THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

TRAINING ON
COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING OF HIV AND AIDS HEALTH SERVICES

PARTICIPANT'S MANUAL

NATIONAL AIDS CONTROL PROGRAMME (NACP)

AUGUST 2011

TANZANIA

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ACRONYMS

A&B	Abstinence and Being Faithful
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retro Viral
AZT	Zidovudine
BCC	Behaviour Change Communication
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CRCHCo	Council Reproductive and Child Health Coordinator
CTC	Care and Treatment Clinic
DACC	District AIDS Control Coordinator
DBS	Dried Blood Spot
DCT	Diagnostic Counselling and Testing
DED	District Executive Director
DMO	District Medical Officer
DNA	Deoxyribonucleic Acid
FBO	Faith Based Organizations
Five S (5S)	Sort, Set, Shine, Standardise and Sustain
FP	Family Planning
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
HMT	Hospital Management Team
HSHSP	Health Sector HIV and AIDS Strategic Plan
HSP	Health Service Providers
HTC	HIV Testing and Counselling
IEC	Information Education and Communication
IPT	Isoniazid Preventive Therapy
ITN	Insecticide Treated Nets
KAIZEN	Continuous Quality Improvement in Japanese
KCMC	Kilimanjaro Christian Medical Centre
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MNH	Muhimbili National Hospital
MOHSW	Ministry of Health and Social Welfare
MOI	Muhimbili Orthopaedics and Trauma Institute
NACP	National AIDS Control Programme

NMSF	National Multi-Sectoral Strategic Framework
OIs	Management of Opportunistic Infections
OJT	on-the-job training
ORCI	Ocean Road Cancer Institute
PCR	Polymerase Chain Reaction
PDSA	Plan, Do, Study and Act cycle
PEPFAR	US President's Emergency Plan for AIDS Relief
PICG	Performance Improvement Consultative Group
PITC	Provider Initiated Testing and Counselling
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPP	Public - Private Partnership
QI	Quality Improvement
QIT	Quality Improvement Team
RACC	Regional AIDS Control Coordinator
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
RTIs	Reproductive Tract Infections
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
TACAIDS	Tanzanian Commission for AIDS
TB	Tuberculosis
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TQM	Total Quality Management
UNAIDS	United Nations Joint AIDS Programme
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
VIPP	Visualization in Participatory Programmes
ZHRC	Zonal Health Resource Centre

COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING ON HIV AND AIDS HEALTH SERVICES

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PREFACE

In response to the HIV pandemic, health service providers have got to take up the new and complex roles for the HIV and AIDS services, that are growing at a rapid pace, while continuing to provide the comprehensive routine health care. In order to ensure that there is consistent adherence to service standards, an effective supportive supervision and mentorship at all levels, need to be put in place. So far, the supervision has been offered erratically, in a vertical and unlinked manner, while mentorship is quite a new concept and practiced by only a few partner organizations, in provision of HIV and AIDS services in Tanzania. Supervisors are not fully equipped to handle comprehensively, technical and administrative issues, of all HIV and AIDS interventions. Therefore, performance- and resource-related problems at health facilities, remain unresolved.

The Health Policy of 2007, the Primary Health Services Development Programme of 2008, the Health Sector Strategic Plan III of 2009 and the Human Resource for Health Strategic Plan 2008, have all emphasized the need to have technical and managerial support to the lower level service providers, through supervision and mentorship, to improve the quality of the services.

The Ministry of Health and Social Welfare (MOHSW), through the National AIDS Control Programme (NACP), has therefore developed "A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services", in March 2010, with the technical and financial support from the Japan International Cooperation Agency (JICA). Through this manual, the MOHSW urges all stakeholders, on the importance of combining comprehensive supportive supervision and mentorship in order to strengthen the administrative, programmatic and technical support from the regional to the council health management teams and health facilities management teams, of all the levels, for the improvement on the quality of HIV and AIDS health services.

Operationalization of the comprehensive supportive supervision and mentorship in accordance with the manual, requires a lot of inputs. Among those, the first step was to develop an intensive training for the supportive supervisors and mentors, who are to be equipped with the required knowledge and skills, and to change their mindset. That required to develop a standard training package, for comprehensive supportive supervision and mentorship.

This training package has now been developed in response to the needs, and it includes the Participants' Manual, Facilitator's Guide and Facilitation Slides. The contents included herein are the minimum requirement, for the training of comprehensive supportive supervisors and mentors, that can be done in a comprehensive manner. The standard recommended duration of the training is six days, and can be extended depending on the needs and capacity of the participants. The training is an initial step, and alone it cannot make the supervisors and mentors effective enough, in changing their practice. They have to apply the knowledge and skills at their work stations, on routine basis and be able to provide administrative and morale support.

The package shall be recognised as a "living document," that needs to be reviewed and revised on a regular manner, since new issues and challenges keep on emerging in the field of HIV and AIDS. Putting in place a mechanism for continuous feedback on the training package to the MOHSW/NACP, would highly be appreciated.

DR. DEO M. MTASIWA
CHIEF MEDICAL OFFICER
MINISTRY OF HEALTH AND SOCIAL WELFARE

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MoHSW wishes to extend its appreciation to the trainers of training of comprehensive supportive supervision and mentoring for their inputs for improvement of the draft documents.

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Dr. G.J.I. Lija (MoHSW/ NACP)

Dr. P.E. Mwidunda (MoHSW/ NACP)

Ms. L. Chovenye (MoHSW/ NACP)

Dr. Z. Sekilasa (MoHSW/ NACP)

Dr. M. Nkingwa (MoHSW/ NACP)

Dr. Z. Chaula (Dodoma Regional Hospital)

Ms. F.G. Yambesi (Temeke Hospital)

Dr. P. Luvanda (Iringa Regional Hospital)

Dr. D. Bwogi (ICAP Tanzania)

It is not possible to mention by name all those who contributed to the development of this training package in one way or another. However, we wish to acknowledge the contributions of all experts who participated in the development process.

DR. D. W. MMBANDO
DIRECTOR OF PREVENTIVE SERVICES
MINISTRY OF HEALTH AND SOCIAL WELFARE

CHAPTER 1:

COURSE OVERVIEW

1.1 BACKGROUND

For decades it was assumed that poor performance was simply due to lack of knowledge and skills. As a result, most interventions concentrated on training, which has had mixed and sometimes disappointing long-term results. An in-service training is expected not only to transfer new knowledge and skills but also to change behaviour of health service providers (HSPs) for application of the knowledge and skills at their work stations. However, this behaviour change doesn't come along with the training alone because other physical, social and systemic problems may be hindering the individual HSP from applying the knowledge and skills.

Therefore, supervision is important to identify and solve gaps and reinforce HSPs in application of and adherence to the standard knowledge and skills. The main challenges for supervision have been improving quality, increasing the time supervisors actually spend with HSPs, and measuring its cost-effectiveness. These challenges, however, are still at large. Too often supervisors lack skills, useful tools and transportation and are burdened with administrative duties.

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

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

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

In Tanzania, however, supervision has generally been erratic, vertical and unlinked. Supervisors have limited capacity to comprehensively cover both administrative and technical issues while mentoring is quite a

new concept and practiced by only a few partner organizations for HIV care and treatment services with limited coverage. Therefore, performance- and resource-related problems at the health facilities remain unsolved.

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

In view of the above, a standardized way of conducting and developing capacity in comprehensive supportive supervision and mentoring, which is appropriate and applicable in a resource-constrained setting like Tanzania, has become a critical need.

The manual describes comprehensive supportive supervision and mentoring for HIV and AIDS health services, their introduction into the health care system in Tanzania, the training activities for their initiation, and the support activities that management must carry out to ensure success.

1.2. OVERVIEW

The course:

- Provides a standardized definition of comprehensive supportive supervision and mentoring
- Provides a rationale for a standardized approach to comprehensive supportive supervision and mentoring in Tanzania
- Provides guidance on planning and implementation of comprehensive supportive supervision and mentoring activities for HIV and AIDS health services
- Identifies the critical elements of a sustainable system of comprehensive supportive supervision and mentoring to improve the quality of health services as well as the competence and satisfaction of staff
- Provides strategies for bringing about synergy between comprehensive supportive supervision and mentoring activities
- Explains how to use the manual and tools for comprehensive supportive supervision and mentoring to meet specific conditions at national, regional, district, primary care facility and community levels.
- Describes basic monitoring and evaluation in HIV and AIDS interventions

The purpose of the course is to provide a standardized training in comprehensive supportive supervision and mentoring process and activities for HIV and AIDS health services.

1.3. GOAL AND OBJECTIVES

The GOAL of the training is to improve quality of care in health sector HIV and AIDS services through effective comprehensive supportive supervision and mentoring. Effective and sustained comprehensive supportive supervision and mentoring will contribute significantly to quality improvement in the long term.

OBJECTIVES:

By the end of this training

- Supervisors will be able to effectively conduct comprehensive supportive supervision in line with the National Manual and Tools
- Mentors will be able to effectively conduct mentoring to HSPs in line with the National Manual and Tools
- Supervisors and mentors will be able to work synergistically to improve quality of care in HIV and AIDS health services

1.4. COURSE DESIGN

A 6days training that focuses on essential comprehensive supportive supervision and mentoring knowledge, skills and their application, five days of theory and one-day practicum session on day 5 at relevant selected health facilities to give the participants an opportunity to have hands-on application of learnt skills.

Topics to be covered include:

1) Overview of HIV and AIDS in Tanzania
2) Principles of Adult Learning and Communication Skills
3) Coaching
4) Introduction to Quality of Care
5) Comprehensive Supportive Supervision
6) Mentoring
7) Relationship between comprehensive supportive supervision and mentoring
8) Structure and functions of comprehensive supportive supervision and mentoring system
9) Monitoring and Evaluation

1.5. COURSE ORGANIZATION

A variety of approaches to teaching and learning will be adopted, with the underlying consideration that participants are adult learners who will take considerable responsibility for their own learning. The focus will be on active learning and should emphasise the key knowledge and skills needed for comprehensive supportive supervision and mentoring.

The course outline is as follows:

The arrangement of the presentation will go in line with the topics and flow of slides.
Supervisors and prospective mentors will be together during the first three days in a classroom. On the Day 4 the class will be split into two groups: one is for supervisors and the other for mentors. Each group will thoroughly go through the process and tools of comprehensive supportive supervision and mentoring respectively and conduct role plays using the tools. On Day 5, the participants will be split into teams to go for practical training in health facilities whereby they will apply the knowledge and skills learnt in the classroom. On the Day 6, each team will present and share the field reports and discuss issues in the plenary.

1.6. SELECTION CRITERIA FOR PARTICIPANTS

Participants selected for this course are those who will be providing comprehensive supportive supervision and mentoring to HSPs in HIV and AIDS health services.

Supervisors:

Supervisors are those who are in a position to regularly supervise HIV and AIDS health services at either national or regional or council level and have the following attributes:

- Be familiar with health care system;
- Have sufficient knowledge about whole range of HIV and AIDS health services provided at each level of health system;
- Be familiar with QI concept;
- Have ability to address both administrative and programmatic issues and needs in HIV and AIDS health services;
- Be committed, responsible and have strong interpersonal skills;
- Have ability to train, motivate and support supervisees; and
- Be flexible, respectful and hardworking.

Mentors:

A mentor shall have the following attributes:

- Be a practitioner of a specific HIV and AIDS related intervention/health service;
- Be highly knowledgeable, skilled and experienced in the intervention/service;
- Be approachable and accessible with good interpersonal communication skills and appropriate language;
- Be familiar with health care system, QI concept, common illness, the context of the disease, likely patient reactions and outcomes;
- Be willing, committed, responsible and available to provide coaching and technical assistance to less experienced HSPs; and
- Be flexible, respectful and hardworking.

It should be noted that the training is not for somebody who is not familiar with the provision of HIV and AIDS health services. The training doesn't provide technical and clinical knowledge and skills required for each specific HIV and AIDS intervention. Rather, the course is designed to equip comprehensive supervisors and mentors with knowledge and skills on how to empower HSPs through application of effective communication and coaching skills, identify and solve problems and promote quality improvement concept in health service provision.

The secondary readers of the manual are the trainers of the training on comprehensive supportive supervision and mentoring for HIV and AIDS health services, who must be competent for training on all the contents included in this manual.

The tertiary readers are programme planners and evaluators. The operation of comprehensive supportive supervision and mentoring including its training needs to be incorporated in the health plans and to be evaluated its outcome and impact.

1.7. TEACHING METHODOLOGY

- Lectures/discussions
- Group discussions
- Small and large group activities
- Case studies
- Role plays
- Demonstrations
- Practical work
- Visualization in Participatory Programmes (VIPP)

1.8. REFERENCE MATERIALS

This manual was developed using the following important reference materials that should be introduced to the participants of this training course:

- A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services (MOHSW, 2010) with Supportive Supervision and Mentoring Tools
- National Guidelines for Quality Improvement of HIV and AIDS Services (MOHSW, 2010)
- National Essential Health Sector HIV and AIDS Interventions Package (MOHSW, 2010)
- Implementation Guidelines for 5S–KAIZEN(CQI)-TQM Approach in Tanzania: "Foundation of all Quality Improvement Programs" (MoHSW, 2011)
- Other national guidelines and standard operating procedures (SOPs) for service provision of HIV and AIDS related health services such as care and treatment, PMTCT, management of STIs, HTC, TB/HIV and HBC

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CHAPTER 2:

OVERVIEW OF HIV AND AIDS SERVICES IN TANZANIA

LEARNING OBJECTIVES:

By the end of the chapter , the participant will be able to:

- Describe the National Response to HIV pandemic in Tanzania
- Provide an overview of HIV and AIDS interventions in Tanzania
- Describe the rationale for comprehensive supportive supervision and mentoring

1.1. HIV AND AIDS IN TANZANIA

Since the first cases of Acquired Immunodeficiency Syndrome (AIDS) in Tanzania were reported in 1983, AIDS has evolved into a pandemic. According to the 2007-08 Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS), the estimated national HIV prevalence of the population aged 15-49 years is 5.7% while in the mainland, the estimated HIV prevalence rate is 5.8%. The prevalence is higher among women than men (6.8 and 4.7%). Compared with HIV prevalence data of Tanzania HIV Indicator Survey 2003-04, there has been a slight decrease from 7% to 5.8% in overall prevalence of HIV among adults.

There are large variations in HIV prevalence by region in Tanzania. The highest HIV prevalence rate is found in Iringa (15.7%), followed by Dar es Salaam (9.3%) and Mbeya (9.2%). Regions on the Mainland with the lowest HIV prevalence (less than 2 % each) are Arusha, Kigoma, Kilimanjaro and Manyara. There continues to be a significant difference in the prevalence among urban (9.1%) and rural (4.8%) areas of the Mainland. According to HIV/AIDS/STI Surveillance Report No.21 (MOHSW, 2009), overall, 1.4 million Tanzanians (1,300,000 adults and 110,000 children) are living with HIV infection, in a total population of 41 million. The social, economic, and environmental impact of the pandemic is sorely felt as an estimated 140,000 Tanzanians have perished, leaving behind an estimated 2.5 million orphans and vulnerable children, representing approximately 10-12% of all Tanzanian children. Close to 85% of HIV transmission in Tanzania occurs through heterosexual contacts, less than six percent through mother to-child transmission, and less than one percent through blood transfusion.

2.2. INTERNATIONAL AND NATIONAL RESPONSE TO HIV AND AIDS

There are some milestones of international response to HIV and AIDS. The Millennium Development Goals (MDGs) were set through the Millennium Declaration made in 2000. In this Declaration, the world's leaders committed themselves to halting and beginning to reverse the spread of HIV and AIDS by 2015. The United Nations further called a special session of the General Assembly on HIV and AIDS in 2001 (UNGASS) recognizing that HIV and AIDS is the most formidable development challenge and aiming to secure a global commitment for intensified and coordinated action at the global and national levels. Through the UNGASS Declaration of Commitment, comprehensive HIV prevention, care, treatment and support services to all who need them was emphasized as the basic right. This was accelerated with WHO's "3 by 5" initiative whereby a global target of treating 3 million people with antiretroviral therapy by the end of 2005 was set. This was again reinforced by the UNAIDS 'brainchild' of Universal Access to comprehensive Prevention,

Care, Treatment and Support Services by setting what later turned to be an ambitious target of HIV services for all by the end of 2010. The target is far from being met but periodic reviews and reports keep countries focused.

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

The National Care and Treatment Plan was developed in 2003 and was operational by 2004 with a major focus on expanding HIV Care and Treatment services to meet the ever rising demand. Since then, many HSPs have been trained in HIV and AIDS interventions such as HTC, PMTCT, Home-based Care(HBC), management of Opportunistic Infections (OIs), ART, Syndromic Management of STIs, laboratory tests for HIV diagnosis, OI diagnosis and monitoring patient on ART, management of Tuberculosis and HIV co-infection.

With funding mainly from the Government of Tanzania, the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR), HIV care and treatment services have been rolled out to 740,040 PLHIV out of whom 384,816 were on antiretroviral therapy (ART) by December, 2010 (MOHSW, 2011). This can be attributed to the increased access to ART, HIV testing and counselling (HTC), prevention of mother to child transmission (PMTCT) services and the impact of the National Testing Campaign which was carried out in 2007.

Passing the law on HIV and AIDS in Parliament in 2010 was a major sign of government commitment, which is very encouraging.

Various documents such as NMSF, Health Sector HIV and AIDS Strategic Plan (HSHSP), in addition to being aligned with the National Vision and Strategies, have also been aligned with the international commitments and goals.

2.3. HIV AND AIDS INTERVENTIONS IN TANZANIA

This training is focusing to equip supervisors and mentors with knowledge and skills on comprehensive supportive supervision and mentoring on the following thematic areas:

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

ii) **Care and Treatment:** Antiretroviral Therapy (ART), Tuberculosis (TB)/HIV collaborative approach, Community and Home Based Care (HBC) and Monitoring HIV status and nutritional support.

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

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2.4. HEALTH SERVICES STRUCTURE IN TANZANIA

Tanzania Mainland is divided into 25 administrative regions and 130 districts with 133 Councils. There are 10,342 villages (MOHSW, 2009). Tanzania has adapted a decentralized system of Government including health services. Figure 2.1 depicts the structure of the health care system organized in a pyramidal pattern as per experts' recommendations way back in 1993.

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

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

Each administrative district is served by a district hospital. There are 55 public owned district hospitals, 13 Faith Based Organizations (FBO) owned designated district hospitals and 86 other hospitals at first referral level (owned by Government, parastatal and private sector). District hospitals form an integral part of the PHC system. They provide clinical services to inpatients and outpatients referred from primary health facilities and other hospitals within the district. District hospitals may differ in size and bed capacity but are generally capable of managing common medical, obstetric, paediatric and surgical emergencies.

Regional Hospitals are designated health facilities, forming the secondary referral level in the pyramid. There are 20 regional hospitals providing specialized clinical services with better equipment and staffing (have one or more specialist doctors). Plans are underway to ensure that all regional hospitals have specialists in the major clinical disciplines: surgery, medicine, obstetrics and gynaecology, and paediatrics. Referral, consultant and specialized hospitals are tertiary-level multi-specialist hospitals. There are four referral hospitals i.e. Muhimbili National Hospital (MNH), Mbeya , Bugando and Kilimanjaro Christian Medical Centre (KCMC). Of the four, the MNH offers services of a wider range much more specialized than the other

referral hospitals. Patients who may not be adequately managed at these hospitals are referred outside Tanzania. Specialized hospitals offer specialist services of one kind and these are: Muhimbili Orthopaedics and Trauma Institute(MOI), Ocean Road Cancer Institute (ORCI), Mirembe Hospital for mental health and Kibong'oto hospital for Tuberculosis. The MOHSW is gearing itself to improving staffing and the health system in general as a way of improving access to quality.

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

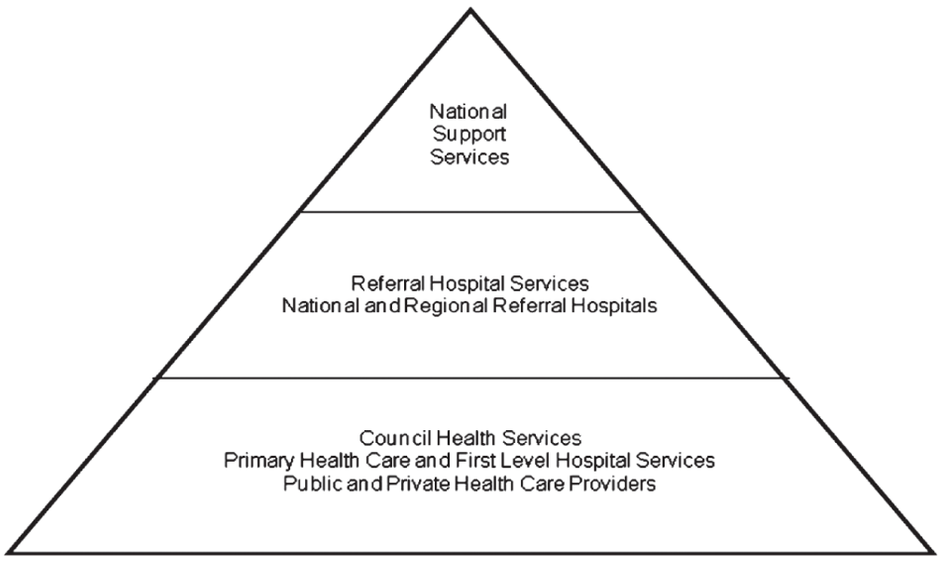


Figure 2.1: Health services structure in Tanzania (MOHSW,2009)

2.5. CHALLENGES OF SUPPORTIVE SUPERVISION AND MENTORING IN HIV AND AIDS SERVICES

The current supportive supervision depend more on the availability of transport or other resources than on any regular schedule. Several supervisors may visit a facility within a short time. Conflicting guidance by a multitude of supervisors of the several vertical programmes often leaves the facility staff confused and demoralized. The resulting pressures on these HSPs are enormous, counterproductive, and often disruptive to facilities' functioning.

Technical/clinical follow-ups for a specific intervention require ample time and experienced practitioners. Vertical though regular supervision cannot meet all the requirements including specific technical and clinical needs of HSPs.

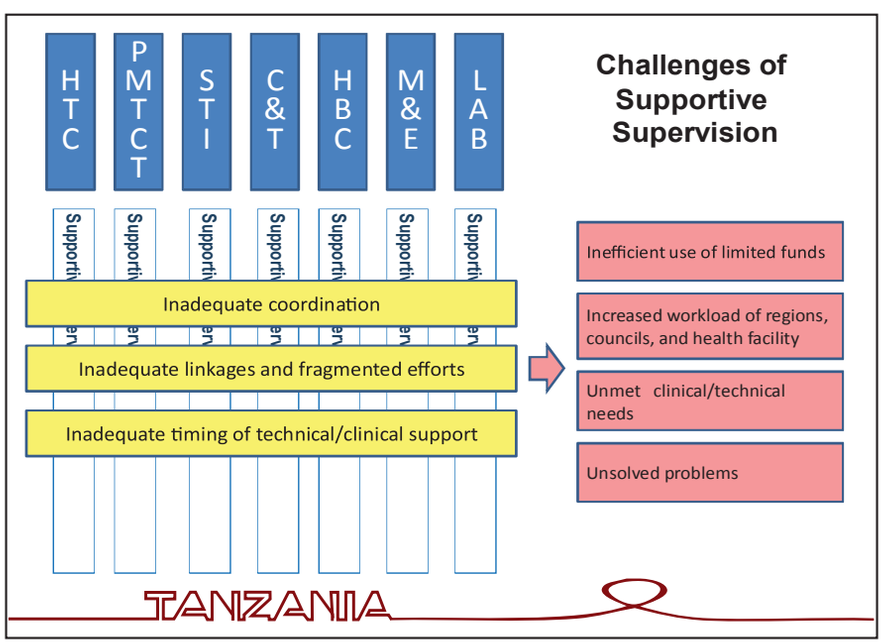


Figure 2.2: Challenges of supportive supervision in HIV and AIDS interventions in Tanzania

2.6. COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING

The Need for change in the approach to comprehensive supportive supervision and mentoring has been long standing. Integration of Programmatic /administrative and technical activities is a cost effective and efficient approach. Mentoring by experienced HSPs should be conducted based on the technical needs. It is demand driven. Strengthening supportive supervision with introduction of mentoring are gaining more recognition than ever as critical parts of human resource management for the delivery of quality health services especially in HIV and AIDS.

2.7. RATIONALE FOR COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING

HIV and AIDS pandemic has affected the entire health service delivery system and HSPs, a situation which has added on the shortage of human resource for health. This makes the performance- and resource-related problems at the health facilities remain unsolved.

Recognising these challenges, the MOHSW through NACP developed a manual for comprehensive supportive supervision and mentoring on HIV and AIDS services. Comprehensive supportive supervision and mentoring are supposed to be complementary activities that are necessary to build a continuum of care and support. Supervisors need to have comprehensive managerial and administrative knowledge and skills while mentors need to be practitioners and experienced in a specific intervention.

In this regard, comprehensive supportive supervision combined with mentorship programme for both administrative and technical support to health facilities at all levels is critical for delivery of quality HIV and AIDS health services.

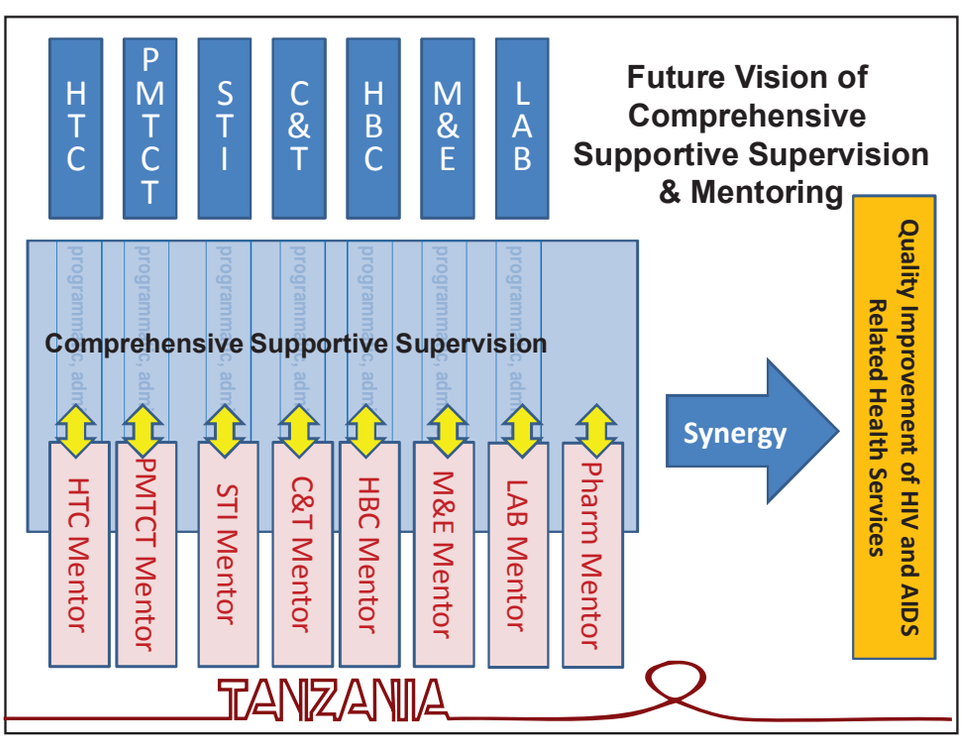


Figure 2.3: Future vision of Comprehensive Supportive Supervision and Mentoring in HIV and AIDS Health Services

CHAPTER 3:

PRINCIPLES OF ADULT LEARNING AND COMMUNICATION SKILLS

LEARNING OBJECTIVES:

By the end of this chapter, the participants will be able to

- Explain the principles of adult Learning
- Demonstrate communication skills
- Demonstrate application of communication skills in comprehensive Supportive Supervision and Mentoring

3.1. PRINCIPLES OF ADULT LEARNING

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone else perform (model) a skill or activity. For modelling to be successful, the trainer must clearly demonstrate the skill or activity so that participants have a clear picture of the performance expected of them.

The training approach described in this chapter is guided by the principles of adult learning. These principles are based on the assumption that people participate in training courses because they:

- Are interested in the topic
- Wish to improve their knowledge or skills, and thus job performance
- Desire to be actively involved in course activities

To be effective, clinical trainers must use appropriate training strategies. Participatory, hands-on' training techniques emphasized in this manual are best reflected in this proverb.

WHAT I HEAR, I FORGET;
WHAT I SEE, I REMEMBER;
WHAT I DO, I UNDERSTAND.

Adult Learners need respect and are people with self-esteem. A thorough understanding of this helps to establish Facilitator-Participant friendly learning atmosphere for optimal comprehension. Effective training is designed and conducted according to according to the following **Adult Learning Principles:**

1) Learning is most productive when participants are ready, are highly motivated to learn and are not overwhelmed by feelings of anxiety and fear.
2) Adults often experience fear when learning new tasks, especially if they feel their self-esteem or image with colleagues will be damaged or if previous learning experiences, in medical school for example, have been embarrassing or threatening.
3) Although motivation is internal, it is up to the trainers to create a climate that will encourages motivation in participants.

4) Learning is more effective when it builds on what the participants already know or have experienced.
5) Learning is more effective when participants are aware of what they need to learn.
6) Participants associate new skills or techniques they are learning with the entire environment in which they are learning them.
7) If the learning environment is pleasant, favourable and supportive, the participant is more likely to learn and use the skills.
8) If the learning environment or the behaviour of the clinical trainer produces feeling of discomfort or stress, participants may try to relieve the discomfort by discrediting the quality of the training or the relevance of the skill. Participants may also use other defence mechanisms that restrict learning.
9) Learning is made easier by using a variety of training/learning methods and techniques than a single technique.
10) Opportunities for practicing skills initially in controlled or simulated situations (e.g. through role play or use of anatomic models) are essential for skill acquisition and for development of skill competence
11) Repetition is necessary for participants to become competent or proficient in a skill.
12) The more realistic the learning situation, the more effective is the learning
13) To be effective, feedback should be immediate, positive and nonjudgmental

Motivation to learn can be increased by creating an environment that boosts participants confidence in their ability to learn.

3.2. COMMUNICATION SKILLS

3.2.1. Definition of communication

Communication is exchange of ideas, experiences, knowledge and feelings through transmission of messages verbally or nonverbally. Verbal communication involves use of words either spoken or written while in nonverbal communication no words are used but body language.

Without effective communication skills, you will find it difficult to function well as a supervisor or Mentor. Being able to communicate effectively so that what you say is **what is heard** and **understood** will help you to be successful.

Communication has two elements—sending and receiving. When the message that is sent is not received, communication has not taken place. Therefore, the supervisor (or any other communicator) should always use some means of checking that the message was received and understood (e.g., by asking a question about the message).

3.2.2. Factors encouraging communication:

- All people should be free to express their views, and should be encouraged to do so.
- All people should be treated with respect.
- A message, whether oral or written, should be expressed clearly and in language that can be understood by all concerned.

3.2.3. Types of communication:

Communication can be either verbal or non-verbal

- Verbal = Spoken words
  - Loud, pitched and shout
  - Medium, friendly
  - Low, murmuring and whispering
- Nonverbal:
  - The way we stand and sit
  - Facial expressions
  - Silence
  - Eye contact (Eye expression is a vital aspect of body language.) Significant in our dealings with others
  - Gestures (smiling, leaning forward, nodding)
  - 7 to 11% of all communication is verbal, and the rest is nonverbal.
  - Non-verbal communication may not always match a verbal message.
  - Differences in how messages are perceived can lead to confusion.

3.2.4. Skills in Communication

- Active listening
- Clarification
- Reflecting
- Effective Questioning
- Positive Feedback
- Paraphrasing
- Summarizing

3.2.4.1. Active listening:

Active Listening is an essential component of good communication. Often, instead of truly listening to what the other person is saying, we're thinking about what our response will be to what they are saying, or what we want to say next, or something else entirely different

Active listening is a communication technique that encourages open communication of ideas and feelings and helps people establish trust to each other. In active listening, the listener accepts what is being said without making any value judgments. The listener makes sure that s/he understands clearly the ideas or feelings being expressed, and confirms with the other person that s/he understands them.

It enables a speaker to stimulate open and frank exploration of ideas and feelings and establish trust and rapport with a listener. It helps the speaker clarify the listener's comments and enables the listener to be heard and understood. In active listening, the speaker accepts what is being said by the listener without making any judgment, clarifies the ideas or feeling being expressed and reflects them back to the listeners.

The following are examples of active listening techniques:

- Stop talking and listen to the speaker don't interrupt
- Restate the speaker's exact words

- Paraphrases in your own words what the speaker said
- Understand and reflect the underlying feelings of the speaker (identify the emotion)
- Identify with the speaker's emotions and state the implications of those feelings. Make eye contact that is culturally acceptable.
- Face the speaker.
- Concentrate on the speaker and what he/she is saying
- Pay attention
- Demonstrate interest in what is being said.
- Avoid distractions, like phone calls, talking to other people, or doing paperwork (note that this is a factor related to the environment in which you are holding a conversation—in this picture, the pair has chosen a meeting place that is free from any distractions).

Figure 3.1: Active Listening

When actively listening, it is appropriate to ask non leading questions such as, 'Can you tell me more about that:" or "Help me understand what you said. 'It is also appropriate to ask for help as a part of active listening: for example, 'I am not sure I fully understand what you are saying. " I am confused as to whether you mean the doctor or the nurse. Can you explain more?

Active listening does not include probing questions of a cross – examination type such as 'Why did do that?" or "What are you going to do about that?" Active listeners are not accusatory, nor do they ask questions that lead to only one answer. Active listening reflects what has been said and draws the participant out to expand further on the meaning or feelings. It also is a communication tool which can be used to shape learning and reinforce effective behaviour in a positive way.

3.2.4.2. Clarification

It involves asking questions in order to make sure that you understand what the speaker has said. To use clarification, restate the message you heard in your own words as you understand it. Ask if your interpretation is correct. Use phrases such as, "Do you mean that…?" or "Are you saying that …?" or " I am hearing you say…."

Example:
Statement: "It is difficult to get clients to listen to my advice."
Clarification: "I am not sure I understand you completely. Are you saying that clients are not following your recommendations?"
Statement: "No, they are following my recommendations, but they are not coming back to the clinic at the time I tell them. They come whenever they wish and ignore the appointment time that has been set."
Using clarification here defined it so that the supervisor could be more helpful.
Using clarifying questions shows that you are genuinely interested in what you are being told because you are taking the time to restate the speaker's point. But do not use clarification too much. People may resent being interrupted if it happens too often.

3.2.4.3. Reflection

Reflective listening builds on active listening. This is also a very good technique for HSP-patient relationship as well.

- This is the Process of verbally "reflecting" back what someone has said.
- It helps the supervisor/mentor check whether s/he understands the supervisee/mentee.
- It helps the supervisee/mentee feel understood and respected as a HSP.
- It confirms that you have understood the supervisee/mentee by using statements such as:
  "So you feel like there's not enough time to do a complete physical exam."
  "It sounds like you're concerned about this patient's ability to adhere to treatment."
  "You're wondering if this patient should be started on GUD treatment."

Supportive comments from the supervisor or mentor strengthen and reinforce desired behaviour.

Figure 3.2 below presents an interpersonal relation between a HSP and her clients. There is verbal and non-verbal communication between the HSP and the clients. The clients look at ease and satisfied.

Figure 3.2: Interpersonal relation between a HSP and her clients

3.2.4.4. Summarizing

Synthesizing /re- stating what has been said to capture key concerns / issues

- To make sure message sent = received
- To check your understanding of issue raised
- Changing topics, closing discussion, or clarifying something

3.2.4.5. Effective questioning

It is important to know how to ask questions in such a way that they encourage responders to provide as much information as possible. Responders who are uncomfortable or shy may respond with one-word answers that do not provide enough information to explain what is happening. Use open-ended (who, what, where, when, or how) questions instead of close-ended (yes/no) questions to help avoid one-word answers and to encourage discussion. "Why" questions are judgemental and should be avoided. Because close ended questions require only a "yes" or "no" answer, they do not always result in sufficient information. Open-ended questions cannot usually be answered with one word, so responders will be encouraged to explain the situation in more detail. You, as a supervisor or mentor, will then have a better understanding of the situation and be able to assist more effectively.

Examples of closed questions (they can be answered with a yes or no):

- "Did you solve the problem of the stock out of reagents?"
- "Are you going to meet with that client who has been having problems with her ARVs?
- "Are you going to reorganize the staff in the outpatient department?"

Examples of open-ended questions (they usually begin with who, what, where, when, or how):

- "What has been done about the stock out of reagents?"
- "How will you handle that client who is having problems with her ARVs?"
- "How are you going to organise the client flow in the immunization unit?"

Both types of questions are useful in assessing the participant's level of acknowledge.

When using questioning to assess a participant's knowledge in a clinical situation, the clinical trainer should consider using different types of questions. Questions can range from those that ask for facts and information to questions that present new or hypothetical situations for consideration. Questions can also probe the depth of a participant's knowledge and understanding. They can even be used to assess decision-making skills. Questioning does not mean interrogating. The trainer should let participants know that the purpose of questioning is to help target instruction, not to rebuke them. Asking them what they know and what they want to learn will help assess their needs and focus training more precisely.

3.2.4.6. Body Language

Body language is the way you send messages to others through gestures, the posture of your body, the position of different parts of your body, and the space between you and others. Body language can include:

- The way that you look at people when you speak to them and when they speak to you, for example, what facial expressions you use (smiling, nodding, frowning) or appropriate eye contact
- The way that you place your arms and hands (e.g., your arms are crossed in front of you)
- The way that you position yourself (e.g., sitting behind your desk, sitting at the same level as the other person, sitting next to or in front of the person, the distance from each other)

Active listeners use positive body language to show respect or, interest in, and willingness to share the feelings of the other person. For example, in some cultures, sitting next to someone, looking the person

in the eyes, and nodding indicate that the listener is interested in what the person has to say. By contrast, sitting across a desk, looking down, and writing notes may indicate a lack of interest and possibly even hostility. Sometimes body language can frighten people and discourage them from offering suggestions for solving problems.

Try to be aware of your body language to make sure that it sends, in a positive way, the same message as your words.

Figure 3.3: Non-verbal Communication

3.2.4.7. Barriers to effective communication

- Talking too much, not giving others time to express him or herself
- Being critical and/or judgmental
- Laughing at or humiliating others
- Contradicting
- Arguing
- Being disrespectful of others' beliefs, way of life, method of providing patient care
- Lack of trust or rapport

3.2.4.8. Effects of Ineffective Communication

- Information is not shared, understood.
- The client may ask fewer questions.
- Problem may be difficult to understand.
- Situation may be uncomfortable.
- Lack of adherence to medical appointments and/or treatment.

3.2.5 Application of Communication Skills in Comprehensive Supportive Supervision and Mentoring

Supervisors and mentors are always interacting with people. The more skilled in communication a supervisor/ mentor is, the more successful that s/he will be in improving performance in service provision and quality of health services. The skills presented in this session are necessary for successfully implementing the performance improvement process in a health facility.

At the heart of supervising health services is communication between people. You need to work well with people at different levels and in different situations to make it possible for staff to perform their best in order to provide high-quality services. The supervisor and mentor can achieve this by:

- promoting teamwork,
- being aware of and responding to the needs of staff, and
- encouraging and motivating staff members to do their best.

To perform well, you need good communication skills. Much of your work will take place in meetings; therefore, you must be able to plan and conduct productive meetings. To increase your effectiveness, you must also be able to develop relationships with different stakeholders,
including staff, community members, and representatives of different levels of the health care system.

3.2.5.1 Effective Feedback

Feedback is essential throughout the coaching process, including before, during and after demonstrations, practice sessions and skill evaluation. Many supervisors and mentors find it difficult to acquire the skill of giving performance-enhancing feedback which is very useful. Supervisors/mentors usually need practice to become more confident with this essential skill. If they are unable to give feedback effectively, and/or the supervisee/mentee is unable to receive constructive feedback, not much will be accomplished. How, when and what we say are critical in giving feedback to make it effective to achieve the intended effect.

Guidelines to follow in giving feedback are:

- Ask permission from a recipient to give a feedback.
- Use the first person: “I think,” “I saw,” “I noticed.”
- Describe what you observed and be specific. State facts, not opinions, interpretations, or judgments.
- Address what a person did.
  - Say “You skipped several sections of the counselling script.”
- Not your interpretation of his or her motivation or reason for it.
  - “I know you want to finish quickly because it’s almost lunchtime, but you skipped several sections…”
- Don’t be judgmental or use labels:
  - Avoid words like “lazy,” “careless,” or “forgetful”
- Don’t exaggerate or generalize:
  - Avoid terms such as, “you always,” or “you never”
- When making suggestions for improvement, use statements like:
  - “You may want to consider…”
  - “Another option is to…”
- **Be timely** – Give your feedback soon after the event
- **Be specific** – Describe specific behaviours and reactions, particularly those that the participant should keep and those that should be changed. (Consult the information recorded on the checklist to help focus the feedback on key points).
- **Be descriptive**, not judgmental. Describe the consequences of the behaviour; do not judge the person.
- **Take responsibility** for your own feedback. Speak for yourself, not for others
  Example: **(descriptive, specific feedback);**

"When you gave the injection of local anaesthetic, you did not tell the client what to expect. I saw her wince and was tense, making it difficult for you to gain her cooperation later in the procedure"

***Example* (judgmental, non – specific feedback):**

" You always seem to be in such a hurry that you completely ignore the client's needs"

Guidelines when receiving feedback include:

- **Ask for it**. Find supervisors and mentors who will be direct. Ask them to be specific and descriptive.
- **Direct it**. If you need information to answer a question or to pursue a learning objective, ask for it.
- **Accept it**. Do not defend or justify your behaviour. Listen to what people have to say and thank them. Use what is helpful; quietly discard the rest what is not useful.

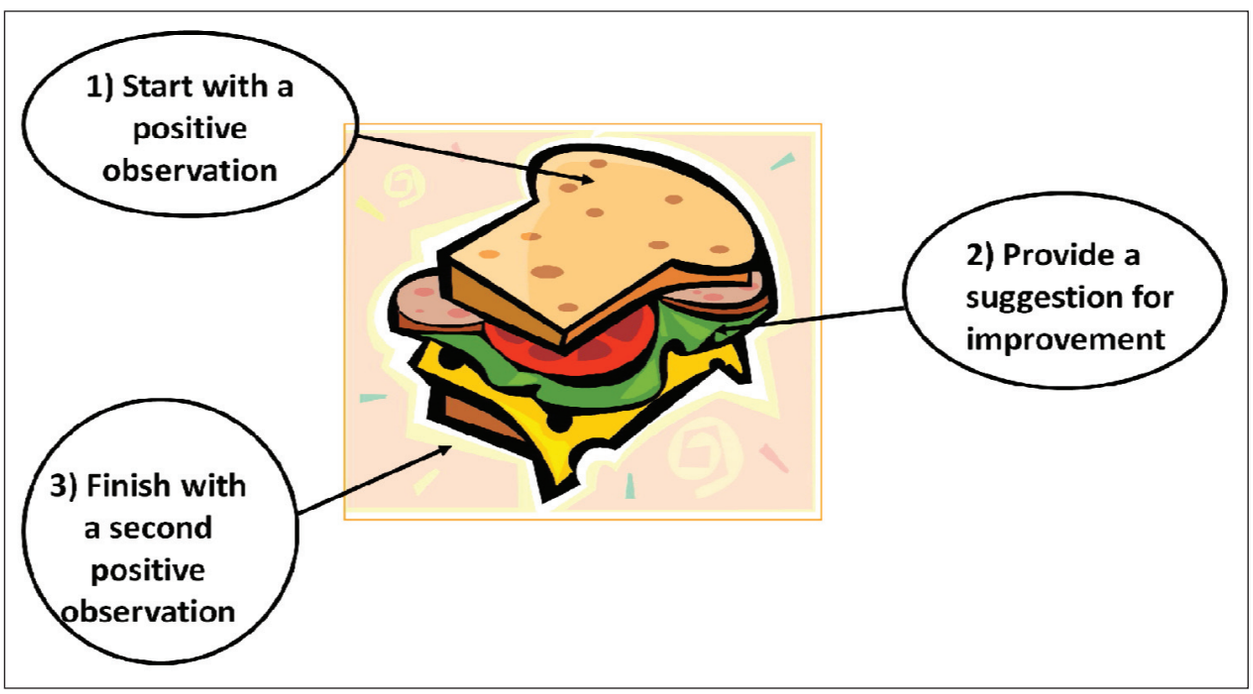


Figure 3.4: Sandwich Principle in Feedback

3.2.5.2. Problem Solving

One of the main purpose of training is to help HSPs become confident and independent problem solvers. Each client and each situation are unique. Effective problem solving is based on the following steps:

1) Recognize that there is a problem
2) Identify the problem
3) Analyze the problem
4) Generate alternative solutions to the problem
5) Implement the chosen solution
6) Evaluate the implemented solution

A wide range of formats can be used for presenting clinical situations to enhance problem-solving capability such as:

- Written case studies
- Videotaped situations to trigger discussion

- Case presentations by participants based on their own experiences
- Discussion of practice cases during clinical training sessions

The most effective way to teach problem-solving is to use the supervisees' or mentees' own clinical practice cases as the material to be discussed. For example, a mentee might have clinical practice cases in the morning and get together with the coach in a group in the afternoon. During the discussion, they would be asked to present situations they encountered in the morning and the group would then discuss alternative solutions to the problem.

'Problem-base learning' can replace many of the lecture-based classes that have been the traditional feature of clinical/technical education. Both trainers and trainees find it a highly acceptable learning method.

3.2.5.3. Facilitating Teamwork

A team is a small number of people with various and different skills who are committed to a common purpose and performance goals. Each member is responsible and accountable to other team members.

You will be more likely to succeed as a supervisor if you work with staff and stakeholders as a team. You can agree on a common purpose, determine what is good about the facility and what might need to be improved, and find ways to make improvements as a team.

Some teams are permanent and may be planning and monitoring continuously. An example of this type of team is a Council Health Management Team (CHMT) or RHMT. Some teams are formed for specific purposes. An example of this type of team is one that is formed to make recommendations about what hours the clinic should be open in the evenings. This team (committee) would disband after recommendations have been made.

The team-building process that is presented in this manual can be managed through a permanent team, such as a management or performance improvement team that meets regularly, or a team that is formed as needed to address specific performance gaps. Most likely, you will want to establish both kinds of teams. The most important point is that improving performance is a team effort. It is not the responsibility of just one person.

Composition of the team:

- Those interest in the issues being addressed
- Those who are directly affected by the issues, and
- Those who can do something about the issues.

At a small clinic, the whole staff can be on the team. At a larger facility, there may be multiple teams. For example, in a large regional hospital, there would likely be teams for different services such as PMTCT, HTC, Laboratory services, VCT, Pharmacy, outpatient, the list is long. Make sure to include on the team all levels of staff at your facility and also community members when appropriate (e.g., as members of the facility management committee). To build a successful team and to be a successful participant on a team, you should know how to facilitate teamwork.

There are several stages in **Building a Successful Team**:

- Select five to eight members (identify members based on the goal to be achieved); the larger the team, the harder it is to manage. (Remember, if you are at a small facility of fewer than 10 people, include everyone on the team.)

- Work with the team to develop a common goal that is known by everyone.
- Acknowledge all team members so that they feel that they have something to contribute.
- Help team members work together harmoniously and efficiently to solve problems.
- Encourage members to place the goal of the team before some of their personal goals and desires.
- Treat team members fairly and equally.
- Structure the work of the team in a simple and logical way; make sure the work is distributed fairly.
- Create an environment that supports and rewards openness, creativity, trust, mutual respect, and a commitment to the provision of high-quality health services.

One way to create teamwork is regular communication among staff or team members. When staff communicate regularly and are aware of each individual's roles and responsibilities, they tend to feel a sense of ownership and responsibility to their colleagues.

3.2.5.4. Keeping Staff Motivated

Comprehensive supportive supervision with appropriate communication skills can be used to keep HSPs motivated though it can be a challenge. Motivation can decline when supervisors and HSPs are poorly paid or transferred, and when results are hard to see. Staff can become discouraged when performance planning is a burden. The following suggestions may help overcome the challenges:

10 Ways suggested for staff motivation:

1. Personally thank employees for doing a good job—verbally (in front of colleagues), in writing, or both—in a timely way, often, sincerely and correct mistakes in privacy.
2. Take time to meet with and **listen** to your staff.
3. Provide specific and frequent feedback to staff about their performance. Support them in improving performance.
4. Recognize, reward, and promote high performers; deal with low or marginal performers so that they improve.
5. Keep staff informed about how the organization is doing, upcoming services or products, strategies to be competitive, financial position, new policies, etc.
6. Involve staff in decision making, especially in decisions that affect them. Involvement leads to commitment and ownership.
7. Give staff an opportunity to learn new skills and develop; encourage them to do their best.
8. Show all staff how you can **help them meet their work goals while achieving the organization's goals.** Create a partnership with each employee
9. Create a work environment that is open, trusting, and fun. Encourage new ideas, suggestions, and initiative. **Learn from, rather than punish for, mistakes**
10. Celebrate successes—of the organization, of the department, and of individual staff members. Take time for team- and morale-building meetings and activities. Be creative!

3.2.5.5. Planning and facilitating productive meetings

Planning and facilitation of meetings are important to strengthen regular communication.

1) Questions to ask yourself before preparation of a meeting

As a supervisor, you will find yourself in the position of planning, calling and facilitating many meetings. They may be with community leaders or administrative staff or the clinic staff. Some of the questions you may want to consider as you plan and facilitate meetings are:

- **What information do I wish to give or obtain?**

For example, if you want to inform staff of recent changes in procurement procedures, you might call a meeting to explain the new procedures to them. Or, if you are trying to determine the best hours for the clinic to provide CTC services, you might call a meeting of community members to find out their needs and expectations (e.g., the most convenient times for coming to the clinic). These kinds of meetings work well with groups of 10 or more participants.

- **Is there a decision to be made or a problem to be solved?**

After gathering information from the community about their preferences for CTC services, you might meet with staff members to brainstorm about how to change the clinic's hours to better meet community needs.

- **Is there a specific goal to be accomplished or a task to be completed?**

For example, to complete a report for the MOHSW, you may need to get information from various services of the hospital. You might call a meeting of people from different services and ask them to bring relevant information so that you can complete the report together.

2) Preparing for a Meeting

Consider the following questions when preparing for a meeting;

- **Is a meeting necessary?**

Ask yourself if there is an alternative way to accomplish the task apart from calling a meeting (e.g., memos, letters, reports, telephone conversations, face to-face conversations). If the answer is no, you should proceed with planning your meeting.

- **What is the objective of the meeting?**

The meeting objective is a statement of purpose. This is part of the agenda. It shows what the meeting intends to accomplish. To avoid confusion and focus the participants' attention, you should keep the meeting centred on one objective.

Examples of different objectives:

- Inform the staff of new procurement procedures and answer their questions
- Determine the best hours to provide CTC services in the community
- Complete the quarterly report for the MOHSW

- **What information do you need to gather about the topic prior to the meeting?**

It is important that everyone attending the meeting know something about the topic to be discussed. This information can be made available before the meeting or you can begin the meeting with an introduction to the topic.

- **Who should participate?**

- Who needs this information?
- Who will do the work or make the decisions?
- Who are the people who will be affected by the discussions and decision about the meeting's agenda?

- **Where, when, and for how long will the meeting take place?**
  - Are the meeting place and time convenient for everyone?
  - Is there enough time to accomplish the meeting objective?

3) Conducting a meeting

Once the above questions have been addressed, be sure to do the following:

i) Prepare the agenda for the meeting.

The agenda should be based on the meeting objective, the amount of time available for the meeting, and the number of participants invited. (The more people who are invited, the more ideas will be suggested and the more information shared, and thus the more time will be required.) You may wish to ask the meeting attendees for agenda items, or ask certain participants to introduce specific items. The agenda should be distributed to participants before the meeting. If the team has regular meetings, allow time at the beginning of each meeting to follow up on actions recommended in previous meetings (and recorded in previous minutes) to encourage continuity and closure.

Finally, list agenda items in order of priority. Put them in a logical order. Decide how each item will be addressed (e.g., brainstorming, small group discussion). Allow enough time for each item.

ii) Announce the meeting.

People should be informed of a meeting well ahead of time. Distributing the agenda before a meeting is very helpful to the participants. It helps them to prepare themselves for the meeting and provides an opportunity for participants to give their input on the agenda. For public meetings with community members, written announcements can be posted on walls and doors in public places such as shops or post offices. HSPs should also meet with community leaders and ask them to spread the information about the meeting.

iii) Conducting the Meeting

The type of meeting will determine how it is conducted. Three simple rules, however, apply to all group meetings: The person conducting the meeting:

- Should allow no rudeness or personal remarks
- Has the absolute right to control the discussion, rule out irrelevant remarks, and stop the proceedings if necessary
- Is responsible for the progress of the discussion (e.g., by raising questions or new topics, encouraging all participants to take part)

4) Roles of the Facilitator

The person conducting the meeting is often referred to as the facilitator. To be an effective meeting facilitator, you must use all of the team leadership and communication skills described earlier in this chapter. As a

leader, you must keep the group focused on its objective and draw the group together to accomplish its goal. Keep in mind the following major responsibilities of the meeting facilitator or chairperson:

- Define the objectives and agenda for the meeting ahead of time.
- Start and end the meeting on time.
- Set the rules of conduct for the meeting (e.g., raising a hand to be recognized).
- Keep the meeting moving forward by managing the discussion.
- Encourage full participation of all attendees.
- Encourage active discussion, expression of opposing viewpoints, and teamwork.
- Restate or summarize participants' positions for clarity.
- Help resolve conflicts.
- Maintain order and courtesy; the climate of the meeting should be one of mutual respect.
- Clarify and summarize conclusions or actions to be taken.
- Delegate responsibilities and make effective use of subcommittees to work on activities before the next meeting.
- Delegate responsibility for creating and distributing the minutes of the meeting.
- Establish the time, place, and agenda for the next meeting.
- Follow through on the future work that was decided on at the meeting.

If you are left with too little time to discuss all remaining agenda items, deal with the most important ones first and leave the rest of the items for a future meeting. Rushing through the agenda items is not productive

3.2.5.6. Coordinating multiple stakeholder

For the supervisor or mentor to have an impact, you must promote linkages among many stakeholders including:

- Among all of the services within the facility
- Among the clinic and other clinics or hospitals
- Among the clinic and central supply systems
- Between the clinic and the community
- Among district, regional, and national authorities

Some problems can be solved within the health facility while others cannot. Some are more efficiently and effectively dealt with at district or regional levels. Be prepared to address problems at the appropriate level. For example, if your clinic is having a problem with referring clients for further care, you will need to communicate with the following stakeholders:

- **Staff**—to make sure that they are identifying the need for client referral in a timely manner and know how to refer clients effectively
- **Staff**—to make sure that they know the outcome of the referral and whether it was appropriate.
- **Clients**—to make sure that they are receiving high-quality counselling and that they understand what is involved in referrals;
- **Other community members**—to make sure transport is available;
- **Other clinics, hospitals, and community care/hospice care facilities to which you are referring clients**—to make sure that you refer each case to the appropriate place; and

Maintaining Strong Community Links

The supervisor, mentor and staff must maintain close links with the community. For your team to have a positive impact on the people in the community, it is essential to understand the community's way of life. This is best done by listening to what people say, watching how
they behave, and participating in community events. Specific ways for your team to stay in touch with the community it serves include:

- Inviting community members to be a part of the management of the facility
- Holding community meetings to share health information, leaving time at the end for community members to ask questions and voice concerns
- Placing a suggestion box in the clinic, reviewing suggestions, and implementing them when possible
- Conducting periodic exit interviews of clients
- Serving as an active member of the community (e.g., going to religious meetings, attending social functions)
- Participating in radio or television discussions on relevant health matters and using the opportunity to pass on health information to the community
- Writing articles in newspapers or reading for the local news
- Asking community leaders for their ideas, suggestions, and comments (they may serve as the "voice" for others who hesitate to give their opinion)
- Involving community-based health providers in activities at the facility
- Networking with other social or community services (e.g., local schools, youth clubs)

3.2.6. Managing Change

3.2.6.1. Sustaining and institutionalizing change

As a supervisor, the concern is the quality of services provided by the facility to the community. The supervisor plays a critical role in effecting change both at the facility and within the health care system. Introducing interventions to improve performance and quality of health services involves change, and people do not always accept change. It is not enough to design solutions for improving the quality of care at a facility. The best ideas can fail because the people who are supposed to implement them are resistant to change. To improve quality of services, one must know how to manage the change process. This requires complete involvement of all stakeholders. Therefore, supervision becomes a team effort to make these improvements happen.

A key lesson from successful quality and performance improvement interventions is that for change to be sustained and institutionalized, there must be an internal enabling environment conducive to initiating, expanding, and sustaining the change. This enabling environment includes policies, leadership, organizational values, and adequate resources to support improved practices. Short-term improvements in comprehensive supportive supervision and mentoring thus cannot be sustained or successfully scaled up unless organizations strengthen their overall human resource management systems

For example, after an intervention to improve supervision in India by defining a clearer role and responsibilities for supervisors and shifting emphasis toward joint problem solving, some supervisors reported that they did not like the more participatory, supportive style and preferred the status they enjoyed when supervision was geared toward inspection and control. But even when supervisors want to be more effective, change can be difficult and threatening.

3.2.6.2. Managing resistance to change

People may resist to change because they feel:

1) Threatened by a change: Staff may fear losing their jobs as a result of changes in their work environment. They may believe that they will end up doing more work or have to work under unfavourable conditions. HSPs could think that:

- Focusing more on quality will result in more time spent with each client and therefore longer working hours for the same salary.
- Introducing a preventive health care approach that is proactive will mean that they will have to conduct home visits instead of working only at the health facility.
- Measuring their performance and the quality of their work might have them declared incompetent in their jobs and cause them to be fired.
- Changing behaviour provides no benefit.

2) Excluded: If staff believe that they have not been involved in the changes, or do not know or understand why changes are being suggested, they are likely to resist. They may feel underrated, out of control of the situation or threatened. This feeling could be particularly strong among staff with leadership roles. These staff may believe that they already know the day-to-day realities and any changes that are needed. They may react negatively to proposals for change**.**

3) Unhappy: HSP, especially in the public sector, frequently receive very low salaries. Resisting change is a way to express their dissatisfaction with the low salaries.

4) Isolated: As workload increases or changes, staff often feel there is lack of commitment, support, awareness, and communication from the administrators.

Steps to be followed to minimize resistance to change

It is difficult to eliminate resistance to change completely and permanently. Steps can be taken to minimize it if you:

- **Develop a common goal:**
  Work with staff to keep in mind the goal that you have for your facility and to see how the proposed interventions will help you achieve it. A common goal will be the main force to pull the team together and move the change process forward.
- **Involve stakeholders:**
  Before starting an intervention, it is important to identify the key stakeholders. In the case of a clinic, you should consider the different groups of HSPs, clients, MOHSW officials, community organizations, local governments, media, etc. It is important to identify the real or perceived interests, fears, and influence of each group. Develop a plan to involve specific stakeholders as appropriate.
- **Communicate:**
  The purpose of the intervention and its likely effects, both positive and negative, should be presented clearly from the start to those involved in the process. These people must understand what they will gain as a result of the changes.

- **Involve all staff:**
  It is important to promote the broadest possible participation in the change process by different groups of staff members. Team building and teamwork mechanisms are essential. This helps them anticipate reactions, both positive and negative, and provide adequate feedback or solutions.
- **Negotiate with stakeholders**:
  Frequently, it is necessary to negotiate with stakeholders to ensure their ongoing support and commitment to the process.
- **Monitor:**
  Even if there is an initial stakeholder agreement to participate in and support the process, it is important to monitor how the situation evolves. Interventions might produce changes that were not expected at the beginning and provoke negative reactions from stakeholders.
- **Demonstrate commitment and consistency:**
  Assuming staff have been involved and considered during the entire change process, it is important to demonstrate continued interest and support toward the staff and the proposed changes. Because there is rarely complete certainty about the root causes of gaps in performance, selecting and enacting interventions should be closely monitored. If you find that the intervention is not the appropriate solution, other interventions can then be selected and implemented.

CHAPTER 4:

EFFECTIVE COACHING IN COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING

4

LEARNING OBJECTIVES:

By the end of this chapter, the participants will be able to

- **Describe effective coaching in comprehensive supportive supervision and mentoring**
- **Describe the qualities of an effective coach**

4.1 OVERVIEW OF COACHING

Coaching is assisting the individual or the team to bring out the ability and to find the best way to improve or develop his or her or its performance.

Coaching has been used successfully for sports training and technical training in industry for many years. Coaching is provided through purposeful, planned and regular meetings and demonstration between a coach and a trainee or a team of trainees for the purpose of envisioning, planning and improving performance in accordance with evidence based practice. Coaching is goal driven with a clear articulation of the purpose, expected outcomes and the agenda for each encounter. Coaching in this context can be conceived of as a "thinking partnership" between the coach and the trainee, and must be grounded in mutual trust and respect.

4.2 SKILLS IN COACHING

Coaches use key skills to help trainees integrate changes into their practices as follows:

1) Observing,
2) Active listening,
3) Asking thought provoking questions,
4) Feedback,
5) Making agreement for improvement,
6) Reinforcing strengths,
7) Re-framing of situations,
8) Transforming ideas into action steps, and
9) Timely and consistent follow-ups.

Coaching practice is based on a belief that an individual or a team has potential ability to improve or develop his/her/its performance within himself/herself/itself.

4.3 STAGES OF PERFORMANCE DEVELOPMENT

Performance development is a process that has three stages as shown in the Figure 4.1.

In the first stage of **skill acquisition**, a trainee sees others perform the procedure and acquires a mental

picture of the required steps. Once the mental image is acquired, the trainee attempts to perform the procedure, usually under supervision. Second stage, the trainee practices until **skill competency** is achieved and s/he feels confident performing the procedure. The final stage, **skill proficiency**, only occurs with repeated practice over time. **A coach is therefore assist the trainees to smoothly go through these stages.**

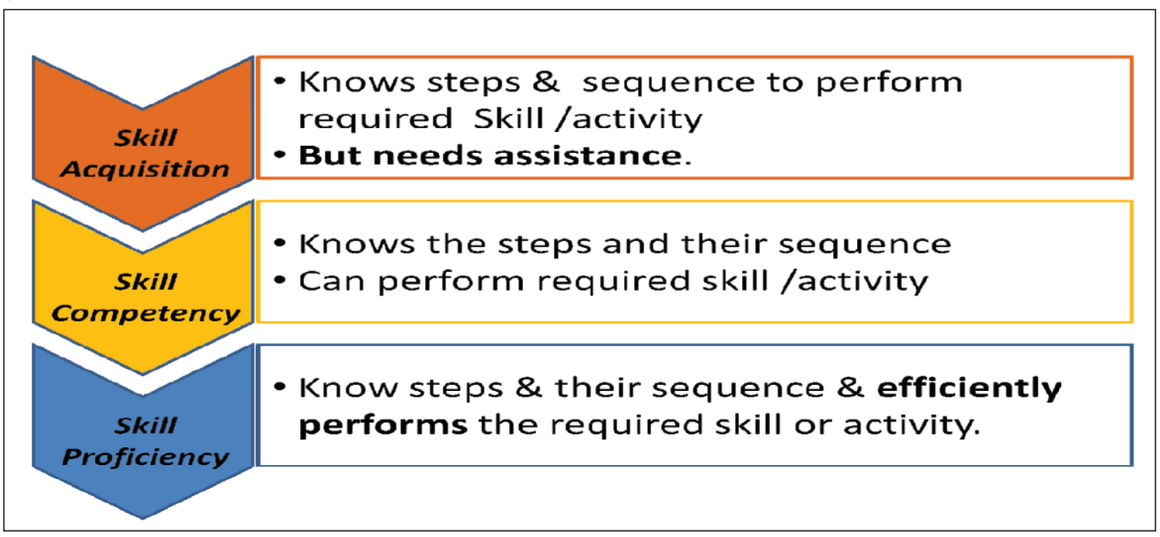


Figure 4.1: Stages of Performance Development

4.4 COACHING FRAMEWORK

Coaching is a catalytic and supportive style of supervision and mentoring. It should not be used to confront poor performance or to prescribe what clinicians need to do to succeed.
A coach would start the coaching session by assessing the trainee's perspective about the area of practice identified for improvement. Then the coach would work to challenge the trainee or encourage the trainee to stretch his or her thinking about the practice.

Challenging is not telling. The coach cannot prescribe what a trainee should do, rather the coach works to engage the trainee in the weaknesses and in figuring out potential solutions or learning needs on his or her own. This is when a coach needs to listen more and talk less and come prepared to ask open ended *"Socratic Q*uestions." Socratic questions are thought-provoking open-ended questions that motivate or challenge a trainee to think critically about an issue to practice. Coaches need to prepare these questions ahead of time, as it was trainers' natural tendency to want to prescribe the solution rather than to ask the trainee and then wait through the silence and thought processes as he or she comes up with a solution. Prescribing a solution is often easier than coming up with a good question, so coaches are urged to resist the temptation to prescribe. An answer tends to stop thought, whereas a good question will motivate critical thinking and practice change.

Examples of "Socratic Questions":

- What is your experience with this clinical problem?
- How do you manage this problem when it occurs with a patient in your care?
- How did patients respond when you have managed the problem this way?
- What other ways are there of managing this problem?

- What is another perspective you could consider?
- What is another approach to care you could try?
- What would superb care of this patient look like? What would be the outcomes of this care?

The session concludes with questions about what the trainee would like to do as a result of the preceding discussion, and what resources he/she needs to do this. Trainee and coach share responsibilities for creating an action plan and for following through on the action items. Scheduling the next coaching session before the end of the current session proved a pragmatic and supportive intervention.

Planning for the follow up from a coaching session is a way coaches support trainees. Without planned follow up, the coaching session is little more than stimulating conversation and good intentions. The final 10 minutes or so of the session should be devoted to developing an action plan based on the discussion. What does the trainee want to do as a result of this discussion? What learning needs does he or she identify? What resources can you identify together to help the trainee act on what was discussed? It's important for both the coach and the trainee to have some "to do" items in the action plan, but the coach must take care not to "do for" the trainee. The trainee needs to be responsible and accountable for an equal amount of the action plan.

Action plans should be written down, have a short term goal, a small number of objectives (or "to do " items) and a time line. Without an action plan that defines what the deliverables are, who is to deliver them, and when they are to be delivered, expectations are not met.

Following up on coaching sessions is a challenge for coaches as something always seems to take priority. Coaching is a process and a relationship that takes place over time with regularly scheduled sessions that build on previous sessions. Follow up not only holds coaches and trainees accountable for action plans, but also it continues the conversation and the performance growth. Approaching follow up in a casual way or leaving it to chance encounters reduces coaching to a nice chat, rather than as a managerial tool to support trainees and improve practice. Follow-up must be scheduled.

"It takes a lot of practice to adopt a coaching approach to improve practice and to stop wrestling with trainees and start partnering with them."

The following table indicates a coaching framework as explained above.

Table 3.1 Coaching Framework

Coaching Element	What's Involved?	Skills that can help
ASSESS	• Identifying what you see as an area for practice improvement. • Discovering the trainee's perspective about what you have identified. • Assessing trainee's motivation to improve this area of practice; to grow and/or change his or her practice. • What are the trainee's strengths and interests and areas for growth? • What would the trainee consider improvement or success in this area of practice?	• Socratic Questioning • Active Listening
CHALLENGE	• Engage the trainee in dialogue, problem solving about a particular situation, and/or envisioning about how care/ performance could be even better than it is now . • You want to create a bit of a disequilibrium for the trainee between current practice and what practice could be. • You want to challenge the trainee – or better yet - get him/her to challenge him/herself to growth in his/her practice around this issue.	• Socratic Questioning • Active Listening
SUPPORT	• Support a plan for practice growth, but not a plan to "do for " the trainee. • End the session by getting the trainee to identify learning needs and then help in finding resources to meet those needs. • Help by managing or problem solving barriers to the trainee addressing learning needs. • Recognize wins and setbacks. • Acknowledge small gains and improvements. • Celebrate success.	• Written action or follow up plans • Regularly planned follow up meetings • Regular and spontaneous feedback

(Adapted from the *Centre for Creative Leadership's Coaching Framework Applied to Clinical Coaching in Home Care, "Clinical Coaching: An Approach to Motivating Clinical Practice Change in Home Care" (Visiting Nurse Association of Boston and Affiliates).*

4.5 QUALITIES OF AN EFFECTIVE COACH

A coach needs to:

- Be proficient in the skills to be taught
- Encourage participants in learning new skills
- Promote open (two-way communications)
- Provide immediate feedback:
- Recognise that clinical/technical training can be stressful and knows how to regulate participants' as well as coach stress:
- Be patient and supportive

- Provide praise and positive reinforcement
- Correct participant errors while maintaining participant self-esteem
- Be good at listening and observing.

4.6 ROLES OF AN EFFECTIVE COACH

To understand fully the roles of the coach, it is helpful to compare the do's and don'ts of effective coaching. The effective coach involves all participants in the learning process and provides them with positive feedback. The ineffective coach is controlling, avoids involving the participant and typically fails to provide positive feedback. A comparison of the effective and ineffective coach is presented below:

The Effective Coach…….	The Ineffective Coach……
• Focuses on the practical	• Focuses on the theoretical information
• Encourages working together (collegial relationship)	• Maintains a distance (status is above the participants)
• Works to reduce stress	• Often creates stress
• Fosters two-way communication	• Uses one-way communication
• Is a facilitator of learning	• Acts as the authority or the only source of knowledge

4.7 CONDITIONS FOR COACHING TO SUCCEED

- Training needs assessment reveals specific training needs
- Specific performance standards been established for the skills
- Availability of experienced clinical trainers available to demonstrate / teach skills
- Facilities, instruments available for practicing skills
- Availability of resources /opportunities to apply newly acquired skills at work immediately

Handout 4:
Coaching Role Play

Objective:

By the end of this session, the participants will be able to:

- Apply coaching skills in demonstration through role play

Scenario:

You are an HTC mentor. You have a mentee (HTC counsellor) who does not demonstrate how to use male and female condoms to clients. You visit the mentee to coach and empower him/her for provision of the demonstration to clients.

✂----------

Role Play Instructions – Mentor

You are an HTC mentor. You have a mentee (HTC counsellor/provider) who does not demonstrate how to use male and female condoms to clients. You visit the mentee to coach him/her to provide the demonstration to clients.

Assess the situation (why he/she does not want to give demonstration, what are the strengths and weakness), challenge the counsellor to provide the demonstration and support him/her in any way he/she needs. Use the Socratic questions you learnt in the session to coach the mentee. Refer to the **Coaching Framework** on page 34 for more information on coaching.

✂----------

Role Play Instructions– The Mentee

You are an HTC counsellor who has been trained to provide demonstrations on how to use male and female condoms to clients, but you do not demonstrate to clients because you are shy and don't like to hold penile models. You are visited by a mentor to discuss why you don't provide the demonstrations to clients. Provide answers to the mentor on why you don't provide demonstrations.

CHAPTER 5:

INTRODUCTION TO QUALITY OF CARE IN HEALTH SERVICES

LEARNING OBJECTIVES

By the end of the chapter , the participants will be able to :

- **Describe the quality of care in health services**
- **Describe challenges in the provision of quality HIV and AIDS services**
- **Explain the Quality Improvement Model**
- **Explain different approaches to Quality of Care**
- **Describe the process of defining performance standards**
- **Explain assessment of performance**

5.1. QUALITY OF CARE

5.1.1. Definition of Quality

The word quality has been associated with excellence, superiority, high calibre, high cost, value, performance according to standards and compliance with requirements or specifications.

This shows that quality means different things to different people: a quality refrigerator should maintain the proper temperature with minimum energy consumption, quality bus service could mean on-time, comfortable and reasonable bus fare or affordable cost, while quality health services could imply minimum waiting time, correct diagnosis and prescription, confidentiality and reasonable charge or affordable cost sharing amounts. Quality is generally defined as “the totality of features and characteristics of an entity that bears on its ability to satisfy a stated or implied need”.

For people living with HIV (PLHIV), quality service may manifest itself as effectiveness of care (such as reduction of opportunistic infections, weight gain, resumption to work, decrease in symptoms), respect and compassion from caregivers, clarity and relevance of information given, ease of use of facility (friendliness of support staff, short waiting time, cleanliness of facility,.) and confidentiality to name a few examples. For their families, partners and friends quality can mean the same as above and confidence that their loved ones are satisfied with the care they receive.

In health care generally, quality entails developing a statement regarding input, process and outcome standards that health care delivery system must meet in order for its population to achieve optimum health gains. However, quality is a complex and multidimensional concept and thus has been defined in different ways by different people, using different terms, labels and models, the choice of which definition depends on intended use. Furthermore, having numerous clients in various institutions, "quality" can mean different things to each client. To satisfy every client’s "needs" entails "compliance to clients’ requirements".

5.1.2. Definition of Quality of Care

Quality care can be defined as accessible and effective care that is delivered in compliance with evidence-based standards and meets clients’ needs. Evidence-based standards define for both HSPs and clients what constitutes quality care and have been associated with improved health outcomes. There are several

definitions which differ in their emphasis on quality of life, delivery of services and components of care. While the definitions may all be justified depending on the perspectives and objectives, common aspects at the centre of the concept of quality are the **needs** of the **client or community** and those of the **service provider**.

In simple terms, quality of care is:

- Performing according to standards
- Doing the right things (what) by applying correct interventions to meet clients' needs
- Providing services to the right people (to whom) at the right time (when) and
- Doing things right the first time and every time by following the correct processes, efficiently and on time using set standards. This avoids re-work or repetition.

5.1.3. Guiding Principles for Quality of Care

- A client-oriented mindset
- Staff involvement and ownership
- Focus on processes and systems
- Cost-consciousness and efficiency
- Continuous learning, development, and capacity building
- Ongoing quality improvement

A client-oriented mindset:

The clients who come to the facility are considered external clients while the service providers are internal clients. Each supervisor is a client of his or her supervisee. Comprehensive supportive supervisors and mentors focus on the needs and expectations of both external and internal clients. Clients have rights to quality services and service providers have needs which should be met for them to fulfil the rights of the external clients with their services. Comprehensive supportive supervisors keep these rights and needs in mind when assessing quality, involving staff to identify problems and seeking solutions.

Staff involvement and ownership:

Comprehensive supportive supervisors involve staff in the performance improvement process and try to foster a spirit of ownership and teamwork by emphasizing the importance and contribution of everyone to provide good quality of services, including involvement in decision making.

Focus on processes and systems:

Comprehensive **s**upportive supervisors emphasize the importance of improving processes and systems rather than focusing on individual mistakes. Comprehensive supportive supervision approach recognizes that 75% of problems in organizations are due to overly complex or faulty processes or systems and not due to the people who try to implement these processes or systems. People only contribute 25% of problems in the institution. Comprehensive supportive supervision also puts emphasis on the use of data, communication, feedback and problem solving.

Cost consciousness and efficiency:

If something is not done correctly the first time, it has to be re-done. Repetition is costly. Poor quality is

costly both financially and in terms of the health of individuals and the community. In addition, it may have an opportunity costs. Poor quality is wasteful and good quality is cost saving. When processes are made better, total costs usually fall.

Continuous learning, development, and capacity building:
Supervisors and mentors pay close attention to staff development and capacity-building. They transfer the knowledge and skills needed to improve quality. Supervisors ensure opportunities for staff refresher and training in new processes and procedures. They enable staff to identify learning needs and assist staff in developing a plan on how to address those needs. Supervisors and mentors organise the transfer of knowledge and skills acquired by staff to other staff members and ensure the application of newly acquired skills by trained staff.

Ongoing quality improvement:
External supervisors visit sites systematically to foster the quality improvement process. External supervisors disseminate the quality improvement tools to internal supervisors who then disseminate the tools to their staff. Changes in quality of services are regularly monitored and evaluated, while problem areas are constantly identified and improved.

5.1.4. Benefits of Quality of Care

- Ensures safety to both internal and external clients.
- Ensures effectiveness (desired results from the services given).
- Promotes confidence in HSPs and facility/programme.
- Improves communication among service providers, clients, colleagues and other stakeholders.
- Increases clearer understanding of community needs and expectations.
- Improves the job satisfaction of HSPs.
- Cost saving whereas poor quality is expensive.

5.2. STANDARD

A standard of care is a formal diagnostic and treatment process a HSP shall follow for a patient with a certain signs and symptoms or a specific illness. That standard will follow guidelines and protocols that organizations, panels of experts or governments have agreed upon as the most appropriate process. Standards also refer to a statement of “desired”/ “achievable” performance of health service intervention, which serves as a reference point for evaluation. It is generally classified as addressing a system’s **inputs**, **processes** the organization carries out, or **outputs** it expects from the services provided. Standard describes explicitly who should be doing what, in which way, at which level of the health system at what time and the expected output.

5.2.1. Definition of standard

A standard is defined as an explicit predetermined expectation set by a competent authority (professional societies, health care organizations, panels of experts or government) that describes an organization’s acceptable performance level. (An implicit standard can be described as a practice that is simply “understood.”).

A standard is an agreed, repeatable way of doing something through a set of technical specifications or other precise criteria designed to be used consistently as a rule, guideline, or definition. Standards help to increase the reliability and the effectiveness of the services we provide.

5.2.2. Characteristics of Standards

The following criteria must be considered in identifying standards that are valid, credible and able to be surveyed (WHO, 2004):

- The standard reflects current and accepted knowledge and evidence.
- The standard clearly identifies the compliance expected.
- The standard is specific, measurable and time-bound – by self-assessment and by external assessment processes.
- The standard permits a valid measuring process.
- Organizations can identify what "evidence" they need to present to validate that they meet the expectation of the standard.
- The standard is associated with the quality and safety of the care provided to service users.
- They use simple language – no jargon.
- Each standard has one major principle to simplify the compliance expected.
- The standards-setting body writes the standard in the active voice ("The organization provides…" or "Caregivers support…").
- The performance expected is resource neutral: both resource-rich and resource-constrained settings can mostly meet the indicator.
- The standard sets exact expectations and does not use "should" or "may" to reflect desirable but not required expectations.
- The standard identifies a person responsible for upholding the standards.

Note that standards should:

Be available and used by all HSPs for them to continually work to improve quality of care.

Examples:

- All HIV exposed infants should start on Cotrimoxazole from the age of 4 weeks.
- Wear gloves when drawing blood.
- Trained providers should be in provision of HIV care according to the National Guidelines.
- Facility should have rooms that provide for privacy and confidential record keeping.
- Facility should have the capacity to conduct HIV testing and counselling.
- Care provided must include counselling, testing and adherence counselling.

5.2.3. Use of standards

Standards are used for:

- Developing and/or strengthening national quality evaluation and accreditation programmes for health care facilities providing HIV care;
- Developing public policy related to HIV care;
- Improving the quality of current programmes or treatment facilities;
- Creating new programmes or treatment facilities for HIV care; and
- Building the capacity of communities and facilities to provide more effective and efficient HIV care.

Standards are used to objectively measure an organization's performance. When the organization performs to the minimum level of desired standards, it will be awarded a **license** that allows it to deliver the services.

As performance improves towards the maximum level of standards as objectively measured, it will be certified or accredited for meeting the highest expected standards. Standards show what the performance should ideally be.

Measurement against standards allows identification of opportunities for improvement.

5.2.4. Improvement by Setting Standards

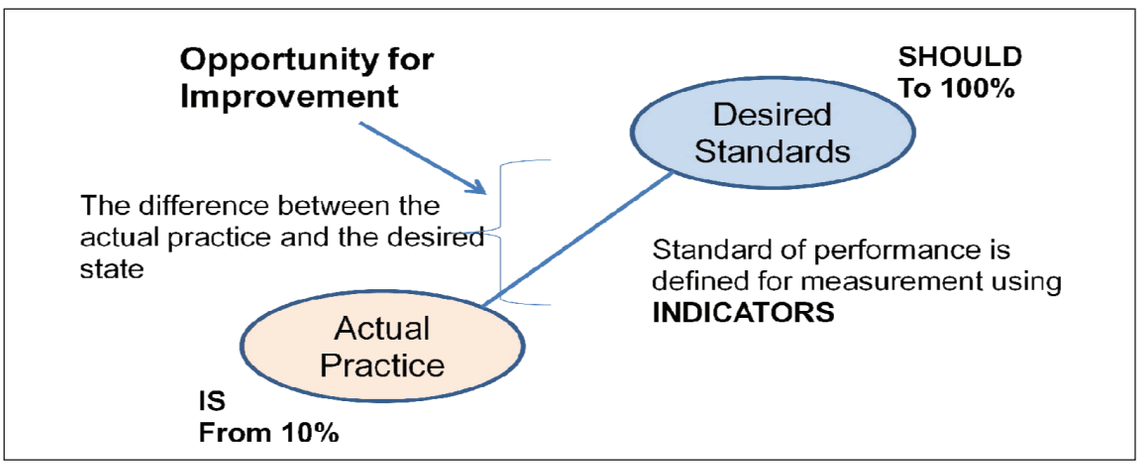


Figure 5.1: Improvement to fill in gaps between desired standards and actual situation

Comprehensive supportive supervision and mentoring is **a** process to identify and develop solutions for the gaps in order to achieve quality improvement.

5.2.5. Challenges in provision of quality HIV and AIDS services

As a result of rapid expansion of the health services, the health care system faces a number of challenges in the provision of quality HIV/AIDS services:

- **Weak health infrastructure**
  Health service infrastructure does not have the capacity to meet the demand imposed by the big burden of disease as HIV infection continues to spread in the country.
- **Critical shortage of human resources for health**
  The health sector is currently facing a critical shortage of human resources for health both in terms of numbers, skills and qualification. The country is apparently operating at about 30% of required staff.
- **Vertical interventions**
  The vertical approach to implementing HIV and AIDS intervention is a result of the following:
  - Urgent need to introduce and scale up the interventions
  - Complexity of the interventions
  - Emergence of new interventions

  Vertical interventions mean an increase in workload to the already overburdened HSPs, a situation which affects quality of services at the facility and community. Several supervisors visit the facilities within a very short time.
- **Budgetary constraints**
  The health sector is also facing budgetary constraints that contribute to lack of essential resources, equipment and or supplies for the provision of quality health services.

- **Weak pre/in-service training of HSPs on HIV and AIDS**
  Weak integration of HIV and AIDS training into pre-service as well as in-service training of HSPs to bridge the skills gap.

The above mentioned challenges have in one way or another contributed to the weakening of the health service delivery system thus compromising the quality of health services. Addressing these challenges within the context of constrained resources on one hand and the need for universal access to HIV and AIDS services on the other, is key to the provision of quality health services.

Realising these challenges the MOHSW through NACP has developed the quality improvement package that will contribute positively to improvement of quality HIV and AIDS services in the country.

5.3. QUALITY IMPROVEMENT MODEL AND APPROACHES

Quality improvement is a systematic process of assessing performance of health system and its services, identifying gaps and causes and introducing measures to improve quality and monitoring the impact. There are different models and approaches, however in this training the PDSA cycle model and two approaches, 5-S and improvement collaborative will be described.

5.3.1 Quality Improvement Model

In this model, quality improvement takes place through four steps. Steps 1-3 involve responding to three basic questions and step 4 is applying the PDSA cycle. The three fundamental questions when combined with the Plan, Do, Study and Act cycle (PDSA cycle) form the basis of the model for improvement in health service setting. The PDSA is a systemic way of implementing identified changes measuring the effects of changes and decide whether to abandon, modify or implement the change.

The four steps of the model are:

1) **Identify** what needs to be improved by asking "What are we trying to accomplish?"
2) **Analyze** the problem and answer the question of "How will we know that change is an improvement?
3) **Develop** a hypothesis about solutions by asking "What changes will result in improvement?
4) **Implement** the hypothesized solutions by applying **PDSA** to see if they result into improvement.

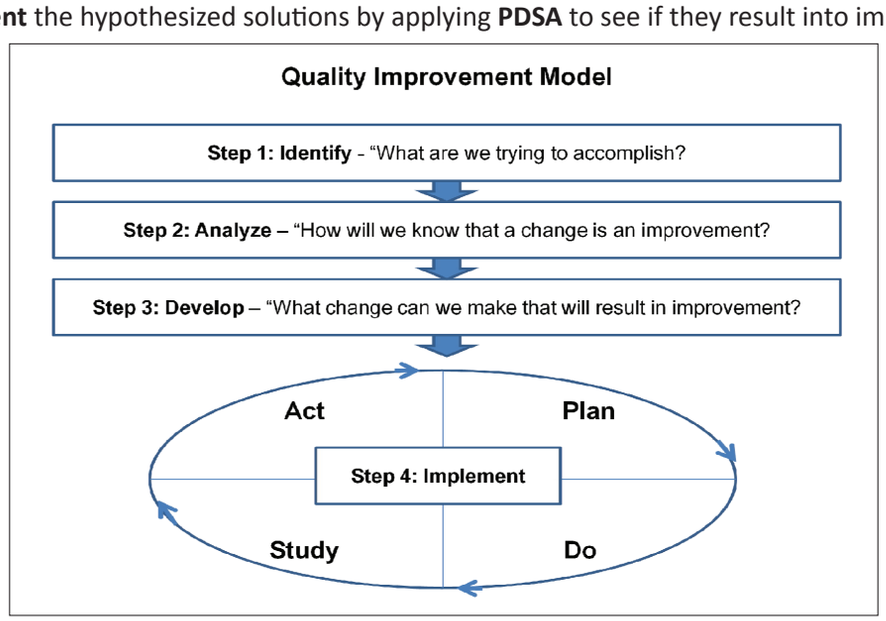


Figure 5.2: Quality Improvement Model

Supervisory and Mentoring teams should continuously be looking for ways to further improve performance by using this model. Repetition of the four steps may be needed to test the change before desired results are achieved. In addition teams can continue to strive for further improvements with the same problem and/or address other opportunities for improvement that have been identified.

Step 1: Identify what needs to be improved

The goal of this step is to determine what to improve. This may involve a problem that needs a solution, an opportunity for improvement or a process or system that needs to be improved. Examples of problems in HIV and AIDS services are:

- Stock outs of ARV medicines and/or laboratory reagents
- Few clients have follow up CD4 tests done
- Few infants are initiated breastfeeding within the first hour of delivery

The important question in this step is to ask: What is the problem as regards the perceived performance gap? In HIV and AIDS services and in other services for chronic conditions, supervisory and mentoring efforts should be geared towards addressing the following performance issues:

Access: Those who are in need of service receive the appropriate services, e.g. Are all those who undergo HIV testing and found to be positive are enrolled into care and treatment and receive appropriate care?

Retention: All those receiving the services for example ART services are retained, e.g. Are there very few lost to follow up for those on ART?

Wellness: All those who receive health services have better health outcomes, e.g. Are all patients' CD4 counts raising, ambulatory and continue with routine work?

In health service settings, there are two main ways of identifying problems related to delivery of quality health services., These are record review and seeking clients' opinions.
1) Record review:

Use available data to help identify current gaps that need to be addressed, for example:

- Use pre-ART register to determine if patients who are eligible for ART are being started
- Use ART registers or CTC database to check if patients are having CD4 count as scheduled and if patients who are supposed to return to clinic in a specified time frame do come.
- Examine pharmacy registers to see whether patients with ARVs prescriptions picked the drugs
- Review indicators for QI that have been used elsewhere, for example
    - Were patients assessed for active TB at last clinic encounter?
    - Did HIV exposed infants receive daily Cotrimoxazole after eight (8) weeks of birth?
    - Did female patients between 15 - 49 years of age receive family planning counselling during their most recent clinic visit?

2) Obtain ideas from both internal and external clients:
This can be done by encouraging regular meetings with staff and patient groups, holding focused group discussions, patient exit interviews as well as using suggestion boxes.

Step 2: Analyze the problem

Analysis is gaining a deeper understanding of the opportunity for improvement before considering changes. When analyzing a problem, the key question to be considered is "How do you know that it is a problem?" Once a problem or opportunity for improvement has been identified, the second step analyzes what is known or understood before changes are considered. The objectives of the analysis step can be achieved through the following questions:

- Who is involved or affected?
- Where does the problem occur?
- When does the problem occur?
- What happens when the problem occurs?
- Why does the problem occur?

Learn about internal and external clients, such as their involvement in the process being analyzed and needs and opinions about the problem. Analysis requires use of existing or collection of additional data and drawing flow charts or process analysis diagrams. The existing or collected data can be used to measure the current level of performance and compare with the expected or set standards. Performance measurements provide an objective way of understanding what is really happening, as opposed to assumptions.

During measurements, it is important to have a clear and specific measure with defined time line.
Performance data usually shows gaps in quality but does not explain why the gaps exist. The information on why the gaps exist is obtained by having a clear understanding of the process of care. This can be achieved by developing a flow chart of the existing process and making a team review about the potential barriers of the process to performance.

Step 3: Develop a hypothesis about what changes will improve the problem

This step uses information gathered from the previous steps to explore and propose changes which might improve the existing performance problem. It is crucial to remember that at this point the proposed interventions remain theoretical as they have not yet been tested.

Changes may affect different processes and impact a lot of people, so they require planning before implementation. Although the change may result in improved performance, HSPs may often feel apprehensive about change and resist it, especially if they did not participate in developing the change. Therefore, it requires time for organizational members to be accustomed to the new ideas and learn the new methods. Resistance to change can be prevented through group participation and time for adjustment.

Step 4: Implement the PDSA Cycle

To facilitate development of and implementation of changes, the Plan, Do ,Study and Act framework is applied. Test and implementation are key to the PDSA cycle model for quality improvement. During this step it is important to note that not every change will result into an improvement. The quality improvement team should test the proposed change and measure performance over a period of time to see if proposed change results into improvement. The PDSA cycle of "measure – test – identify change – re-measure" forms a fundamental part of improvement framework.

Once the change has been demonstrated to result into improvement, the change can be institutionalized into routine health service delivery processes. It is important to emphasize that a variety of changes may be tested before an improvement is observed. The quality improvement teams are encouraged to start implementing the changes on a small scale and assess the impact before expanding.

The PDSA cycle model is a simple way to help answer the three fundamental questions when they introduce a new activity using an effective method to learn and assess changes in their own settings. In HIV and AIDS, the PDSA cycle model can be used to test and adapt best practices and new approaches and use them widely in the facilities.

For example, after a quality improvement team clarifies what it wants, it develops measures to monitor its progress to complete a PDSA cycle model.

5.3.2 Quality improvement approaches

5.3.2.1 The 5S-KAIZEN-TQM Approach

The 5S-KAIZEN-TQM approach applies 5S principles as the entry point to continuous quality improvement. 5S is a way of organizing and managing the work place and work flow with the intention to improve efficiency of work by eliminating waste, improving flow, improving safety and minimizing time wastage that often occur secondary to a disorganized environment. It is an entry point for overall Quality Improvement in health system.

5S principles are reliable instruments which help to make improvement in your working environment and staff attending various service provisions in an institution. This is a set of actions, which has to be conducted systematically with the full participation of staff working in the institution.

5S activities are practiced in a real participatory manner to improve the quality of both the work environment and service content which are delivered to your clients using the improved environment. It is used as a basic systematic approach for productivity, quality and safety improvement in all types of institutions.

The 5S stands for Sort, Set, Shine, Standardise and Sustain.

1) Sort (*Sasambua*)

It is to remove unused materials and supplies from your working place by

- Categorizing and colour coding the items
- Developing an inventory of all categorized items
- Removing all unnecessary items for discarding
- Storing materials which “may be needed” items
- Regular sorting of unused items
- Developing a culture of returning items to where they belong

2) Set (*Seti*)

It is to organize all necessary items in proper order for easy services provision

- Organize cabinets with labelling/numbering
- Keep items at their respective areas and label them accordingly
- Directional arrows leading to service areas for clients to follow
- Labelling of service rooms

- Update stock/equipment inventories
- The rules and regulations must be written and well known to all staff

3) Shine (*Safisha*)

It is to maintain high standards of cleanness

- Routine and mass cleaning campaigns
- Clean not only the place you can easily see but also behind/under furniture or equipment
- Clean and attractive environment will be appreciated by internal and external clients

4) Standardize (*Sanifisha*)

To set up the Sort, Set, and Shine as norms in every section of health facility

- Working instructions
- Standard Operating Procedures (SOPs)
- Standards and regulations for both administrative and technical staff

5) Sustain (*Shikilia*)

- To train and maintain discipline of the HSPs engaged
- Apply regular self assessment
- Perform quarterly 5S audit and implementation of improvement activities

Importance of 5S

- The workplace gets cleaned and better organized.
- Hospital and office operations become easier and safer.
- Results are visible to everyone..
- Visible results enhance the generation of more and new ideas.
- People will be proud of their clean and organized workplace.
- As a result the health facilities good image attracts more clients.

The targets of 5S principles are Zero:

- Zero changeovers leading to product/ service diversification
- Zero defects leading to higher quality
- Zero waste leading to lower cost
- Zero delays leading to on-time delivery
- Zero injuries thus promoting safety
- Zero breakdowns bringing better maintenance
- Zero customer complaints, i.e., customer satisfaction
- Zero mistakes, i.e., betterment of organization’s image

Furthermore, introduction of 5S is expected to instil team spirit, increase morale and motivation and improve job satisfaction. They are simple but effective methods to organize the workplace. In the long-run implementation of the 5S principles also helps in creating positive altitude to the staff.

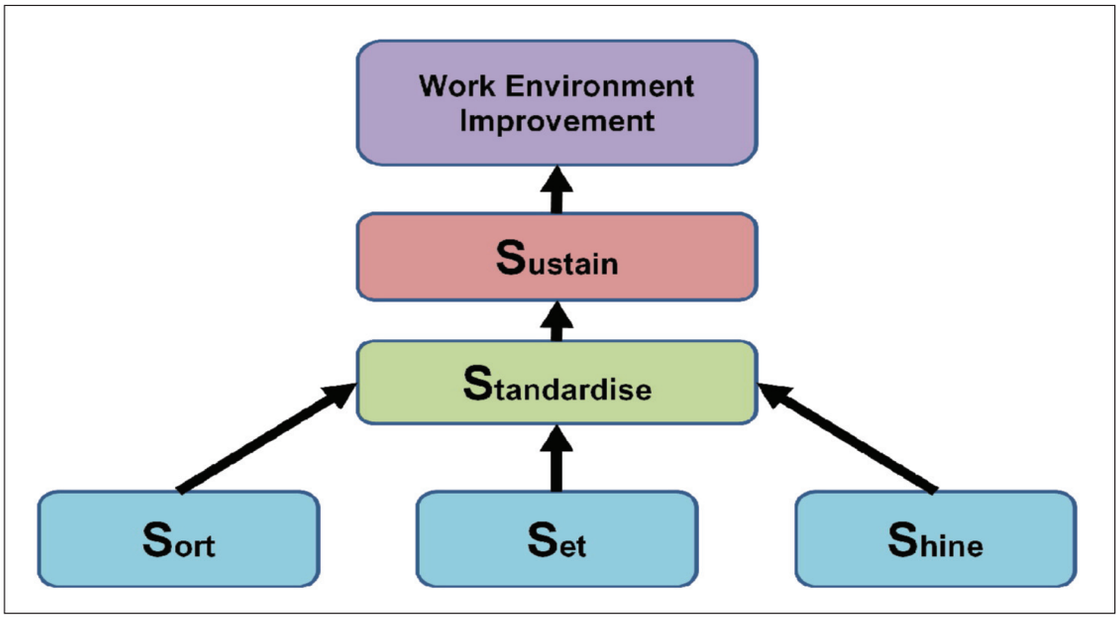


Figure 5.3 Illustration of 5S

The 5S principles are implemented in four phases: preparatory phase, introductory phase, implementation phase and maintenance phase as an on-going implementation. With a strong implementation of 5S activities, then a health facility can enter the Continuous Quality Improvement (KAIZEN) stage of the approach. It is well known that the "foundation of Continuous Quality Improvement is 5S, especially *Standardize* and *Sustain*. Ideally, Continuous Quality Improvement will be smoothly introduced when 50% of service areas in a health facility are standardizing and sustaining the activities.

5.3.2.2 Improvement Collaborative Approach

Improvement Collaborative activity is an organized network of large number of sites (eg, districts, facilities or communities) that work together for a limited time, usually 9 to 24 months to rapidly achieve significant improvement in a focused topic area through shared learning and internal spread methods.

The approach uses rapid team problem solving approach which tailors the problem solving process to the situation at hand and minimizes activities to ones just necessary to make improvements (the PDSA cycle model just described).

During the learning session teams receive updates on the technical content and evidence based standards of the problems identified and develop common improvement indicators. In between learning sessions, teams go into action periods to analyse processes of care and design process changes to implement evidence based standarvds with the help of the mentors.

At the learning sessions, teams exchange results and learn about the changes. If a team is stuck, it can learn from another team that found something that worked..

These elements of competition, sharing and rapid follow up help maintain energy and momentum. A particular strength is that peer to peer learning, as it occurs during the learning session, is often more powerful than top down technical assistance.

5.4. PERFORMANCE STANDARDS

5.4.1 Definition Performance Standards

A set of standards that a facility produce to reflect international and national standards and guidelines, yet remain specific to the realities of the facility's situation. It is important that service providers and community members have to be involved in setting performance standards for them to be effective.

5.4.2 Reasons for Setting Performance Standards

- Showing what performance is expected from the service provider
- Assess whether expectations have been met.
- Makes clear what supervisors and supervisees are working toward, and staff is provided with a clear and achievable target against which to measure progress.

For most clinical skills, performance standards are available in-country. If not, defining desired performance is best done by a team, with significant contribution from technical experts, staff, and the community from different programme areas. Involving staff members in setting performance standards and agreeing on what steps and activities are necessary to achieve the standards ensures that they know what to do and gives them a sense of pride and ownership of the tools.

The clinical performance standards once set by the team should reflect international and national standards and guidelines, yet be specific to the realities of the facility. The performance standards set for the management of the facility (e.g., waiting time, record-keeping, cleanliness) should be based on the needs of the staff, clients and community. Involving staff will ensure that they understand why standards are important.

5.4.3. Characteristics of performance standards

- **Under the control of individual or facility:**

  You can set standards only for the functions that you or the facility can control. The person who orders drugs has no control over the suppliers and the transport, and cannot guarantee that this standard will be met.

- **Realistic and relevant:**

  Desired performance should be realistic and take into account the resources (e.g. the number of staff, training, budget, equipment, transport, supplies) at the facility. If standards are not realistic, it will be unlikely that the staff members will achieve them. For example, if a standard requires an expensive equipment that a facility cannot afford, or that is used for a procedure that the facility does not perform, staff members will ignore it altogether.

- **Clear and well documented**:

  Everyone must understand the performance standard in the same way. Clarify standards by providing clear steps and activities necessary to achieve the standards. Make sure that performance standards are documented in a format and language that are easy to understand and available for quick reference.

- **Flexible:**

  One must be able to make changes to suit a specific environment. For example, sometimes new information about recommended practices in the provision of services needs to change. You must be able to adjust the standards for provision of services accordingly.

- **Selective:**

  Set standards for specific areas of work such as priority areas for your clinic or department, or areas that need improvement. You do not need to set performance standards for all areas at once.

- **Observable and measurable:**

  It must be possible to observe the performance standard. If the performance standard as stated is not observable, use indicators (e.g., a list of steps or activities) to describe how the standard will be met. An indicator breaks the steps down into observable and measurable tasks or behaviours. Examples of indicators and standards are shown below.

Table 5.1a: Performance Standard Based on a National Standard for ensuring client privacy

PERFORMANCE STANDARD	INDICATORS
The provider maintains privacy during the consultation.	1. The door to the exam room is closed. 2. The client is shown a curtain, privacy screen, or bathroom where s/he can change, if necessary. 3. The client is covered with a sheet during the physical examination, if necessary. 4. No other people should be in the room during the examination.

Adapted from: Bossemeyer D. 2000. *Steps to Develop Standards*. PROQUALI PowerPoint presentation. JHPIEGO Corporation: Baltimore, MD.

Table 5.1b: Performance Standards to Address a Priority Work Area

PERFORMANCE STANDARD	INDICATORS
An adequate stock of ARVs is maintained	1. The recommended formula to stock supplies is used. 2. ARVs are ordered once a month. 3. A physical stock inventory is conducted once a month
Methods for involving the community are in place and functioning.	1. A general meeting for stakeholders is held at least once a year to review services provided at the clinic and discuss future needs. 2. Two community members participate regularly in the clinic's team meetings. 3. Client exit interviews are conducted quarterly. 4. A staff member from the clinic participates regularly in community development meetings

5.4.4. Communicating Performance Standards

If service providers and community members have been involved in setting performance standards, the job of communicating the standards will be easy. If you are adapting national standards, you might want to simplify them and present them in more user-friendly formats. Staff members will be more likely to use

performance standards if they are stated briefly, the language is simple, they include pictures, and are readily available. The standards are also referred to when giving feedback or assessing performance.

Share relevant performance standards with clients. For example, if you have set certain performance standards on how you greet and treat clients, post those in a visible place so that clients will know what to expect from the providers and can appreciate what you are trying to do.

5.5. ASSESSMENT OF PERFORMANCE

5.5.1. Areas for Assessment

The performance standards that teams produce for facility should reflect international and national standards and guidelines, yet be specific to the realities of the facility's situation.

After the performance standards have been set, and the supervisor and staff have identified the performance standards that the health services should meet, one should regularly ask him/herself: How are we performing? Are we meeting those standards? The following are examples of questions to ask in determining whether standards are being met:

- Are clients satisfied with the quality of services received?
- Are procedures being performed correctly?
- Is the environment safe and clean?
- Does the availability of supplies meet the clients' needs?

Ensuring that performance is meeting agreed upon expectations, as well as the expectations of the staff and clients, is one of the most important functions of a supervisor. The supervisor and key staff members can use the performance standards that were set to assess the actual performance of the facility, the systems that make the facility work (e.g., logistics, client flow, record keeping). The supervisors should continually assess how staff are performing compared to how they are expected to perform. This assessment can be done on an ongoing or periodic basis.

To find out how well services are being provided at the clinic, periodically assess various aspects of the services within the facility, for example:

- **Client satisfaction**— Do clients think their needs are being met by the services offered?
- **Clinical practices**— Do clinical practices meet performance standards that have been set?
- **Provider satisfaction**— Are the providers satisfied with how services are being delivered?
- **Client numbers and movement through the system**— Is the clinic functioning as effectively and efficiently as expected?
- **Interaction between clients and providers**— Is communication between clients and service providers respectful and mutually satisfying?
- **Management of stock**— Are the essential supplies available and accessible when needed?
- **Record keeping**— Are the records being completed correctly and consistently?

If you have drawn standards from reliable, evidence-based sources, as well as included staff and client input into those standards, and the staff have agreed that the standards are reasonable, you just need to make sure that the procedures are being followed. Your job is not to manage the stocks, but enable staff to manage them according to standards and to help solve problems when they arise.

Assessment results can be used to:

- Guide and support staff on how to perform their work so that it is consistent with standards
- Identify which facility services meet standards and which need improvement
- Empower staff and motivate them to provide high-quality services

5.5.2. Assessment methods

Assessment is an ongoing process. It can be especially useful in helping a new supervisor understand how systems work. Assessment helps supervisors and the staff identify gaps, acquire new ideas on how to do things better, asses clinical skills of providers, and monitor administrative systems. There are a number of assessment methods that can be used regularly to obtain information and monitor the performance of the facility and staff. Being able to use a variety of these methods is an important skill for the supervisor. There are seven methods for assessing performance and are summarized in the table below:

Table 5.2: Summary of Methods for Assessing Performance

ASSESSMENT METHOD	FOCUS OF ASSESSMENT	PERSON CONDUCTING ASSESSMENT	ASSESSMENT METHODS/TOOLS	HOW TO USE THE ASSESSMENT RESULTS
Conduct Supervisory Assessment	Any provider at the facility teams of providers	Supervisor	Meetings with staff observation of clinical practice case reviews Audits	Supervisor can share the results with individuals or teams to acknowledge good performance and identify specific areas needing improvement.
Conduct Self-Assessment	Any provider at the facility	Staff member	Checklist based on job description and appropriate guidelines	Person using self-assessment tool can meet periodically with the supervisor to discuss areas of achievement and areas needing improvement.
Conduct Peer Assessment	Any provider at the facility teams of providers	Staff colleagues	Checklist based on job description and appropriate guidelines	Peers can give feedback to one another in an informal and comfortable environment on specific performance areas.
Obtain Client Feedback	People seeking services at the facility	Staff members Supervisor	Meetings Questionnaires/ Interviews Suggestion box	Staff and supervisor can evaluate clinic operations and staff performance based on feedback from clients.
Solicit Community Perceptions	People living in the community where the facility is located	Staff members Supervisor	Meetings Questionnaires/ Interviews	Staff and supervisor can make changes to clinic operations, maybe even add new services, based on feedback from community members.
Review Records and Reports	Any system or aspect of clinic operations	Staff members Supervisor	Review of records, reports, log books, statistics	Staff and supervisor can assess compliance with standards and monitor efficiency and outcomes of clinic operations.
Compare Your Services with Others	Any system or aspect of clinic operations	Staff members Supervisor	Visit other facilities Interview providers at other facilities Interview clients and community members at other facilities	Staff and supervisor can get new ideas about how to provide better services. They can also motivate themselves and others toward better quality services by showing that it can be done.

5.6. FINDING ROOT CAUSES

It is likely that one will find gaps between how the facility and its staff should function (according to the performance standards that have been set) and how they **are** functioning (based on your assessments). When an assessment reveals gaps between actual performance and desired performance, one should determine **why** the gaps exist (i.e., the root cause) before attempting to close the gap. If one does not analyze why the gaps exist, you may end up wasting time and money implementing an intervention that does not address the real problem.

5

5.6.1. Methods of finding out the causes of poor performance

Once you and the staff have decided which gaps to act on, you can work with the staff to determine the cause or causes. The gap should be looked at on many levels to show the true, and often multiple, root causes. Only then can effective interventions (actions) be
identified and implemented. Finding the root causes of a gap helps you to see the true gap more clearly. There are several techniques that can help you do this.

1) Brainstorming

The purpose of **brainstorming** is to generate a list of ideas, suggestions, or solutions focusing on a specific topic, issue, or problem. Brainstorming is a useful technique for communicating in a team setting, and for making decisions and solving problems being addressed in a meeting. Brainstorming stimulates creativity and is often used with a group discussion. You can use brainstorming with staff to examine why a gap exists.

2) Why-Why-Tree

"Why" questions always look for the root cause. Asking three to five "why" questions increases the chance of finding the actual cause of the problem rather than just the problem.

Example:
Identified problem: The community and clients complain that they have to wait a long time for services.
Start by asking: "Why are clients waiting too long for services?"
You might get answers like the following:
"*There is a high volume of clients, especially on certain days."*
"There are too few service providers."
"All clients arrive first thing in the morning."
"Client records are hard to find."
"There are too few examination rooms."
You can use a "why-why tree" to help further identify the root cause of the gap.

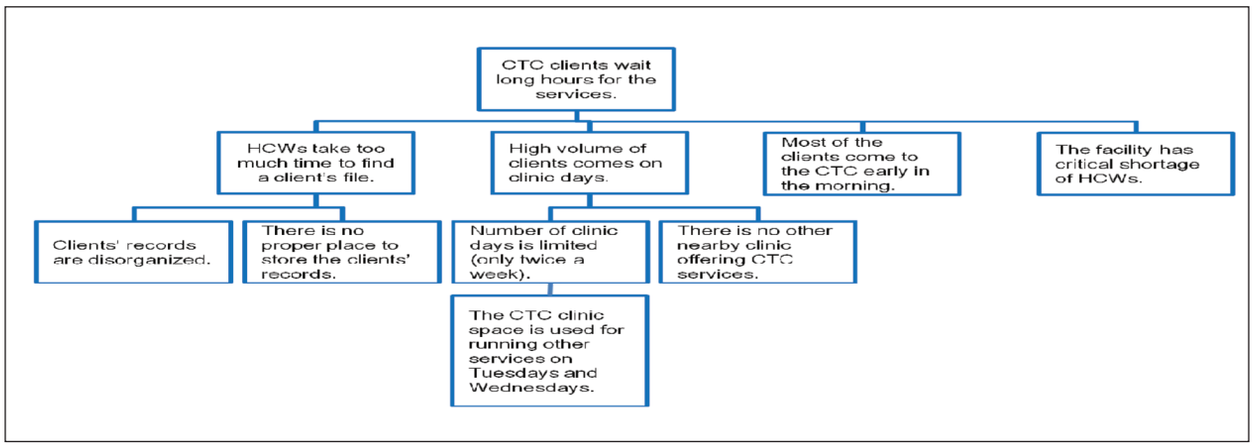


Figure 5.4 is an example of a why-why diagram used to determine why waiting time is too long.

Figure 5.4: Why-Why Diagram Example

3) "Guided discussion" (or interviews) about Key performance factors (Lande 2002)

There are certain key factors that are known to affect performance. As a supervisor, consider these factors and the impact that they are having on the performance of the facility and staff. For example, before you decide that staff training is needed for improving provider-client interaction, it would be wise to make sure the staff know that welcoming, helpful, informative, and respectful provider-client interaction is expected at all times. Sometimes just discussing with people what is expected of them can result in the performance you are seeking. The following are some of the performance factors:

Job Expectations. Do staff members know what is expected of them?

Sometimes the only thing needed is to make expectations clear to staff. This alone can have an impact on performance.

Performance Feedback. Do staff members know how they are performing? Have you or others told them? They need to be given feedback and encouragement to continue to perform well or to improve their performance.

Facilities, Equipment, and Supplies. Do staff members have the tools, equipment, or supplies needed to perform to standard?

Motivation. Are staff members motivated? Recognition and rewards for performing well can increase motivation. Recognition of staff not performing well also affects motivation.

Organizational Support. Does the management staff encourage and support good performance? Is there a vision for high performance? Do organizational policies allow performance to improve, or are there policies in place that prevent improvement (e.g. if only doctors are allowed to to request for lab tests, it is not possible to meet the high demand for services).

Knowledge and Skills. Do staff members know **how** to do their jobs? They need to be appropriately trained. Then they should receive continuing education courses or training, as needed, to maintain their skills and acquire new ones.

Client and Community Needs. Are staff members focused on the needs, desires, culture, and observations of the surrounding community? Do they seek the opinions and ideas of community members? Do they respond to them?

5.7. SELECTING INTERVENTIONS

Once a gap between desired and actual performance has been identified and the causes of that gap (i.e., the root causes) have been analyzed, the supervisor and staff can begin to work together as a team to close the gap and thereby improve performance and the quality of services being provided.

Some gaps can be solved at the facility while others may have to be addressed at the district, regional or ministerial levels. The supervisor plays a critical role in effecting change both at the facility and within the health service delivery system. The staff and community members must be involved to make these improvements happen.

5.7.1. Matching interventions with root causes

The interventions selected must respond to the root causes. For example:

- If you find that complications of ARVs are not managed properly and you determine the reason is that staff lack the knowledge and skills to manage complications, you might decide to arrange for training in these skills.
- If you discover that the cleaning staff are not using approved infection prevention practices because they have never been trained on what to do, you will want to focus first on creating clearer job expectations.
- If staff are not providing clients with drugs for opportunistic infections and you find that the reason is because the facility lacks the supplies needed to treat OIs you will need to work with the supply system to avoid future stock outs.

There are many interventions that can be planned to improve performance. However, you have to know the root cause in order to select the appropriate interventions. Usually a combination of interventions will be needed to make a difference. When you have found the root cause of the performance gap, the intervention becomes more obvious.

5.7.2. Determining resources

As you begin selecting interventions to find solutions to the root causes of gaps, encourage the team to focus on what does work well. Avoid concentrating only on what does not work. This approach will help the team keep a positive attitude. It will also provide ideas for interventions that might be successful and ideas for strengths that can be built upon. Sometimes, focusing only on problems can lead to a sense of hopelessness. Instead, you want to create an atmosphere in which the team is positive and hopeful about changes that they can make.

By focusing with the team on things that work well, you will find many resources existing in your facility and community that can help improve staff performance and the quality of services. This gives people a sense of hope, and also identifies already existing resources that you can draw upon when designing interventions, rather than assuming that all types of actions will require new resources.

5.7.3. Setting priorities

Usually there will be a number of interventions needed when trying to improve performance. HSPs should work together to determine which action will be culturally acceptable to all stakeholders. Because not all interventions can be implemented at once, priorities must be set. The staff, clients and other community

members must decide which interventions are the most important to be acted upon first and which ones not to be attempted at all. Potential costs and benefits of all proposed interventions should be weighed carefully. In determining priorities, consider the following:

- **Resource allocation**
  Is the intervention affordable? Do the necessary resources exist to continue with this intervention? If so, is the availability of resources sustainable? Are there other ways to act on this intervention that might cost less?
- **Feasibility**
  Are systems in place to support this intervention? Is it realistic? How long will it take to mobilize the resources to get it done? How many other people or groups of people need to be involved to get it done?
- **Acceptability by staff**
  Will the staff agree on and support the intervention? Did they suggest the intervention? Are they aware of what is being proposed?

Using these points, you and your team can consider each proposed intervention. This process will help determine which interventions will be most effective and should therefore be acted on.

5.7.4. Other considerations in selecting Interventions

A crucial question when selecting interventions is:

- who will pay for the interventions or provide materials and services?
- Is it ethical?
- Is it culturally acceptable?
- Is it in line with national policy or guidelines?

5.8. IMPLEMENTING INTERVENTIONS

5.8.1. Action plans

A simple tool you can use when planning, carrying out, and monitoring an intervention is an action plan. An action plan lists the following minimum information:

- All planned activities
- Date by which they will be accomplished,
- Resources they will require,
- Person who is responsible for carrying them out, and
- Methods that will be used to measure success.

In creating an action plan, it is important to define the measurable goal or objective that is expected as a result of the actions to be taken (e.g., implementation at the facility level of new national guidelines for care and treatment). It is also important to decide how to measure your success before implementing the actions. Consider what documentation and data collection will be needed. Consider whether the action can be observed. Direct observation could also measure success.

Staff who contribute to developing this plan are more likely to be committed to implementing it than staff who simply receive action plans that were developed by their supervisors. Involve the staff in monitoring the progress toward the measurable goals that they set. Having participated in developing an

action plan, staff members feel a sense of ownership in the final plan and as a result, will take on more responsibility and be more enthusiastic in carrying out their work.

Celebrate successes, however large and small. If you find that you are not achieving your intended goal, analyze further the performance gap to make sure that the root causes of the gap are being addressed.

5.8.2. Finding Additional Support

Resources are not only financial. There are other types of resources such as equipment, supplies, and labour that can also be mobilized to support your intervention. Try to find resources that will help you and the staff improve the quality of services. Potential sources include:

- **Central and regional government**
  This is usually the most important resource but often the hardest to access Efforts to improve services can attract the attention of government officials, who may be willing to give additional resources for these efforts.
- **Local governments**
  Have a role to play,. Local authorities may be more willing to give funds to support facilities which are meeting expectations, and may see that high-quality health services and satisfied clients can strengthen their position in the community. Depending on resources and budgets, local governments can support construction and improvement of primary care facilities, and provision of additional staff, equipment, and supplies not provided by the central level.
- **Private industry and commerce**
  In some places, private businesses are willing to provide funding and other resources to support specific health services or prevention programmes. For example, they may pay for part or all of the equipment that is needed. In return, they may want to see their business name or logo shown as a sponsor of the goods or service. It gives them more visibility in the community and can help them market their products and services. Company programmes for employees and outreach health services are a good example particularly related to HIV and AIDS. Private industry has a vested interest in the health of its employees, which depends on good health services.
- **Community organizations**
  The community can help in many ways. Volunteers can provide free labour to improve the clinic building or environment. Community members can actively support promotional or educational activities. There may be local groups that are interested in service work; some have made important contributions to global health activities. These groups can provide support at the local level for specific items or activities at the clinic. For example, secondary school students have proven resourceful in educational and consciousness-raising health programmes in communities.
- **Clients and Community members**
  Clients and community members can be mobilized to help with a variety of needs in the clinic. For example, they can help keep the clinic clean and in proper order. In some cases, clients support the clinic by paying for part or all of the services they receive. This can increase client expectations for high quality services and also increase their commitment to their health.

- **Staff**
  Resources may already be available at the facility but need modification, organization or rearrangement by the staff (e.g., to ensure privacy, the organization of the waiting areas needs to change). Working with their supervisors, staff members may be able to make many of the necessary changes that will result in improved services.

To have the best chance of obtaining resources from these sources, you need to clearly present:

- Benefits that their support will bring to the community;
- Benefits for the donors (e.g., public image, better services); and
- Systems that show where the donors' contribution has gone, how it is being used, and (in the case of goods) how they are being protected from theft or damage.

5.8.3. Learning from other individuals or facilities

See if you can find a "role model" person or clinic that has an excellent reputation. If you find one, go there and talk to the people. Try to find out what makes them perform we ll. If there are elements that you can replicate at your facility, do so. This may be a way to improve performance at your facility because these elements have already been proven to be effective elsewhere.

Once you have started implementation of your interventions, it is important to determine whether the interventions have been implemented according to the action plans through regular follow-up and monitoring.

Handout 5a:
Performance Improvement Process

Similar to PDSA cycle model, there is another model of performance improvement process, which has the following steps:

1. **Get and maintain stakeholder participation**
   For the performance improvement process to be implemented, acceptance by all stakeholders is necessary. Stakeholders may include staff, community members, and representatives of different levels of the health care system. The community is the largest component of the stakeholders in health services. The services of a health facility are most effective when the community is involved from the beginning in the process of improving performance, and therefore, quality of services. Getting stakeholders to agree on using the performance improvement process and then keeping them informed about the services at the facility is the first step in implementing the process.

2. **Define desired performance:**
   For staff members to perform well, they must know what they are supposed to do and how.

3. **Assess performance:**
   The supervisors should continually assess how the staff and the facility are performing compared to how they are expected to perform.

4. **Find causes of performance gaps:**
   A performance gap exists if the supervisor and staff find that what they are actually doing does not meet the set standards of performance.

5. **Select and implement measures to improve performance:**
   Once the causes of the performance gap have been identified, the supervisor and her/his staff will need to develop and implement ways to improve performance.

6. **Monitor and evaluate performance:**
   Once interventions have been implemented, it is very important to determine whether or not performance has improved.

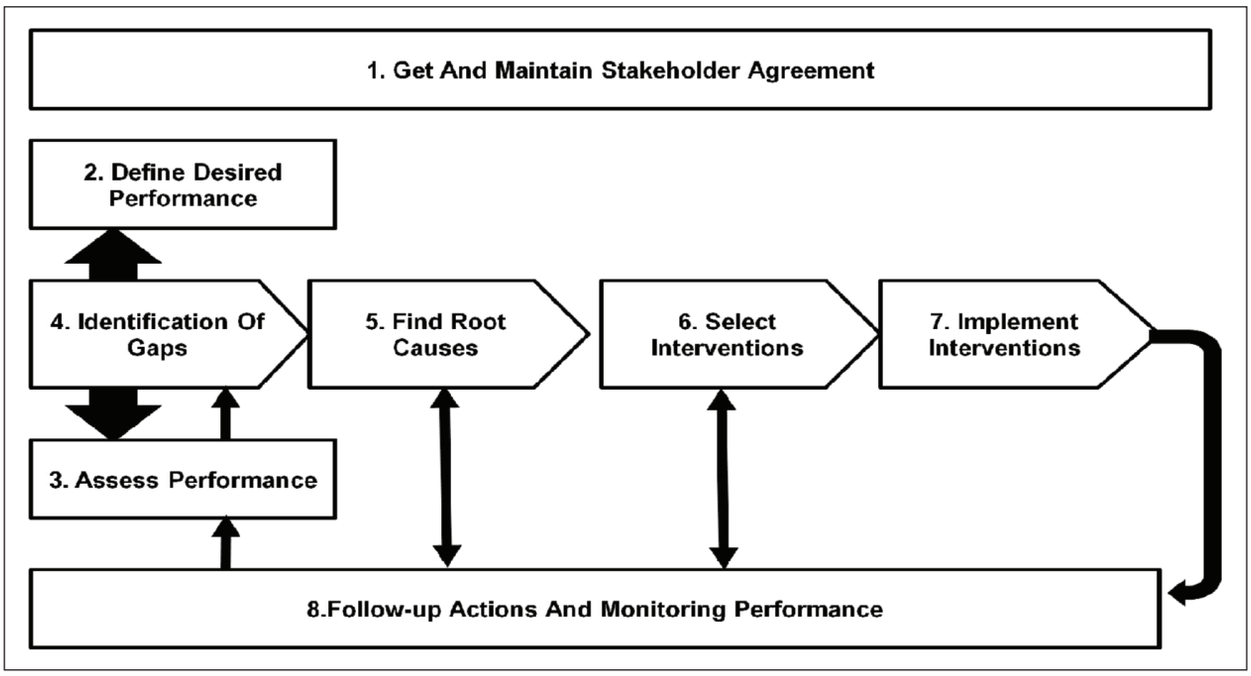


Figure 5.5: The Performance Improvement Process

Adapted from: Performance Improvement Consultative Group (PICG). The performance improvement framework was developed through a collaborative effort among members of the PICG. The PICG comprises representatives of USAID and USAID-funded cooperating agencies. The framework in this manual simplifies the language in each step to make the process easy to understand by different audiences.

Handout 5b:
Case Study - Application of Quality Improvement Model and 5S

Learning Objectives:

By the end of this session, participants will be able to:

- **Apply why-why-tree for making cause-effect analysis**
- **Apply objective tree analysis to identify means-ends relationship for making the situation desirable.**
- **Develop an action plan to make solutions matching to the problems.**
- **Practically apply Quality Improvement Model and 5S.**

Scenario

Magu district supervision team visited Pilipili Health Centre for supportive supervision. During the supervision the team found that there were too many CTC clients waiting for the services. Many of the clients complained of long waiting time. They said that it is very normal that a patient comes here early in the morning and receives services in the late afternoon. They said that most of the clients come early in the morning expecting to receive the services early. HSPs at this facility were busy looking for misplaced clients' files and investigation results from a laboratory. There was no proper place for record keeping. Files were piled up in boxes, which were scattered in different rooms of the clinic. The CTC clinic operates on Mondays and Fridays only and there is no other CTC clinic nearby. The nearest CTC clinic is 50kms away and no public transport to the clinic. The CTC in-charge also reported that the facility has critical shortage of HSPs and that the same space is used for running other services as well on Tuesdays and Wednesdays.

Question:

How would you improve the situation?

Apply as instructed below steps and incorporate 5S concept:

1. Identify a core problem. Think how we could know that the core problem is really a problem and how we can measure it.
2. List all the problems described in the scenario, which are related to the core problem.
3. Analyze CAUSE-EFFECT relationship of the problems and make a why-why diagram.
4. Make objective-tree analysis by turning negative problem statements into desirable future situation. The relationship can be described as IF-THEN. Make an objective tree.
5. Identify objectives in the tree for interventions.
6. Select objectives which are realistic and achievable and prioritize them.
7. Develop an action plan in consideration of 5S by filling out the following table.

Issue	Objective	Activity	Responsi-ble person	Resource required	Timeline	Expected Output

Application of the Quality Improvement Model

PDSA Cycle	Methods to be applied
Step 1: Identify	Identification of a core problem. Think how can we be sure that the core problem is really a problem and how we can measure it.
Step 2: Analyze	Analysis of the root causes of the core problem is a critical initial stage of PDSA model. The problems are normally related each other with cause-effect relationship. Through analyzing the relationship, root causes could be identified. Setting up and implementing interventions without matching them with root causes would end up waste of resources. There are several ways to analyze the cause-effect relationship of problems such as why-why-tree and fishbone diagram. Conduct Why-Why-Tree Analysis (Cause-Effect Analysis) for Identification of Root Causes "Why" questions always look for root causes. Asking three to five "why" questions increases the chance of finding the root causes of the problem rather than just the problem. **Why-Why-Tree Analysis Procedure:** 1. List all the problems identified. 2. Write one problem statement on one card. You will have many problem cards. 3. Identify the core problem among the problems. 4. Identify problem statements that could be immediate causes of the core problem by asking a question "Why?" The immediate causes should be able to answer the question by stating "Because ….." Place the cards under the core problem. If there are some other immediate causes, then write the problem statement and place them under the core problem. 5. For each of the problem statements, again ask a question "Why" and identify immediate causes of each of the problems. Place the cards under each of the problems. 6. Continue this process until you have enough details to identify the causes of causes. You will have a problem tree at the end.

Step 3: Develop	**Objective Tree Analysis (If-Then Analysis)** Based on the Why-Why-Tree created, conduct Objective Tree Analysis. This analysis will give you a picture of future desirable situation which could be attained once the problems are solved. The relationship between the cards shall be means-and-ends upwards. In other words, the logic is "if-then" relationship, which means that if the lower level objectives are accomplished, then the upper level objectives would be achieved. **Procedure:** 1. Restate all problem statements of the why-why-tree into positive desirable statements. 2. Examine the means-ends relationship of each pair of cards related. 3. Identify the objectives that are realistic and achievable. There could be some objective statements that are too difficult for you and your staff to deal with. 4. Prioritize the objectives. 5. Identify interventions to be tested.
Step 4: Implement the solutions by applying PDSA Cycle	**PLAN: Develop an action plan with the following information:** • Issue/problem • Objective • Action/intervention • Expected output with indicators to monitor • Responsible person • Resource required • Timeline • Actual output and completion date. **DO:** Implement the action plan • Monitor the progress/changes. • Begin analysis of data collected. • Document problems and unexpected observations. **STUDY:** • Complete an analysis of the data. • Compare results with initial goals. • Summarize what have been learnt. **ACT:** • Abandon the change due to undesirable results. • Refine the change by going back to the planning stage. • Implement the change and institutionalise it.

CHAPTER 6:

SUPPORTIVE SUPERVISION

LEARNING OBJECTIVES

By the end of the chapter, the participants will be able to:

- **Describe concept of supportive supervision**
- **Describe issues in traditional supervision**
- **Outline qualities of a supportive supervisor**
- **Identify challenges in implementing supportive supervision**
- **Differentiate traditional supervision from supportive supervision**
- **Describe stages of supportive supervision**
- **Describe interventions to be covered during supportive supervision**

6.1. DEFINITION OF SUPPORTIVE SUPERVISION

Supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, optimizing the allocation of resources, promoting high standards, team work and better two-way communication (Marquez and Kean 2002).

6.2. ISSUES IN TRADITIONAL SUPERVISION

- Supervision tends to emphasize “inspecting” facilities and “controlling” by external supervisors, who often believe that providers are naturally unmotivated and require being pushed to perform adequately. In most health service delivery systems, supervisors tend to focus on administrative issues such as inspection of facilities, use of resources, supply logistics, review of records and directives from higher to lower levels. In a climate of inspection and control, problem-solving is reactive and episodic.
- Supervision in developing countries has often been viewed as an instrument through which to impose the health system’s rules and regulations on HSPs rather than as a means to address HSPs’ needs.
- Many supervisors lack the necessary technical and managerial skills or have limited authority to resolve service delivery problems.
- Traditional approach locates supervisory activity entirely on the official supervisor.
- The focus is on finding faults or errors and then punishing those involved rather than support or facilitate the service provider. This type of supervision causes negative feelings, instils fear apprehension and hatred. It rarely results in improved performance.
- Supervisors often blame individuals rather than look for root causes for deficiency in processes and systems. For this reason, traditional supervision has not tended to “empower” staff to engage in problem-solving and to take the initiative to improve service quality and access.
- Supervisors are expected to deal with many types of problems, but they may lack the skills and knowledge to carry out that ambitious role.

- Supervisors who are not knowledgeable about the technical tasks that supervisees perform can monitor and support the service provider; however, they cannot effectively train them in these tasks.
- Lack of authority of supervisors to take action, for example, to help solve a problem, reward good performance, or sanction poor performance. Supervisors who have not been given authority to act or make decisions based on performance have limited credibility with supervisees.
- The site visit is typically short in which the supervisor focuses on filling out forms and checklists and reviewing these results with the in charge at the facility. Often such visits are isolated events, not tied to what happened during a previous site visit or to what may happen during the next visit.
- Resources for supervisory activities—for example, transportation resources or human resources for supervision—are frequently unavailable, even when budgeted or mandated by organizational policy. Resource shortages result in infrequent and episodic visits.
- HSPs often receive little guidance or mentoring on how to improve their performance. They are frequently left undirected, with few or no developmental stages to help assess their performance, until the next supervisory visit. Motivation is hard to maintain in such an atmosphere.
- Finally, lack of planning, failure to define priorities, non adherence to work plans, diversion of resources from planned allocations, lack of financial stability, lack of accountability and the low morale among HSPs which often results from these conditions are all systemic problems blocking health systems.

Table 6.1. Typical Barriers to Effective Supervision

Problem	How it limits the Performance of Basic Supervision Tasks
Narrow focus of supervision on inspection of certain areas	Emphasises monitoring to the detriment of other key supervisory tasks, especially problem-solving and taking action
Punishment approach	Inhibits problem-solving and demoralizes staff
Lack of supervisory skills and knowledge	Inhibits supervisors from effectively performing any of the basic supervision tasks and undermines supervisor credibility
Lack of supervisor authority to reward or sanction performance	Deters supervisors and staff alike from taking action, because no consequences (positive or negative) result
Infrequent or irregular supervision due to lack of resources	Undermines continuity and limits supervision to only certain tasks, such as facility assessment
Lack of direction and accountability in the overall health system	Undermines the performance of all supervision tasks and demoralises staff and supervisors alike

6.3. CHANGING FOCUS OF SUPERVISION

A major trend in efforts to improve supervision has been to shift the focus of supervisors and supervisees away from simply inspecting facilities and gathering service statistics to concentrating on the performance and resolution of problems experienced by the HSPs, as well as to increase feedback from supervisors. There have been allot of efforts to refocus supervision toward activities such as assessing compliance with quality standards, transferring knowledge and skills, identifying problems and developing action plans.

The growing concern with quality assurance and improvement in developing countries is creating a climate where greater attention is paid to both clients' and providers' safety and human resource development. Moving from inspection and hierarchical supervision to more supportive supervision requires innovative thinking, national acceptance and time to change attitudes, perceptions and practices.

Although different organisations define supportive supervision differently, the principles and methods of supportive supervision are the same. The major concern is meeting the needs of both external and internal clients. Experience with using supportive supervision shows that emphasising the needs of the client helps to focus the entire facility on solving problems as they arise. In turn, this focus improves staff performance and the quality of care.

6.4. COMPREHENSIVE SUPPORTIVE SUPERVISION

Comprehensive supportive supervision is an approach that integrates programmatic, administrative and technical activities during supportive supervision making it effective and efficient in performance improvement.

6.4.1. Rationale for comprehensive supportive supervision

HIV and AIDS pandemic has affected the entire health service delivery system and HSPs, a situation which has added on the shortage of human resource for health. This makes the performance- and resource-related problems at the health facilities remain unsolved.

Recognising these challenges, the MOHSW through NACP developed a manual for comprehensive supportive supervision and mentoring on HIV and AIDS services. Comprehensive supportive supervision and mentoring are supposed to be complementary activities that are necessary to build a continuum of care and support. Supervisors need to have comprehensive managerial and administrative knowledge and skills while mentors need to be practitioners and experienced in a specific intervention.

In this regard, comprehensive supportive supervision combined with mentorship programme for both administrative and technical support to health facilities at all levels is critical for delivery of quality HIV and AIDS health services.

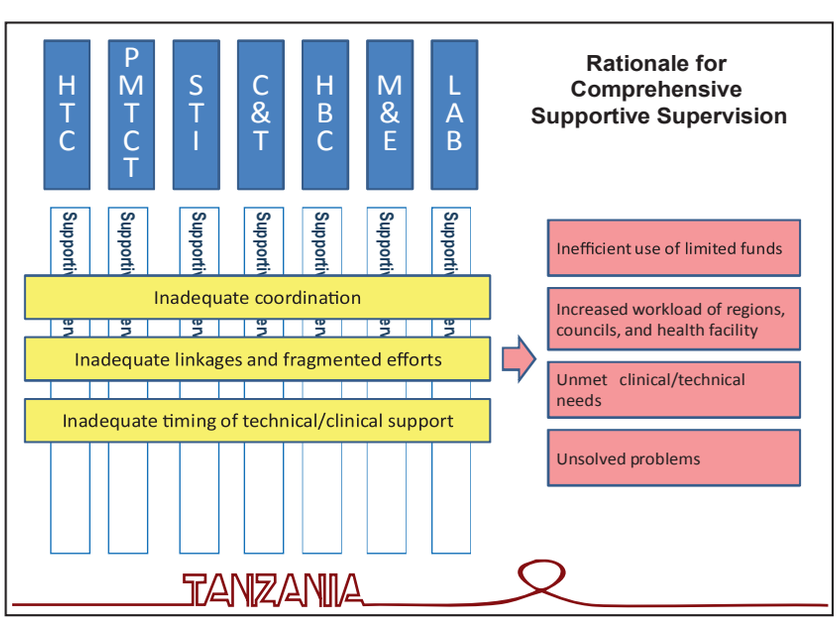


Figure 6.1: Rationale for Comprehensive Supportive Supervision

The Need for change in the approach to comprehensive supportive supervision and mentoring has been long standing. Integration of Programmatic /administrative and technical activities is a cost effective and efficient approach. Mentoring by experienced HSPs should be conducted based on the technical needs. It is demand driven. Strengthening supportive supervision with introduction of mentoring are gaining more recognition than ever as critical parts of human resource management for the delivery of quality health services especially in HIV and AIDS.

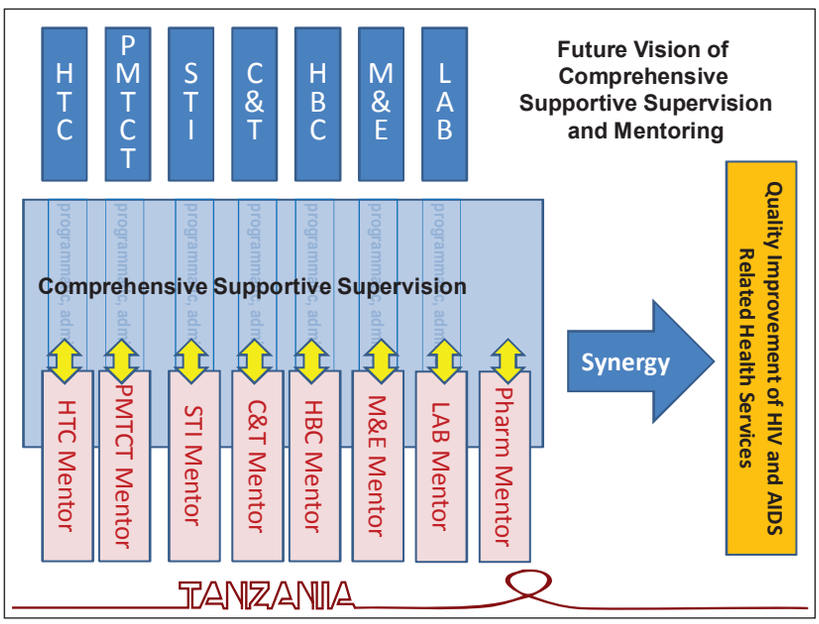


Figure 6.2: Future Vision of Comprehensive Supportive Supervision and Mentoring for HIV and AIDS Health Services

6.4.2. Key Features Of Comprehensive Supportive Supervision

- A supervisor acts as a facilitator, trainer and coach who enhance implementation of institutional goals, solve problems at lower levels and serve as a mediator between higher levels of authority and HSPs to resolve problems.
- The supervisor brings people and resources together to pursue clear objectives, assess results, identify and solve problems and develops relationships based on trust and responsiveness.
- Comprehensive supportive supervision focuses on the results of processes as well as individual performance.
- It focuses on measuring performance against expectations/standards and using data for decision-making. This also makes supervisors to be held accountable for results and helps promote continuous improvements in quality at all levels of the health system.
- The focus of supervision is on problem identification, problem solving, on-the-job training (OJT), through coaching supervisees and team building within the health facility to assure quality of services and meet clients' needs.
- It involves participatory decision making process.
- The entire team (including the external supervisor) is responsible for quality, so attention shifts from individuals to teams and processes.

- HSPs participate in supervising themselves and each other, thus they are empowered to monitor and improve their own performance which makes the process sustainable.
- It addresses the needs and aspirations of HSPs themselves, recognizing that they need clear standards, knowledge, skills materials to effectively perform their jobs, a safe working environment and that they need recognition and opportunities for professional development and advancement.
- It is implemented by multiple parties, including officially designated supervisors, informal supervisors, peers and HSPs themselves.

A cornerstone of supportive supervision is working with health staff to establish goals, monitor performance, identify and correct problems, and proactively improve the quality of service. Supervisory visits are also an opportunity to recognize good practices and help HSPs to maintain their high-level of performance.

6.5. TYPES OF COMPREHENSIVE SUPPORTIVE SUPERVISION

Comprehensive supportive supervision is a process that builds trust and increases competence in both supervisors and supervisees. This process takes time and guidance. Over time, the whole nature of the supervisory relationship will evolve and become increasingly participatory.

Operationalising the concept of expanding the **locus** of supervision to include peers and HSPs themselves can be understood by viewing supportive supervision as happening at three levels:

- External supervision (from outside the health facility),
- Internal supervision (from within the health facility),
- Self- and peer supervision (by HSPs, of themselves and each other).

External supervision is the process used to oversee the operations and performance of individuals and facilities within a larger system, such as a district, regional, or national health system. External supervisors make site visits; set and implement clear programme goals and standards; jointly define performance expectations with supervisees; monitor performance against those expectations; allocate resources within the system; facilitate supervision at lower levels of the system; and follow up to solve problems that require intervention from higher levels of the health system.

Internal supervision is the process in a particular facility or department to oversee the performance of individuals and the quality of service delivery. Internal supervisors set and monitor standards; support and motivate providers with materials, training, and recognition; build teams and promote team-based approaches to problem-solving; foster trust and open communication; and collect and use data for decision-making.

Self- and/or peer supervision is the process by which individuals monitor and improve their own skills and performance or that of their colleagues. The process encompasses setting clear performance expectations (including professional standards); assessing skills and measuring performance; eliciting client feedback; and monitoring health outcomes, among others.

As depicted in the Figure 6.3. These three levels of supervision are simultaneous, complementary, and overlapping.

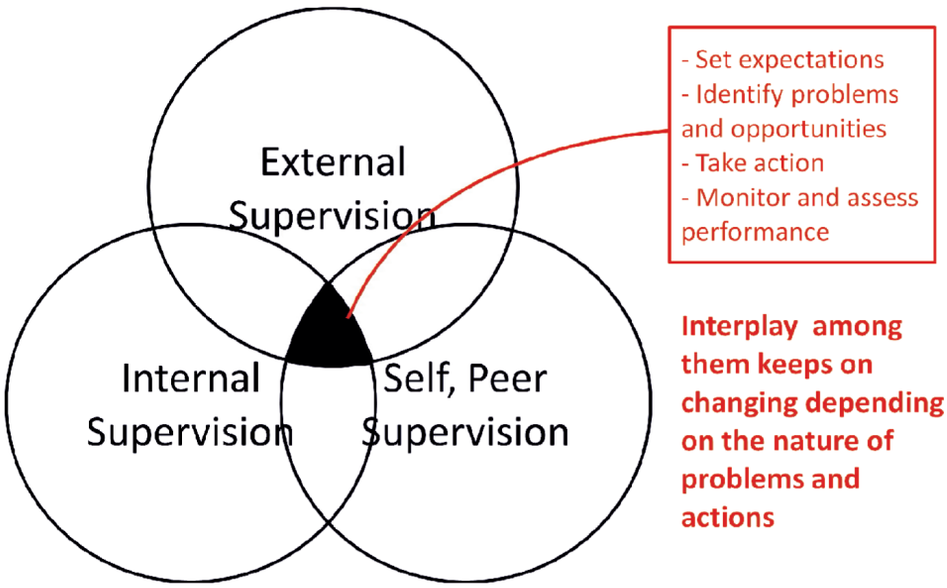


Figure 6.3: Three types of comprehensive supportive supervision

The shaded area of the Figure represents the full performance of the basic tasks of supervision through the contributions of each mechanism of comprehensive supportive supervision.

The interplay among these three-types supervision keeps on changing all the time. The greatest impact is expected when all three types of supervision take place.

For example, when self- and/or peer supervision is highly effective, internal and external supervisors have more time to focus on improving other aspects of the overall quality of care. Conversely, if there are gaps in self/peer supervision, then internal and/or external supervisors will need to devote more time and resources to monitoring the performance of individuals.

The relationship between internal and external supervision is similar. Where internal supervision is strong and effective, external supervisors can focus on other activities to improve the overall quality of the system (such as sharing effective approaches among facilities and addressing system wide needs). But where internal supervision is deficient, the external supervision process must put more efforts to address problems and fill gaps.

While introducing comprehensive supportive supervision requires resources initially to develop staff capacity to implement it, in the long term, organizations may end up spending less on supervision once external supervisors engage in more facilitative, team-based activities and HSPs regularly perform self- and peer supervision.

At present, there is more emphasis and dependence on external supervision in health care delivery systems. But external supervision is generally the most resource-intensive and logistically difficult mechanism. External supervisors generally occupy higher positions in the organizational hierarchy; they tend to have more skills and experience. Furthermore, external supervision usually requires travel, is conducted only

once in a while and involves numerous people at a site. In contrast, internal and self/peer supervision are continuously done on site, with no travel, which means that staff members spend less time away from the workstations. Fewer people are generally involved in these processes, decreasing the human resource costs associated with them.

6.6. ATTRIBUTES AND ROLES OF A COMPREHENSIVE SUPPORTIVE SUPERVISOR

A comprehensive supportive supervisor has to:

- Be familiar with the setting, supervision tools, job description of supervisees
- Be organised and uses guiding, training and coaching approach
- Focuses on problem solving to assure quality improvement
- Empowers supervisees to monitor and improve their own performance
- Fosters relationship to improve individuals skills and performance
- Serves as an intermediary between lower and higher levels and within the facility
- Be able to collect, analyze and interpret information/data
- Be able to promote teamwork
- Be honest and open to new and creative ideas

Roles and responsibilities of a comprehensive supportive supervisor:

- Advise and advocate for proper distribution of resources for health services delivery
- Maintains relationships at various levels (community, district, region and central)
- Facilitates meetings and discussions
- Communicates clearly and effectively with staff and decision makers
- Delegates duties to staff members
- Creates and facilitates an environment of teamwork
- Motivates staff to perform well
- Assesses competence on quality of health service delivery based on standards
- Provides constructive, timely and interactive feedback to stakeholders including partners
- Works with staff and the community to identify gaps and plan for improvement

6.7. BENEFITS OF COMPREHENSIVE SUPPORTIVE SUPERVISION

The following are the benefits of comprehensive supportive supervision:

- Helps service providers to achieve work objectives by improving their performance;
- Ensures uniformity to set standards;
- Identifies problems and solving them in a timely manner;
- Makes a follow-up on decisions reached during previous supervision visit;
- Identifies staff needs and providing opportunities for personal development; and
- Reinforces administrative and technical link between high and lower levels.

The hypothesis is that if service providers are empowered and motivated to provide high-quality services and their needs satisfied, and if clients' needs are met, then client satisfaction and outcomes will be enhanced.

6.8. CHALLENGES IN COMPREHENSIVE SUPPORTIVE SUPERVISION

Implementing and institutionalizing supportive supervision present an enormous challenge for health systems, especially those with longstanding hierarchies as reflected in traditional, inspection-and control supervision. Under these circumstances, it is important to consider the risks of supportive supervision:

- Few competent supervisors who can supervise all HIV and AIDS interventions
- Resistance to change from traditional ways for some supervisors and supervisees
- Requires sustainable and adequate resources
- Donor dependency

6.9. COMPARISON OF TRADITIONAL SUPERVISION AND SUPPORTIVE SUPERVISION

Table 6.2: **Comparison of Traditional and Supportive Supervision**

	Traditional	Supportive Supervision
WHO performs supervision	External supervisors designated by the service delivery organization	External supervisors designated by the service delivery organization, staff from other facilities, colleagues from the same facility (internal supervision), community health committees, staff themselves through self-assessment
WHEN supervision happens	During periodic visits by external supervisors	Continuously: during routine work, team meetings, and visits by external supervisors
WHAT happens during supervision encounters	Inspection of facility, review of records and supplies, supervisor makes most of the decisions, reactive problem-solving by supervisor, little feedback or discussion of supervisor observations	Observation of performance and comparison to standards, provision of corrective and supportive feedback on performance, discussion with clients, provision of technical updates or guidelines, on-site training, use of data and client input to identify opportunities for improvement, joint problem-solving, follow-up on previously identified problems
WHAT happens after supervision encounters	No or irregular follow-up	Actions and decisions recorded, ongoing monitoring of weak areas and improvements, follow-up on prior visits and problems
Underlying PHILOSOPHY	Suspicion Fear creation through punishments	Trust Desire creation through motivation

6.10. CONDUCTING COMPREHENSIVE SUPPORTIVE SUPERVISION

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

Table 6.3: Stages and Specific Tasks in Conducting a Comprehensive Supportive Supervision

Stages	Tasks to be Performed

Planning stage	• Identify sites/health facilities to be supervised and develop a route plan.
	• Inform the relevant authorities and supervisees on the dates, team composition, time, objectives of the visit and support needed.
	• Take note of:
	  ○ All the vital information about the supervision sites/health facilities such as types of HIV and AIDS health services and the capacity;
	  ○ All the strengths and limitations regarding the supervision site/health facility performance in delivery of HIV and AIDS health services; and
	  ○ Important supervision site/health facility issues, action points already known/ reported if any.
	• Arrange logistics
	• Organize a preparatory team meeting the preceding day.

Getting started	• Pay a courtesy call to the relevant authority according to the level of supervision
	  ○ Introduce yourself and the team
	  ○ Objectives
	  ○ Sites to be visited
	  ○ Debriefing date and time
	At the supervision site/ health facility:
	• Establish rapport - always start by greeting and introducing yourself and the rest of the team to the supervisees;
	• Tell the in-charge and supervisees the purpose of the visit. Let the supervisees introduce and listen in a relaxed manner but attentive and avoid interruption;
	• Explain the whole supportive supervision plan e.g. supervisee to be met, time to be spent, feedback session etc.;
	• Avoid making unrealistic promises and be honest; and
	• Use communication skills to encourage active participation.

Conducting supportive supervision	• Show respect and patience throughout the supervisory visit. • Allow time for staff to complete any consultations underway and for any hand over. • Review the previous action points and status of implementation. • Observe and gather information using the checklist. • Listen to their problems and challenges. • Address and follow up on problem areas. • Provide corrective and supportive feedback on performance. • In case a procedure is performed incorrectly, demonstrate the correct procedure and ask for return demonstration. • If there is a need, liaise with mentors. • Update supervisees on new guidelines and information. • Give on-the-job training on new techniques and approaches if required.

Immediate feedback	• Once you are done with supervision, find a conducive environment with appropriate privacy to give feedback.
	• Use positive feedback, when performance is good; and constructive feedback, when performance needs improvement.
	• Start with those areas they are doing well followed by those where there are problems.
	• Focus on systems and processes, the performance or action, not on the person.
	• Discuss previous action points which were not implemented and include them in the new action plan.
	• Outline areas needing improvement and guide them to come up with corrective actions and time line. Link the behaviour to programme goals e.g. “If we don’t get the reports on time, the patient on treatment numbers will be out of date by the time we get them back. Then we won’t be able to use the information to improve our patients’ services.”
	• Listen attentively, with encouragement and open mind believing that everyone has good contributions to make. Give a chance to the supervisee to respond.
	• Invite the supervisee to give you feedback and questions. You may ask:
	  ○ How did the process go?
	  ○ What things did you find helpful?
	  ○ What are some things that you didn’t like, or were not helpful to you?
	  ○ Are there things you want help with which we did not address today?

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

6.11 INTERVENTIONS FOR COMPREHENSIVE SUPPORTIVE SUPERVISION

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

6.11.1. Issues/Areas to be covered during Comprehensive Supportive Supervision to R/CHMTs:

Patient care:

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

Health infrastructure:

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

Human resources for health:

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

Logistics and resource management:

- Availability and adequacy of medicines, lab reagents and other commodities
- Availability of reliable transport

- Sources and management of funds
- Implementation status of Comprehensive Council Health Plan (CCHP) and regional annual plans

Monitoring and Evaluation:

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

6.11.2. Issues/Areas to be covered during Comprehensive Supportive Supervision to ZHRCs:

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

6.11.3. Interventions to be covered during Comprehensive Supportive Supervision of Health Facilities

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

Category 1: Prevention Services

Prevention of Mother to Child Transmission of HIV (PMTCT)

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

Management of STIs/RTIs

- Availability of STI/RTI guidelines and protocols/flow charts for management of STIs/RTIs
- Inventory of staff trained in STI/RTI case management
- Provision of PITC services

- Syphilis screening at ANC during the first visit
- Availability of essential STI/RTI drugs (1st and 2nd line)
- Availability of penile and/or pelvic models and their use
- Condom availability (both male and female)
- Contact tracing
- Availability and use of IEC materials
- Availability of essential equipment and commodities (see annex for checklist)
- Availability of recording and reporting tools for STI/RTI services
- Data Management – recording, analysis, utilization, reporting and record keeping
- Availability of reagents for syphilis screening
- Challenges in providing STI/RTI services in HIV era

Category 2: Treatment, Care and Support Services

HIV Care and Treatment

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

TB and HIV

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

Home Based Care

- Availability of palliative care including pain management
- Provision of adherence counselling and support services to patients on ART adherence to medication

- Patients' adherence to schedules of visits to the CTC
- Effectiveness of referral systems i.e. referral of PLHIV to CTC, TB, RCH and Family Planning
- (FP), and social and legal services
- Availability and use of recording and reporting tools (check the registers/forms for completion and accuracy)
- Positive health, dignity and prevention services such as condoms, Insecticide Treated Nets (ITN), safe water and male circumcision
- Care for the carers – for members of support groups through meetings, training, provision of incentives etc
- PLHIV involvement and participation through membership to support groups, providing services in CTC, compiling lists of contact persons in different health facilities, linking patients to services etc
- Male involvement and participation: their participation in caring for patients, accessing HIV test, in PMTCT in couples testing and counselling and in home/family testing and counselling
- Training of HBC providers – number of trainings conducted in a given period
- Challenges of implementing HBC and how they are addressed

Category 3: Cross Cutting Services

HIV Testing and Counselling

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

Laboratory Services

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

Pharmaceutical services

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

Information, Education and Communication (IEC)

- Availability and use of IEC materials
- IEC materials given to patients/clients
- HSPs trained in Abstinence and Being Faithful (A&B)
- HSPs trained on IEC/Behaviour Change Communication (BCC)
- Availability of guidelines on A&B
- Recording in the Ledger book IEC materials received and distributed
- Display of IEC materials
- Periodic exit interview with patients/clients on IEC materials
- Conducting social/community sensitization meetings
- Locally developed IEC materials

Monitoring and Evaluation (Recording and Reporting)

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

CHAPTER 7:

MENTORING

LEARNING OBJECTIVES

By the end of the chapter, the participants will be able to:

- Describe the concept of mentoring
- Outline qualities of a mentor
- Describe mentorship procedure
- Describe mentoring methods
- Describe interventions to be covered

7.1. CONCEPT OF MENTORING

Mentoring is a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. Mentoring should be seen as part of the continuum of education required to create competent HSPs. It should be integrated with and immediately follow initial training. Initial in-service training should be case-based and participatory, based on the principles of adult learning. Mentoring therefore is an integral part of the continuing education process taking place at the facilities where HSPs manage clients.

When expertise in managing antiretroviral therapy and opportunistic infections is not found at the primary health facility level, an experienced clinician at care and treatment centre in a hospital can provide mentoring to less-experienced clinical providers by responding to questions, reviewing clinical cases, providing feedback and assisting in case management. This mentoring occurs during site visits as well as via ongoing phone and e-mail correspondence. Mentoring is critical to building successful national, regional and district networks of trained HSPs for HIV care and treatment in resource-constrained settings.

Mentoring requires the HSPs with an opportunity to integrate what was learnt during pre- and in-service training into actual practice to result into improved performance and subsequent improved quality care. When on-the-job training and learning does not sufficiently occur, continuous ignorance ensures and there is knowledge decay and depreciation of skills that invariably results into provision of rudimentary services and highly jeopardizing clients' outcomes. In this case the HSP becomes a liability not only to the profession but also to the clients who receive such services. Mentoring relationships work best without directive approach to where both a mentor and a mentee learn from each other. It is a learning opportunity for both parties. It should be noted however that a mentor must be a practicing person who is more experienced with greater knowledge and skills, and who is willing to support a junior or inexperienced HSP.

7.1.1 Definition of Mentoring:

Mentorship is a system of practical training and consultation that fosters ongoing Professional development to yield sustainable high-quality clinical care outcomes or a technique for allowing the transmission of knowledge, skills and experience in a supportive and challenging environment like coaching does. Mentors need to be experienced practitioners in their own right, with strong teaching skills.

7.1.2 Key features of mentoring

Mentoring has its unique features that differentiate it from supportive supervision. Some of these features include:

Mentoring:

- Mostly targets individuals or a small group of individuals for on the-job-training.
- Bridges the gap between didactic trainings and clinical practice.
- Occurs at the facility level**.**
- Creates a supportive environment to practice skills and attitudes learnt from training
- Focuses on clinical case review, bed side teaching, journal clubs, morbidity & mortality meetings/ rounds, assisting care & referral of complicated cases and distance communication approaches.
- Is an ongoing knowledge and skills transfer from a mentor to a mentee.
- Leads to capacity building of facility staff and should be reflected in terms of improved services delivery and improved outcomes.
- Allows the health facility to mature and eventually offer independent quality services.
- Motivates staff by providing effective technical support.
- Promotes a culture of continuing education practice among HSPs
- Builds and maintains long-term relationship with mentees
- Ensures that multiple mentoring visits are conducted guarantying that mentees have adequate knowledge/skills to provide each aspect in minimum package of care.

7.2. ATTRIBUTES OF A MENTOR

Effective Mentorship requires that the Mentor should have the pre-requisite mentoring attributes which may include some of the following;

- Have adequate knowledge, and sufficient skills and experience in a specific HIV and AIDS intervention or service area
- Personality with approachable and interpersonal communication skills
- Actively participating in practicing and provision of specific HIV and AIDS intervention/service area.
- Familiarity with the country's health system, common diseases, context of the disease, likely patient reactions, outcomes and appropriate language.
- Willingness, commitment and the availability to provide technical assistance to less experienced HSPsv
- A Mentor could be a nurse, a clinician, pharmacist, laboratory technologist or any other practitioner in the specific HIV & AIDS intervention/service area with the above mentioned attributes.

7.3. MENTORS' ROLES AND RESPONSIBILITIES

Mentors have numerous roles and responsibilities that do not only require them to be morally highly committed individuals, but those who will live to aspire to see the HSPs are potentially developing and being assisted to update and sharpen their knowledge and skills for overall improved services delivery. Mentors should emphasize that mentees take continuing education and continuous professional development seriously so that they don't become a liability to the patients/clients they serve. Support in continuous learning and facilitation of a friendly learning environment becomes the main responsibility of any mentor.

Their roles & responsibilities are to:

- Ensure mentees are able to perform practically.
- Provide correct, appropriate and relevant support according to standards.
- Identifies the gaps of the mentee.
- Give suggestions and advice for improvement of mentee performance.
- Conduct discussions on various HIV- activities.
- Make sure clients receive proper care.
- Oversee implementation of national guidelines.
- Assist with case management.
- Conduct case discussions, coaching and consultations.
- Carry out monitoring and evaluation.
- Support professional development and application of knowledge in service provision.

7.4. MENTORING PROCEDURE

7.4.1 Four phases for a mentoring procedure

There are four fundamental phases for a mentoring procedure. Here below the phases are outlined with a brief description of what happens at each of the phases:

1) Development need phase:

This is the initial phase in which mentoring needs are identified and prioritised both for the services offered and the mentees. In fact one finds out the actual gaps or shortfalls in terms of the quality of services offered and how patients and or clients perceive them. Observation of procedures, patient/client exit interviews and satisfaction surveys are some of the methods that can be used to identify the perception of quality of services offered by mentees. This can be done by internal or external supervisors or external intervention-specific experts. The mentoring needs are then prioritised and listed.

2) Facilitation of self management learning phase:

This is another very important step where a mentor, a mentee and a patient/client interact to identify areas for improvement. Observation of certain clinical/technical procedures done by a mentee in the presence of a mentor helps to identify strengths and weaknesses in the performance. The identified problems during this initial mentor-mentee-patient/client interaction will form a basis and focus of learning agreed upon when carrying out the actual mentoring process.

3) Support learning phase:

During this step the mentor is now supporting the mentee to learn building on the deficient performance problems which were identified as priority and focus of learning. However the mentor and mentee discuss first the strengths where the mentee performed well. Then they discuss the weak or poorly performed areas that may include knowledge, attitudes and technical skills to give positive and constructive feedback. It is absolutely important that this process is undertaken with extreme care so that the Mentor-Mentee-Patient/Client relationship is not injured.

4) Assist Evaluation phase:

During this phase the mentor assists the mentee to make or carry out an evaluation of his/her overall

performance as seen during the mentoring process. In doing so the evaluation process should be as objective as possible including giving room for a self evaluation by mentees and the peer mentor. Having done the evaluation, then both the mentor and the mentee sit to agree on the evaluation results and begin to plan together for the next steps. This results into an agreed follow-up action plan by both the mentor and the mentee.

7.4.2 Conducting a mentoring process and major tasks performed at every stage

Details are given in the Table on how to go about conducting the mentoring process including the major issues or tasks performed at every stage. This includes the frequency and the methods of conducting mentorship, an outline of the sequences of the process and the summary of major tasks performed at every stage. Mentors need to understand this very well for carrying out a successful mentoring process.

Table 7.1: The Mentoring Process and Tasks Performed in Each Stage

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

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

Post mentoring feedback session	• After all the clients/patients have been attended to, find a quiet and ideally private place for a feedback session with the mentee
	• Ask the mentee: "how did the session go for you?" "What did you like" and "what did you learn?"
	• Provide feedback to mentee, utilizing principles of providing effective feedback (discussed in chapter 6):
	  ○ Start with positive, encouraging feedback. (things that you observed the mentee doing well); and
	  ○ Then, identify areas you feel the mentee should work on. Be specific and concrete. Conclude feedback with encouraging remarks, restate positive things that the mentee is doing. Encourage the mentee to keep working on self improvement.
	• Ask the mentee to give you feedback. Examples of how to do this include asking the following questions:
	  ○ How did the mentoring session go for you?
	  ○ What things did you especially like? What was particularly useful for you?
	  ○ What are some things that you didn't like, or was not as helpful to you?
	  ○ Are there issues that we did not cover today? Are there things you want help with which we did not address today?

Planning the way forward	• At the end of the feedback session, make a plan with the mentee about next steps for continued professional growth. Agree on things the mentee will:
	  ○ Work on after this mentoring session; and
	  ○ Try to teach or support on a future mentoring visit.
	• Identify a means of communication between mentor and mentee between mentoring sessions
	  ○ Invite mentee to call you (the mentor) with any questions that may come up between mentoring visits
	• Identify other ways that mentor can support mentee between mentoring visits
	  ○ Does the mentee need job aids? Were there questions/issues that came up today which the mentor did not have the answer to? Identify issues or questions that the mentor will look up (from other colleagues, senior mentors, internet, etc). Identify how the mentor will share what she/he learns with the mentee.
	  ○ Plan the next mentoring session: When?
	  ○ Prioritizing the issues for the next mentoring session

Documentation and reporting	• Mentors should document all mentoring visits made: who was mentored, what was mentored, what methodologies were used, number of clients/ patients seen together • Mentors should document the mentee's performance. This allows mentors to track mentee's improvement in specific areas. • Mentors should use mentoring tools to keep track of what has been mentored/taught and what has not been addressed. Make a reminder to yourself to look for ways to introduce topics that have not yet come up. • Mentors should provides regular communication with Quality Improvement/ Supportive Supervision Team and give feedback to the team on gaps regarding administrative, logistic and systemic gaps observed during mentoring visits.

7.5. MENTORING METHODS

In order that a potential and prospective mentor acquires mastery of the skills of mentoring, adherence to certain guiding principles and concrete techniques is mandatory. Some of these are presented and discussed here so that prospective mentors can learn them and be able to apply them in real life mentoring work situations.

7.5.1 Identification of a teaching moment:

A teaching moment refers to any opportunity that comes up for a mentor to share insights, knowledge or skills with a mentee. However it requires proper timing without interrupting a client/patient as the mentor interacts with the mentee. Identifying clinical or knowledge gaps needs to be undertaken properly as it forms the basis and focus for the mentorship teaching. Here below some tips for identifying clinical or knowledge gaps (potential teaching moments):

- During file review before patient encounter: Mentor reviews the patient file with mentee before meeting the patient and ask what exactly he/she wants to know about the patient based on file review information obtained like repeat CD4 count? Assess medication toxicity? Or something a mentee forgot to do? Etc
- During initial client/patient encounter: Observe how the mentee interacts with the client/patient. If the mentor has suggestions for improving the establishment of a warm client/patient care environment, the mentor can model how this is done. Modelling effective care behaviour is a powerful way to teach.
- During history-gathering: Listen closely to what questions the mentee is asking of the client/patient. If there is something that the mentee overlooks which the mentor feels is important, this can be a teaching moment.
- During physical examination: Mentors can demonstrate how to perform a physical exam, and how to utilize physical examination findings to assist with clinical management decisions.
- During formulation of management plan: Mentors can help mentees to formulate an optimal management plan. This is an opportunity for mentor and mentee to discuss the case.
- During client/patient instructions and education: Mentors can model how to communicate client/ patient instructions. This is an opportunity to educate the client/patient, but also a chance to educate the mentee discreetly.

7.5.2. Bedside teaching:

An effective and powerful way of teaching. Mainly used for demonstration of physical findings, modelling communication skills and optimal patient care, making a synthesis of history taking, physical examination findings, laboratory/radiological data and arriving at clinical decision making and formulating a management plan as well as providing an opportunity mentees to practice the skills while being observed/guided by an experienced Provider/Mentor.

7.5.3. One-on-one case management observation:

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

7.5.4. Review of Patient Monitoring Data:

Close monitoring particularly chronic diseases involves careful monitoring to ensure treatment efficacy, toxicities and side effects. In HIV care particular attention be drawn to the following:

- CD4 count within one month of enrolment, and every six months
- Vital sign trends especially weight-much more in children
- Growth chart and developmental milestones in children
- Baseline investigation
- Screening for TB and
- Safety monitoring eg HB for patients on Zidovudine (AZT) and rash as well as hepatotoxicity for patients on NNRTI.

7.5.5. Documentation Reviews:

HIV and AIDS health services operation depend on care documentation in cards, registers, patient files and other records. It is absolutely essential that assisting mentees in this area becomes extremely necessary for proper records maintenance. Mentors can cooperate with Supportive Supervisors in guiding mentees on proper documentation. A Mentor can do this through modelling on how to chart thoroughly and efficiently while prioritizing on what is to be documented to Mentees.

7.5.6. Clinical Case Discussion:

Teaching that is based on a clinical case rather than a lecture. This is a very powerful way of to teach clinical decision making skills and promote active dialogue from participants. Patients where possible be those that have been seen by both Mentor and Mentee to evoke a good teaching moment. It is desirable that discussion of a clinical case be done where facilities like chalk board, flip chart, pencil and paper etc are available for easy illustration of key points. The mentor guides the teaching by asking important questions to the audience like what else could you have asked the patient?, What physical findings would you look for? What do you think is the problem? Etc. Make a brief case summary of the patient before commencing the discussion to focus the discussion. Mentee should make a case summary which may contain;

- Basic information about the patient like age, sex, CD4 count etc
- The main complaint
- History-positives and negatives
- Vital signs

- Physical examination findings
- Laboratory/radiological findings
- Generate a problem list
- Issues identified during assessment and discussion for each problem
- Tentative Differential Diagnosis and
- Management plan as proposed by health care team members.

7.5.7. Clinical Team Meetings:

This brings all clinical team members at the clinical site to discuss issues related to patient care, promote continuous quality improvement at the health facility, and for staff to provide support for each other. The spirit of a clinical management team is to foster exchange of ideas and trust among different cadres. They all share the successes and challenges associated with HIV and AIDS services provision. In this way a burn-out from extra work load exerted by HIV and AIDS services provision at the health facility is psychologically shared by all. Clinical team meetings can serve as a forum for;

- Various clinical team members to share what is going on well in the clinic
- Share what is not going on well, brainstorm on causes and ways of improving the problem area with each team members contribution
- Provide clinical updates that are important for all staff
- Health care staffs to provide support for each other especially on the burden of providing care to medically ill patients and deaths. It helps to prevent burn out among HSPs.
- Promote continuous quality improvement at the health facility.

7.6. PREPARATION OF A LESSON PLAN

In order for a mentor to prepare him/herself for mentoring, it is highly recommended that the mentor prepare a lesson plan based on the needs identified from the initial visit as shown below:

Main Subject----------**Topic**----------

Sub-topic	Learning objectives	Teaching strategy/ method	Teaching resources/ Aids	Teacher activities	Participant activities	Time al-located	Assessment/ Evaluation

The content under each key heading is as follows:

Heading	Content
Subject or topic	This means the main subject may be HIV care and treatment services but the focus topic could be “Adherence Counselling and Assessment.”
Introduction to the topic/overview	Give an introduction to what it is, area of emphasis contained to the target in other words the importance and significance/relevance of it to what mentees do. You can also tell how it relates to the previous topic in a nut-shell.
Teaching objectives	Give what you think by teaching this topic mentees are going to achieve

Teaching strategy/ methods	This relates to what exactly you will go about teaching the topic to make sure that the mentees understand it and master the skills. You may want to demonstrate on mentees themselves before they practice on a client, conduct a role play, organise a field visit, etc
Sub-topics	For the topic given as an example in No. 1 above, the topic being The use of clinical and non-clinical mentors, the sub-topics may include for example; • Definition of a clinical mentor • Definition of a non-clinical mentor • How to select and prepare clinical and non-clinical mentors The roles and responsibilities for each category of mentors etc
Necessary teaching resources	What teaching resources or teaching aids are required during the teaching e.g. presentation slides, LCD, a flip chart board, VIPP cards, etc.
Evaluation	It describes how teaching will be assessed/evaluated. Plan ahead as to how you will assess the teaching at the end, e.g., by asking questions on what was taught, give a written test or examination, etc.
Summary on key points	This is a summary of main points that mentees need to master and what they will apply in their work.

7.7. RISKS OF IMPROPER MENTORING PROCEDURE

- Perception of being highly controlled & monitored
- Process may be highly mechanical and lose its inherent value.
- Can allow reinforcement of bias towards certain mentees if mentors can pick who to mentor.
- Senior Mentors may perceive to be criticized by juniors especially where and when juniors demonstrate more knowledge and skills than seniors.
- Patients/clients may lose trust and confidence in Mentees if the mentoring process is done without professional dignity and respect.

7.8. INTERVENTIONS FOR MENTORING

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

7.8.1 Category 1: Prevention Services

Prevention of Mother to Child Transmission of HIV Services

- HIV education, counselling and testing
- History taking and physical examination, including WHO staging
- Information on testing family members
- Laboratory test including CD4 count
- STI screening and management
- TB Screening
- ARV prophylaxis or treatment

- Counselling on infant feeding, family planning and prevention
- Adherence counselling and assessment
- Appointment systems, tracking and tracing defaulters including linkages and referral to other supportive services
- Disclosure counselling and partner involvement
- Management of HIV exposed children
- Maternity (Labour and delivery), delivery practices and standard precautions
- Early Infant Diagnosis

Management of STIs and RTIs

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

7.8.2 Category 2: Treatment, Care and Support Services

HIV Care and Treatment Services

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

TB and HIV Services

- Prevention, screening, diagnosis and management of TB and HIV co-infection
- Linkages and referral mechanisms between TB clinics and CTC.
- Observe an assessment of a TB/HIV infected patient
- Observe initiation of ART and other interventions
- Interpret x-rays

- Start Cotrimoxazole prophylaxis
- Use of the TB screening questionnaire
- Use of Paediatric Score Chart for children
- Demonstrate TB infection control and universal precautions
- Demonstrate measures for HIV prevention
- Manage side effects of ART and anti TB drugs
- Monitor clients on TB and ARV treatment.
- Assess IPT usage

Home Based Cares Services

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

7.8.3 Category 3: Cross cutting Services

HIV Testing and Counselling Services

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

Laboratory Services

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

Pharmaceutical Services

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

Monitoring and Evaluation (Recording and Reporting)

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

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

7.9 FACTORS INFLUENCING PERFORMANCE OF A MENTOR

There are many factors aside from working with a mentee alone that can heavily influence mentoring activities. Good mentors are able to view their work with a wide angle lens to be able to examine the entire picture of what's going on at a facility. Mentors need to consider each of these layers to gain comprehensive perspective of issues that need addressing.

Figure 7.1 depicts the macrocosm of a mentor's work world. It illustrates some of the common factors that can affect a mentor's work. It is important to consider these influences in order to gain a better understanding of the variety of challenges that mentors face in their work.

1) National Level:

Government policies/ guidelines provides guidance to the mentor regarding models of care at clinics as well as the clinical content that a mentor is reinforcing for mentees.

2) Regional/District Management:

This may influence how a mentor works within each region/district, e.g. how to prioritize which clinics receive mentoring.

3) Hospital/Clinic Administration:

It may influence how the mentor functions within a given facility; for example, if the hospital administration wants a mentor to focus efforts in an ART clinic at a hospital , then that's where a mentor will work; however if the administration wants a mentor to work with all physicians and nurses within a given hospital, then a mentor will work across several wards/ departments within the hospital.

4) Internal Facility Systems:

Facility systems refer to the systems in place to help support clinical services. For example, within a hospital this includes ancillary departments in a hospital, e.g. pharmacy, lab services. This can also refer to the set up of services for a patient, e.g. when a patient comes to the clinic, s/he first goes to the registration desk, then to the nurse, then to the physician, then to the lab, then to the pharmacist, etc. This is a "system" for patient flow within a facility. This also refers to the resources within the facility that are available for clinical management, e.g. the availability of equipment and medications

5) Mentees :

The unique learning needs of each mentee influences how much effort a mentor has to exert when he/she provides teaching. Interpersonal relationships with mentor and mentee also influences a mentor's work on communication/building relationships. For example, if a mentee is resistant to a mentor being in the clinic, this can make a mentor's work more difficult.

6) Mentors Themselves:

The characteristics of the mentor him/herself can influence the type of work that they do; for example if a mentor is an ART expert but also has strong skills in monitoring and evaluation, the mentor likely applies M & E skills to help evaluate outcomes in his mentoring setting. Personal motivation of mentors also affects their performance – highly motivated mentors most likely are able to produce positive changes with their mentees.

7) Supportive Supervisors:

The relationship with supportive supervisors can also influence the performance of mentors. Effective and timely communication would make the work of the mentors easy and consume resources less.

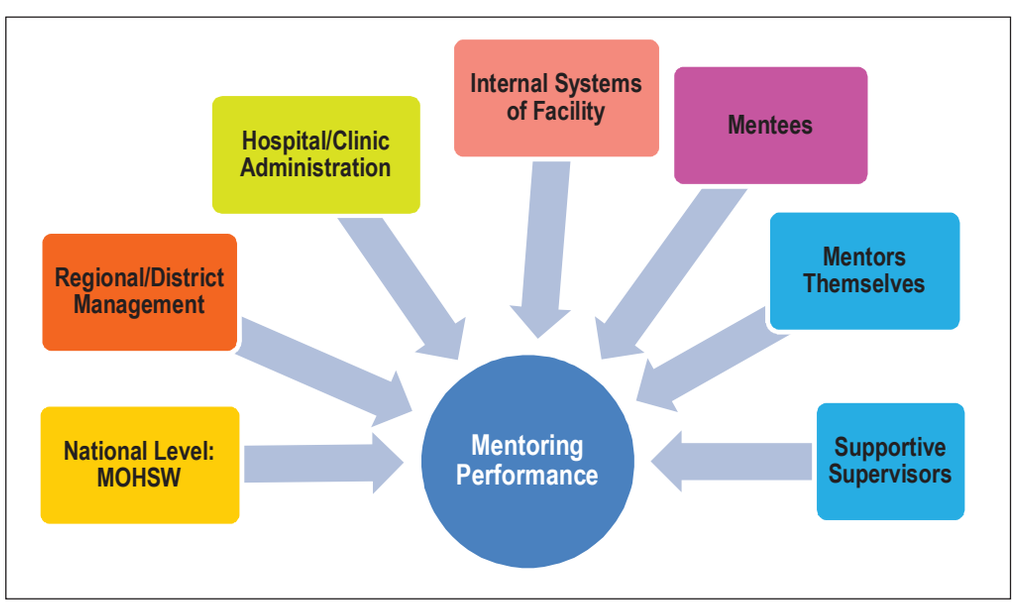


Figure 7.1 Factors influencing performance of a mentor

Handout 7b:
Case Study - PMTCT

Learning Objective

By the end of this session, the participants will be able to:

- **Apply mentoring steps.**

Case Scenario

A Council Reproductive and Child Health Coordinator (CRCHCo) visited Mwambani Health Centre with an objective of supervising PMTCT service delivery at the centre.

During this supportive supervision she discovered that PMTCT registers have not been filled properly and reports have not compiled and sent to the DMO. The supervisor stressed to the health service provider (HSP) on the importance of data recording and reporting to the DMO through appropriate use of tools.

Two months later, the same supervisor visited the facility and found out the registers were still not being filled properly and no report was sent to the DMO's office.

Mwambani H/C has a good number of ante-natal and post-natal attendees and has CTC clinic which has 1,500 clients ever enrolled to care. HTC services at the health centre records a good consumption of test kits for HIV.

During conversation with the HSPs at the centre, the supervisor found out the following weaknesses:

- No record of exposed infants at the facility.
- No record of mothers receiving ARV prophylaxis for PMTCT.
- No record of mothers tested positive for HIV and referred to CTC.

The supervisor also found out that the reason for the above weaknesses was lack of knowledge of filling registers among the HSPs at the centre.

The next day the supervisor went back and shared the issues at the CHMT meeting.

You are the mentor sent by the CHMT to Mwambani H/C to provide mentorship to the HSPs on data management.

Question:
How are you going to mentor the providers, using the steps in mentoring?

CHAPTER 8:

Relationship between COMPREHENSIVE supportive supervision and Mentoring

LEARNING OBJECTIVES

By the end of the chapter, the participants will be able to:

- Describe the relationship between comprehensive supportive supervision and mentoring
- Explain the similarities and differences between comprehensive supportive supervision and mentoring
- Describe the mechanisms of bringing about synergy by levels of health services

8.1 RELATIONSHIP BETWEEN COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING

It was stated earlier that the two processes of supportive supervision and mentoring, although each focuses on certain specific areas and skills, the two have many things in common. They compliment and synergize each other to ensure that quality performance and total quality improvement is not only assured but also highly sustained.

The two concepts of supportive supervision and mentoring will always coexist and support each other for that effect. Supportive supervision emphasizes on abandoning the traditional supervision to overall mastery of skills for total or comprehensive improved performance and improved quality care. Mentoring emphasizes on individual on job career skills improvement based on continuous professional improvement through continuous education and learning. The job provides a unique opportunity for the individual HSP to learn the job challenges, determine the possible solutions to deal with such challenges and draw lessons for future. Thus while the Supportive Supervision focuses on a programmatic total improvement approach, mentoring focuses on the individual human resources factor and its impact on productivity. However, there are things the two concepts share.

It is important to understand that Supportive Supervision requires different skills and is done by a different team as opposed to clinical mentoring. However the two processes are very much complimentary and bear significant relations for both performance improvement and quality improvement to occur.

The two processes have a mutual and interdependent relationship with some overlapping functions. Figure 8.1 and Table 8.1 summarises the differences and the overlapping areas. Both support each other in terms of performance improvement and quality improvement. However, Supportive Supervision focuses on a programmatic management approach promoting quality at all levels of the health system. Thus Supportive Supervision promotes sustainable & effective programme management through interactive communication, performance planning & monitoring. Mentoring focuses on individual career development thus helping the person to do a job more effectively. Mentoring supports the application of classroom learning to clinical care thus maintaining & progressively improving the quality of care. Supportive supervision provides excellent opportunity for follow-up training, improve overall performance improvement and solve systemic problems contributing to poor quality services provision.

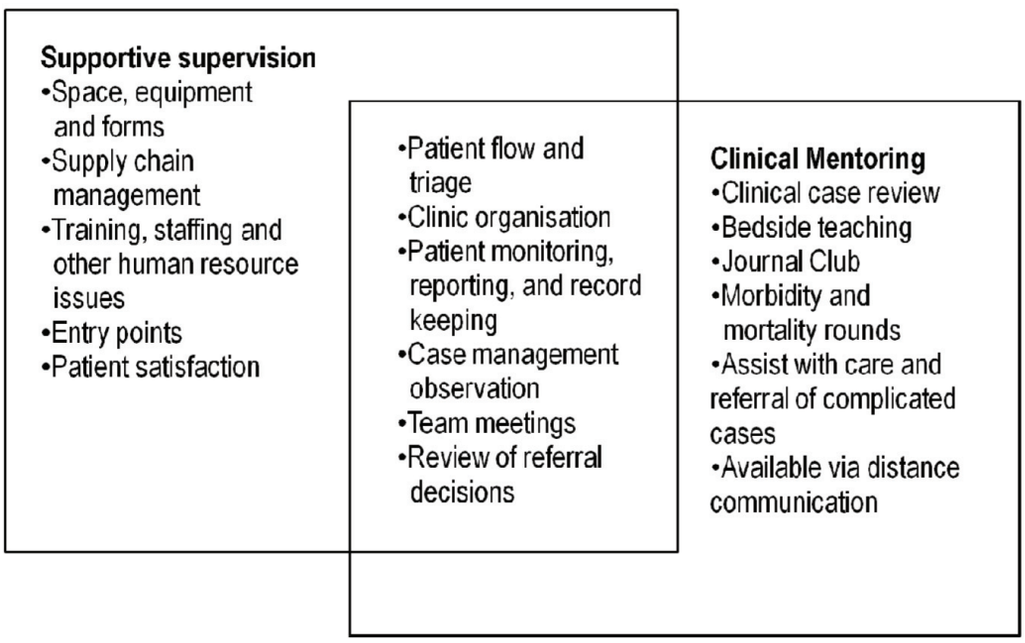


Figure 8.1: Relationship between Supportive Supervision and Mentoring

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

Supportive supervision specific performance areas are:

- Space, equipment and forms
- Supply chain management
- Training, staffing and
- Other human resource issues
- Entry points
- Patient satisfaction

Mentoring specific performance areas are:

- Journal Club
- Case review
- Bedside teaching
- Morbidity and mortality rounds
- Assist with care and referral of complicated cases
- Available via distance communication

However, both Supportive Supervision & Mentoring do the following in common/overlap;

- Monitor clinic activities like patient flow & triage
- Clinic organization
- Patient monitoring
- Record keeping
- Case management
- Team meetings and
- Review of referral decisions

While supportive supervision is a regular activity, mentoring is conducted based on technical/clinical needs. It is therefore important that the two work together for maximizing the effectiveness of each.

Table 8.1 Differences and relationship between supportive supervision and mentoring

Supportive Supervision	Mentoring
• Is a regular activity. • Focuses on a systemic and programmatic total improvement. • Provides an opportunity for follow-up training, to improve overall performance, and solve other systemic problems that contribute to poor operations.	• Is required when technical/clinical needs arise. • Focuses on the individual or small group human resources and their impact on productivity. • Provides individuals with on-the-job skill training for a specific area of intervention as part of continuous education and learning for professional development.
Supportive Supervisors need the following skills: • Comprehensive knowledge on health systems and HIV and AIDS interventions • Leadership, managing, coaching, negotiation, advocacy, facilitation and team building skills • Problem identification and solving • Information/data collection, analysis and interpretation	Mentors need the following skills: • Rich clinical/technical knowledge and skills in a specific intervention • Coaching, negotiation and facilitation skills • Problem identification and solving • Information/data collection, analysis and interpretation

8.2 SYNERGY BETWEEN COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING

8.2.1 Definition of Synergy

"Synergy" is defined as the increased effectiveness that results when two or more people work together. In other words, "the effect whereby one plus one can result more than two."

The term synergy refers to the process of carrying out the two processes of supportive supervision and mentoring to the same group or groups of HSPs for achieving more substantive added effect and or impact on performance outputs/outcomes for overall quality improvement. This means that the results of carrying out the two processes together are better than each of them done individually.

It is extremely important to note that synergy of the two processes is a desirable factor for resulting into an enhanced performance results effect. Both the supportive supervision and mentoring need each other to double their performance effects or results. Important areas where the two processes work best together are given as examples here below for illustrating the point. These are:

- **Planning resources:** In planning for various needed resources to implement the two processes a synergy is required in determining the right needed resources like budgets, financial sources, stationeries, human resources etc

- **Setting standards of performance-**Both processes aim at performance improvement and quality improvement of services delivered at various levels of care. This emphasizes that the two need each other for quality improvement to occur. They all target at achieving same performance standards set.

8.2.2 Mechanisms for Synergy by Levels of Health Services

The two processes of supportive supervision and mentoring are usually conducted by different teams. However, we reiterate the earlier point that even though they need each other and are highly synergistic in nature both in terms of processes and outputs/outcomes. There are various mechanisms for this synergy to happen. We outline here below the various mechanisms that should be explored and used in ensuring that synergy does occur by levels of care as follows;

1) National level: Meet twice in a year to share experiences, challenges and lessons learnt. Key players are supervisors, mentors, partners and National QI Team. Information could be shared and discussed during technical and management meetings, national sub-committee meetings and biannual MOHSW stakeholders' coordination forum. Apart from discussing key findings, lessons learnt and challenges, further actions to be taken for improving quality shall be discussed. Make action plans as well as monitoring and evaluation plans.

2) Regional level: Meet on a quarterly basis using biannual PHC meetings, RHBs or any health related meetings. Key players are the RHMT, RACCs, co-opted members, regional supervisors and mentors, Regional QI Team and implementing partners. Apart from discussing key findings, lessons learnt and challenges, further actions to be taken for improving quality shall be discussed. Make action plans as well as monitoring and evaluation plans. Involve Regional Commissioner (RC) and Regional Administrative Secretary (RAS) in the meetings depending on the issues discussed since they are the decision makers at the regional level.

3) Council level: Meet on a monthly basis using existing forum like Hospital Governing Committee meetings, Council Health Service Board meetings and standing committee on HIV and AIDS. Key players are CHMT, co-opted members, supervisors, mentors, Council QI teams and implementing partners. Discussion topics could be similar to those discussed at the regional level. Involve District Commissioner (DC) and District Executive Director (DED) in the meetings depending on the issues discussed since they are the decision makers at the district level.

4) Health facility level: Meet during health facility governing committee meetings on a monthly basis. Key players are Health facility in-charge, Health facility management team, facility QI team and in-house mentors. Discussion issues to include key findings arising during supervision and mentoring, lessons learnt and best practices, challenges and actions taken, further action oriented recommendations for improvement and consolidate action plans. Involve community leaders in the meetings depending on the issues discussed.

CHAPTER 9:

STRUCTURE AND FUNCTIONS OF NATIONAL COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING SYSTEMS

LEARNING OBJECTIVES

By the end of the chapter, the participants will be able to:

- Describe the structure and functions of comprehensive supportive supervision
- Describe the structure and functions of mentoring
- Describe the interaction between comprehensive supportive supervision and mentoring

9.1 STUCTURE AND FUNCTIONS OF COMPREHENSIVE SUPPORTIVE SUPERVISION SYSTEM

Levels of structure and functions of CSS are:

- National
- Regional
- Council
- Health Facility
- Community

9.1.1 National Level

At the national level, a supportive supervision team for HIV and AIDS health services will be composed of 2-4 members including heads of programmes, partners and co-opted members trained in comprehensive supportive supervision.
The team will conduct supportive supervision at the regional level, targeting RHMTs, national and referral/special hospitals and ZHRCs. The visits shall be twice a year and each visit will take five working days. From time to time, when it is required, the team may also visit a few selected lower level health facilities. Several teams shall be formed and trained to be able to provide the service across the country.

The team shall pay a courtesy call to the Regional Administrative Secretary (RAS) for briefing at the start of the visit and de-briefing at the end of the visit. While at RHMT level, the team reviews progress reports, finance management and implementation of regional annual plans and CCHPs.

The team also reviews the activities of the regional Quality Improvement (QI) team and share the debriefing report. In addition, the team reviews reports of supportive supervision to CHMTs.

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

At national and referral/special hospitals, the team spends at least two days providing supportive supervision to all HIV and AIDS health services in respect to infrastructure, equipment and forms, supply

chain management, patient and provider satisfaction, training and staffing and other human resources issues. The team also looks into patient flow and triage, clinic organization, patient monitoring, record-keeping and reporting, team meetings and challenges.
When the team visits a ZHRC, the main interest shall be in looking at availability of National HIV and AIDS documents, their capacity and plan in supporting regions and districts on HIV and AIDS related trainings and the ability to develop IEC materials to meet local needs.

9.1.2 Regional Level

Supportive supervision at the regional level shall be conducted by RHMTs and co-opted members and partners. They provide supportive supervision to the regional hospital and CHMTs every quarter. The team shall pay courtesy calls to the District Executive Director (DED) for briefing at the beginning of the visit. The regional team shall also review the activities of the QI team The RHMT shall conduct supportive supervision to the regional hospital for one day and provide feedback on the next day in areas related to infrastructure, latest guidelines, equipment and forms, supply chain management, patient flow and triage and clinic organization. Other areas include patient satisfaction, patient monitoring, record keeping and reporting, team meetings, linkages, financial, managerial, training and staffing and other human resources issues and challenges. At the end of the visit, the team shall debrief the Regional Hospital Management Team.

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

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

9.1.3 Council Level

A team of supportive supervision in HIV and AIDS health services at the district level consists of 2-4 members from CHMT and co-opted members, HIV focal persons and partners. The team targets health management teams of the District Hospital and other health facilities under the CHMT (hospitals, health centres, dispensaries, pharmacies, and laboratory).
Before visiting a health centre, the team shall visit the Ward Executive Officer for a briefing. The team is expected to conduct the visit quarterly and spend a full day especially at the hospital level and at least half a day at health centre and dispensary level.

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

9.1.4 Health Facility Level

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

The team shall supervise all relevant units in the facility providing HIV and AIDS health services and all its HSPs. The team shall also discuss and promote the utilization of SOPs and look at infrastructure especially space issues, equipment and forms, supply chain management, patient monitoring and record-keeping and reporting, financial management, and supply chain management. Other areas of interest are human resources, HIV service delivery based on guidelines, patient satisfaction, training needs as well as referral systems and community linkages. The team shall be responsible for implementing follow-up actions recommended by district supervisors and mentors.
At this level, the team will also supervise inventory, patient flow and triage, clinic organization and team meetings. The health facility in-charge will bear the responsibility of ensuring that all agreed upon actions are implemented.

9.1.5 Community Level

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

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

This has described supportive supervision clinic visit process which includes planning, getting started, conducting supportive supervision, giving feedback, wrap up and report writing. It also gives details on the roles and responsibilities of the supervisors at different stages .

9.2. STRUCTURE AND FUNCTIONS OF NATIONAL MENTORING SYSTEM

Levels of structure and functions of Mentoring are:

- National
- Regional
- Council
- Health Facility
- Community

9.2.1. National Level

At the national level, mentoring activities shall be done by a pool of national mentors identified, trained

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

9.2.2. Regional Level

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

9.2.3. Council Level

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

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

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

9.2.4. Health Facility and Community Levels

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

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

9.3. SELECTION CRITERIA OF A MENTOR

- Be a practitioner in a specific HIV and AIDS intervention.
- Has adequate knowledge, sufficient skills and experience in a specific HIV and AIDS intervention.
- Be committed and responsible in provision of services.
- Personality with approachable and interpersonal communication skills.
- Be familiar with the country's health system, common diseases, context of the diseases, likely patient reactions, outcome and appropriate language.
- Be willing to provide technical assistance to and to motivate less experienced HSPs with positive attitude for improvement.

9.4. TRAINING AND PREPARATION OF MENTORS

Effective training and preparation of mentors to undertake the work successfully cannot be overemphasized. A well prepared training programme for mentors must invariably and always cover the following key components in their training:

- Basic concepts of HIV and AIDS health services, national health policies, guidelines and any relevant SOPs
- Basic concepts of supportive supervision and mentoring
- Basic knowledge on quality improvement
- Coaching skills including interactive communication and relationship building
- Mentoring methods
- Mentoring tools
- Complimentary and synergetic relationship between supportive supervision and mentoring

9.5. RESOURCES REQUIREMENT IN THE MENTORING PROCESS

A mentoring process to be done satisfactorily needs essential requirements which must be made available to facilitate the process of implementation. Mentorship recognizes the importance of capacity development, continuing education, adult learning and support for HSPs. This contributes to long-term sustainability and well being of both the personnel and the health care system. It therefore requires that stakeholders gather or mobilize the necessary resources for the implementation of mentoring successfully.

Resources needed is as follows:

- Reliable transport
- Adequate time for mentors preparation, travel, field visit, reporting and follow-up activities
- Allowances for the mentors
- Adequate stationeries
- Tools for mentoring
- Current HIV intervention guidelines
- Monitoring and evaluation tools
- Communication support such as radio call, airtime, landline, e-mail and internet access
- Support for periodic mentors review meetings

9.6. STRUCTURE OF COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING FOR HIV AND AIDS SERVICES

Figure 9.1 depicts the national structure of comprehensive supportive supervision and mentoring for quality improvement of HIV and AIDS health services. Day-to-day activities for quality improvement (QI) should be conducted internally at each health facility. The QI team under the supervision of hospital (or health facility) management team (HMT) at each health facility is the driving force for these activities. The health facility QIT is supervised by the QI team under CHMT comprises of 3-4 members from CHMT and co-opted members. The district supervisors shall comprehensively cover the HIV and AIDS health services during supervisory visits in line with the manual and tool. CHMTs are supervised by RHMTs and RHMTs are supervised by NACP or its appointed national supervisors. Upon identification of technical/clinical gaps in a specific area of service, through external supervisory visits, which require intensive mentoring, a mentor for the specific area of service shall be mobilised to conduct mentoring at the health facility. District-level mentors provide mentoring to primary health facilities, regional-level mentors to district hospitals, national-level mentors to regional, referral and special hospitals.

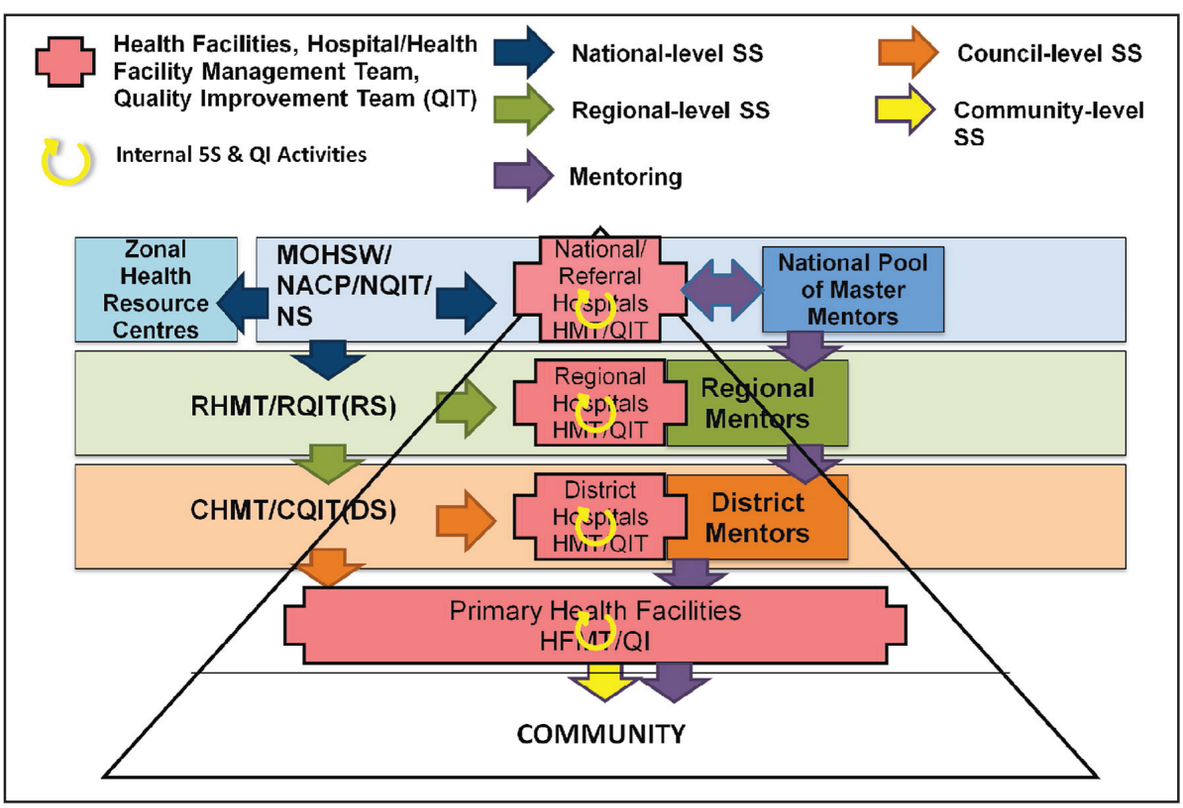


Figure 9.1: National Structure of Supportive Supervision and Mentoring

9.7. Documentation and Information Sharing/Flow Mechanism for Comprehensive Supportive Supervision and Mentoring

9.7.1. Health Facility Level

Internal supportive supervision and in-house mentoring activities must be documented as much as possible, so that the issues identified and actions planned through those activities will be easily discussed during health facility governing committees on a monthly basis and also be shared with external stakeholders. All

critical issues identified through those activities which need urgent attention shall be urgently discussed and reported to the DMO through DACC. The documents shall be appropriately filed for easy reference. After an external supervision or a mentoring is conducted, it must be documented and the report and action plan shall be shared with the health facility in-charge, facility QI team, site supervisors for their follow-up of the actions planned at the facility level. The original copy shall be appropriately filed for reference. All the documents shall be accessible and easily retrievable to internal and external supervisors.

9.7.2. Council Level

All regular supportive supervision and needs-based mentoring visits shall be documented using the standard tools. Summary reports with concrete action plan shall be submitted to the DMO immediately after the visits and shared with the relevant CHMT members, Council QI Team, district supervisors and mentors and implementing partner using existing meeting mechanisms. All technical issues that need follow-up actions by district mentors need to be discussed at the council level. Critical issues that need urgent regional or national attention and follow-up action (red flag issues) shall be discussed within CHMT and reported to the RMO and the NACP as soon as possible for further actions. Those are issues that include stock-outs of ARVs or HIV test kits or reagent, shortage of registers, broken refrigerator and CD4 machine. All important administrative issues shall also be shared with the DED for consultation and follow-up action. The original reports shall be appropriately filed in folders by health facilities and kept on a shelf for easy reference. All the documents shall be accessible and easily retrievable to CHMT and co-opted members and implementing partners at the district level.

9.7.3. Region Level

All regular supportive supervision and needs-based mentoring visits must be documented using the standard tools. Reports with concrete action plans shall be submitted to the RMO through RACC immediately after the visits and shared with the relevant RHMT members, Regional QI Team, regional supervisors and mentors and implementing partners through existing meeting mechanisms on a monthly basis. Technical issues that need follow-up actions by regional mentors need to be discussed at the regional level. Very critical issues identified through those activities, which need urgent national attention (red flag issues), shall be discussed and reported to the NACP as soon as possible. Administrative issues shall be also shared with the RAS for consultation and his/her follow-up action. The original reports shall be appropriately filed in folders by councils for easy reference. All the documents shall be accessible and easily retrievable to RHMT and co-opted members and implementing partners at the regional level.

9.7.4. National Level

All regular supportive supervision and needs-based mentoring visits shall be documented using the standard tools. Reports with concrete action plans shall be submitted to the PM of the NACP immediately after the visits and shared with the National QI Team, relevant NACP technical staff, national supervisors and mentors and implementing partners through existing meeting mechanisms. Very critical issues (administrative, logistical and technical) reported, which need urgent national attention, shall be discussed as soon as possible. Technical or logistical issues may need to be reported to the relevant directors or departments of the MOHSW for their actions depending on the magnitude and urgency of the issue. The original reports shall be appropriately filed in region folders for easy reference. All the documents shall be accessible and easily retrievable to national supervisors and mentors and implementing partners at the national level.

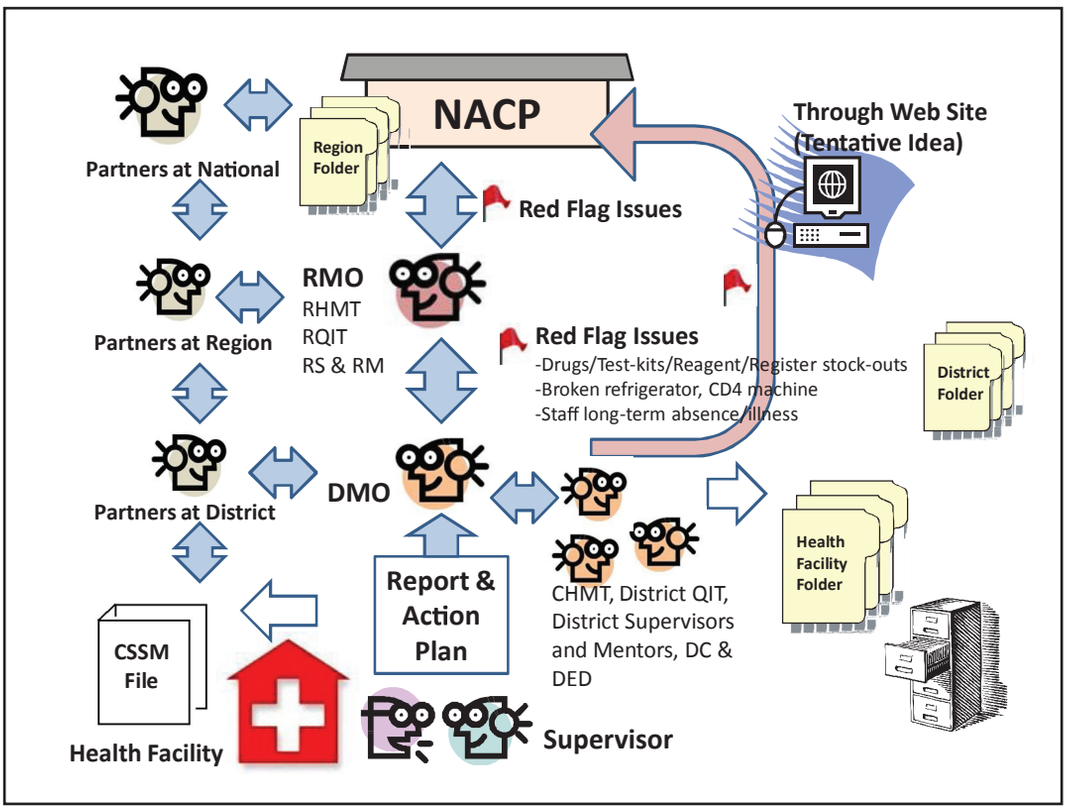


Figure 9.2. Documentation and Information Flow Mechanism

The figure above indicates the mechanism of documentation and information sharing in case of a supportive supervision from a CHMT to a health facility. The following is the explanation on the figure.

1) A team of supervisors conduct comprehensive supportive supervision (CSS).
2) The team shall compile CSS report with a concrete action plan fully discussed and agreed with the health facility.
3) The report shall be copied and kept at the facility for their action. It shall be submitted to the DMO and shared with the CHMT, District QI Team including District Supervisors and Mentors. Depending on issues emerging, it could be shared with the DED. Necessary follow-up actions at the council level shall be made including dispatch of mentors to the health facility.
4) The report shall be kept in the facility folder so that the report is easily retrieved and follow-up can be done easier.
5) The report can also be shared with partners for their attention.
6) If there are any urgent issues that need higher level attention (red flag issues), the DMO shall report to the NACP as well as the RMO for their action. NACP shall facilitate actions for problem solving. The report shall be stored at each level by specific folder for the council.
7) The information shall also be shared with partners at each level for their attention and assistance.

CHAPTER 10:

MONITORING AND EVALUATION

LEARNING OBJECTIVES:

By the end of the chapter, participants will be able to :

- **Define Monitoring**
- **Define Evaluation**
- **Describe the framework for Monitoring and Evaluation**
- **Describe the key features of Monitoring**
- **Describe the key features of Evaluation**
- **Describe the tools for Monitoring and Evaluation**
- **Explain the importance of Monitoring and Evaluation within the context of comprehensive supportive supervision and mentoring**

10.1. MONITORING

Monitoring and Evaluation (M&E) is at every stage of the process of supervision and mentoring. Notice that the process does not stop once you have implemented interventions to improve quality and performance. Rather, implementing interventions is linked back to finding out how your facility is performing through the important step of monitoring.

Monitoring is a very natural day-to-day process. For example, if you decide to take a new route to your working station in the morning because you think it can save you time, you will probably look at how much time it takes to get to the station and compare the time before and after you changed your route. If you find that the new route is faster, you are likely to continue to use the new route instead of the previous one. You wouldn't think of changing routes and not noting whether the change had an impact on what time you arrived at work.

10.1.1. Definition of Monitoring

Monitoring is a process for finding out whether the changes you intended to achieve have in fact been achieved. This implies that:

- Monitoring is the routine process of data collection and measurement of progress towards the programme objectives.
- Monitoring is therefore a tool for identifying strengths and weaknesses during implementation of the programme and for providing stakeholders with sufficient information to make the right and timely decisions.
- It involves counting what we are doing and routinely looking at the quality of our services.
- Monitoring focuses on **INPUT, PROCESS AND OUTPUT.** In other words, it is usually carried out to ascertain whether the activities are being implemented as planned and whether the activities are bringing about expected outputs. if not, study why, share the information with stakeholders and take necessary actions.

- Monitoring is an internal function in any programme or organisation.
- It uses assessment techniques to measure the performance of the organization, person, or specific intervention in order to:
    - make improvements or changes by identifying those aspects that are working according to plan and those that are in need of midcourse corrections, and
    - track progress toward the performance standards that were set.

As a supervisor, you need to be concerned with day-to-day monitoring of performance and quality as well as formal data gathering and analysis.

10.1.2. Steps of Monitoring

- First define what changes you intend to achieve and how those changes could be measured.
- Identify gaps between current performance and the set standards.
- Find root causes of the gaps.
- Describe what and how HSPs should do by setting specific standards for clinical procedures and support systems. Let the team know the interventions.
- Check the progress and find out how things are working at the facility, if progress is being made, if change is taking place, and if that change is positive, by using some combination of the following six ways:
    - Conduct self-assessment
    - Conduct peer assessment
    - Review service records and reports
    - Conduct supportive supervisory assessment
    - Obtain client feedback
    - Poll community perceptions
- Repeat the cycle of identifying the gaps, analyzing root causes and take appropriate actions if the interventions are not bringing actual performance closer to the standards set.

Change can occur as soon as you start to work with the team to make improvements. Monitor the impact of that change throughout the process. Do not wait until the end to see if there has been any change in performance. Just working with the team to identify strengths or root causes of problems can have a positive impact on performance. This is why there is a need to put in place a continuous assessment process using a combination of the methods listed above. Unless performance and quality at the facility is continually assessed, one cannot know if the interventions are progressing or situation is improving and what is making it improve.

10.1.3. Tools for Monitoring

The tools used for monitoring are checklists, action plans and recording and reporting tools.
They include:

1) **Checklists**

Serve for crosschecking actual performance against set standard

2) Action plans:

Action plans can serve as a very practical tool for monitoring specific activities being undertaken. The action plan has a column for "Result and How to Measure," which helps to detect whether or not the actions are having real results.

3) Recording and Reporting tools:

Key information should be collected for every service encounter for all services at all service provision settings, in order to monitor the service delivery against the set standards and to allow for useful analysis of HTC data. The key information shall be recorded on recording tools standardized at the national level. Quality completion of these recording tools is the foundation of monitoring performance and identifying trends in service delivery. All service providers should be trained to complete the recording tools for each client or patient. Service providers and programme managers should aggregate, analyze and collate the data for identification of areas for improving their services.

At the end of every month or quarter, the service provision sites should tally and summarize data from the recording tools and enter the information into the standard reporting forms. The information shall be shared with the facility supervisors and management for monitoring the progress and trend. Reporting forms then should be sent to the office of the District Medical Officer (DMO). The DMO's office shall aggregate, analyze and collate the data submitted by the service provision sites under their jurisdiction for assessing the progress. The DMO's office should share the information with the stakeholders for utilization in decision making. The DMO's office should submit the district summary to the office of the Regional Medical Officer (RMO) as well as give feedback to the service provision sites on data collection, data quality and service uptake trends. The RMO's office takes the same procedure for monitoring performance, sharing information and giving feedback and then submits the regional summary to the NACP. The NACP should manage the information at the national level for monitoring the progress, compiling reports for dissemination, providing information to decision makers for policy making, resource allocation and other decision makings as well as providing feedback to the regions.

For M&E to be done, data has to be collected and managed appropriately. The data management should be done through data management cycle as shown in Fig10.1.

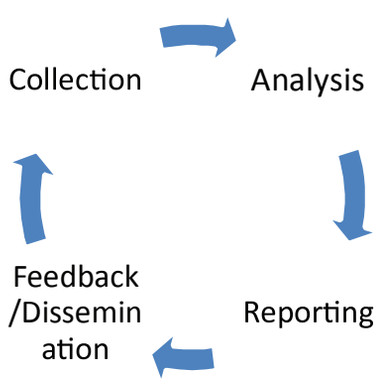


Figure 10.1: Data Management Cycle

10.2 EVALUATION

10.2.1. Definition of Evaluation

Evaluation is the process of demonstrating how much a specific intervention contributed to the changes being brought about in short and long period of time, i.e., **OUTCOME AND IMPACT**. It needs vigorous and

intensive investigation because there are many factors that cause things to change.
The measurement of how much things have changed because of the intervention(s) implemented. It is usually an external process with people from outside the facility coming in and assessing services.
It is important to keep in mind that evaluations are usually:

- formal assessments,
- implemented by a person or a group of people who are objective and external to the programme,
- resource-intensive, and
- carried out when someone has to demonstrate how much the situation has changed because of the intervention(s).
- focusing on what the intervention intended to achieve in a short-term and long-term period.

10.2.2. Key Features of evaluation

For evaluation there are should be clear purpose and objectives. What the evaluation wants to achieve is to determine what and how much changes had occurred due to specific interventions. A clear purpose or aim should lead the evaluators in designing the specific and clear evaluation objectives.

Objectivity is the term describing the nature of evaluation in which bias/confounders of the evaluation results are minimized or avoided. Objectivity is promoted by use of reliable and valid tools and use of clear, specific evaluation indicators. A tool is usually a predetermined checklist or questionnaires whereas the indicators is predetermined standard of care. Therefore, evaluation is a basis of quality improvement.

10.2.3. Data collection methods for evaluation

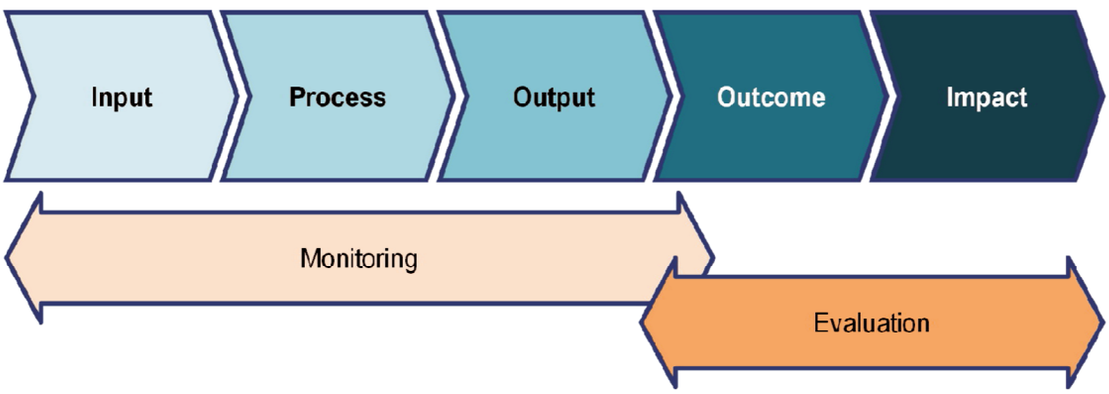
There are different methods of data collection such as:

- Chart review
- Surveys
- Data base review
- Interviews and questionnaires
- Focus group discussions

10.3. MONITORING AND EVALUATION FRAMEWORK

Varying frameworks are applied to M&E. During the past few years, one largely agreed framework has commonly been used is the **INPUT–ACTIVITY–OUTPUT–OUTCOME–IMPACT FRAMEWORK.** This reflects indicators used at different levels to measure what goes into a program or project and what results are achieved. For a program or project to achieve its goals, **input** such as money and staff time must result in **output** such as new services, trained staff, people reached with services, etc. These outputs are the result of **process** of specific activities, such as training for staff. If these outputs are meaningful and are achieved in the populations intended, the program or project is likely to have positive effects or **outcome** in the medium or longer term, such as increased condom use with casual partners, adherence to ARVs or later age at first sex among young people. These positive outcome should lead to changes in the long-term **impact** of programs, measured in fewer new cases of HIV and related burden of disease among those infected and affected (such as orphans and vulnerable children or widows). A desired impact among those HIV infected includes quality of life and life expectancy.

Measuring impact requires extensive investment in evaluation, and it is often difficult to ascertain the extent to which individual programmes, or individual programme components, contribute to overall reduction in cases and increased survival. In order to establish a cause-effect relationship for a given intervention, studies with experimental or quasi-experimental designs may be necessary to demonstrate the impact. Outputs or outcome indicators, however, can also be used to a certain degree to identify such relationships and can give a general indication of programmes progress according to agreed upon goals and targets.



input	Process	Output	Outcome	Impact
Fund Health Care Workers (HCWs) Trainers Training facility	Training on PMTCT services	Increased # of trained HCWs on PMTCT	Increased % of HIV+pregnant women received PMTCT services	Increased % of HIV- infants born from HIV+ mothers

Figure 10.2 M&E Framework

10.4. DIFFERENCES BETWEEN MONITORING AND EVALUATION

Monitoring and evaluation are two complementary, but separate functions, which often serve distinct purposes. Monitoring is the routine ongoing assessment of activities applied to assess resources invested (inputs) in the programme, services delivered (outputs) by the programme, outcomes that are related to the programme. Evaluation in non-routine assessment and will be concerned with evaluation of programme's impact on the health and lives of the people. The differences between Monitoring and Evaluation is summarized in the table below:

Monitoring	Evaluation
• Tracking input, process and output to assess whether programme is performing according to plans • Continuous process of measuring performance • Doesn't require study design • Doesn't require a control or comparison group	• Assessment of outcome and impact of the programme on behaviour or health outcome • Involves measurement over time • Requires study design • Sometimes requires a control or comparison group

Questions to be answered through M&E	
• What interventions and resources are needed? • Are we doing it right? • Are we implementing the program as planned? • How well are the services being provided?	• Are interventions working or making a difference? • What outcomes are observed/seen? • Are collective efforts being implemented on a large enough scale to impact the epidemic (coverage and impact)?

Monitoring and Evaluation shall go together because:

- Monitoring, as an internal process, assesses progress on a regular basis for the sake of on-the-spot management and decision making, while evaluation reflects on what has happened and is happening in order to improve the future. We rely on service providers for routine monitoring and data collection BUT NOT vigorous evaluation.
- Evaluation uses data and records built during the process of monitoring such as surveys to review performance and identify ways to make improvements.
- Therefore, monitoring and evaluation are complementary project management functions which ensure that the project is running on the right track.

10.5 MONITORING AND EVALUATION OF COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING

Mentoring, supportive supervision, and quality improvement are different activities but related and complementary functions – all with the aim of expanding and improving clinical services, especially at the primary health care health facility level. For example, the evaluation of a mentoring programme requires close coordination with the supportive supervision team. Clinical systems gaps identified by mentors can be fed back to the supportive supervision and QI teams for ongoing support and follow-up actions. Therefore, monitoring and evaluation of supportive supervision and mentoring activities should occur at all levels by the National Programme Leaders and Coordinators, RHMTs and CHMTs as well as mentors and partners.

Activities should include:

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

Handout 13a:
Group Activity and Role Play (Supportive Supervision)

Learning Objectives:

By the end of this session, supervisors will be able to:

- Make specific problem statement.
- Conduct comprehensive supportive supervision using the tool.
- Develop an action plan involving health facility staff.

Case Scenario

Buigiri Health Centre is located in Morogoro town. It has PMTCT, CTC, STI, TB/HIV, HBC, VCT and PITC, Laboratory and Pharmaceutical services for HIV and AIDS. The CTC has average of 50 clients per day. On 15th July 2011, the DACC of Morogoro town council, visited the facility for supportive supervision. During this supervisory visit, he supervised CTC In-Charge and Adherence Counselling Nurse of the facility. The following is his memo regarding the CTC service.

1. Guidelines are available.
2. Improper filling in CTC cards.
3. No indication of data analysis and data use.
4. One single room is shared by clinicians.
5. No flow pattern and triage system.
6. No CD-4 follow up every 6 months for both ART and Non-ART.
7. CTX prophylaxis is provided.
8. TB screening tool is available and used.
9. No PEP protocol displayed.
10. No action taken to loss to follow-up patients.
11. All clinicians were trained.
12. Only one nurse was trained.
13. Female condoms and a pelvic model not available.
14. The stock of some OI drugs will be sufficient only for the next one month.

1. **Group activity 1:**

   Respond to the following questions:

   a) Are there any vague statements in the DACC's memo? If yes, how can you improve the statements?

   b) Is there a need for mentor's intervention?

2. **Group activity 2:**

   Develop an action plan for the facility using the attached summary report format.

3. **Group activity 3: Role Play**

   By using the above scenario and the following additional background information with some instructions, conduct role play in groups. Rotate the roles within the group and practice supportive supervision by using the tool.

Roles:

Supervisor:

You are supervisor, who has been working as the District AIDS Control Coordinator (DACC) of the town council. Today, you pay a visit to the Buigiri Health Centre for supportive supervision. You start with the CTC and its dispensary using the comprehensive supportive supervision tool and record your comments on the tool. You give feedback to the CTC staff and develop an action plan for improvement with them.

Instructions to the supervisor:

1) Follow the process of comprehensive supportive supervision.
2) Ask questions and fill in the supportive supervision tool (Pages 117-120).
3) Identify strengths and areas for improvement.
4) Give feedback to the supervisees.
5) Identify areas that need a mentor to intervene.
6) Make an action plan with the supervisees.
7) Explain how to use the action plan.

✂----------

Supervisees (CTC in-Charge and Adherence Counselling Nurse):

You are the CTC In-Charge and an adherence counselling nurse of the CTC of the Buigiri Health Centre. The CTC started its operation two years ago. Since then, there have been 1,500 clients enrolled. It started with 2 clinic days per week; however, it operates 5 days per week now due to the high demand for the service. The CTC receives about 50 clients per day. The CTC has 3 clinicians, 3 nurses and 1 data clerk at the moment. Two of the 3 clinicians are retired clinical officers. You were informed of the supervision visit by the DACC one week before. Today, you are ready to receive him.

Instructions to the supervisees:

1) Respond to the questions in accordance with the information provided in the above scenario.
2) Respond to the feedback.
3) Make an action plan with the supervisor and agree the actions and timeline.

Care & Treatment (C & T)

Check Items	Status and Comments	Action Points and Responsibility
Q1. Average number of clients attended at CTC per day		
Q2. Availability and utilization of the following latest documents 1) National guidelines 2) SOPs 3) Protocols (e.g. PEP)		
Q3. Data management 1) Availability and correct usage of Recording and Reporting tools Forms a) CTC 1 and 2 b) Patient clinical chart/ file & sheets 1st visit c) Lab request forms d) Referral forms e) Pre/ART registers f) Pharmacy ART registers g) Electronic Database 2) Data flow 3) Filling and Storage of Data/Reports 4) Data analysis, use and dissemination		
Q4. Space adequacy 1) Waiting space 2) Room for triage 3) Consultation rooms 4) Record keeping room 5) Others (Specify)		

Q5. Patient flow and triage system 1) Availability of patient Flowchart 2) Provision of information, identifying clients with immediate needs, taking patient's weight, retrieving files, filling CTC 1&2, directing to next unit etc.		
Q6. Testing records 1) Pre-ART patients for CD4 every 6 months (check records) 2) ART patients for CD4 every 6 months (check records) 3) Essential biochemical		
Q7. Provision of Cotrimoxazole prophylaxis to eligible HIV patients		
Q8. Screening all PLHIVs for TB at each visit (check records) Availability of Active TB Screening Tool		
Q9. Availability of PEP services 1) For HSPs with occupational exposure 2) General public (e.g. Rape cases) 3) PEP records		
Q10. Loss to follow-up and how they deal with it		
Q11. 2nd line ARV regimen 1) Availability 2) Proportion of patients on the 2nd line regimen		

Q12. Referral and linkage system in place 1) Internal 2) External		
Q13. Staff training Triage nurse, doctor, treatment nurse and adherence nurse		
Q14. Availability of IEC 1) C&T specific IEC materials 2) AV equipments 3) Others (Specify)		
Q15. Availability of equipment and commodities 1) Condoms and demonstration tools 2) Infection control supplies 3) BP machine 4) Stethoscopes 5) Weighing machine 6) Height measuring device 7) Others (Specify)		

Challenges in Providing C&T Services

Summary Report Format:

Name of the Facility:			
Date of Visit:			
Supervisors:	**Name**	**Designation**	**Organization**
Supervisee:	**Name**	**Intervention/service**	**Organization**

1. Summary of Strengths

C & T	

2. Summary of Challenges and Action Plan

	Challenges / Issues	Action Points	Responsibility	Timeline
C & T				

Handout 13b:
Role Play (Patient-Mentee-Mentor Interaction)

Learning Objective:

By the end of this session, the participants will be able to:

- Identify strengths and areas for improvement of the mentor

Case Scenario:

Mr. Michael Swai is a clinical officer working for a health centre at OPD. He has 4 years experience on syndromic management of STIs/RTIs. For the past three years, he has been skipping some of the procedures in providing STIs/RTIs services. This was due to the large number of clients he has to attend on daily basis. He was told by the facility-in-charge to observe the standard procedures but he ignored the instruction. He was informed by the DACC that he will be visited by a mentor, Dr. Mary Mwalilo from Mbeya District Hospital. He has never heard about mentorship and feels a little nervous.

Upon arrival, Dr. Mwalilo finds Mr. Swai on his routine clinical practice. His next patient is Mrs. Flora Kisangi, a 30-year-old married female patient, who has a complaint of lower abdominal pain accompanied with vaginal discharge. Mr. Swai remembers her but doesn't remember her previous complaint due to the poor recording. Mr. Swai attends to Mrs. Flora Kisangi as usual and skips some of the procedures such as history taking, general examination, partner notification, condom demonstration and offering an HIV test to STI clients.

ROLES:

Instruction to the Mentor:

- Use mentoring skills for mentorship

Instruction to the mentee:

- Attend the patient according to the scenario

Instructions to the patient:

- Respond to the clinical officer realistically.
- Use the background information below when you are prompted by the clinician.
- You may make up additional information as needed but be consistent with the role.

  Background Information of the patient:

  You are a patient, Mrs. Flora Kisangi, who is 30 years old and married. Your husband is a long-distance truck driver who frequently travels to far places. You are a sincere Christian and have never had any affairs outside your marriage. Three months ago, you came to the clinic with the same kind of symptoms and was treated and cured. In fact, this is the third time you visit the health centre for the similar symptoms in this year. You have neither been told to bring your husband for treatment nor how to prevent the infection. You have never been tested for HIV before and have a deep concern about the possibility of being infected with HIV. However, you cannot express the concern to anybody. You wonder if the doctor could attend your concern.

Instruction to the Observer:

- Check if the mentor is taking proper stages of mentoring process using the following checklist.

Stage/Process	Comments
Pre-mentoring planning	
Arrival at mentoring site	
Establish a warm mentoring climate	
Arriving at a mentoring agreement with mentee	
Review records	
Establishing warm care environment for client/ patient	
Begin client/patient care encounter with mentee	
Identifying teaching moments	
Client/Patient education and instruction	
Between clients/patients	
Next client/patient	
Post mentoring feedback session	
Planning the way forward	
Documentation and reporting	

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ANNEX

TRAINING COURSE SCHEDULE FOR COMPREHENSIVE SUPPORTIVE SUPERVISION AND MENTORING OF HIV AND AIDS HEALTH SERVICES

DAY 1: PLENARY

Time	Topic/Activity	Responsible
08.00-09.00	Opening: • Registration, Welcome and Opening remarks, Introductions, Ground Rules, Admin issues, Participants' expectations	
09.00-09.40	Pre-course questionnaire (30 min)	
09.40-10.10	Session 1: Course Overview: • Goals, objectives and schedule • Review course materials	
10:10-11:00	Session 2: Overview of HIV and AIDS Services in Tanzania	
11.00-11.30	TEA BREAK	
11.30-13.10	Session 3: Principles of Adult Learning, Communication Skills	
13.10-14.10	LUNCH	
14:10-15.00	Session 4: Effective Coaching in Comprehensive Supportive Supervision and Mentoring	
15.00-16.00	Session 4: Coaching Role Play	
16.00-16.15	Daily Evaluation	
16.15-16.30	TEA BREAK	
16.30-17.10	Facilitators' Meeting	

DAY 2: PLENARY

Time	Topic/Activity	Responsible
08.00-08.30	Agenda and recap	
08.30-09.45	Session 5a: Introduction to Quality of Care in Health Services	
09.45-11.25	Session 5b: Case Study - Application of PDSA Model and 5Ss	
11.25-11.50	TEA BREAK	
11.50-13.40	Session 6: Supportive Supervision	
13.40-14.40	LUNCH	
14.40-15.40	Session 7a: Mentoring	
15.40-16.40	Session 8: Relationship between CSS and Mentoring	
16.40-16.55	Daily Evaluation	
16.55-17.10	TEA BREAK	
17.10-17.50	Facilitators' Meeting	

DAY 3: PLENARY

Time	Topic/Activity	Responsible
08.00-08.30	Agenda and recap	
08.30-09.50	Session 7b: Case Study – PMTCT Mentoring	
09.50-10.20	TEA BREAK	
10.20-11.50	Session 9: Structure and Functions of National Comprehensive Supportive Supervision and Mentoring Systems	
11.50-12.50	Session 10: Monitoring and Evaluation	
12.50-13.50	LUNCH	
13.50-14.50	Session 10: Monitoring and Evaluation (Group Activity)	
14.50-15.50	Session 11: Orientation for field practicum	
15.50-16.05	Daily Evaluation	
16.05-16.20	TEA BREAK	
16.20-17.00	Facilitators' Meeting	

DAY 4: TWO GROUPS

Time	Topic/Activity			
08.00-8.30	Agenda and recap			
	Group A: Supportive Supervisors Group	Responsible	Group B: Mentors Group	Responsible
08.30-09.30	Session 12a: Review of Supportive Supervision Process		Session 12b: Review of Mentoring Process	
09.30-10.30	Session 12a: Introduction to Supportive Supervision Tools		Session 12b: Introduction to Mentoring Tools	
10.30-11.00	TEA BREAK			
11.00-11.30	Session 12a: Cont…		Session 13b: Role Play and Practice	
11.30-13.00	Session 13a: Group Activity and Role Play			
13.00-14.00	LUNCH			
14.00-15.30	Session 13a: Cont…		Session 13b: Cont…	
15.30-16.00	Field Practice Team Meeting			
16.00-16.15	Daily Evaluation			
16.15-16.35	TEA BREAK			
16.35-17.00	Facilitators' Meeting			

DAY 5: FIELD PRACTICE BY TEAMS OF SUPERVISORS & MENTORS

Time	Topic/Activity	Responsible
08.00	Departure to the respective health facilities	
08.30-14.00	Field Work 1) Courtesy to the health facility management team 2) Supportive Supervision and Mentoring Practice 3) Internal group meeting 4) Feedback session	
14.00-14.30	Travel back to the conference venue	
14.30-15.30	LUNCH	
15.30-16.30	Participants Compiling report from Fieldwork	
16.30-16.45	Daily Evaluation	
16.45-17.00	Facilitators' Meeting	

DAY 6: PLENARY

Time	Topic/Activity	Responsible
08.00-08.40	Post-course Questionnaire (30 min)	
08.40-10.30	Presentation of Action Plans	
10.30 -11.00	Tea Break	
11.00-11.30	Reviewing Action Plans to Incorporate Comments	
11.30-11.45	Final Course Evaluation	
11.45-12.30	Feedback on Pre, Post course assessment and end of course evaluation	
12.30-13.00	Closing	
13.00-14.00	LUNCH	
14.00-15.00	Facilitators Meeting (Summary and report writing assignment)	
15.00-15.30	Clearing the venue	

CONTACTS

Ministry of Health and Social Welfare

National AIDS Control Programme

P.O. Box 11857

Dar es Salaam, Tanzania

Tel: +255 22 2131213 Fax: +255 22 2127175

Web: http://www.nacp.go.tz

Japan International Cooperation Agency