Conducted an orientation on CSS&M to RHMTs and CHMTs in the model regions in July 2011
2) Trained regional and council-level supervisors and mentors for Dodoma and Pwani during January – March 2012
3) Conducted an orientation workshop on CSS&M documentation and information flow in January 2013
4) Conducted an assessment on CSS&M implementation in the past one year during July – August 2013
5) Conducted a regional stakeholders meeting in October 2013 to share the findings of the assessment and the good practices identified. Each R/CHMT conducted SWOT analysis and made an action plan to improve the situation
6) Conducted a regional stakeholders meeting in March 2014 for each R/CHMT to present implementation status of the action plan made during the previous meeting
7) Conducted a re-assessment on CSS&M implementation in the past one year during July – August 2013
8) Conducted a regional stakeholders meeting in October 2014 to share the findings of the re-assessment and each R/CHMT's experiences in CSS&M

7. WHAT WERE THE RESULTS?

7.1. At the national level

1) One coordinated CSS&M plan is in place: The Quality Improvement Unit has been established at the NACP since 2012 to coordinate all units of the NACP for planning, implementation of comprehensive supportive supervision and mentoring.
2) Retrievable documentation rate has become 54% as of 31 August 2014: The number of retrievable CSS reports covering all interventions for the past one year became 14. The number of regions visited by the national supervisors was 26 (Dodoma was visited 2 times).
3) Execution rate of mentoring to the model regions has become 75%: Four mentoring needs were identified at the regional hospitals and documented by national

supervisors in the model regions during the period of May – April 2014. In total three mentoring needs were attended by national mentors. Therefore the execution rate of mentoring to the model regions was 75%.

7.2. At the regional level

1) Documentation rate has become 28.0%: During the period of May 2013 – April 2014, the Dodoma RHMT conducted 18 supportive supervision visits in total covering HIV and AIDS to the Regional Hospital and the CHMTs, of which 4 reports were retrievable. The Pwani RHMT conducted 7 SS visits, of which 3 reports were retrievable. Therefore, documentation rate increased from 0% to 28.0%
2) Execution rate of mentoring has become 33%: During the same period, regional supervisors of Dodoma identified and documented 3 mentoring needs in 2 districts. Regional mentors were dispatched to the districts but no documentation was found for the mentorship. Four mentoring needs identified by supervisors of Kondoa District at 2 HFs were attended by regional mentors and their reports were retrievable. Five mentoring needs were documented by regional supervisors of Pwani but no mentors were dispatched. The execution rate was therefore 33% (4/12).

7.3. At the council level

1) Retrievable documentation rate of SS covering HIV and AIDS to health facilities increased from 22% to 44%: During the period of May 2013 – April 2014, all councils in the model regions used the NACP tool for their supportive supervision and most of the reports were HF specific with action plans. The total number of HFs covered by the SS decreased from 412 to 329. The number of HFs covered by the retrievable reports increased from 90 to 145.
2) Execution rate of mentoring increased from 0% to 53.8% (42/78): The number of mentoring needs identified and documented by district supervisors were 78 in total. The number of mentoring needs attended and documented was 42. It should be noted that 9 out of 14 councils have started to identify and document mentoring needs. It is also worth noting that during the period of May - July 2014 (after the endline assessment), 4 councils dispatched many mentors and the reports were retrievable.

7.4. Other remarkable achievements:

1) Out of 14 CHMTs in the model regions, 12 have started to integrate HIV and AIDS supervision into their general routine supervision.

2) Out of 14 CHMTs in the model regions, 12 have incorporated a budget line for mentoring into the CCHP 2014/15.

8. WHAT WERE LESSONS LEARNT?

Development of a national guidelines/manual and tools of a new approach, dissemination of them from central to regions and councils and training for the approach may not suffice for adoption of the new approach. Adoption process is rather slow. Follow-up activities such as an assessment of the implementation status, sharing the findings and arousing a spirit of competition, developing an action plan to improve the situation and re-assessing the implementation status could facilitate the adoption process.

Figure 3: Improvement of Documentation Rate and Ratio and Project Inputs

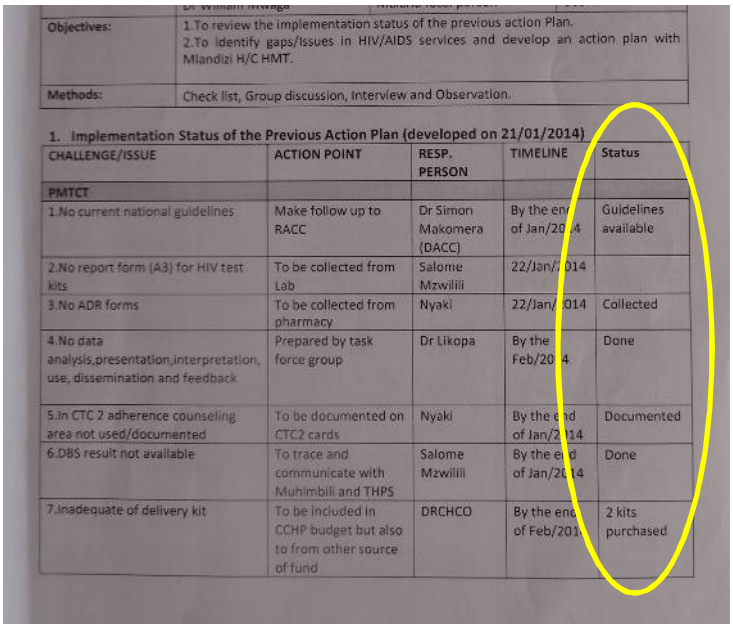
Note: Documentation Ratio = (# of retrievable SS reports covering HIV and AIDS in the past one year) / (# of health facilities supervised covering HIV and AIDS in the past one year)

The CSS&M training was intensively conducted for the two regions during January – March 2012. Baseline data was collected retrospectively in 2012. At the baseline, all retrievable reports were monthly or quarterly summarized and not health facility specific. The baseline information was shared in January 2013 and weaknesses in documentation were highlighted. At the midterm, most of the reports became health facility specific and the documentation ratio has increased but the health facility coverage by supervision was

dropped and documentation rate remained the same. During the period of July – August 2013, an assessment on implementation of CSS&M was conducted. The findings were shared in a meeting held in October 2013 and each R/CHMT team developed an action plan to improve the situation. A follow-up meeting was held in March 2014 for each team to present the implementation status of the action plan. A re-assessment was conducted during May – July 2014 to assess the situation with an immediate feedback to each team after the re-assessment. According to the re-assessment data, both documentation ratio and rate increased while the health facility coverage remained almost the same as the level of the midterm. All the three indicators need to be monitored to capture the level of operationalization of CSS.

9. ANY GOOD PRACTICAL EXAMPLES?

1) Mafia DC and Dodoma MC have integrated HIV/AIDS into general supportive supervision using one reporting format.
2) Actions taken for solving problems identified through supportive supervision have started to be documented. For example, the Chemba DC identified stock out of HIV test kits at several health facilities through supportive supervision in March 2014 and placed an emergency order to the MSD in early April 2014, all of which were documented. Furhtermore, mentorship was provided to the health facilities on logistic to prevent stock out.
3) Chamwino DC and Kibaha DC have started to make follow-ups and document implementation status of the action plan developed in the previous supportive supervision visit.
4) Kongwa DC held a synergy meeting between supervisors and mentors in January 2014 and discussed mentoring needs identified through supportive supervision. Based on the resolution made in the meeting, mentors of STI, PMTCT and HTC were intensively dispatched to HFs in February 2014. The minutes and the mentoring reports are retrievable.



Objectives:	1.To review the implementation status of the previous action Plan. 2.To identify gaps/Issues in HIV/AIDS services and develop an action plan with Mlandizi H/C HMT.
Methods:	Check list, Group discussion, Interview and Observation.

1. Implementation Status of the Previous Action Plan (developed on 21/01/2014)

CHALLENGE/ISSUE	ACTION POINT	RESP. PERSON	TIMELINE	Status
PMTCT				
1.No current national guidelines	Make follow up to RACC	Dr Simon Makomera (DACC)	By the en of Jan/20 4	Guidelines available
2.No report form (A3) for HIV test kits	To be collected from Lab	Salome Mzwilili	22/Jan/ 014	
3.No ADR forms	To be collected from pharmacy	Nyaki	22/Jan/ 014	Collected
4.No data analysis,presentation,interpretation, use, dissemination and feedback	Prepared by task force group	Dr Likopa	By the Feb/20 4	Done
5.In CTC 2 adherence counseling area not used/documented	To be documented on CTC2 cards	Nyaki	By the end of Jan/2 14	Documented
6.DBS result not available	To trace and communicate with Muhimbili and THPS	Salome Mzwilili	By the en d of Jan/20 14	Done
7.Inadequate of delivery kit	To be included in CCHP budget but also to from other source of fund	DRCHCO	By the end of Feb/201	2 kits purchased

Figure 4: A supportive supervision report by Kibaha DC with the record of implementation status of the previous action plan

10. ANY EVIDENCE SHOWING IMPROVEMENT OF SERVICES?

1) The Mafia CHMT is one of the councils that have been actively applying the CSS&M and documenting the activities. Incomplete filling of TB Screening tool at Chemchem Dispensary (CTC Client Files) was identified as an issue through supportive supervision conducted in August 2012. A mentor was dispatched to the dispensary twice in September and October 2012. The rate of incomplete filling of TB screening tool decreased from 27% in June 2012 to 5% in December 2012.

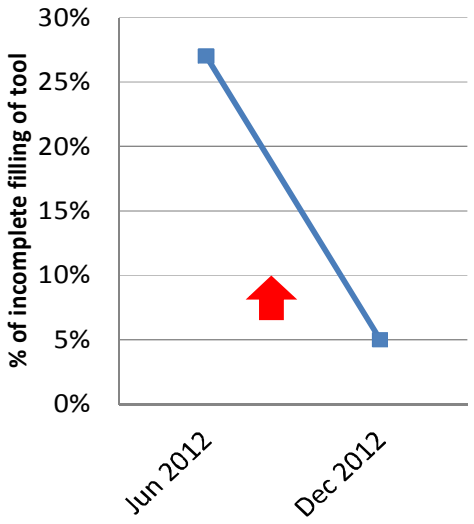


Figure 5: Problem solving in TB/HIV through supportive supervision and mentoring

2) The Kongwa CHMT identified several issues on STI service provision at many health facilities in the district through supportive supervision during Jul – Sep 2013. However, the CHMT had to wait for funds to dispatch mentors. The mentors were dispatched to 23 health facilities in Feb 2014 to improve the situation. One of the issues was that STI clients were not counselled and linked to HIV testing. The situation has been improved as the Figure 6 indicates.

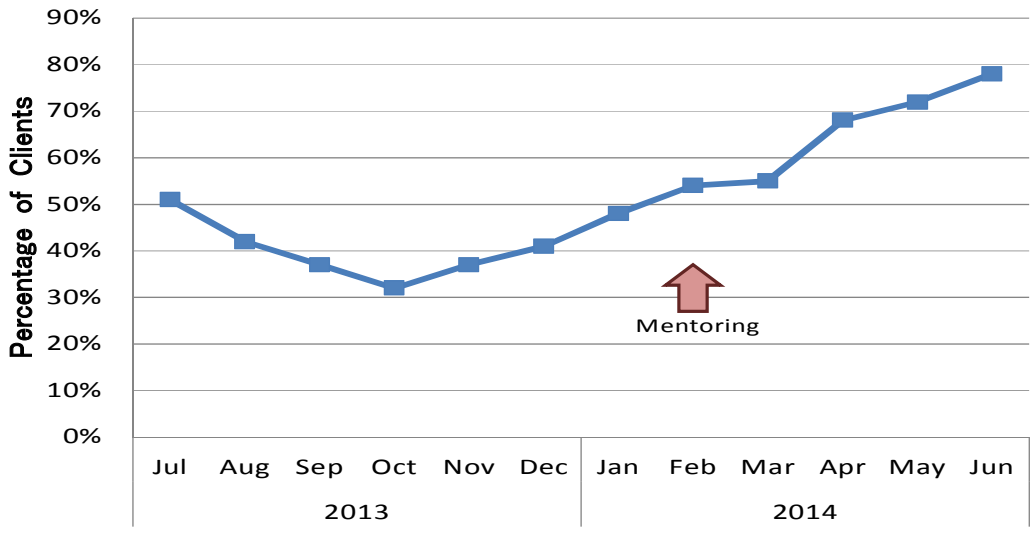


Figure 6: Percentage of STI clients counselled and linked to HIV testing

11. WHAT RECOMMENDATIONS DOES THE PROJECT HAVE?

Figure 6 depicts Quality Improvement Cycle (PDSA). An action plan is not the final product of supportive supervision. It shall be followed by implementation, monitoring of the implementation, information sharing among relevant people, taking further actions and start again with assessment. An action plan is a tool to facilitate the cycle. The destination of an action plan shall not be a folder at a health secretary's office but at the hands of supervisees, supervisors, mentees, mentors and managers for their follow-up actions. Supervision and mentoring activities shall be evaluated at each level. If they are not contributing to problem solving, the way they have been conducted shall be critically reviewed and changed, otherwise, wasting resources will continue.

The project assisted NACP, RHMTs and CHMTs in the model regions to operationalize supervision and mentoring with the focus on HIV and AIDS services. However, the approach undertaken may be applied to other health programmes as well.

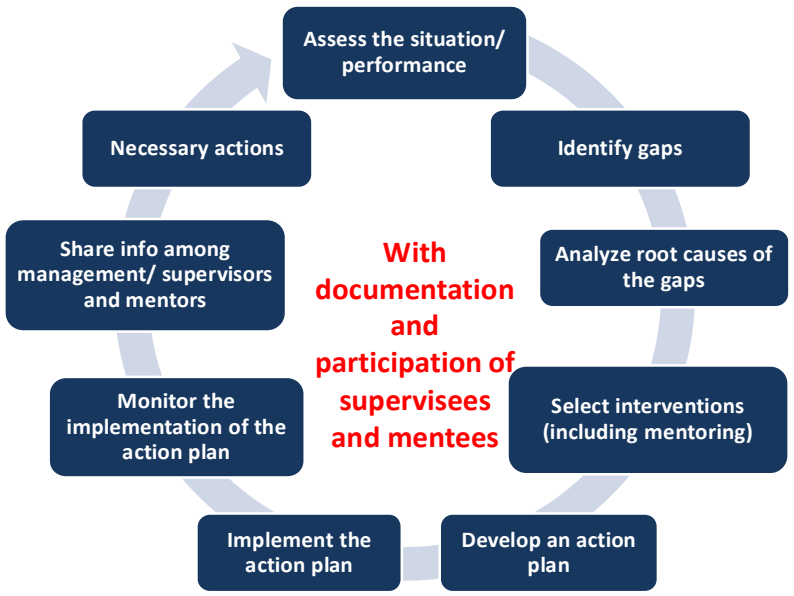


Figure 6: Quality Improvement Cycle

REFERENCE:

MGIMBA, C. et al. (2013) A study on linkages between activities and improvement of HIV and AIDS services in Mafia District Council. *The Third National Quality Improvement Forum of Health Care Abstract Book.* p. 40.

MINISTRY OF HEALTH AND SOCIAL WELFARE. NATIONAL AIDS CONTROL PROGRAMME. (2014) *A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services Second Edition.* Dar es Salaam: NACP.

MINISTRY OF HEALTH AND SOCIAL WELFARE AND JAPAN INTERNATIONAL COOPERATION AGENCY. (2014) *Joint Terminal Evaluation Report on the Health Systems Strengthening for HIV and AIDS Services Project (Not Published).* Dar es Salaam: MOHSW.

WORLD HEALTH ORGANIZATION. (2006) *WHO recommendations for mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained settings*. Geneva: WHO.

Contacts:
National AIDS Control Programme
P.O. Box 11857
Luthuli Street
Dar es Salaam, Tanzania
Tel: +255 22 2131213
Fax: +255 22 2127175
Hppt://www.nacp.go.tz