Federal Ministry of Health Ethiopia

Participant Manual

For the

Clinical Mentoring Training Course

August, 2018

Foreword

Achieving and maintaining acceptable levels of quality of care in the view of decentralization and rapid scale up of HIV prevention, care and treatment in Ethiopia is a matter of concern. But providing good quality health care to the increasing number of PLHIV is a great challenge mainly due to lack of resources. One strategy in response to the human resource constraints of HIV/AIDS activities in Ethiopia is task-shifting. While performing task-shifting activities, we have to maintain quality of HIV/AIDS services in the health facilities. Even though many factors govern HIV service quality, a well-designed and coordinated clinical mentoring program is taken as an immediate option of interventions to achieve and maintain the desired quality of HIV care/ART.

It is evident that clinical mentoring has been practiced by different stake-holders in the country which significantly contributed to the scale up of HIV/AIDS programs. At this time when the government is integrating clinical mentoring activities into the existing health care system so that regional health bureaus would take responsibility to coordinate the endevour. To this effect and to address sustainability issues of the program, a nationally agreed upon guideline and standardized training manuals are crucial. Therefore, these National HIV Care/ART Clinical Mentoring Training Manuals are developed through consultations and active participation of partners under the guidance of FMOH.

It is our hope that health care providers and program managers will benefit from these standardized training manual to provide quality care and treatment services.

Finally, I would like to express my sincere thanks to CHAI-Ethiopia Country Office for technical and financial support in finalizing this document.

Kebede Worku (MD/MPH)

State Minster, Ministry of Health

APPROVAL STATEMENT OF THE MINISTRY

The Federal Ministry of health of Ethiopia has been working towards standardization and institutionalization of In-Service Trainings (IST) at national level. As part of this initiative the ministry developed a national in-service training directive and implementation guide for the health sector. The directive requires all in-service training materials fulfill the standards set in the implementation Guide to ensure the quality of in-service training materials. Accordingly, the ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST implementation guide.

As part of the national IST quality control process, this Clinical Mentoring Training Course has been reviewed based on the standardization checklist and approved by the ministry in August, 2018.

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Table of Contents

Rationale of the training

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

Decentralizing HIV care and treatment is linked with the national Health Network Model which is crucial for effective prevention, building ART pipeline, ensuring the continuum of care and quality service.

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

Sustainability of a public health intervention depends much on crafting a doable framework which is well aligned with the existing health infrastructure. Even though implementing partners was working on health system strengthening, significant site levels technical support was also part of their activity especially with regard to clinical mentoring. Recently however FMoH, in collaboration with IPs and other stakeholders developed a national transition plan for HIV care and treatment services. In this transition framework, integration of clinical mentoring in the health system is considered as one of the key elements. In line with this the clinical mentoring training materials has been developed to equip the clinical mentors with clinical mentoring knowledge and skills as well as to aware them how the clinical mentoring is being integrated in the existing health system.

This training package has the following core competencies

- Effectively apply clinical mentoring steps during clinical mentoring visits
- Apply effective communication skills to provide constructive feedback
- Demonstrate clinical skills to mentee during clinical mentoring visits
- Demonstrate relevant recording and reporting needs during clinical mentoring visits
- Provide consultations through telephone and other technologies as required to mentee

Course Syllabus

Course Description

This is a five days in-service training designed to enable participants initiate and maintain clinical mentoring for health care providers in order to maintain the quality of care provided at all levels in a similar fashion.

Goal of the Training

This training is designed to enable health care workers become a knowledgeable and skilled clinical mentors.

Objectives of the Training

After completing this course, participants will be able to:

- describe the magnitude of HIV epidemic current status and the national response
- explain the basic principles of adult teaching required during the clinical mentoring process
- describe the theoretical concepts of clinical mentoring and its relationship with supportive supervision
- explain the basic interpersonal communication skills of clinical mentoring
- Describe how to Initiate and maintain clinical mentoring as per the national guide line.
- explain the national health system structure
- list the available HIV related services at the health facilities
- describe the recording and reporting system of the HIV program for clinical mentors
- provide updated knowledge and skills on HIV case management

Target audiences

- Clinical mentors
- Health program managers working at FMoH, RHBs, ZHDs, W-HO and health facility
- Health Professionals working in development partners including local universities

Participant Selection criteria

Participants of this training will be health care providers working in HIV care and treatment clinics of selected mentor health facilities who have had taken the comprehensive HIV care and treatment training.

Trainer Selection criteria

- Trainers will be selected by the organizing institute.
- The team should consist of Course director and two facilitators per room.
- The training course director and the facilitators should be well versed with the area of the training and have completed TOT in the clinical mentoring training.

Course Evaluation

There will be three methods to assess and evaluate participant learning and the usefulness of the course.

A. Pre & Post-Test Assessment

An anonymous pre-test assessment and post-test assessment will enable course coordinators to evaluate the transfer of knowledge. Provide participants 20 minutes at the beginning of day one to complete the pretest assessment and time at the end of the last day to complete the same test again. A copy of the pre-test assessment is provided in the Facilitator's Guide (Annex 1).

If time allows, review answers to the assessment together as a group. The answers to the pre/posttest assessment are provided to trainers in the Facilitator's Guide.

B. Daily Course Evaluation

Ask participants to write or discuss responses to the following three questions (Annex 2):

1. What is the most important information/activity you learned today?
2. What did you **not** like about the training today?
3. Training organization & content of the training related questions

Review the feedback after each day's training. Take particular note of the questions participants provided. Prepare responses and use these to begin the next training session.

Teaching aids/materials

- Blank flip chart and markers
- LCD Projector and Screen
- Updated slides
- ARV treatment Guideline and other references

Training Methods

It has 2 basic types of approaches: Classroom sessions and practical sessions.

- **Class room sessions include:**
  - Overview of HIV/AIDS Program
  - Adult teaching Methodology
  - Introduction to Clinical Mentoring
  - Interpersonal Communications Skill
  - Initiation and Approaches to Clinical Mentoring
  - Adult and Pediatrics Case Studies
  - Simulation of Mentoring Activity
- **Practical Session includes:**
  - Practical attachment to ART clinics for observation of clinical mentoring
  - Practical attachment to ART clinics to conduct clinical mentoring

Certification criteria

Certificates of successful completion will be provided if a participant scores 80% or better in post-course knowledge assessment and if s/he is competent in skills assessment. Participants should attend all sessions of the course to be eligible for this certificate.

Course duration

The course duration is five days.

Suggested class size

The class size suggested is 15-20 with three facilitators.

Training Venue

This training will be delivered in accredited IST centers.

Trainers/Facilitators

- The training course director will ensure the availability of full package of training materials, trainees and trainers, and will follow the daily progress of the training by conducting daily meetings with the facilitators/trainers.

- The training team leader will also ensure the suitability of the training rooms, and other logistics.

Schedule/Course agenda

Day 1	**Time**	**Activity**	**Responsible**	**Remark**
	8:30 – 9:00	Registration		
	9:00 – 9:10	Opening Speech		
	9:10 – 9:20	Introduction of Participants and Setting norms		
	9:20 – 9:30	Expectations & Objectives of the training		
	9:30 – 9:50	Pre-test		
	9:50 – 10:30	Chapter 1: Overview of HIV/ AIDS In Ethiopia		
	10:30 – 11:00	**Tea Break**		
	11:00 – 12:30	Chapter 2: Adult Teaching Methodology		
	12:30 – 1:30	**Lunch Break**		
	1:30 – 3:30	Chapter 2: Adult Teaching Methodology contd…		
	3:30 – 4:00	**Tea Break**		
	4:00 – 5:00	Chapter 3: Introduction to Clinical Mentoring		
	5:00 – 5:30	Wrap-up		
Day 2	**Time**	**Activity**		
	8:30 – 12:00	*Practical Attachment & Plenary session in small groups		
	12:00 – 1:30	**Lunch Break**		
	1:30 – 3:00	Chapter 4: Interpersonal Communications Skill		
	3:00 – 3:30	**Tea Break**		
	3:30 – 5:30	Chapter 5: Initiation and Approaches to Clinical Mentoring		
Day 3	**Time**	**Activity**		
	8:30 – 12:00	*Practical Attachment & Plenary session in small groups		
	12:00 – 1:30	**Lunch Break**		
	1:30 – 3:30	Chapter 7: Adult Case Studies		

	3:30 – 4:00	**Tea Break**		
	4:00 – 5:00	Chapter 7: Adult Case Studies contd…		
	5:00 – 5:30	Wrap-up		
Day 4	**Time**	**Activity**		
	8:30 – 12:00	*Practical Attachment & Plenary Session in small groups		
	12:00 – 1:30	**Lunch Break**		
	1:30 – 2:30	Chapter 6: HIV related Services and Health Network Model		
	2:30---3:30	Peculiarities in HTS and PMTCT Mentoring		
	3:30 – 4:00	**Tea Break**		
	4:00 – 5:00	Chapter 7: Pediatrics Case Studies		
	5:00 – 5:30	Wrap-up		
Day 5	**Time**	**Activity**		
	8:30 – 12:00	*Practical Attachment		
	12:00 – 1:30	**Lunch Break**		
	1:30 – 3:30	Chapter 7: Pediatrics/PMTCT Case Studies contd…		
	3:30 – 4:00	**Tea Break**		
	4:00 – 4:20	Post-test		
	4:20 – 4:35	Course Evaluation		
	4:35 – 5:00	Certificate and Closing		

Chapter 1: Overview of HIV/AIDS in Ethiopia

Chapter description

This chapter is intended to describe the situation of HIV epidemic in Ethiopia and the responses to the epidemic so far. Additionally, the chapter describes the current national ART program status.

Primary Objective

By the end of the chapter the participant is expected to describe the epidemiology of HIV in Ethiopia and respective responses to the epidemic.

Enabling Objectives

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

- Describe the magnitude and trends of the HIV epidemic in Ethiopia
- Explain the national response against HIV/AIDS including major policy and strategic directions
- Describe the current status of the Ethiopian ART/PMTCT program

Chapter outline

1.1. Background

In Ethiopia, the first confirmed cases of HIV were detected in 1984 and the first hospitalized AIDS patients were reported in 1986, suggesting that the HIV epidemic had probably began in the late 1970's or early 1980's. The first sero-survey conducted in 1984-85 among military recruits showed a prevalence of 0.07. Initially, the epidemic was localized in urban areas, along the major commercial routes and among certain occupational groups. By 1988, high rate of HIV prevalence (17%) were detected among commercial sex workers residing along the main trading roads and long-distance truck drivers (13%). In some urban areas, prevalence rate as high as 38% were recorded among sex workers. In Addis Ababa, HIV prevalence rate in female commercial sex workers rose rapidly, from 24.7% in 1988 to 54.3% in 1990.

Since HIV incidence data generating systems were almost non-existent, at the beginning of the epidemic, sero-prevalence data from specific populations have been the only option to estimate the

magnitude and monitor the trend of the HIV epidemic in the country. Like in other African countries throughout the continent, the main source of HIV prevalence data in Ethiopia has been from sentinel surveillances on pregnant women attending antenatal clinics (ANC). ANC-based HIV prevalence monitoring in urban Ethiopia was initiated as early as 1989, but expansion to rural areas has occurred only since 2001.

1.2. Epidemiology of HIV/AIDS

Global

HIV continues to take a tremendous toll on human health, having claimed more than 35 million lives so far. In 2015, about 1.1 million people died from HIV-related causes globally. There were approximately 36.7 million people living with HIV (PLHIV) at the end of 2015 with 2.1 million people becoming newly infected with HIV. Sub-Saharan Africa is the most affected region, with 25.6 million PLHIV and accounts for two-thirds of the global total of new HIV infections.

Between 2000 and 2015, new HIV infections have fallen by 35%, AIDS-related deaths have fallen by 28% with some 8 million lives saved. This achievement was the result of great efforts by national HIV programs supported by civil society and a range of development partners. Expanding Anti-Retroviral Treatment (ART) to all PLHIV and expanding prevention choices can help avert 21 million AIDS-related deaths and 28 million new infections by 2030. The world has exceeded the AIDS targets of Millennium Development Goal (MDG) 6, halting and reversing the spread of HIV, and more and more countries are getting on the Fast-Track targets to end the AIDS epidemic by 2030 as part of the Sustainable Development Goals (SDGs).

N*ational*

Currently the data sources for HIV prevalence estimations in Ethiopia are ANC sentinel surveillances and national Demographic and Health Surveys (DHS). According to 2016 EDHS estimate, the adult HIV prevalence for 2018 is 0.9% of which 2.9% is urban and 0.4% is rural. The 2016 EDHS also showed that the HIV prevalence varies from region to region ranging from less than 0.1% in Somali to 4.8% in Gambella. According to HIV Related Estimates and Projections for Ethiopia by EPHI the estimated number of people living with HIV is 610,335, of which 56,515 are children and 379,251 are female .The number of peoples who are in need of ART are the same since 'Treat all' is adopted by Ethiopia since 2017. Besides, an estimated 13,556 people will be newly infected during 2018, of which 2993 are children. An annual AIDS death for 2018 is estimated to be 10,374.

Urban versus rural trends

Throughout the epidemic period the estimations at hand show the urban prevalence of HIV in Ethiopia surpass significantly those of rural areas. The reason can be due to the differences in socio-economic and structure that make urban dwellers more vulnerable for HIV infections. The trends show that there is significant declining of HIV prevalence in urban areas. According to national estimates HIV prevalence declined from 7.9 % in 2004 to 3.3% in 2014 in urban areas of the country. The data on rural areas show no significant decline, rather they show stabilization. For instance, the prevalence in rural areas was 1.0 % in 2004 and stabilized on 0.5% from 2012 to 2014. According to EDHS 2016 the current urban HIV prevalence is 2.9% whereas the rural prevalence is 0.4%.

The national response to HIV/AIDS Epidemic

Ethiopia responded to the HIV epidemic promptly by establishing a taskforce in 1985 soon after the report of the first confirmed case of HIV. Two years later, in 1987, the national taskforce was upgraded to a department level under Federal Ministry of Health (FMOH). The department had the responsibility of coordinating the national prevention and control program. Subsequently, short-and medium-term plans were prepared and implemented in collaboration with national and international partners. However, the National AIDS Policy was issued only a decade later (1998). Further, in 1999, the Strategic Framework for the National Response against HIV was prepared. Both documents served as the basis for the expanded and multi-sectoral response against the epidemic.

Despite the prompt initial response, the national response was evaluated to be slow and interrupted. As a result, further restructuring in the response mechanism was required. In April 2000, the National AIDS Council (NAC) was established with secretariat offices from federal down to Kebele levels. This further evolved into an office, the HIV/AIDS Prevention and Control Office (HAPCO), in 2002.

The 1998 Ethiopian HIV Policy and The Strategic Plan for Management (SPM) of 2010 – 2014 have clearly articulated guiding principles including: multi-sectionalism, shared sense of urgency, ownership and active involvement of the community, leadership commitment, partnership, gender sensitivity, public health approach, promotion and protection of human rights, greater involvement of PLHIV, and best use of resources, equitable and universal access, sustainability and coordination.

Since December 2007, the Health Programs Department (HPD) in FHAPCO is charged with the responsibility of coordinating the health sector response against HIV/AIDS in Ethiopia. The major

components of this comprehensive response include: HIV testing and counseling (HTSHTS), prevention of mother-to-child transmission of HIV (PMTCT), Infection Prevention (IP), antiretroviral therapy (ART), opportunistic infection (OI) management, and ensuring the quality of all services.
Since 2010 onwards the health sector response has been under the Disease prevention and control directorate of FMoH while HAPCO has been in charge of the multispectral response.

Ethiopia has achieved exemplary successes in terms of HIV service expansion and uptake, which impacted to a 95% decline of new HIV infection from 1994 to 2012 and 73 % reduction of AIDS deaths compared to the periods 2006 to 2016 respectively. Ethiopia has developed HIV/AIDS prevention care and treatment strategic plan in an investment case approach which is being implemented from 2015-2020. This strategic plan aims to pave the path for ending AIDS by 2030 through averting 70,000- 80,000 new HIV infections and saving about half a million lives till 2020. The targets set in this investment case are in line with the three 90's (90-90-90) targets set by UNAIDS to help end the AIDS epidemic. Ethiopia under the leadership of FHAPCO has revitalized HIV prevention to make it the community and public agenda with the vision of preventing new HIV infection and Ending AIDS by 2030.

1.3. ART program in Ethiopia

As was elsewhere, Ethiopia's initial response to the epidemic had primary focus on prevention, with little attention to treatment. With the introduction of highly active antiretroviral therapy (HAART) in resource-limited settings in early 2000's, Ethiopia was among the first few African countries to introduce ART in 2003 in selected health facilities following the issuance of the national antiretroviral drugs (ARVs) supply and use Policy in 2002. The first adult treatment guideline was issued in 2003, and it has been revised (in 2005, 2007, 2014 and 2017). Also, a pediatrics treatment guideline was developed in 2007. The current guideline, revised in 2017, is comprehensive that consolidates HIV prevention, care and treatment interventions.

Ethiopia started its free ART program in early 2005 and since then a lot of lives have been saved due to the concerted efforts of the government and its partners. However, until recently, like many other countries, Ethiopia, has provided ART only for patients who reached a specific threshold in HIV disease progression. Starting ART used to impose long waits and multiple clinic visits which could lead many patients to drop out of care before they even begin treatment. Ethiopia addressed this by

implementing ‘Test & Start’ strategy which enables all people diagnosed with HIV to start ART regardless of their clinical staging and CD4 count status.

In 2016 around 398,277 adults and 21,686 children under the age of 15 are taking ARV. Based on the spectrum estimate the 2017 ART need is 665,116 for adults and 57,132 for children under 15 years of age. Recently ART service is being available in more than 1224 Health facilities of which around 909 are Health centers. On the basis of the new spectrum estimate for 2016, ART coverage for adults (age 15+) has reached 61% but the coverage remains low (33%) for children (age <15) living with HIV.

Summary

- There were approximately 36.7 million people living with HIV (PLHIV) at the end of 2015 with 2.1 million people becoming newly infected with HIV.
- Sub-Saharan Africa is the most affected region, with 25.6 million PLHIV and accounts for two-thirds of the global total of new HIV infections.
- According to EPHI estimates and projections for Ethiopia for 2017, the national HIV prevalence is 1.16%.

Chapter 2: Adult learning Methodology

Chapter Description

This chapter describes the adult teaching methodologies that participants need to use during every mentoring session after the training.

Primary Objective

By the end of the chapter the participant is expected to list and explain adult teaching methodologies.

Enabling Objectives

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

- Describe the key features of adult learning.
- Identify three basic styles of learning.
- Apply basic principles of adult learning.
- Use training methods and group process skills effectively.
- Describe the role of a trainer as leader and as a coach.
- Provide feedback to adult learners.

Chapter Outline

2.1. Introduction to Adult Learning

Adult learning is a theory, pioneered by Malcom Knowles. Adults learn differently from children and require different training approaches. An effective clinical training is usually designed and conducted according to adult learning principles whose features stress on learning as participatory, relevant and practical.

Whenever there is an opportunity and a need to practice skill (skill acquisition, skill competency and proficiency), adults learn better in more realistic conditions. It should also be noted that repetition is one condition for participants to become competent and proficient, particularly in skill acquisition. Adult Learning becomes more effective when a feedback is included in the process of learning.

Experience and Learning *"To children, experience is something that happens to them; to adults, their experience is who they are."* (Malcolm Knowles, "Father" of Adult Education).

2.2. Features of Adult Learning

1. Adults feel anxious if participating in a group makes them look weak, either professionally or personally.
2. Adults bring a great deal of experience and knowledge to any learning situation, and likes to be respected.
3. Adults are decision-makers and self-directed learners.
4. Adults are motivated by information or tasks that they find meaningful.
5. Adults have many responsibilities and can be impatient when their time is wasted.

1 - Adults feel anxious if participating in a group makes them look weak or uninformed

Because learning is enhanced by challenge and inhibited by threat, establish an environment where participants feel safe and supported; where individual needs and uniqueness are honored; where abilities and life achievements are acknowledged and respected. Treat participants as peers, accepted and respected as intelligent experienced adults whose opinions are listened to, honored, and appreciated.

- Design training workshops, educational exercises, and discussion sessions that help people feel:
  - Safe to ask questions.
  - Confident that they will be respected.
- Provide clear instructions for group activities so that participants know what is expected of them.
- Provide opportunities and allow time for people to establish themselves in a group.

2 - Adults bring a great deal of experience and knowledge to any learning situation and likes to be respected.

- Adults like to be given opportunity to use their existing foundation of knowledge and experiences gained from life experience and apply it to their new learning experiences.

As a clinical mentor:

- Adults want to test what they learn with what they already know. Encourage them to answer questions from their own experience.
- Don't just present information as truth… Use people's different experiences to encourage questioning and discussion so that they can arrive at the truth for themselves.
- Assist them to draw on those experiences when problem-solving, reflecting and applying clinical reasoning processes.
- Facilitate reflective learning opportunities which can also assist the trainee to examine existing biases or habits based on life experiences and "move them toward a new understanding of information presented".

Respect can be demonstrated to your mentee by:

- acknowledging the wealth of experiences that the mentee brings;
- Regarding them as a colleague who is equal in life experience
- Encouraging expression of ideas, reasoning and feedback at every opportunity.

Recognize that they may be a good resource for learning about HIV and ART. An assessment of participants' experiences and knowledge can tell you more about them which:

- Can be done before or on first day of training with a short questionnaire or
- orally during introductions

3 - Adults are decision-makers and self-directed learners

Deliver content that has immediacy; people learn best what they can apply right away. Facilitate self-directed learning, where participants make action plans and take responsibility for their own on-going, professional development. Provide opportunities for participants to give feedback and input to the learning process, and to give and receive feedback and input from trainers and other participants.

- Do not seek to make people obey you; adults will do what they need to do
- Listen to what they want and need, and be flexible in your planning.
- Change your approach if your agenda or methods are not working.

- Seek feedback from the group.

4 - Adults are motivated by information or tasks that they find meaningful

- Adult learners want to know the relevance of what they are learning to what they want to achieve.
- Adults prefer to focus on real life, immediate problems rather than on theoretical situations.

As a clinical mentor:

- Determine what people want (and need) to learn based on their job responsibilities and provide useful information that is relevant to their needs.
- Find out how much they already know.
- Ask them what challenges they have had in their work with treating positive clients.
  You may get different responses from different groups of participants. Focus on what they need in the jobs they perform and the patients they see.

5 - Adults have many responsibilities and can be impatient when time is wasted

- Be thoughtful, kind and respectful.
- Begin and end your session on time.
- Understand who is in the audience and why they are participating.
- Learn what questions they have about the subject.
- Don't cover material they already know unless there is a good reason for review.

Therefore, an Adult trainer should be an interactive trainer who is capable to facilitate and coach focusing on learner, collaborating and cooperating. S/He is someone who empowers learners to be the source of their own authority and encourage participants to manage themselves believing that everyone in the group, including the trainer is a learner.

Group processing skills

Adult education and learning involves group– based trainings. A trainer has to assume leadership of a group and acts as a coach and therefore must work with the individual members to encourage his/her supportive network.

Table 1 Appropriate method to address Adult Learning needs

Adults learn best when	Matching adult learning needs with appropriate methods
1. They feel valued and respected for the experiences and perspectives they bring to the training situation.	1. Elicit participants' experiences and perspectives through a variety of stimulating activities.
2. The learning experience is active rather than passive.	2. Actively engage participants in their learning experience through discussion and a variety of activities.
3. The learning experience fills their immediate needs	3. Identify participants' needs; develop training concepts and learning objectives to the identified needs
4. They accept responsibility for their own learning	4. Make sure that training content and skills are directly relevant to participants' experiences so that they will want to learn.
5. Their learning is self-directed and meaningful to them.	5. Involve participants in deciding on the content and skills that will be covered during the training.
6. Their learning experience addresses ideas, feelings, and actions.	6. Use multiple training methods that address knowledge, attitudes, and skills participants already know
7. New material relates to what participants already know	7. Use training methods that enable participants to establish this relationship and integrate new material
8. The learning environment is conducive to learning.	8. Take measures to ensure that the physical and social environment (training space) is safe, comfortable, and enjoyable
9. Learning is applied immediately.	9. Use training methods that allow participants to practice new skills and receive prompt, reinforcing feedback.
10. Learning is reinforced.	10. Use training methods that allow participants to practice new skills and receive prompt, reinforcing feedback.
11. Learning occurs in small groups.	11.Use training methods that encourage participants to explore feelings, attitudes, and skills with other learners
12. The trainer values participants' contributions as both learners and teachers.	12. Encourage participants to share their expertise and experiences with others in the training.

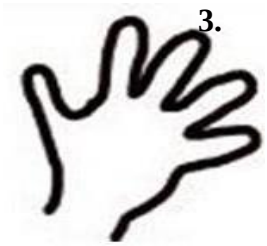
2.3. Training methods

Training deals primarily with obtaining knowledge, attitude and skills needed to carry specific activity or task. Training presumes an immediate application of the information or skills being learned. This learning process is conveyed to us through senses. The following paragraphs describe the way we learn.

Basic Ways to Learn

1. ***Visual:*** Learning through watching, observing, and reading (e.g., reading ART course manual, watching other pharmacists or nurses) Visual learners– usually have the following features: fast talking, use demonstrations, inpatient, often interrupt visually pleasing materials, use visual phrases, paint mental pictures and learn by seeing and imaging.

2. ***Auditory:*** Learning through listening (e.g., listening during a course, listening to other physicians, listening to clients. Auditory learners speak slowly and are natural listeners, think in a linear manner plan and deliver organized conversation**,** use 'hearing' type words and learn by listening and verbalizing.



3. ***Kinesthetic:*** Learning through doing, practicing, and touching (e.g., working with patients, practicing teaching skills. Kinesthetic Learners are slowest talkers of all, hands-on determination**,** slow to make decisions, 'walk them through' everything, use 'tactile' phrases and learn by doing and manipulating.

As it has been described earlier the goal in any training is to use a variety of methods in order to reach all participants, because some trainees learn better in one method than the other, and therefore, combining the different methods of teaching is the best approach.

To be effective adult trainers must use appropriate training strategies including the participatory hands-on training techniques to address all the competencies (domains of learning), designed to be delivered; domain of learning like knowledge, attitude and/or skill (which can vary based on level

of performance from skill acquisition, skill efficiency to skill proficiency).

The purpose of any learning teaching process or event is to obtain improvement (change) in knowledge, attitude and skill. All these three competencies could not be achieved by any single method of teaching hence combining the different methods of training has to be used.

Common teaching methods

Here are some of the commonly used methods (styles) to address knowledge, attitude and skill needs during training to acquire the required competency

Interactive Lecture: is the main way of conveying knowledge but with little effect on attitude and particularly for skill

Question and Answer: - can be used to deliver knowledge with some effect on attitude

Discussion: – when used can address attitude and knowledge

Role-play, coaching and case studies: – are very effective to address all domains: Knowledge, attitude and skill

E- Learning (computer-based training and web-based lessons or on-line lessons)**:** – is one of the means where by knowledge, attitude and /or skill can be acquired based on the type of E- learning method that will be used.

Telephone: – mainly knowledge

Group learning

Table 2 Styles of learning and teaching

Learning Styles	Consider using:
• Learn best with abstract concepts and lectures	• Case studies and discussions about theories and research
• Learn best while observing others	• Demonstrations and videos
• Learn best from exercises	• Role playing and other experiential activities
• Learn best through visual means	• Videos, images, and slides

Successful adult learning usually depends on how well the following conditions are met to achieve its goals;

- How well a trainer knows his or her subject matter – knowledge on the competencies one is supposed to teach?
- Learn best with abstract concepts and lectures.
- Case studies and discussions about theories and research.
- How effectively teachers communicate with learners?
- How well participants learn from each other and?
- How motivated the trainer and participants are to teach and learn the subject?

2.4. Feedback and adult learning

Giving and Receiving Feedback use standard definition

Mentoring relationships can play an important role in facilitating the feedback loop – helping the mentees to reflect on their learning and mistakes and to develop and become more competent health care providers. It allows us to look at our own attitudes, skills and knowledge, and therefore provides an opportunity to improve our own performance. It also provides an opportunity to ask questions and support fellow participants.

Basic Principles

Feedback is an integral part of adult learning. It is directed at skills, not personal characteristics. Feedback is not negative criticism. It combines both what worked well during training or activity and what could be improved**.**

Effective Feedback should have the following Characteristics:

1. **Goal-Referenced**; - a person has a goal, takes action to achieve the goal, and receives goal-related information about his or her actions. It should be specific, not general statements.
2. **Tangible and Transparent; -** combines both what worked well during training and activity and what could be improved.
3. **Actionable;** concrete, specific, and useful; it provides actionable information. It must also be accepted by the performer.
4. **Timely; -** should be given at the time of mentoring or during or immediately after the process rather than later. “The sooner, the better”.

5. **Ongoing; -** Adjusting our performance depends on not only receiving feedback but also having opportunities to use it.
6. **Consistent; -** performers can only adjust their performance successfully if the information fed back to them is stable, accurate, and trustworthy.
7. **Progress Toward a Goal; -** The key is to gear feedback to long-term goals.

The way a feedback is given is very important, it should be given as a "feedback sandwich:"

- Positive observation
- Constructive critical observation or suggestion
- Second positive observation as a summary statement
- Ask the learner for his/her own reaction or opinion.
- What do you think you did well?
- What do you wish you had done better?

If possible, suggest resources that might help the person improve.

Receiving Feedback

- Try not to become defensive; listen with openness.
- Focus on the specific suggestions you are receiving. Separate facts from opinions. Form an action plan to improve. Ask questions about the feedback if you are unclear or would like more information.

Exercise 2-1

1. **Issue of choosing the appropriate time, knowing the subject matter well & respecting one's experience**

Sr. Genet is a very good mentor with very good experience and clinical background. She was well prepared and has great insight of what her role is as a mentor. She went to one of the ART clinics she is assigned to mentor, early in the morning on their hectic working day. There were about 45 patients sitting in the waiting area. She introduced herself and after establishing a good rapport with her mentee, Abeje, she directly embarked on her mentoring. The mentoring process was going well on the first patient. For one and half hour, Sr. Genet was discussing the case with Abeje but he was not comfortable discussing with her leaving behind the other 44 restless patients waiting for their turns.

Question: *Comment on Sr. Genet's time management and other mentoring skills*

2. Exercise on the basic principles of giving & receiving feedback

Sr. Genet from the previous exercise (Exercise 2, # 1), was angry that Abeje was not focusing on the subject matter she was discussing. She finally being cognizant of the time-patient load factor, stopped temporarily and completed her mentoring process on the agreed less hectic time on the same day. She has noted all the positive and negative comments hidden in her note book. When rapping up her mentoring, she promised she would send her feedback a week later. When the feedback arrived a month later, it focused on the negative observations only. Abeje was disappointed by the comments as he was not asked of his opinion and was profoundly demoralized. He ascribed the condition to emanate from his comment to Sr. Genet on her inappropriate timing in trying to mentor him.

Question: *Comment on the feedback giving and receiving process in the above scenario and suggest on how it could improve*

Summary

- Effective teachers are good verbal and nonverbal communicators.
- Adults learn best in environments where they feel respected and confident.
- Trainers need to allow participants to use their experience and knowledge in the learning environment.
- An effective trainer is a leader and a coach.
- All of us benefit from receiving feedback.
- Practice using the basic principles of feedback.

Chapter 3: General Introduction to Mentoring

Chapter Description

This chapter will discuss the meaning and relevance of mentoring in relation to the Ethiopian HIV/AIDS care and treatment services. The chapter also describes the main differences of mentoring and supportive supervision.

Primary Objective

By the end of the chapter participants are expected to explain clinical mentoring and its objectives.

Enabling objectives

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

- Define clinical mentoring
- Describe the objective of clinical mentoring
- Differentiate between clinical mentoring and supportive supervision

Chapter Outline

3.1. Introduction

The first recorded modern usage of the term MENTOR can be traced to a book entitled "Les Aventures de Telemaque", by the French writer François Fénelon. In the book the lead character is that of Mentor. This book was published in 1699 and was very popular during the 18th century and the modern application of the term can be traced to this publication.

Mentor was defined then as parents or other relatives, a trusted friend, counselor or teacher, usually a more experienced person. Some professions have "mentoring programs" in which newcomers are paired with more experienced people in order to obtain good examples and advice as they advance, and schools sometimes have mentoring programs for new students or students who are having difficulties.

Today mentors provide their expertise to less experienced individuals in order to help them advance their careers, enhance their education, and build their networks.

Clinical mentorship in the context of HIV care and treatment is defined as a system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes.

Expertise in managing antiretroviral therapy and opportunistic infections is often not found on the management team in programs that are starting to scale up HIV treatment. a clinical mentor in HIV care/ART context is a clinician with substantial expertise in comprehensive HIV care and treatment who can provide ongoing mentoring to less-experienced HIV clinical care providers by responding to questions, reviewing clinical cases, providing feedback and assisting in case management. Mentoring should be seen as part of the continuum of education required to create competent health care providers

Thus clinical mentoring can be done during site visits as well as via ongoing phone and e-mail consultation. Clinical mentoring is critical to building successful health networks of trained health care workers for HIV care and treatment in resource-constrained settings. Clinical mentors need to be experienced, practicing clinicians with strong teaching skills.

3.2. Objectives of clinical mentoring

- Supporting the delivery of HIV care, antiretroviral therapy and prevention with high-quality care at all levels.
- Supporting the application of classroom learning in clinical care.
- Maintaining and progressively improving the quality of clinical care
- Building the capacity of clinical service providers to manage unfamiliar or complicated cases or referring them when appropriate; &
- Improving the motivation of health care workers by providing effective technical support.

3.3. Clinical mentoring versus supportive supervision

Mentorship and supervision generally aim at a common set of outcomes as listed below but differ in the emphasis and approach given to each.

Protection – looking after both the client/patient interests and the health worker interests

Enhancement – promoting and developing capacity and competencies

Management – ensuring smooth functioning of the system and monitoring and evaluation

Supervision tends to emphasize protection and management. Supervision is often more hierarchical and managerially oriented.

Mentorship places more emphasis on the enhancement of the professional skills and competencies. This is both an end in itself as a means to achieve positive outcomes in the other domains of protection and management.

Mentorship should be a voluntary contracted relationship. This is a crucial component of the definition of mentoring. Two parties enter into a contract and agree on a set of clear goals.

Often, supervision is mandatory in many organizational settings and the goals are predetermined by the system. The relationship with a supervisor is more hierarchical. Supervision may be more critical and evaluative than the more non-judgmental approach associated with mentorship. Making sure supervision is 'supportive supervision' may moderate this.

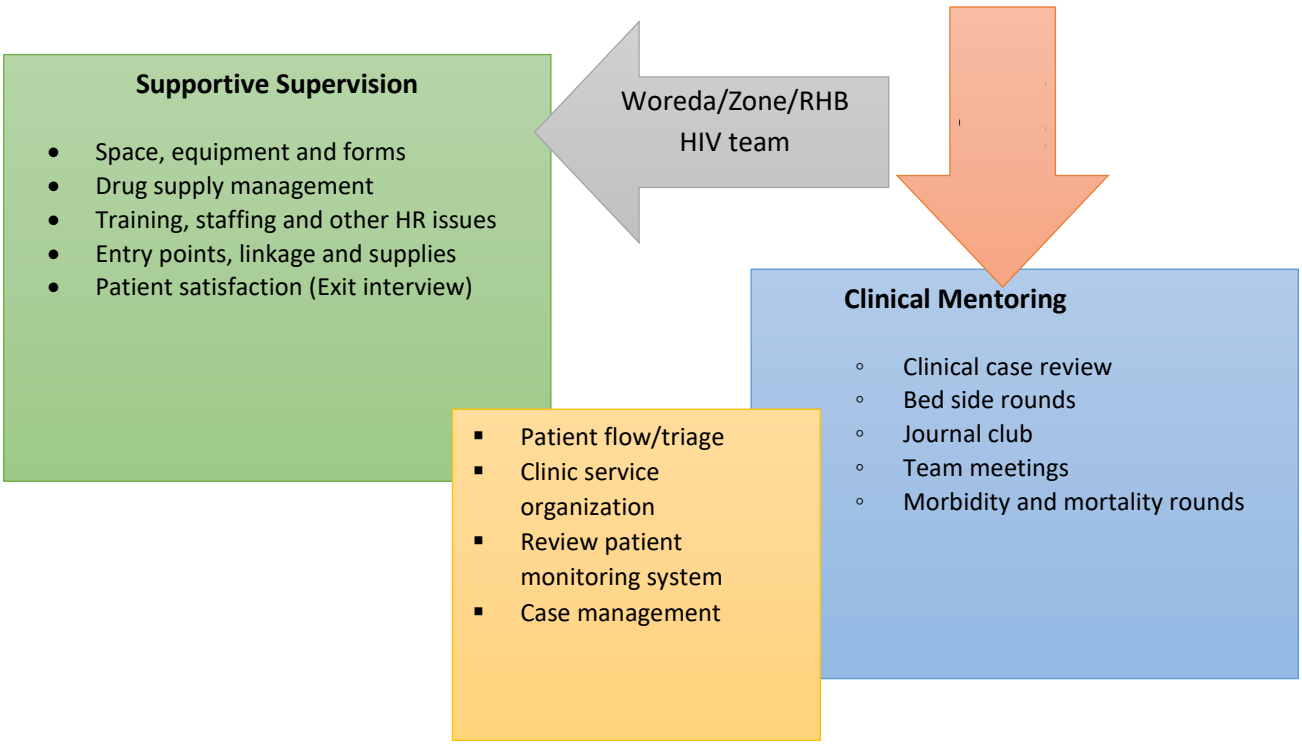


Figure 1 Venn diagram showing distinction of Clinical Mentoring and Supportive Supervision

Table 3. Summary of differences and similarities between clinical mentoring and supportive supervision

Mentor	Supervisor
• Deals with personal issues impacting on work • Provides clinical practice opportunities • Provides feedback on performance • Conduct case management and support skill development • Conduct clinical case review • Assist with care and referral of complicated cases • Provides bedside teaching • Address ethical issues with regard to practice • Acts as knowledge and skill resource • Updates on current developments and guideline changes • Guides career path • Promotes and supports health worker HIV prevention, care and treatment • More oriented to supporting health worker's development	• Deals with managerial & administrative issue • Provides feedback on line management functioning • Manages policy issues • Address ethical issues with regard to organizational procedure • Organizes some career development opportunities (training, etc) • Ensures supply chain management • (including provision of commodities for health worker protection) • Patient satisfaction, linkage with PLHA and community

This list is not exhaustive but helps to build the distinction between the two approaches. As it has been said, these distinctions and consequently the meanings of the terms may blur or merge into each other depending on contextual and personal factors.

There are shared responsibilities for visits by clinical mentors and by the supportive supervision team from the district. Individuals may be able to perform both functions if they have adequate, current clinical skills.

Summary

- Clinical mentoring is critical to building successful district networks of trained healthcare workers for HIV care and treatment in resource-constrained settings
- Mentors need to be experienced, practicing clinicians with strong teaching skills.
- Mentoring should be seen as part of the continuum of education required to create competent health care providers.
- Mentorship should be a voluntary contracted relationship & two parties enter into a contract and agree on a set of clear goals.
- Supervision tends to emphasize protection and management. Supervision is often more hierarchical and managerially oriented.

Chapter 4: Interpersonal Communication Skills

Chapter Description

This chapter discusses the interpersonal communication skills a mentor need to master and know by heart.

Primary Objective

By the end of the chapter participants are expected to list and explain interpersonal communication skills.

Enabling Objectives:

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

- Identify and demonstrate the skills required for interpersonal communication during clinical mentoring.
- List group facilitation and management skills during group mentoring.
- State skills required during a one-on-one telephone consultation.
- Describe how conflict between mentor and mentee can be resolved

Chapter Outline

4.1. Introduction

Interpersonal skills are the skills we use every day when we communicate and interact with other people, both individually and in groups. It is a broader terminology that includes communication skills, negotiation, mediation, decision-making and problem-solving, working in a group or team and emotional intelligence.

Since mentoring involves a lot of discussion and open conversation between the mentor and mentee, the mentor should know how to effectively get the message across to the individual with

ease. The mentor must be able to relay feedback and remarks constructively and positively without demeaning the mentee's self-esteem. Mentoring is a partnership between mentor and mentee. Mentoring implies a relationship of trust and two-way beneficial learning where the mentor provides advice, shares knowledge and experiences and guides the mentee through a self-discovery approach.

This section will therefore discuss on the specific interpersonal skill with focusing on communication skills that are required by a mentor to do a hands-on training and coaching to a mentee.

4.2. Interpersonal Communication Skills

Interpersonal communication skills are those skills which directly relate to initiating and maintaining effective and open communication between the mentor and mentee – they are the micro skills of listening and responding appropriately. It is not just about what is said – the language used – but how it is said, and the non- verbal messages sent through tone of voice, facial expressions, gestures and body language. These skills are used in a one-to-one session (face to face and over the telephone) and in group facilitation. While initiating mentoring explain the purpose of the mentoring visit, duration, expectation and benefits to the mentee. The skills can be grouped thematically into the following clusters:

1. Attending skills

Attending means being physically, intellectually and emotionally "present" in a mentoring session. These skills indicate to the mentee that the mentor is listening, is aware and is ready to interact. They show in a non-verbal way that the mentor is attentive and available. The acronym SOLER is often used to summarize these basic skills:

S-Sit or stand squarely: this means facing the mentee so that they can see the mentor and communicate openly. Sometimes a more "conversational" sitting or standing style is used where the mentor and the mentee sit or stand at right angles to each other while they talk. In a group mentoring session, the mentor must face the group to convey openness and attentiveness and when appropriate turn his or her body to face a specific speaker.

O-Open posture: this means not crossing arms or holding a folder/file in such a way that it indicates a closed body, and possibly a closed or "switched off" mind. It can also refer to minimizing barriers between mentor and mentee, such as a desk or bed. If mentoring a mentee next to a patient, try to stand next to each other.

L-Leaning forward: this means leaning in to the mentee at appropriate times to convey interest and concern. This should be used carefully so as not to intimidate a mentee too soon in an encounter. In addition, mentors must be mindful of body space differences in people from different backgrounds. Good observational skills will soon pick up what is an appropriate space.

E-Eye contact: this means keeping natural eye contact to show the mentee that the mentor is listening to what is being said. Eye contact in group sessions is vital to focus in on a specific participant and to notice what is going on in the group. Remember that for some people too much eye contact may be experienced as threatening or disrespectful: good contextual knowledge will assist here.

R-Relaxed posture: this means not fidgeting excessively or holding one's body in a tense manner. The mentor should convey a calm sense of containment to the mentee and should role model how patients may too be calmed and contained by this method.

While these attending skills mostly apply to face to face encounters, they can be used in a telephone conversation to maintain focus. Sitting up, leaning forward, being relaxed but alert, eyes focusing on something neutral, all help to keep the mentor "in tune" with the mentee. It is also useful to think about appropriate use of touch. In some cultures, it is acceptable and even desirable to convey empathy and understanding through a pat on the shoulder, a warm handclasp or even a hug. In others there may be strict limitations on cross gender touching. Working with people who are living with HIV or AIDS has special considerations around fears of infectivity and they may often feel untouchable. It would be useful to explore:

- What are the norms around touch in the specific clinical setting?
- How comfortable are you as a mentor with touch?
- The mentee's comfort levels with touch. This may be done through a direct question such as "When you greet a patient do you shake hands?" or "If a patient is crying how you would comfort them?"

2. Listening skills

Listening is the ability to accurately receive and interpret messages in the communication process. It is a skill that underpins all positive human relationships and a key to all effective communication. Without the ability to listen effectively, messages are easily misunderstood.

What is a mentor listening for in a mentoring encounter?

- Themes and threads: in a presentation the mentor must extract key messages and link ideas so that sense is made of the material a mentee is presenting. These may be reflected back to the mentee to show that the mentor has been listening well.
- What is said and not said: what does the mentee focus on in his or her presentation of a case and what is left out? She or he may be editing out mistakes, or being very matter of fact, or overly emotional. These are clues that tell the mentor something about the speaker.
- Tone and delivery: these may tell the mentor about the personality of the mentee, about their social skills or about their comfort with presenting in a group. They may reveal information about how the mentee interacts with patients.
- Feelings and facts: some mentees may present difficult patient stories in a very clinical and detached way, or they may become emotional about a dying patient. This is important information to store and work with.
- Knowledge gaps: is the mentee revealing a key gap in clinical know-how? This gap needs to be tactfully corrected.
- Strengths and weaknesses: the mentor may learn through good listening about a mentee's clinical, intellectual, emotional and relational skills and growth areas. These all need to be factored into the responses and approach of the mentor.

Most of us listen in spurts and are unable to give close attention to what is being said for more than 60 seconds at a time. We concentrate for a while, our attention lags, then we concentrate again. This can be improved with some simple techniques. The following are typical listening challenges:

- You had trouble understanding the speaker's words or language usage.
- You were thinking of what you were going to say while the speaker was talking.
- You were preoccupied with how strongly you disagreed with the speaker's views.
- You listened for what you wanted to hear.

- You were too tired mentally to pay attention.
- There were outside noises and distractions.
- The speaker had poor delivery – slow, irrelevant, rambling or repetitious.
- Something the speaker said intrigued you: you thought about it and when you tuned back in you had lost the thread.
- The speaker had an accent you found hard to understand.
- You tuned out because you thought you knew what the speaker's conclusions were going to be.
- You forgot to paraphrase and give feedback to show you were listening effectively.
- You felt you were being given far too much information.

Listening can be improved with some simple approaches:

- You must care enough to want to improve. Without this motivation, it will be too much effort.
- Try to find an uninterrupted area in which to converse. Keeping your train of thought is difficult when there are obstructions to conversation.
- Try not to anticipate what the mentee will say.
- Be mindful of your own prejudices or biases so they do not unduly influence your listening.
- Pay careful attention what is being said – don't stop listening to plan your rebuttal to a particular point.
- Be aware of "red flag" words which trigger an overreaction or stereotyped reactions – when they occur mentally remind you to keep focused on what the mentee is saying.
- Don't allow yourself to get too far ahead of the mentee by trying to understand things too soon.
- At intervals, paraphrase or summarize (see below) what the mentee has been saying – the more accurate you are the more you show you have been listening. However even if you are wrong you should paraphrase in a tentative way so that the mentee can correct you and put you on track.
- If you are not sure why a mentee is telling you something, ask. For example you could say "It's not clear to me what point you are making, can you clarify it for me?"
- If you are losing the train of the conversation, home in on key words or concepts to keep focus.

- Don’t interrupt the mentee to ask for clarification of a minor or irrelevant detail.
- If the mentee is making many points it is acceptable to jot down key words to keep track – but make a point of using the attending skills to make up for the temporary loss of eye contact, for example through nodding in acknowledgement of what the mentee is saying.

3. Observational skills

The mentor should use observational skills to get a sense of how the mentee is presenting him or herself. Aspects to look out for include:

- What is the mentee’s general demeanor: are they positive and upbeat, pessimistic and depressed, angry and confused, defensive and wary?
- What kind of body language is the mentee using? The ideas expressed in SOLER (above) are useful to think about – is the mentee open with the patient and the mentor, does the mentee use appropriate eye contact and physical distance, is the mentee tense and withdrawn in an encounter with a patient?
- Is the mentee neat and appropriate in dress and physical presentation? Not only do these reflect the general wellbeing of the mentee but they suggest levels of professionalism in dealing with patients.
- How does the mentee use language? Rate of speech, tone of speech and volume of speech may be key to how well the mentee can be understood and can also suggest mood and mental state. Sometimes it is appropriate to temporarily match these to “tune in” to the mentee and lead them to a calmer and more relaxed encounter. The mentor may also wish to ask the mentee to slow down to aid understanding.
- The mentor should also observe what is going on in and around the mentoring context: how are wards maintained, what are the challenges clinician’s faces, what levels of privacy exist, and so on? These need to be factored into the advice or support given to the mentee.

4. Speaking skills

The mentor should develop an awareness of how she or he uses language and attempt to modify vocal skills to improve understand ability and communication. Awareness of vocal style can be gained through taping of one’s voice and reviewing for clarity or by asking for feedback from others, including the mentee. The kinds of things to look out for include:

- Tone of speech and volume of voice: the tone can convey warmth and empathy or indicate a

desire to bring formality into a particular encounter. If a mentee is being rude to a patient the mentor can use a warm tone with the patient to model compassion. In a group mentoring context the mentor must be audible to all and be able to use volume to "take control" of the session.

- Rate of speech: in general one should use a slower rate with an audience unfamiliar with one's accent – but this should not become sing song or patronizing.
- Range of inflections: stressing certain words and varying emphasis will prevent boredom in an audience. Again, the mentor can model the way in which a patient should be spoken too by using this variety with the patient.
- Modifying accent/pronunciation: it may be useful in some settings to adapt pronunciation of certain words to accommodate local style and usage, in order to improve comprehension.
- Rhythm of speech: the mentor should try to modify their rhythm of speech to be clear and interesting.
- Appropriate words and language: the mentor needs to understand the particular mentoring context to make better choices of words and phrases which mentees use and understand.
- Use of minimal encouragers ("mmm, uh huh, I see"): these encourage the mentee to keep talking and show one is listening. This could go along with nods of the head. Minimal encouragers are particularly important in telephone sessions as the normal visual cues are absent.

5. Responding skills

Responding skills are those skills which allow the mentor to respond directly to what a mentee has said to take the conversation further in a useful direction. They also show the mentor has been listening or, if the response misses the mark, gives permission to the mentee to put the mentor back on track. It is always important to begin a response with a qualifier such as "it seems to me" or "it appears that" and to use a tone of voice which conveys tentativeness. This is not because the mentor wishes to appear uncertain but to show respect for the mentee's right to be the final arbiter of the "truth" of their utterances, thoughts and feelings.

Three key responding skills include:

Responding to content/facts through paraphrases

This shows the mentee that the mentor has been listening well, allows the mentee to hear their own ideas reflected and digested through the ears of another, and begins the process of "ordering" the mentee thoughts and concerns. A paraphrase is a simple reflection of the key idea a mentee has expressed. If the mentee says "When I first saw the patient she seemed very sick and I wasn't sure if she was going to survive. I wondered if she was a good candidate for ARVs because she seemed so far gone. Even her family seemed to have given up on her." The response of the mentor could be "So it sounds like when you first saw this patient you didn't think there was anything you could do for her". Depending on the mentee this could go in the direction of an exploration of feelings of hopelessness in the mentee or in the direction of a clinical/technical decision about initiating ART in patients with low CD4 counts. In a group mentoring session the paraphrase can be used to "hear" two different points of view without taking sides, as in "Gabriel seems to think this patient should first have been supported nutritionally before commencing ART but you, Simeon, feel that the ART should start at the same time as the nutritional support."

Responding to feelings

Apart from responding to the "simple facts" of a mentee statement it is also possible to respond to the emotional aspect of what they have said. Responding to feelings brings in a "relational" element in that connecting to others at this level is usually deeper and more meaningful, conveys empathy and can build trust if handled sensitively. Using the example above the mentor could have said "it seems that you experienced a sense of hopelessness when you saw this patient for the first time." If the feeling identified is accurate, the mentee feels understood at an emotional level. This is always more effective than saying "I understand how you feel." Working with feelings can be uncomfortable at first and it presupposes that the mentor is themselves comfortable with their own emotions and is adept at identifying feelings. In some cultures, a "feelings vocabulary" may be limited or men may be socialized not to express feelings. These differences must be respected but not necessarily seen as a barrier to some effort to working with feelings.

Linking feelings to content/facts

This enhances empathy because it starts to bring depth, meaning and texture to the mentoring encounter. By associating the feeling with a situation or even the mentor is helping to tie up the threads of the conversation and to help the mentor see why, in a certain situation, they responded in a certain way. Using the example above, the mentor could have used this skill in saying "So it seems that when you first met this patient you felt a slight sense of hopelessness because her illness seemed so far advanced and those around her had also given up." This shows a high level of listening and brings together the various themes in the mentee's statement. As the mentor becomes more skilled in using these ideas she or he can in effect draw together paraphrasing, summarizing and reflecting facts and feelings to show the mentee they have been listening well, and perhaps even "listening between the lines."

6. Exploring skills

In any communication with a mentee in which the ultimate aim is to understand the mentee, convey information and promote health and wellness in people living with HIV or AIDS, the mentor will have to go beyond reflecting what has been heard to explore what is not clear and to deepen understanding on both sides. The mentor should use exploring skills after the first phases of the encounter have been completed (joining, contracting and hearing the initial concerns, facts and feelings). This exploring can be done in a number of ways.

• ***Clarifying what is not clear through asking questions for greater understanding or repeating mentee statements with a questioning tone.***

In both instances the mentor is looking for clarity on a specific point a mentee has made. For example if the mentee says "The patient told me that she always remembers to take her ARVs because of the children," the mentor could respond in at least two ways:

- By asking a clarifying question such as "When your patient said 'because of the children' what do you think she meant?"
- By saying "because of the children?" with a rising tone to indicate a question.
- Both methods prompt the mentee to expand further on the particular point and clarify for the mentor what he/she meant.

Asking open questions: open questions have more than one answer and usually begin with "how" "when" or "what", as in the example given above. These probes encourage mentees to think

expansively and reflect an attitude of respect from the mentor because they assume the mentees have ideas and experience to draw on. Open questions also presume there is time for an extended discussion. In certain contexts, a closed question, one which has a yes or no or some other forced choice answer, also has its uses, especially if time is limited or if the mentor wishes to be more directive. Some closed questions can be "leading" in that they point the mentee in a very specific and "socially desirable" direction – leaving the mentor unsure if learning has happened. For example if the mentor asks "You do understand this don't you?" the mentee will often answer "Yes" because this is the expected answer and they do not wish to come across as foolish.

Asking hypothetical questions: these are usually open questions which prompt lateral thinking in mentees. An example would be "What would you do if a patient with a CD4 count of 250 presented with an AIDS defining illness? This explores knowledge and encourages mentees to be creative.

- Asking reflecting questions: these are questions which encourage mentees to summarize or reflect on a particular discussion. This could be very effective in a group mentoring session where a number of cases had been presented and the mentor asks "What are the key themes that have come out of today's cases?"
- Asking evaluative questions: these are questions which take a specific issue and case and "evaluate" a course of action. For example if a mentee has embarked on ART with a patient who has a pre-existing cholesterol problem the mentor could ask "How do you think this will work over time?"

7. Immediacy skills

These skills tend to reflect on the "relationship" between the mentor and mentee or the "process" of what is happening i.e. "how are we getting on?" If, for example, the mentor says to the patient he and the mentee are examining, "Fatuma when the doctor explained to you how to take your ARVs was it clear to you what to do?" and the mentee gets angry and says "of course it was clear", the mentor may need to tackle the mentee's response as soon as possible. This should be done in private and the mentor could respond in a number of different ways:

- "Tigist I noticed you got angry when I asked the patient about your discussion with her, what was going on for you in that moment?"
- "Tigist that seemed to be an awkward moment between you and me there, perhaps we should talk about it?"

- "Tigist it seemed inappropriate to me that you should get angry in front of the patient. Would you like to tell me what angered you?"

Tigist's angry response might have been because she felt humiliated or her skills doubted in front of the patient; she could have sensed a pattern of challenging questions from the mentor; or she could have been defensive because she knew she had done a poor job of explaining ARVs and adherence to Fatuma. Only by using the skill of immediacy will the mentor get to the root of the issue and allow the air to be cleared. Once the issue is out in the open it can be addressed and the "relationship" between the mentor and mentee put back on an amicable and workable footing.

Immediacy skills can be used to **give feedback.** Feedback is a crucial part of facilitating and vital to the role of the mentor. This feedback may be of a technical nature ("The dosage you have prescribed is wrong."), may relate to general improvement of the mentee ("You have made good progress as a clinician."), may relate to the way in which a mentee has conducted him or herself in a mentoring session ("It seems it was difficult for you to hear the negative comments of your colleagues") This session is covered in your adult teaching methodology session and therefore we won't be going into it again. In a telephone mentoring session the immediacy skill may help to address situations which would be less problematic in a face to face session. For example, if there is a silence in a face to face session, it may be obvious from the mentee's body language that they are thinking about a point the mentor has made. In a telephone encounter the mentor does not have the luxury of visual cues and may have to address the silence with a question or some other intervention such as a reflection or summary.

Some tips for giving feedback:

- Be sure the mentee is ready: if not the feedback will not fall on fertile ground.
- If possible, preface your feedback with something positive before giving negative or critical feedback.
- Base your comments on facts not emotions.
- Be specific: give quotes and examples of exactly what you are referring to.
- Give feedback as soon after the event as possible: if you give the feedback immediately the mentee is more likely to understand exactly what's meant.
- But pick a convenient time: if the receiver is very busy with other urgent matters they will not be able to concentrate on your feedback.
- Pick a private place: critical feedback given in front of others can be damaging rather than

helpful – one exception to this is feedback given to a group if there is conflict or avoidance in the group, not to address this would be a disservice to group process.

- Concentrate on what can be changed.
- Request co-operation: invite the mentee to work with you and seek their "buy in" to the desired change.
- Focus on one thing at a time: too much feedback will be overwhelming to the mentee.
- Be helpful: always consider your own motives for giving your opinions – are you trying to be helpful to the mentee or are you unloading some of your own feelings (if you are angry say so but include a description of the behavior that caused your anger).
- Encourage the mentee to give feedback in return

8. Summarizing skills

Summaries are essentially paraphrases of a larger chunk of material or conversation from a mentee. A summary provides order and focus and sorts out relevant material to explore in an encounter. Good summaries act as natural "stopping and reflecting" points in a conversation and can also be used to bring a session to a close. In a group session a summary can be used to check out how well group members have been following the discussion, by asking someone to draw together the key points as they see them. It would be useful not to "pounce" on someone who clearly hasn't understood the session!

Other uses of summaries include:

- To give direction to a mentoring encounter.
- To prevent getting stuck on a particular issue.
- To check out if the mentor has really understood what the mentee is trying to say.
- To link different points and themes together.

Some tips for summarizing:

- A good summary is brief and includes not only the facts and the words but also the feelings the mentee has expressed.
- Put the ideas and descriptions at least partly into your own words but the language should still be primarily in the words used by the mentee.

9. Problem solving skills

In general it is advisable to use problem solving skills after there has been a thorough exploration of

all aspects of a problem. If this exploration is done in an engaging way solutions may naturally start to emerge, the mentee feels heard and the solution that is arrived at is relevant to the context or situation. The process of problem exploration also teaches the mentee a structured way of thinking about and approaching problems – the mentee can take this approach into other situations. Remember that giving solutions too soon encourages dependency and lazy thinking in mentees.

The first step in problem solving is to partialize the problem, i.e. to break it down into its component parts or sub-problems. This is particularly useful when a problem appears to be large and overwhelming so that no one solution is immediately apparent. By breaking the problem down, the task of finding solutions is made easier because the smaller problems will then each be easier to solve. The next step is to agree on a clear definition of the problem (or sub-problem). It is often useful to define a problem in terms of specific needs. For example if the mentee has presented a case in which the patient has not disclosed to anyone but needs assistance with adherence, it may be helpful to define the problem as: "The patient needs help with disclosure," rather than "The patient is resistant and reluctant to disclose". Then encourage the mentee (or mentees in a group session) to brainstorm as many solutions as possible. These can be written down for review – all ideas should be considered as this is a creative process to stimulate lateral thinking. Only when the mentee has exhausted all ideas should the mentor make his or her contribution as this respects the ideas of mentees.

Sometimes the mentor could encounter resistance to change and finding solutions. Here are some ideas to counter this resistance:

- "It can't be done," versus "What if we could do it?"
- "We can't do it like that," versus "What if this barrier didn't exist?"
- They would never agree to it," versus "What if we could get them to agree?"
- "It will be too expensive," versus "What if we found a budget?"
- "This is too risky," versus "What if we managed the risk?"
- "I don't have the time," versus "What if we reallocated resources?"
- "That's already been tried," versus "What if we tried again?"

Now evaluate each possible solution or option by considering the advantages or disadvantages of each. This can also be done as a simple list of pros and cons in the form of a balance sheet. Then allow the mentee to choose the best solution for his or her circumstances. Usually the best solution is the one with the fewest disadvantages and the most advantages. In some cases where the solution is a

technical one, such as the right combination of ARVs or a specific treatment for an ARV side effect, the mentor would obviously need to ensure that this is the option that is acted upon. Perhaps is it useful here to distinguish between problems that have right or wrong answers and problems which could have a number of possible solutions.

Then a decision has to be made to implement a specific decision. Mentees must learn to trust their own decision-making abilities and this includes committing to a course of action. Now a practical action plan is drawn up to take the decision forward. It is important to include specifics such as what, when, where and how this should happen. In some cases mentees may need to learn to be more flexible and open to creative solutions that go beyond stock answers. Some questions which can be asked at this point to move the mentee to action include:

- What are you going to do?
- When will you do it?
- Will this action move you to your goal?
- What barriers might you have to overcome?
- Who else will be involved?
- What support do you need?
- Where will you find it?
- What other consequences are there of this course of action?
- What can I do to help?

Reviewing the outcome of the solution is desirable – this allows the mentor to assess with the mentee if the best solution was chosen and whether the mentee was capable of implementing the solution well. This allows for learning and promotes self-evaluation.

10. Evaluation skills

The mentor needs to be able evaluate how the session went in terms of the solution developed and whether the mentor/mentee relationship was amicable and productive. This process of reviewing and evaluating also brings a session to a close. Useful questions to consider include:

- What can the mentee take away from the session that was useful?
- What about the session was less useful?
- Is there any unfinished business i.e. issues that were not adequately dealt with during the session?

The mentor should also ask the mentee about their evaluation of the session and whether it worked for them:

- "How did you find the session?"
- Was the session helpful for you?"
- What did you take from this session?"

11. Planning skills

Planning skills are those skills which help to structure the mentoring relationship and involve all pre-planning and post-evaluation to ensure smooth mentoring encounters. They also include the contracting process to ensure that expectations of mentor and mentee are realized. In addition, we have included a discussion on personal presentation (suitable dress codes etc) as this forms part of being suitably prepared for the mentoring. Much of the planning involves using core communication skills in their execution. So, for example, the mentor will use relevant listening and responding skills when negotiating the contract with the mentee.

4.3. Managing a Disagreement between a Mentor and a Mentee

Certain misunderstandings may occur between the mentor and the mentee during the mentoring process. Such conflicts are better avoided through initial thorough discussion on how the mentoring process will proceed, how and when mentee would like to receive feedbacks and other detail steps of the process. But once disagreements occurred along the process of the mentoring, the mentor should be meticulous enough to tackle the problem without causing much conflict.

The way to deal with a disagreement **between a mentor and a mentee:**

a. Ask for time to think things over. Take this chance to allow both of you to calm down.
b. Pay attention to your body's reactions. Has the fight-or-flight instinct been triggered? Take a deep breath to increase your oxygen intake to your brain so you analyze your situation more clearly.
c. Don't snap at the person. You may regret a fast retort which may have lasting consequences.
d. Determine what it is you want that you're not getting. Should you be willing to negotiate more – to give in a little – so you can both win?
e. If the other person has "lost it", don't negotiate until calm returns. Adopting a quiet manner is always your best approach.

f. Wait until the other person is willing to listen to your side of the story. Make sure you're listening carefully to his or her side of the story.
g. Make sure the other person knows you're listening. Use paraphrasing on a regular basis to confirm that what you've heard is what has been said.
h. If the other person doesn't seem to be listening to what you have to say, insist that you be listened to. Say: "I've made a point of listening carefully to what you have to say. Can I ask that you do the same for me?"
i. Ask: "What do you want me to do?" Clarify that you know what the other person wants. Listen to the answer and confirm or correct.
j. State what you want, clearly and sequentially. Again, be willing to negotiate.
k. Once an agreement has been reached, summarize the particulars and go over pertinent areas again to reconfirm your understanding.

Exercises

Exercise 4-1: Emotional Bank Account

1. Imagine you are making deposits (positive actions) into an emotional bank account. You must work out the value of the deposits that you the mentor make for the nurses or health officers or other health workers that you are mentoring.
2. For example, the deposit **constructive feedback** would create a vale **growth and positive reinforcement.**

Emotional or technical deposit by mentor	Value of deposit for the health worker (mentee)
1. Constructive feedback	
2. Relating to health worker as an equal and a professional	
3. Providing support	
4. Showing respect	
5. Showing empathy	
1. Asking for their clinical opinion and being willing to learn from them	

2. Openness and transparency	
3. Helping understand and manage an emotionally difficult patient	
4. Recognizing achievements	
5. Personal interest	
6. Recognizing and responding to signs of urn-out	
7. Addressing health worker HIV prevention and priority care and treatment during group discussions	

2. Now consider the impact that withdrawals from your emotional or technical bank account (negative actions) have on the health worker. For example, a mentor providing **negative feedback** may have the impact of **eroding confidence** of the health worker.

Emotional or technical withdrawals by Mentor	Impact of withdrawals on the health worker (mentee)
1. Negative feedback	
2. Emphasizing lab tests or CT scan results when discussing cases which are not available at health center level and not included in IMAI/public health approach	
3. Imposing solutions	
4. Showing disrespect	
5. Being deceptive	
6. Trying to promote hospital care while not recognizing value of health center delivery	
7. Showing sympathy	
8. Failing to recognize achievements.	
9. Lack of support	
10. Failure to return phone calls or Emails	
11. Breaking confidentiality	
12. Not understanding or respecting the	

case management process and division of labor at health center level	
13. Pontificating, showing off very expert Knowledge	

Exercise 4-2.

2. Role Play/ exercise on Good/bad verbal and nonverbal communicators Ayele is a very knowledgeable clinician / mentor working in a nearby hospital. He is now in a health center with Asselef who is a nurse working in the ART clinic. Today, Ayele directly went to the clinic and asked for the person working in the ART clinic. When Asselef appeared, he asked for her name and proceeded directly with his mentoring.

Ayele: "Why are you not attending these patients timely?" He asked putting both his hands in his pockets and tapping the floor with his feet.

Asselef: "I was attending another patient inside and the other nurse working with me is on leave" she answered being afraid as she knew nothing about him.

Ayele then directly went and started to examine the patient she was seeing. He stood very close to Asselef and asked her to take history and do physical examination on the patient. While she was doing so, he was interrupting her repeatedly and scolding her in front of the patient.

Ayele: "What is your diagnosis on this patient? And how do you manage this patient?"

Asselef bending her neck burst in to tears and sat on a chair.

Question: Comment on the communication skills of Ayele in mentoring Asselef.

Summary

- Counseling and communication skills are crucial to effectively deliver mentorship service
- A variety of core interpersonal communication skills are required from a mentor in order to have a smooth relationship between a mentor and a mentee.
- The mentor needs to be meticulous in solving disagreements that may arise between the mentor and the mentee

Chapter 5: Initiation and Approaches to Clinical mentoring

Chapter description

The chapter is intended to discuss how to initiate clinical mentoring and the approaches of mentoring as well as the activities need to be done during site visits.

Primary Objective

By the end of the chapter participants are expected to explain initiation of mentoring and approaches used for mentoring.

Enabling objectives:

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

- Describe the activities required to initiate a clinical mentoring process
- Describe the various approaches in clinical mentoring
- Identify the various activities during a site visit for clinical mentoring

Chapter Outline

5.1. Introduction

Clinical mentoring (CM) must be integrated in the health delivery system and inbuilt like Supportive Supervision (SS). The CM model in the guidelines must be implemented with full ownership of the health management arm at all levels. CM needs to be planned, budgeted, monitored and evaluated. Partners may assist the integration and sustainability of CM.

Political commitment is critical to make CM integrated in the system. This can be expressed by allocating sufficient resources, making relevant policy decisions and owning and leading the whole program of CM at all levels.

The management of CM at any level must be integrated with the management of other programs and services; it must not be taken as a standalone program. The effectiveness of CM is ensured when it is inbuilt in the overall health delivery system.

5.2. Initiating a Mentoring Process

Once a clinical mentor is well familiar with the basic interpersonal communication skills required to mentor a health care provider, initiating the actual session will require a number of arrangements beforehand. The mentor should be able to arrange the time and settings of mentoring in discussion with the head of the health facility as well as the mentee.

As part of setting norms and explaining the purpose of the mentor's presence in that facility, the mentor will be required to explain about the components of his/her mentoring activities before initiating the mentoring process.

Setting an appointment with the Mentee:

The mentoring process starts with arranging an appropriate time for the mentoring to take place. The arrangement should normally be done jointly by both the mentor and the mentee. The mentor should first contact the health facility head for facilitation to conduct the mentoring and subsequently contact the mentee and arrange on a suitable date and time for both.

Explaining what mentoring is:

Most mentees will not have been formally mentored before and it is important for the mentor to explain what mentoring is in the first visit and how the process works. It will be important to distinguish between mentoring and counseling, mentoring and teaching and mentoring and coaching.

Explaining one's role:

It will be helpful to define roles, for example the mentor can explain that she or he will listen to the mentee's case presentation, explore and understand it well and develop solutions with the mentee. He or she will give expert input where it is necessary but will try to promote independent thinking and expert knowledge in the mentee. The mentee's role would be to think about a case presentation prior to the mentoring session, to prepare points and problems to share, to interact with the mentor in an open and collegial way, and be willing to receive constructive feedback.

Agreeing on an expectations and outcomes:

In the light of the roles described above, both the mentor and mentee should discuss expectations of each other and the mentoring process as a whole and agree to what they believe they can reasonably achieve. If possible these should be recorded.

Agreeing on how outcomes are to be evaluated:

The mentor should explain how the mentee is to be evaluated. For example, the mentor could say "I will keep notes of each mentoring session and these, combined with my clinical impressions, will form the basis of how I will evaluate your progress." The mentor may go on to explain that the mentee will be assessed on general clinical skills on HIV care, treatment and prevention knowledge, on skills in relating to client communication, on documentation and record keeping etc. The mentor should explain to whom he or she reports on the progress of the mentee.

Setting out parameters for an interaction:

The mentor and mentee should discuss on duration of a session, frequency and number of sessions according to the national guideline, confidentiality parameters of the discussions (especially if the mentee discusses personal information) and on how the mentor's assessment documents are communicated and kept for progress assessment and subsequent actions. `

Agreeing on how disagreement is to be managed:

Because it is possible that the mentor and mentee will disagree at times, and even have serious arguments or points of difference, it may be useful to discuss how conflicts will be handled. The mentor need to use his/her interpersonal skills to understand and resolve all disagreements as much as possible. When disagreements could not be resolved, issues need to be discussed with health facility leadership as well as relevant regional, zonal or woreda program managers.

Context setting skills

It is preferable to set up a space which can help both mentor and mentee feel calm, private, appropriate and relaxed. Ideally this means a space with comfortable seating set up in a conversational way, privacy from interruptions and intrusions such as a ringing telephone. The situation described above is an ideal one: if this is not possible try to create a similar effect with an attitude/approach of respectfulness and collegiality. Some mentoring needs to happen at the bedside of a patient or in clinic and obviously the mentor has less control over this situation. It would still be useful to maintain an

attempt at privacy and respect by drawing curtains and by speaking in a quieter but still audible tone. Some mentors may be more comfortable to work from behind a desk and this is possible but likely to create a barrier and reinforces the power imbalance between mentor and mentee.

Deciding on the way forward

While the problem-solving skills, described in the core communication skills, are useful for setting out the way forward for a particular patient issue, thinking about the way forward for mentorship as a whole is a planning skill. The kinds of things which a mentor needs to think about include: decisions a mentee can take on their own, the number and frequency of mentoring sessions, and recommendations about the mentee to his or her seniors. While much of this is discussed with the mentee, the ultimate responsibility for the advancement of skills of the mentee, and the overall success of the mentoring process, must lie with both the mentor and mentee.

5.3. Approaches to Clinical Mentorship

A mentor may use a variety of approaches to conduct clinical mentoring. The applicability and advantage of the different approaches depend on a number of factors including the distance the health facility is located, the time the mentoring process is intended to take place with regard to time of initiation of the ART service in the health facility, the specific target of the mentoring session and other related factors.

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

Basically, there are different ways of conducting clinical mentoring. These are:

1. **Site Visits by mentors**

Clinical mentoring could be on site or off site

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

Site visits by clinical mentors are particularly important right after the initial training when the clinical team is organizing the HIV care and treatment setting to initiate the service. The main goals of the initial site visits by the mentor are to quickly reinforce the skills learned in the initial training and also to start building a relationship with the members of the clinical team. These visits will take at least one full day per month and consist of the following activities:

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

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

The frequency of off site visits will be:

- For new services established – at least once per month for the first six months, then every 2 – 3 months until graduation
- For existing services –will receive mentorship every 2-3 months until graduation.

The implementation of on-site mentoring will be as follows:

1. Duration of mentorship – Minimum of one day
2. Frequency – Twice in a month
3. Program planning – Facility will develop annual plan for mentorship activities according to the regional plan
4. Activity planning – each mentor will develop detailed activity plan and get approval from the head of the facility
5. Reporting – will report to the head of facility

Table 2: Summary of activates of mentors providing off/on-site mentoring

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

Internal mentoring should be monitored and evaluated by the facility quality committee or relevant committees like MDT.

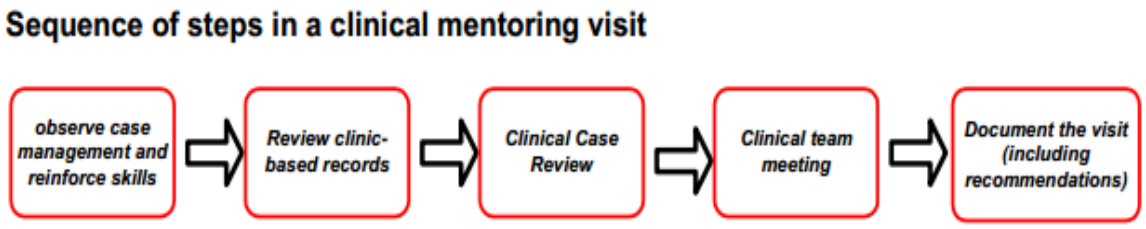


Fig 5.1 Sequence of steps in a clinical mentoring visit picture

1. One-on-one case management observation

Mentor observes the mentee managing a patient and then provides constructive feedback in a tactful and productive approach. It may not be possible to observe and provide feedback to all clinical team members in the same visit. Therefore, the mentor makes sure to observe everyone in the team over several visits. The mentor will use the nationally adopted checklist of clinical mentoring to assess the clinical capacity of the different cadres of health care providers.

(Checklists are annexed at the end of this training manual).

2. Review of patient monitoring data

All health facilities providing HIV care and treatment in the country are using the same nationally standardized documentation and reporting system of the national ART program. These are registers (Pre-ART and ART), intake and follow up forms and other related formats. The mentor is expected to review the record system during the visit. Individual patient record charts should also be checked when reviewing the management of a specific patient with clinical team or the mentee. Furthermore, the mentor randomly selects 5 patient records and look for recording error. Then the registers are checked to make sure that the information has been correctly transferred from patient record to the registers.

Checking the medical recording system may be an overlap with supportive supervision, in particular at the earliest stage of the initiation of the care program. However, there is no much problem with the duplication since medical recording requires considerable attention. While checking the medical recording system and providing feedback, the mentor should always develop good relationship and creates a sense of trust with the clinical team, rather than critical criticism type of approach. The mentor has to ensure the appropriate use of medical documentation as it is crucial for the continuity of care required for HIV care and treatment.

Using Available data to measure Quality of Service: The mentor may get data referable to quality of care by sufficiently reviewing the registers. These data may not be part of the routine reporting to higher level. The clinical mentor should know how to quickly calculate the indicators that are not part of the regular reporting and demonstrate to the clinical team how to do this. This empowers the clinical team to improve quality between mentoring visits and demonstrates the importance of good record keeping.

3. Clinical case discussions

The clinical team can in advance select difficult cases to be discussed with the mentor. Difficult cases include patients not responding to treatment as expected, difficult pediatric cases, patients with severe drug adverse effects or intolerance, suspected treatment failure, etc. The mentor will keep record of cases discussed with the mentee using the national clinical mentoring activity log book for recording clinical discussions and clinical case. (See Annex 3 for the logbook).Actual cases from the facility itself are generally preferable, but mentors can also use pre-prepared cases from other sites in order to address difficult issues for which actual cases aren't available from the health facility being mentored. The mentor should lead the case discussion in the following fashion:

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

The mentor makes assessment of the discussed cases by looking into the logbook and this will assist in recommending the type of case to be selected for the next discussion. The clinical case discussion can also be supplemented by a clinical update by the mentor when appropriate, frequently asked questions and question and answer sessions.

4. MDT Meeting

According to the national ART program standards of implementation, the MDT team meets monthly(in health facilities newly starting ART service the meeting is advisable to be more frequent than monthly) to discuss on clinical and/or programmatic issues. The clinical mentor can join these meetings in order to assist the team with the cases being presented or to give general updates on issues being discussed whenever possible. Possible topics being covered during MDT team meeting include the following:

- Case discussion (as described above)
- Review and discussion of existing guidelines and treatment algorithms
- "Journal club": case presentation and/or specific lecture on topic of interest given to staff and supplemented with 1-2 pertinent articles from the literature. This approach should take

into account the level of most members of the clinical team at the health facility. Adaptation to such circumstances is mandatory rather than mechanically applying an approach that may be counterproductive.

- Personnel and skills development (oral presentation skills focusing on presentation of cases, organization of meetings, etc)
- Communication skills
- Team-building activities
- System of care issues (such as referral); and
- Improving the process (such as organization, triage and patient flow)

Mentoring by Telephone: The mentee functions independently between the visits. Yet case management plans can be reviewed with the mentor by telephone. This improves quality of care and reduces the possibility of frequently displacing the mentor from his work place. Presentation of cases by telephone and subsequent discussion to reach a management plan decision demands training. The telephone is much more convenient than the internet for this purpose since mentor can quickly ask for clarification or additional information from the mentee after case presentation. The mentor may have to initially call the mentee regularly, to solicit problems, discuss cases and follow up on cases and problems discussed during the previous site visits. The mentee should be encouraged by the mentor to call any time and frequently, although agreement when to call may be arranged. Other complementary approaches such as call centers, telemedicine and twining may be used to make mentoring effective, sustainable and easily done.

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

Call centers are an important element of mentee support, and all participants in clinical mentorship programs should be encouraged to use the national phone lines for clinical support.

Summary

- The mentor should be able to communicate head of the health facility beforehand to facilitate the mentoring program
- There should be timely and appropriate communication between the mentor and mentee in order to set goals and identify approaches for each of the mentoring sessions.
- A number of activities may be carried out during a site visit including one-on-one case management observation, review patient records and provider documentation of health care (clinic-based records), clinical case review and multidisciplinary team meeting
- Clinical mentoring can be off-site or Onsite and for facilities with adequate number of expertise, onsite mentoring need to be emphasized rather than offsite which is cost effective and will help to assure sustainability.
- There are tools to be used in the conduction of clinical mentoring that are nationally adopted. These include: Checklist for assessing the mentee and Log book for recording clinical discussions and clinical case.

Chapter 6: HIV related Services and Health Network Model

Chapter description

This chapter describes the HIV related services and health network model that mentors need to know in order to render comprehensive clinical mentoring for HIV service related activities in a mentee facility.

Enabling Objectives

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

- List the different HIV related services at health facilities level
- Outline how the different HIV related services are organized
- Identify the role and responsibilities of the different levels of the health service
- Describe specific challenges of selected programs
- Describe the health service network model and its importance in strengthening national HIV/AIDs program

Chapter Outline

6.1.HIV Related Services

Introduction

In the Ethiopian health system the range of HIV prevention, care and treatment services provided in the health facilities include HTS, PMTCT,STI, ART, and TB/HIV collaborative activities. A mentor needs to be familiar with the different guidelines policies, and implementation challenges of each

program. The capacity of health care provider should be strengthened through pre service and In-service training. The FMoH is responsible to ensure the standardization of both pre service and in-service trainings.

6.2. HIV Testing and counseling (HTS) services

HIV testing is the critical first step in identifying and linking PLHIV to the treatment cascade and it also provides opportunity to reinforce HIV prevention among the negatives. Referral and linkage of clients is the next step of ensuring that patients get the intended service. In order to achieve this objectives National Guidelines, standard operating procedures and protocols needs to be followed and the HTS service must be regularly mentored.

Guiding Principles

All forms of HIV testing and counseling should be voluntary and adhere to the five C's: consent, confidentiality, counseling, correct test results and connections to prevention, care and treatment services.

- **Consent**: People receiving HIV testing and counseling must give informed verbal consent to be tested and counseled. Written consent is not required. They should be informed of the process for HIV testing and counseling and their right to decline testing.
- **Confidentiality**: HIV testing and counseling services are confidential, meaning that what the HIV testing and counseling provider and the person discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Counselors should raise, among other issues, whom else the person may wish to inform and how they would like this to be done. Shared confidentiality with partner or family members and trusted others and with health care providers is often highly beneficial.
- **Counseling**: HIV testing and counseling services must be accompanied by appropriate and standardized pre-test information and post-test counseling.
- **Correct**: HIV testing and counseling providers should strive to provide standardized testing services to reach to correct diagnosis.
- **Connection**: Connections to prevention, care and treatment services should include the provision of effective referral to appropriate follow-up services as indicated, including long-term prevention care and treatment services.

Service Delivery Approaches

There are two major HIV testing and counseling service delivery models; and under these models there are different service delivery approaches. These models are health facility-based HIV testing and counseling model and community-based HIV testing and counseling model.

A. Facility-based HTS

Currently both Voluntary Counseling and Testing (VCT) and Provider Initiated Testing and Counseling (PITC) are the approaches being implemented in health facilities to deal with HIV testing and counseling services. Generally, the HIV testing and counseling approaches in health facilities are:

1. Client initiated HIV testing and counseling (VCT), which can be stand-alone or integrated with other health services.
2. Provider initiated HIV testing and counseling (PITC), which is provided by opt-out approach at clinical service points for eligible patients (who come to the facility for other medical reasons). All health facilities should provide PITC service for eligible clients at outpatient and inpatient departments, using the national testing algorism.

Eligible clients for routine HIV testing and counseling by using PITC approach are:

1. All pregnant, laboring and postpartum women with unknown HIV status; and partners of HIV positive pregnant/postpartum women and partners of high risk* HIV negative pregnant and post-partum women.
2. Eligible family members (siblings under 15 years old and their parents) and sexual networks of index PLHIV.
3. Commercial sex workers and their clients.
4. All TB patients with unknown HIV status and presumptive TB cases.
5. All sexually transmitted infections (STI) patients with unknown HIV status, their partners and sexual networks.
6. Discordant couples.
7. Children orphaned by AIDS and vulnerable* children.
8. Children with malnutrition.
9. Patients with clinical signs and symptoms of HIV/AIDS visiting health facilities (outpatient and inpatient).
10. Long distance truck drivers, mobile workers and daily laborers.
11. Widowed, divorced & remarried.
12. Vulnerable** adolescents / youth clients (15-24 years).
13. All under five children visiting health facilities.
14. Refugees and inmates.
15. Family planning clients with identified risk (history of having multiple sexual partner, inconsistent condom use and their partners).

**High risk includes having multiple partners, divorced and recently married, newly married, sex worker, waitress, daily laborer, mobile worker and age between 15-24 years.*

***Vulnerable adolescents/youth include those living in the street, orphans, adolescents in child headed household, girls engaged in sex with elder men or in multiple and concurrent sexual partnership, out of school youth, and adolescents who are sexually exploited.*

On public health grounds, mandatory and compulsory HIV testing and counseling are forbidden in Ethiopia. Therefore, health facilities and healthcare providers must refrain themselves from testing and counseling individuals without their will and consents. Mandatory testing is allowed in Ethiopia

only for screening purposes of blood and blood components for transfusion, in cases of organ transplantation and by order of court cases.

B. Community-based HTS

Community-based model is one mechanism of addressing eligible clients, who don't appear at health facilities for HIV testing and counseling for different reasons. This model builds public trust and also mitigates issues related to stigma and discrimination. Providing HIV testing and counseling (HTS) in the community relieves clients from transportation and other expenses. It has also importance in identifying HIV positive individuals earlier than facility- based HIV testing approach. Reaching populations through services provided at community level can break existing barriers to HIV testing and counseling. In Ethiopia community-based model of HIV testing and counseling is recommended in the following settings:

- Home-based testing targeting specific sub-population groups:
  - Families of index HIV cases.
  - Widow / widower, divorced and remarried.
  - AIDS orphans.
- Targeted outreach HIV testing and counseling services: Targeting specific geographic areas with high HIV prevalence (hot-spots). While planning outreach HTS, effective linkage of the identified HIV infected clients is very critical. Targeted outreach testing could be implemented to reach:
  - Commercial sex workers.
  - Long distance truck drivers.
  - Mobile workers.
  - Daily laborers.
  - Clients of sex workers.
  - Refugees.
  - Inmates.
- Work place HTS is recommended with high number of eligible persons for HIV testing and counseling. Some of the eligible work places where community-based model of HIV testing and counseling services are:
  - Big farms with huge number of regular and temporary workers.
  - Big construction sites (roads, dams for irrigation and hydro-electric etc.).
  - Big factories and mining sites.

Mixed service delivery approach will be used especially in cases of mobile populations and mega project sites

Monitoring and Evaluation tools for HTS program

The following standardized tools are available for recording and reporting of HTS activities: VCT register, PITC register, Laboratory HIV testing register, VCT client intake form, Laboratory HIV result form, client referral format, HTS reporting format from the site, and HTS reporting format from Woreda health office.

NB: Technical updates on current HTS practice and national recommendations will be discussed in detail by your facilitator.

6.3. Prevention of Mother to Child Transmission (PMTCT)

Prevention of Mother-to-Child Transmission services were started in Ethiopia in 2001 but progressed slowly. Ethiopia has been implementing the PMTCT Option "A" of WHO (2010) recommendations since December 2011 in an accelerated mode to scale up PMTCT services. Since then, substantial clinical and programmatic developments have been made on simplification of HIV treatment for pregnant and breastfeeding women through the introduction of a single fixed drug regimen which can be rolled out on maternal, newborn and child health (RMNCAH) platforms (WHO, 2012). Option B + is a "test and treat" approach that was introduced in 2012 where HIV positive pregnant and breastfeeding women are initiated on ART regardless of their immunological status and continue treatment for life. Hence, the Ethiopian Federal Ministry of Health (FMOH) endorsed Option B+ in August 2010 as an approach to avert new pediatric HIV infections and improve the survival of mothers and their babies. The National Operational Plan (December 2012) was developed to guide the implementation rollout of Option B+ strategy throughout the country. By December 2013, most PMTCT sites across the country have introduced Option B+.Since 2017 the test and treat approach has been adopted by the country for all peoples living with HIV.

Ethiopia has adopted Elimination of mother to child transmission of HIV and syphilis (EMTCT) since 2013.To realize the elimination the country developed EMTCT strategy in two rounds (2013-2015&2017-2020).The details of EMTCT can be viewed in the national EMTCT strategic plan.

The objective of PMTCT services in Ethiopia are;

1. Promote primary prevention of HIV amongst women and men of reproductive age group.
2. Reduce and ultimately eliminate new pediatric HIV infections.

3. Promote access to HIV care/ART services for HIV infected pregnant women and their families.
4. Reduce HIV related morbidity and mortality of HIV infected mothers through care thereby preserve the family unit and reduce incidence of orphans.
5. Promote access of HIV exposed infants to care:
    a. Initiate CTX preventive therapy to reduce morbidity and mortality from PCP and other bacterial infections
    b. Identify infants and children with rapid disease progression and initiate ART early
    c. Facilitate access to early infant HIV diagnosis services
6. Address family planning issues

The four pronged approach of PMTCT:

1. Primary Prevention of HIV infection
    - Communication for Behavior change (ABC approach) to protect men and women of childbearing age from becoming infected with HIV and other STIs.
    - Provide voluntary counseling and testing services following the National HIV Counseling and Testing Guidelines.
    - Promoting correct and consistent use of condoms.
    - Encourage open discussion on RH issues between parents and their children.
    - Early diagnosis and treatment of STIs.
2. Prevention of unintended pregnancies among women infected with HIV
    - Provide family planning counseling integrated into all potential PMTCT and VCT service sites.
3. Prevention of HIV transmission from women infected with HIV to their infants
    - Assure the availability of antiretroviral drugs and other appropriate supplies for PMTCT.
    - Provide testing and counseling services integrated with ANC, labor &delivery and postnatal care.
    - Safer obstetrical practices.
    - Provide appropriate counseling on infant feeding and support exclusive breastfeeding.
4. Treatment, care and support of women infected with HIV, their infants and their families.
    - Start ART for all HIV+ women.

- Ensure appropriate follow-up of infants born to HIV-positive women including: OI prophylaxis and early infant diagnosis.
- Provide partner testing
- Provide HIV testing for family (children).
- Link PMTCT with care and support initiatives organized for infants and HIV-infected women.

Key features of PMTCT service in health facilities include:

- ANC health care provider starts antiretroviral therapy (ART) for HIV + pregnant women at the time of diagnosis without referral to ART clinic and regardless of CD4 level and L&D health care provider starts ART for the new HIV positive pregnant women and refer her to ANC clinic
- Once HIV positive pregnant woman is started on ART, treatment is intended to be continued for life;
- A single triple drug regimen is used for all newly diagnosed HIV + pregnant women and lactating mothers
- The ANC health care provider continues to provide primary care to mother and infant, including prescribing and monitoring of ART, until risk of MTCT has passed (following weaning from breast feeding). Exception to this practice is if infant is diagnosed with HIV, which should trigger immediate referral and transfer of care to the nearest ART site; or if mother or infant becomes ill, which should trigger either referral to or transfer of care to nearest ART site. DBS testing is done by ANC health care provider or designated trained personnel in the MNCH unit;
- Maintaining continuity of care from antenatal period until post-weaning should improve infant testing at 6 weeks and at cessation of breast feeding as well as improve post-partum uptake of FP services.
- When a mother already on ART becomes pregnant, she needs to be linked with PMTCT unit

Care of HIV-exposed infants

Linking ANC, PMTCT, and Maternity to pediatric care and treatment to facilitate identification of the HIV-exposed infant is a critical step. The components of care for HIV exposed children are:

- Growth monitoring and developmental assessment
- Counseling on infant feeding, maternal nutrition and support

- Early infant HIV diagnosis using age appropriate test (DNA PCR or Rapid Antibody test)
- Co-trimoxazole Prophylactic Therapy
- TB risk assessment
- Routine preventive pediatric services including immunizations
- Facilitating enrollment of HIV infected children into care and treatment and timely initiation of ART

Monitoring and evaluation tools for PMTCT program

- Data should be recorded using the PMTCT register.
- Maternal and HIV exposed infant cohort analysis should be done regularly.

6.4. Sexually Transmitted infections

Sexually transmitted infections (STIs) are among the most common causes of illness in the world and have far reaching health, social and economic consequences. According 2016 WHO estimates, 357 million new cases of curable STIs (syphilis, gonorrhea, chlamydia and trichomoniasis) occur annually throughout the world in adults aged 15-49 years. More than 500 million people are estimated to have genital infection with herpes simplex virus (HSV) and over 290 million women have a human papillomavirus (HPV) infection.

According to 2016 EDHS 4% of o Ethiopian women and men reported having had an STI in the past 12 months. Among men, the percentage was 6% in Oromiya, and 5% in Harari compared to less than 1% in the Tigray and Benishangul- Gumuz.

Fewer than one in three women and men (32% for each) who had an STI or STI symptoms sought advice or treatment from a clinic, hospital, private doctor, or other health professional. One percent of women and 3% of men sought advice or treatment from a shop or pharmacy. However, 67% of women and 66% men did not seek any advice or treatment.

In addition to the high prevalence, STIs is fueling the epidemic of HIV. According to EPHI STI sentinel report, 30% of STI patient are co-infected with HIV. Individuals with STIs are at a greater risk of both acquiring and transmitting HIV due to the physiological and pathological changes caused by STI and behavioral risk factors that underline the sexual transmission of both HIV and STIs. Therefore all PLWHIV should be regularly screened for STI and provided with effective STI case syndromic management.

Syndromic approach is a comprehensive approach that addresses:

- Health education and risk reduction,
- Consistent and correct utilization of condom
- Notification and management of sexual partners and
- HIV testing and counseling & (HTS).

STI case management is the base of any STI control and prevention program and there is a need to strength the integrations with ART clinic through

- Capacity building through training and availing job aids
- Availing drugs
- Improving recording and reporting
- Strengthen monitoring system through supportive supervision, mentoring and review meetings
- The clinical mentors are expected to ensure that the STI screening and treatment is conducted according to the latest STI National guideline.

6.5. HIV care and treatment program (Adult and Pediatric)

The goals of ART program are to reduce HIV related morbidity, mortality, and mitigate the impact of the AIDS epidemic. ART has an added goal of HIV prevention in prevention in pregnant mothers and other targeted groups.(Example: PreP in sex workers, PEP in health professionals). In order to achieve these goals, the program will be in a public health approach instituting chronic care model as a sole service delivery modality. .

Management and coordination of ART Program

HIV care and treatment program will be managed and coordinated at different levels: national, regional, zonal/woreda, health facility, and community levels. The FMoH and RHBs, have responsibility to lead and ensure coordination of care and treatment program in the country, at different levels, and also is integrated into the existing health care systems.

National level

The FMoH is responsible for policy formulation; development/updating and standardizing the national program and clinical guidelines, preparation of national plans including target setting, procurement and supply management, capacity building, monitoring and evaluation (M&E),

advocacy and operational research, and for overseeing the overall coordination of the ART program at national level. In order to achieve this, the ministry employs the following coordination mechanisms: Internal coordination and National HIV Care and Treatment Advisory group. At the Federal level, there will be team of experts from MoH departments and bilateral and non-governmental agencies that play key role will form the advisory group. Under the leadership of MoH this team will have regular meetings where issues arising from program implementation are discussed, and recommendations are generated. At national level, the FMoH will be supported by the National HIV Care and Treatment Advisory group. Additionally, this forum will be used to facilitate program coordination among the different partners of the MoH. The advisory group will also support the establishment of technical sub-committees, as deemed necessary.

Regional level:

In the decentralized health care system of Ethiopia, regions are the first level program implementers. The RHBs have an overall responsibility to lead, manage and coordinate ART program implementation in the region. RHBs also work to create an enabling environment for the smooth function of ART implementing partners in their respective region. Besides the public sector, the region should strive for the involvement of the private sector, Faith Based establishments, associations of PLWHA, communities, and the regional council in support of the expansion of HIV prevention, care, treatment, and support services in the region. The RHBs shall promote the development of program leadership and ownership at all levels of the health sector structure in the region. In executing such complex responsibilities, RHBs are urged to establish **HIV/AIDS care and treatment task force** that will also facilitate program coordination.

Zonal level:

The Zonal Health Office coordinates and monitors the HIV prevention and control activities at health facilities in the zone and community levels in collaboration with relevant stakeholders.

The zonal health office is expected to establish Zonal HIV/AIDS Committee to facilitate support in executing its responsibilities. The committee can invite additional partners/stakeholders when appropriate.

Woreda level

The Woreda Health Office leads, coordinates and monitors HIV/AIDS prevention and control activities in the Woreda in collaboration with relevant stakeholders. Woreda Health Office is responsible to mobilize woreda council, kebeles and communities in support of HIV prevention, treatment, care and support services including ART. It supports ART activities at the community level and encourages community mobilization among NGOs, CBOs and FBOs. It also needs to respond to facility needs and timely report M&E data,

Woredas are urged to establish Woreda HIV/AIDS Committee in order to facilitate support and coordination in executing the stated tasks. The committee can invite additional partners/stakeholders when appropriate.

Kebele and community levels

The ART program should use existing structure, as much as possible, to reach the community. Moreover, HIV prevention, care and support activities are already taking place at these levels, and can facilitate the integration of ART. The Kebeles serve as the link between the Health posts/Health Center and the community & households. The main role of the community is in promoting HIV prevention, care and support, including efforts to reduce stigma and improve treatment adherence. Through the Kebele HIV/AIDS Committee, they refer patients to health post/centers &community based organizations/NGOs for psychosocial, spiritual and economical support. The committee can invite additional partners/stakeholders when appropriate.

Role of the Community:

The involvement of the community in HIV prevention, treatment, care and support, including ART will be incorporated within the Health Extension Package and include:

Advocacy: This will include mobilizing political and socio-economic support for scale up of HIV prevention, treatment, and care and support services, including ART. Public advocacy should also aim reducing HIV-related stigma & discrimination, and mobilizing community/local resources.

Service provision: This will include prevention, Care and support as well as adherence, psychosocial and spiritual, nutritional and home support for people living with and/or affected by HIV/AIDS.

Role of Private sectors and professional associations

Professionals' associations, associations of private health care providers, and others play major role in HIV Care service provision, community mobilization, care and support at different levels. The free ART service has expanded to private sectors, both for profit and not- for- profit providers. The MoH/RHBs will continue to support the expansion of HIV prevention, care and treatment services to the private sector. Furthermore, the private sector contributes significantly in drug importation and manufacturing. Therefore, collaboration with the private sector needs to be strengthened and maintained and best practices adopted for further expansion of HIV services. Members of the private sector are encouraged to participate in the HIV/AIDS committees at each program coordination and management level

ART Service delivery: The routine provision of HIV care/ART services rests on health facilities. As part of chronic HIV care/ART, care providers have the responsibility for adherence preparation and support, provide psychosocial support, and ensure the integration of HIV prevention with routine clinical services. Facilities also have responsibility with patient monitoring, data management, analysis, and reporting to the zonal health departments/Woreda health offices or RHB. Facility-based and community level services will be linked to ensure effectiveness of ART program implementation.

Therefore, besides direct service delivery, the facility has responsibilities to:

- Coordinate the different HIV related services at the facility so that patients will not experience difficulty to access service or long waiting time;
- Strengthen referral and linkage among the different services;
- Expand and strengthen entry points for HIV care/ART in the facility;
- Ensure appropriate health workers are trained to provide HIV services, and trained persons are stationed to relevant posts;
- Ensure uninterrupted supply of key health commodities (ARVs, OI drugs, Lab. reagents and test kits, etc.) through proper stock management and timely request;
- Facilitate task shifting and distribution among service providers stationed in the facility in order to reduce the burden of care on few staff; and
- Undertake regular performance review to ensure smooth implementation of different HIV services and quality of care.

Services that should be provided at Health facilities to initiate ART

- Check written documentation of positive HIV status
- Counsel patient and ensure he/she accepted HIV status and desire and readiness for ART
- Check for weight
- Check functional status
- Stage the patient based on WHO staging system
- Screen for and manage TB and other OIs
- Do CBC for each patient
- Request for CD4 count for each patient
- Do retesting of HIV before starting ART
- Check for pregnancy
- Identify and manage psychosocial barriers like psychiatric illness, alcoholism etc.

Before initiating ART:

- Do adherence preparation
- Asses patient readiness to determine initiation ART the same day or within a week
- Choose appropriate regimen based on the national Guideline
- Educate the patient on the selected regimen and describe about dosing and side effect
- Counsel the patient and his supporter about the strict adherence on care and treatment, particularly on ART
- Prescribe enough medication
- Explain access to care in case of emergency
- Schedule follow up visits

Monitoring of patients on ART

- Assess and counsel on adherence
- Check for side effects and manage as per the national Guidelines
- Check for and manage drug interactions
- manage IRIS
- Check for and manage treatment failure(Make sure routine viral load is done as per the GL)
- Follow CD4 count as per the recommended schedule

- Screen and manage for OI particularly TB
- Schedule follow up visits based on the patient category for the differentiated service delivery model

Detection of treatment Failure

- Identify patients with treatment failure using RVL testing
- Maximize adherence of patients with suspected treatment failure
- Change to second line ARV regimen based the

Pediatric HIV/AIDS Care and treatment

All health facilities are expected to provide comprehensive pediatric HIV care and treatment together with adult HIV care and treatment. This is undertaken by every care provider with the following objectives:

- Family Centered Care
- Improve linkages between pediatric, ANC, PMTCT, TB and adult care and treatment programs
- Prevention of pediatric HIV infection, prevention of morbidity and mortality

Care and treatment of HIV- infected children

All children should be initiated on ART according to the current national guideline. (Recommendations)

The main objectives of care and treatment for HIV infected children are:

- Promote and support active case finding (index case HIV testing)
- Growth monitoring and developmental assessment
- Nutrition counseling and support
- Clinical and Immunological staging
- Laboratory tests
- Co-trimoxazole Prophylactic Therapy
- TB screening
- Treatment of OIs, HIV-associated TB infection and other common childhood illnesses
- Routine preventive pediatric services including immunizations
- Provision of ART for infants and children based on current recommendation
- Management of drug toxicities, treatment failure and provision of second-line regimen

- Psychosocial support, adherence and disclosure
- Management and appropriate referral for complicated patients

6.6. FP integration to HIV care and treatment service

Traditionally, family planning (FP) and HIV services have been offered separately. As more people of reproductive age become infected with HIV or are at risk of infection, the benefits of integrating these services have become very clear. Integration of FP and HIV services involves the provision of FP and HIV prevention and care services as part of a unified and coordinated strategy to address clients' risks of unintended pregnancies and prevention of HIV transmission both horizontal as well as vertical.

Integrating FP with HIV care and treatment provides an opportunity to affect many clients' sexual and reproductive health behavior and to meet their related sexual and reproductive health counseling and service needs.

Essential Aspects of FP/HIV Integration

- It involves offering FP and HIV services at the same facility, with the provider of each service actively encouraging clients to consider using the other service during the same visit.
- If services are not offered in the same room, strong intra-referrals are required.

Levels of FP/HIV Integration

Level 1: Assessment of FP need; provision of FP counseling; provision of condoms, oral contraceptive pills (OCPs), and emergency contraception.

Level 2: Includes all elements of the first level and the provision of injectable contraceptives.

Level 3: Includes everything in level 2 as well as the provision of intrauterine devices (IUDs) and implants.

Level 4: Includes provision of all contraceptive methods including permanent/surgical methods.

Depending the health facility capacity and human resource the ART clinic can provide one of the levels above. For further details see national family planning guideline.

6.7. TB/HIV Collaborative activities

Tuberculosis

TB is the most frequent life-threatening opportunistic infection and a leading cause of death, currently, the most powerful risk factor for developing TB disease is HIV. After TB infection, a person with HIV have 10% annual risk and 50% life-time risk of developing TB disease, compared with a 10% life-time risk for person`s without HIV. The HIV epidemic, therefore, create a large pool of persons at high risk of developing TB and, as a result, increases the pool of persons who will ultimately develops TB and transmit TB to HIV-infected and HIV-uninfected persons. HIV-infected patients can develop TB at any level of immune-suppression. Collaborative TB/HIV activities aim to decrease the burden of TB and HIV in a population affected by both diseases through collaboration between programs. This approach aims to provide integrated and comprehensive tuberculosis and HIV prevention, treatment and care service as close to the client as possible, maintaining existing tuberculosis and HIV program management structure rather than combining them or creating a third TB/HIV program.

There are three objectives of the TB/HIV collaborative activities:

1. Reducing HIV incidence among TB patients.
2. Reducing TB incidence among PLWHAS.
3. Improve care of people for people who are co-infected with TB and HIV.

TB/HIV collaboration consists of a set of activities to be carried out at all levels of the health care delivery system. At program management level it deals with establishment of mechanism for successful collaboration and at health facilities level it deals with provision of comprehensive care to reduce the burden of TB/HIV among the community in general and people infected and affected by TB and HIV in particular HIV care settings should implement the WHO Three I's strategy: intensified TB case-finding, isoniazid preventive therapy (IPT) and infection control at all clinical encounters. The rationale for the integration is that Tuberculosis and HIV Prevention and Control programs share mutual challenge of high impact of TB on HIV and vice versa. Therefore, two programs must collaborate to provide better service for the co-infected patients.

Nationally Recommended TB/HIV Collaborative Activities

A. Strengthen the Mechanisms for integrated TB and HIV services delivery

- Strengthen the coordination mechanism for integrated TB/HIV services at all levels;
- Conduct surveillance to determine HIV burden among TB patients and TB burden among HIV patients;
- Carry out joint TB/HIV planning for integrated TB and HIV services delivery;
- Conduct monitoring and evaluation of collaborative TB/HIV activities.

B. The three I's (**I**ntensive case finding, **I**NH Preventive Therapy and **I**nfection control) for HIV/TB

- Intensify TB case finding and ensure quality TB treatment;
- Initiate TB prevention with earlier initiation of ART and Isoniazid preventive therapy (IPT);
- Ensure Tuberculosis infection control in healthcare and congregate settings.

C. Decrease the burden of HIV among TB patients.

- Provide HIV testing and counseling to presumptive and confirmed TB patients;
- Provide HIV prevention services for presumptive and confirmed TB patients;
- Provide co-trimoxazole preventive therapy for HIV positive TB patients;
- Ensure HIV/AIDS prevention, treatment and care for HIV positive TB patients;
- Provide antiretroviral therapy for HIV positive TB patients.

Monitoring and evaluation tools for TB/HIV collaborative activities

The following recording and reporting registers and formats are available at facility level: TB/HIV unit register for HIV positive patients on CPT, unit register for HIV positive clients without active TB taking INH preventive therapy and TB/HIV Quarterly report form. In addition to these registers there is the PICT register for TB clinic, and the ART register and pre-ART registers at the HIV clinics contain some TB/HIV parameters.

Monitoring and Evaluation tools for ART program

Different recording and reporting formats for ART programs are available at health facility levels. A mentor should be familiar with the various tools and should be able to supervise their correct use. Facility based patient record includes: Intake forms, Follow up form. Facility based register: Pre-

ART, ART registers. **The reporting forms used in ART program are the** ART monthly reporting, and cohort reporting forms

Summary

- Health networking involves strengthening and integration of existing public health service through inter and intra facility linkage
- Health network model provides integrated and comprehensive care, treatment and prevention services in all aspects of health problems
- Strengthening supportive supervision and clinical mentoring plays great role in terms of skill and knowledge transfer

Chapter 7: Case studies to augment clinical knowledge of mentors

Chapter description

This chapter is intended to present cases of clients in order to help mentors visualize hot to select cases for discussions and clinical skills demonstrations. The chapter presents cases from adults, children as well as pregnant mothers.

Primary Objective

By the end of the chapter participants are expected to demonstrate case selection and discussion approaches with their mentees.

Enabling Objective

At the end of the chapter participants will be able to:

- Describe cases that can be selected for case discussions
- Explain case discussion methodology
- Demonstrate how to analyze cases for clinical decision making

Chapter Outline

7.1. Adult HIV Care & treatment

7.1.1. HIV Testing and linkage

Case 1:

Part one

- Birtukan, 19, meets a man she likes very much who lives in the same town. Solomon, funny and a few years older, has his own butchery. Solomon is unaware that he has been living with HIV for 3 years. Solomon and Birtukan becomes a couple. They have unprotected sex as Birtukan has been on OCPs (oral contraceptive pills) for a year.
- Ten days later, Birtukan misses work due to a flu-like illness. She has fever, her joints ache and her glands are swollen.
- Three months later, Birtukan decides to be tested for HIV, but Solomon declines. Birtukan feels well. Birtukan gets tested, and is sero-reactive.

Questions:

1. What are some reasons people refuse to be tested for HIV?
2. What will be the care plan for Birtukan?

Part Two

- Six months later Birtukan and Solomon are expecting their first baby and she gets PMTCT service in the ANC clinic. She discloses her status to Solomon who has not been feeling well – he has been having diarrhea and has lost 4 kg in the past 6 months & his baseline weight was 50 kg. Currently Solomon agreed to be tested for HIV and his test result is positive.

Questions

- What WHO stage is Solomon now?
- What will be the next management plan?

Case 2:

Part one

- A 37year woman mother of three children (6, 10 and 16 yrs.), presents with history of oral candidiasis & rapid HIV test is positive and she is referred to your clinic.
- Past Medical History: non contributory
- Social History: lives alone, earns 500 birr/month
- Has no current sexual partner and no prior use of condoms or birth control
- Review of Systems (ROS): non-contributory

- Physical Examination:
  - Tearful woman
  - Vital Signs: T=37^{0}C, Wt= 55kg, Ht= 162cm
  - HEENT: White pseudo-membranous plaques on the posterior pharynx, no oral hairy leukoplakia, no lymphadenopathy
  - CVS, chest & Abdomen: normal
  - Skin: Seborrheic dermatitis on the face
  - Pelvic examination: thick and white vaginal discharge

Questions

1. What is her current WHO clinical stage?
2. What is the immediate care she needs?
3. When do you start ART?

7.1.2. Initiation and Monitoring of Therapy

Case 1: Part one

- A 25-year-old female came to the VCT, because her boyfriend recently died from chronic cough and marked weight loss and she believes he had underlying HIV infection. She was tested positive and referred to ART Clinic.
- **Question**

  What should be done in the baseline assessment to evaluate her (List base line investigations).

Part Two

• When asked her health history, she reports:

No complaints other than weight loss

No history of STI

• On examination, she looks thin with silky hair.

Weight 42 kg and height of 168cm (50 kg 6 months back)

No oral thrush

No other remarkable finding

Question

1. What care package do you provide?

Part Three

• She was counseled by the ART nurse about:

Living positively with the virus

Need for 100% adherence

• Started with co-trimoxazole 960mg daily

What ARV drugs would you start her with?

Part Four

• She was started on ART after retesting.

Question

1. When should her next appointment be?

2. What would you do at the time of her next visit?

Part Five

• Next visit after 2 weeks

Question

• What would you like to know and what investigation will you do?

At her two week visit you find:

No complaints except mild itching over the trunk without rash

No jaundice

What will you do next?

Part Six

At five months post-ART visit she reported:

• cough of 2 days' duration

• Has associated scanty sputum and low grade fever

• Chest findings are unremarkable

Question

List differential diagnosis for her current symptoms?

How do you investigate this patient?

Results

WBC= 5000/mm3; L= 25%

Sputum for AFB negative

CXR showed bilateral lower lung nodular infiltrates with left sided pleural effusion

Pleural fluid analysis revealed lymphocytic & exudative fluid

GenExpert positive

What preventive measures should have been taken?

• Showed significant improvement after 1 month of treatment

7.1.3. Treatment monitoring

Case study 1

- A 50 year old HIV positive male patient who is on AZT+3TC+NVP
- He presents to the emergency room with a bloody nose and bruises on his arm.
- Other current medications include:
  - Warfarin for atrial fibrillation
  - atenolol for blood pressure

Question

1. What is the cause for the current presentation?

Case Study 2

A 50 year old man has taken AZT+3TC+EFV for 3 years. His adherence has been good. He now presents with oral thrush and CNS Toxoplasmosis.

Question

What do you suspect?

What do you do next?

Case Study 3

A 45 year old male on ART for the past one year and came for routine visit. On examination he was found to be stable with undetectable VL after one year of taking ART.

Question:

What is your next plan?

Case Study 4

A 38-year-old woman on ART for the past one year and came for routine visit. On examination she was found to be clinically stable.

Question:

What is your next plan?

Case Study 5

A 50-year-old male on ART for the past five years came for routine visit. On examination he was found to be clinically stable. His VL was 45,000 copies/ml. The VL repeated after enhanced

Question:

What is your next plan?

7.1.4. Changing ART

Case study 1:

Part one

• Abebech, a 30-year- old HIV positive woman has been taking AZT +3TC+NVP for the last 2 months

• Her baseline CD4 count was 150/mm3

• Gained weight and strength in the first 6 weeks of starting ART

• Developed anorexia, nausea and vomiting with jaundice in the last 2 weeks

• Became weak and confused in the last 2 days

• On exam, she has deep icterus and tender liver; confused, with flapping tremor

Question

1. What are the likely differential diagnoses?
2. What tests would you request?

Lab results

• Lab tests revealed:

ALT: 800 IU/L (normal value = upto 40)

Bilirubin (total): 12mg/dl (normal upto 1mg/dl)

HBs Ag and anti HCV Ab: negative

Question

How would you manage her?

7.2. PMTCT

Case Study 1:

A 22-year-old pregnant woman with previously diagnosed HIV infection comes for her first antenatal clinic visit. She is in her first trimester pregnancy. No other complaints.

1. What further information do you need?
2. How do you manage her?

Case study 2

A33 year old pregnant woman came in labour. 1. What do you do?

7.3. HIV/TB co infections

Case study 1

A 44 years old male diagnosed to have PTB.

A. How do you manage him?

Case study 2

A 32 year old HIV +ve woman was linked and newly started on ART. She was screened negative for TB.

What do you do?

7.4. Pediatric HIV/AIDS Care and Treatment

7.4.1. Infant HIV diagnosis

Case study

Part one

Amsale is a 21 year-old woman who was enrolled in the PMTCT program during her most recent pregnancy after she was diagnosed to have HIV.

She had an uncomplicated pregnancy and took TDF/3TC/EFV as directed. Her baby, Kebede, was given nevirapine for 6 weeks, and Amsale has been enrolled at the PNC clinic.

When Amsale and Kebede return for their first post-partum check, both are doing well. Kebede is breast-feeding without difficulty and has gained weight as expected.

Amsale wants to know if Kebede has HIV.

- What do you do?
- When should Kebede be tested for HIV?
- What test should be used?
- What other interventions should be performed?
- When should Amsale bring Kebede back to clinic for his next appointment?

Part Two

Mother and baby return 4 weeks later to review the result of Kebede's first DNA PCR test. DNA PCR result has been negative.

- How will you explain the result to Amsale?
- Does Kebede need further testing? If so, when should he be tested and which test should be used?
- When should Amsale bring Kebede back to the clinic for his next appointment?
- When Kebede is six months old, the team meets to review his case. As his initial virologic test was negative and he is asymptomatic, the team decides that he can now be followed every three months.
- When Kebede is 9 months old, Amsale brings him back. Kebede returns to the clinic for monthly visits, which are often on the same day as Amsale's appointments. He is a healthy baby who gains weight and attains developmental milestones as expected. He tolerates cotrimoxazole without difficulty.
- Does Kebede need further HIV testing?
- If so, when should it take place?
- What type of HIV test should be sent?

Part Three

Amsale brings Kebede back to clinic when he is 12 months old. At this visit, HIV rapid test is done and the result is negative.

- Does Kebede have HIV?
- Does Kebede need further HIV testing?
- Should Kebede continue to follow-up at the ART clinic?

7.4.2. Care of HIV exposed infant

Case Study

- Yared is a 3-month old male infant who is brought in for his monthly checkup
- Baby is breast feeding at night ,but is fed porridge during the day by Grandma, who does not know of mom's status
- Lately the baby has been feeding poorly and has had diarrhea for the past two days.
- Mom notes that he isn't growing well.
- Yared receives cotrimoxazole, but sometimes he misses a dose when Grandma is caring

for him, since she does not know that he takes this. Yared's physical exam is significant for:

- Bilateral cervical and axillary lymphadenopathy
- Not able to cough
- Diarrhea 2 times during the exam
- Depressed developmental stage
- His growth has also slowed

- DNAPCR test is not done

1. Is there evidence of HIV infection?
2. Are there other problems or concerns?
3. What else should be done at this visit?

7.4.3. Pediatric HIV Care

Case Study 1:

- Elias is 12 months old with HIV infection. He has had no major illnesses or hospitalizations.
- He has bilateral cervical, inguinal and axillary adenopathy, persistent oral candidiasis, and is being treated for his 4th episode of otitis media. His growth is at the 10th percentile.
- What do we do for Elias?

Case Study 2:

- Selam is 7 years old girl with HIV infection.
- She is less than the 3rd percentile for weight for age, but no old data is available for comparison. On examination she is thin and small with no other abnormalities noted.
- How do you manage?

Case Study 3

Part one

- A 6 month old HIV exposed infant presents to the clinic 12 days after her appointment date.
- Mother complains her daughter has had a cough and diarrhea for the last 2 weeks

  What would you need to know about the patient's history?

  What would you do next?

How would you proceed?

Follow up in 2 weeks

Counselor noted mother needed to be at the market daily to sustain the family

- She was advised that she could come to the clinic early in the morning so she could still go to work
- The nurse advised her to continue breastfeeding and prepare tasty, tolerable and balanced diet from food available at the market

PART Two case continuation

- Mother does not return till her at her 7 month visit
- Baby's cough resolved, however diarrhea has persisted
- Weight has dropped to 5.2 kg despite mother following nutritional advice
- No fever or vomiting noted
- She is adherent to cotrimoxazole
- Stool studies from previous visit were normal

  What would you do now?
- Follow up in 2 weeks

What ARV drugs would you start her on?

- At next visit 1 week later, she has no new complaints, and is tolerating her medications
- 2 weeks later she has gained 500 gm,

Case Summary

- Good clinical judgment is vital when interpreting virologic test if they are discrepant with the clinical picture
- HIV is rapidly progressive in infants and infants diagnosed with HIV should be started on ART if eligible
- The multidisciplinary team can work together to help improve adherence and to develop a care and follow-up plan

7.4.4. Pediatric Adherence

Case study

- Kebede is a 2 yrs and six months old boy who has been enrolled in the clinic since birth.
- He begun ZDV + 3TC + NVP at 6 mo of age when he was diagnosed with pneumonia and failure-to-thrive. He has done very well on this regimen.

How do You Define ARV Treatment Success in children?

Discuss Kebede's Current Medications

Case continuation Alem, Kebede's mother, reports that lately she has been having trouble giving him medication. In the past he has always taken the ARV treatment easily, but over the last several months it hasn't gone well.

What Questions Should You Ask Alem?

Alem reports that he doesn't like the ZDV. He runs from her when she tries to give him his medications. She must capture him, hold him down, and force his mouth open to take the ZDV. He then gags and chokes, often vomiting the medicine. He takes the NVP and 3TC, but sometimes she thinks he doesn't keep them down either. Alem, having learned the importance of adherence, is worried.

What do you need to know to begin to determine the cause of Kebede's behavior?

What do you want to do now?

What are some possible solutions?

7.4.5. Pediatric Disclosure

Case Study

- Desta is an 11 year old girl. Her mother died five years ago and she has since lived with her aunt Amsale, uncle Yared and maternal grandmother Bogalech.
- Amsale was enrolled in the clinic during her pregnancy last year. Desta and Yared both tested HIV positive and were enrolled as well.
- Desta was eligible for ARV treatment based on a history of recurrent varicella zoster, chronic thrush and low CD4%.
- She began ZDV + 3TC + EFV
- She has done well on treatment.

Desta Resisting Medications

- Grandmother Bogalech brings Desta for her monthly visit. She reports that everything is fine.
- When asked about missed doses Bogalech reports that Desta gets all of her medication. She reluctantly mentions that Desta is fighting with her about taking her medications.
- What do you want to ask Bogalech?

  What should you do?

Why do you think grandmother Bogalech doesn't want to discuss HIV with Desta? What can the team do to help Desta and her family?

Case Study 2

Tarik is a 2 years old girl diagnosed to have Pulmonary TB. She looks very sick. She is also HIV positive and WHO pediatric clinical stage 3. Her CD4 percentage is 38%.

Questions

1. What anti Tb drugs will give to Tarik?
2. When will you start Tarik on ART?
3. What ARV drugs will you start?
4. Describe the challenges in managing children below the age of 3 who have TB/HIV co-infection with regard to use of EFV?

8. Annexes

Clinical Mentoring Tools

A. SKILL CHECK LIST FOR HEALTH WORKERS

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

Mentee:_____ Mentor:_____ Date: _____Facility_____

Qualification:_____.

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

Mentee Competency level assessment category

X= not applicable

1 = **none**: No demonstrated skills at all or does not perform the task (s) completely .Needs a lot of support

2 = **limited: Mentee** demonstrates very limited strengths or skills in this area and needs additional support

3 = **some: Mentee** demonstrates some ability or skills in this area.

4 = **Strong: Mentee** demonstrates excellent skills or strengths in this area

Completeness of Mentor's assessment

A =Comprehensive assessment– skill was assessed completely, Mentor was able to observe fully

B = Satisfactory assessment– assessment was satisfactory, although Mentee's skill may exceed that observed

C =Partial assessment—observations and scores based on incomplete information.

R = **Resource limits**–skill or care limitation clearly related to resource limits.

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

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

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

A. Preceptor Check List

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

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

Demonstrated knowledge and skills	**Comments**	**Codes1-4,A- C,R,X**
Professional and Interpersonal skills		
Provider is welcoming for the clients(Greets with dignity and respect)		
Briefly describe the purpose of the mentor ship program to the patient (i.e., the mentee need to explain to his/her clients who the mentor is and mentor's purpose)		

Patient centered(listens to patient's ideas and concerns)		
Creates trusting/supportive rapport with the patient (encourages open communication- Uses recommended communication skills to encourage and open the client to tell their stories)		
Timely(doesn't rush patient and doesn't take too much time-provides adequate time to address all concerns as well as does not take unnecessary too much time when it is not needed)		
Treats patient with empathy, dignity and respect (including confidentiality; maintain slow speaking voice)		
Assessment		
Conducts focused and open discussion of medical, social and family history and progress relevant to current complaint including assessment of adherence		
Use steam approach (shares information with adherence counselor, efficient interaction and lack of duplication)		
Conducts adequate physical examination(pertinent in relation to history and current complaints)		
Accuracy of assessment and diagnosis(including WHO staging)		
Patient management and care plan		
ART adherence, tolerance and side effects addressed.		
Appropriate involvement of patient in development of a focused management plan		
Appropriateness of recommended drug treatment (ART and OIs)		
Appropriateness of recommended laboratory tests		
Patient education on sexual and other risk behavior		

Emotional and psycho-social support needs discussed and addressed		
Gave appropriate Referral as required		
Develops appropriate follow up schedule		
Documentation and recording		
Appropriate history and physical examination findings are documented on the respective formats		
Documentations are complete and consistent		
All required formats are updated and complete		

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Ministry of Health

B. Chart Abstraction tool

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

CPT provision for eligible clients						
WHO Clinical staging/T-staging						
ART initiated for all clients as per the guideline						
Prevention plan(Disclosure, STI, Psychosocial support)						
Check intake form for completeness and updates on index case family testing						
Eligibility for appointment spacing care and whether client is provided ASM.						
Review last three months record on ART register and assess for Completeness and updates						
Review last three months record on Pre-ART register and assess for Completeness and updates						
Review retesting practice by checking recently initiated clients against the retesting register(Draw three newly initiated clients chart)						

Review completeness and consistency of the EAC support on the high viral load register for at least five clients records						
Service integration						
TB clinic: Check the TB-DOTS register for the last three months						
TB patients HIV testing						
Linkage to ART						
CPT initiation						
ARV initiation						
VCT clinic						
Check linkage of HIV +ve clients to ART care (last 1 month) with linkage confirmation mechanisms						
ANC/Labor ward: check the ANC, delivery and integrated MNCH/mother baby pair cohort registers data of the last one months						
HIV testing of all pregnant						

women						
Provision of ARV prophylaxis to the infant						
DNA PCR testing of the infant						
Review last three months record on mother baby cohort register(Completeness and updates)						
Pharmacy						
Check Stock out of any drugs(ARV,OI drugs)						
Adherence Counseling provided						
Pharmacy records are used and updated(Dispensing register and patient information sheet)						
Laboratory						
Laboratory machines Failure **YES NO**			If **YES** specify which machine			
Stock out of Lab Supplies (sample collection as well as			If **YES** Specify			

reagents **YES NO**						

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

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Ministry of Health

C. ART Pharmacy Mentoring Tool

General direction to the mentor: This checklist is to be filled by the mentor during every mentoring visit. If an activity is covered during mentoring (i.e. mentored), write YES, otherwise write NO. Write challenges (bottle necks) encountered during the mentoring process and write the assignments given to the mentor and the mentee or to any other party.				
Mentee facility: _____; WoHO name: _____ Mentee name: _____; Mentee mobile:_____ Mentor name:_____ ; Date of mentoring: _____				
Mentoring area	Major activities covered during mentoring	Yes / No	Challenges faced	Assignment for mentee **or** mentor
ART pharmacy service related	Briefly describe the purpose of the mentor ship program to the patient (i.e., what the Mentor is)			
	read the prescription correctly (**including patient name & age, medicine description, dosage instructions**)			
	Ask patients for the goal for			

	ART pharmacy visit			
	Check understanding of HIV/AIDS and ARV therapy			
	Ensure patients readiness and willingness for ARV therapy			
	Discuss importance of lifelong treatment adherence and identify adherence barriers.			
	Suggest possible solutions with the patient to improve adherence			
	Educate patients on the importance of adherence in the prevention of resistance			
	Encourage the use of adherence aids/reminder devices (e.g. alarms).			
	communicate the patient politely and provide proper information (**medicine name, dose, frequency and route of administration, medicine handling at home, cautions**)			
	Counsel patients/care taker during initiation of ART on potential side effects and how to			

	cope with them.			
	Explain medication dosing and how to handle missed doses.			
	Advise patients about medication toxicities, how to prevent or control them and when to seek medical assistance.			
	Discuss potential drug-drug, drug-food, or drug-alternative medicines interactions			
	Ensure patients get drugs with sufficient shelf life for use until next appointment (more attention to clients on ASM)			
	Correctly label all ARVs and OI medicines (patient name, medicine description, dose, frequency of administration)			
	Provide drug information specific to pregnant and breastfeeding mothers as well as children.			
	Counselling on family planning and condom use			
	Discuss with patients importance of regular follow-up			

	and scheduled follow-up appointment for refills to assess and identify clinical efficacy or treatment failure and to detect drug related toxicity.			
	Involve patients and their families as an active participant in their adherence plan.			
	Monitors and supports adherence regularly at each visit (especially in children)			
	Assess the patient about their current medications whenever filling a prescription that is new for them.			
	Monitor the ART outcomes and potential side effects of ARV medicines.			
	Monitor and identify potential drug–drug interactions, and recommend for dose adjustment or prevent co-administration of contraindicated medications.			
	Dispense Plumpy nut and Plumpy sup and counsel patients on their proper use.			

	Recommend dosage adjustment in renal and hepatic dysfunction.			
	Provide information to other healthcare providers about the next regimens to be used after switching or changing of therapy.			
	Should educate healthcare team members on ARV drug interactions, and its management			
	Participates in the MDT meetings regularly			
	Should have excellent coordination with multidisciplinary team to avoid/manage drug interactions or to monitor patients for treatment failure or toxicity.			
	Provide information for other healthcare provider on regimen selection, the availability of different options, dosage forms and consult on drug-drug interaction.			
	Discuss with professionals on			

	general issues related to treatment failure and potential prevention strategies.			
	Uses team approach (shares information with adherence counselor/case managers & data clerks)			
	Closely work and collaborate with prescribers in prevention and treatment of OIs.			
	Recommend drugs for the prophylaxis and treatment of common OIs.			
	Filling the patient information sheet (the yellow sheet) properly for every visit of each patient (check for its availability, completeness for each patient, updating practice and the sequential arrangement)			
	If available check for EDT functionality and updating practice			
	Check for the completeness of drug dispensing register			

	Check for the presence and completeness of monthly consumption summary			
	Provide appointment for next visit date			
ARV supply chain related	Continuously avail required medicines for prophylaxis and treatment of OIs.			
	Ensure that LPV/r suspension is kept in refrigerator. (N.B: If unable to refrigerate, use within 60 days. AZT, ABC & NVP suspensions DO NOT need refrigeration)			
	Arranging containers/packs/ with labels, expiry dates and manufacturing dates clearly visible in a way to facilitate FEFO.			
	Check for Bin Card availability, completeness and updating practice at both ART pharmacy and health facility store.			
	Check for RRF (completeness, timeliness, accuracy and chronological filing)			

	Check for IFRR (completeness, timeliness, accuracy and chronological filing)			
	Check for stock out of 1st line ARV drug (TDF/3TC/EFV)			
	Check for stock out of 2nd line ARV drugs (LPV/r)			
	Check for stock out of 100mg INH for IPT			
	Check for stock out of 300mg INH for IPT			
	Check for stock out of Co-trimoxazole for CPT			
	Check for stock out of Fluconazole for FPT			
	Check for stock out of rapid HIV Test Kits			
	Check for stock out of DBS Kits/accessories			

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Ministry of Health

D. Clinical Mentoring Activities Logbook

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

Types of cases discussed

_____
_____

Major achievements

_____
_____
_____

Gaps identified

_____
_____

Challenges

_____
_____

Actions taken

_____
_____

Recommendation/Planned actions

Mentors name and signature _____

Mentees name and Signature _____

Facility head name and signature _____

Date……

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Ministry of Health

E. Clinical Mentoring Activities Reporting Template

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

Mentor's Name_____ Sign_____

Mentee's Name_____ Sign_____

Date_____