‘CLINICAL’ MENTORING PROGRAMME GUIDE
A practical framework for the implementation of mentoring as a training programme in MSF Projects

MSF OCB
SAMU LEARNING UNIT
Acknowledgements

**Main contributors:** Olivier Bluteau, Sylvie Jonckheere, Ian Proudfoot

**Reviewing team & wise advisors:** Helen Bygrave, Tom Elman, Geneviève Erken, Isabelle Greneron, Kleio Iakovidi

**Cover photo:** A mentor guides a mentee in a primary care HIV clinic in Conakry. © Sylvie Jonckheere/MSF

© This 1st Official Version is a SAMU Kitchen Product. Any part of this material may be reproduced, copied or adapted, provided that the parts reproduced are free of charge, that the source is referenced and that notification is sent to Médecins Sans Frontières. All material may only be used for not-for-profit purposes.
**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy</td>
</tr>
<tr>
<td>CME</td>
<td>Continued Medical Education</td>
</tr>
<tr>
<td>DR TB</td>
<td>Drug Resistant Tuberculosis</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EAC</td>
<td>Enhanced Adherence Counselling</td>
</tr>
<tr>
<td>EMCC</td>
<td>European Mentoring and Coaching Council</td>
</tr>
<tr>
<td>HCW</td>
<td>HealthCare Workers</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>I.L.O.</td>
<td>Intermediate Learning Objective</td>
</tr>
<tr>
<td>IPD</td>
<td>In-Patients Department</td>
</tr>
<tr>
<td>L.O.</td>
<td>Learning Objective</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MAM</td>
<td>Medical Activity Manager</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MoU</td>
<td>Memorandum of understanding</td>
</tr>
<tr>
<td>NAM</td>
<td>Nursing Activities Manager</td>
</tr>
<tr>
<td>NCD</td>
<td>Non-Communicable Diseases</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-Patients Department</td>
</tr>
<tr>
<td>PCS</td>
<td>Patient &amp; Community Support</td>
</tr>
<tr>
<td>PMR</td>
<td>Project Medical Referent</td>
</tr>
<tr>
<td>PoC</td>
<td>Point of Care</td>
</tr>
<tr>
<td>SAMU</td>
<td>Southern African Medical Unit</td>
</tr>
<tr>
<td>S.L.O.</td>
<td>Specific Learning Objective</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard operating procedure</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual &amp; Reproductive Health</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>ToT</td>
<td>Training of Trainers</td>
</tr>
</tbody>
</table>
What can you expect from this guide?

MSF has been implementing a variety of clinical mentoring programmes for quite some time. Under the label 'light approach' or 'mentoring', MSF staff have been striving to build the capacity of partners, mainly local MoH staff. Following evaluation of some these programmes (in Gutu - Zimbabwe, Roma – Lesotho and Khayelitsha – South Africa), a shift was activated in 2014 and piloted in the Roma (Lesotho) SRH/HIV project.

This experience - and many others since - has led to the development of a stronger framework to support MSF Projects running mentoring programmes as a main component of their activities. Although initially developed for clinical mentoring at OPD level, it is now being used for IPD, Patient & Community Support, Pharmacy, & Lab capacity-building of MSF and MoH partners.

This guide is meant to support Coordination / Project teams in implementing new or framing existing mentoring activities. It should really be taken as an outline, and not as a protected piece not to be altered. It formalises what many have experimented with.

To help pave your way to successful mentoring activities, this guide
1. defines a few fundamental concepts
2. reviews factors that have been identified in previous MSF project as ‘conditions’ to increase the likelihood of a successful mentorship
3. lays out practical steps for implementation
4. introduces some important tools

Tips on mentoring for mentors are summarized separately in the Mentoring Job Aide.

Some examples from actual MSF projects are made available as inspiration for the teams who will have to go through the process and adapt tools to their context and needs.

 Needless to say, this framework is not set in stone. It is a guide rather than a guideline. It evolves as projects face new challenges. Thus, any feedback, questions or ideas you might have are more than welcome to samu.mentoring@joburg.msf.org.

Mentoring can be adapted to a variety of setting. MSF proposes mentoring for MSF managers (Coordinators) through the Oslo Mentoring & Coaching Hub (mentoring-coaching.msf.org). This guide is specifically addressing clinical and closely related field mentoring, focussing on building individual competence in order to impact patients’ health.
The ‘Clinical’ Mentoring programme Guide – the booklet you are currently reading sets a frame for projects willing to implement mentorship activities.

Mentoring Job Aide – Collects all hand-outs of the SAMU training of mentors (ToT-M), i.e. one-pager reminders on key concept of mentoring, teaching or communication.

ToT-M – SAMU can organise a training of your team in your project. Requests can be addressed to your SAMU Focal Point.

Mentoring MIO Support - This framework is sometimes easier to digest after a quick briefing. All questions and request for support can be addressed via your SAMU Focal Point.

SAMU Website – You will find all tools (including mentee & mentor handbooks) as actual Word or Excel documents in the Resources section on samumsf.org.

Important Information

Ideas from the Field

Detailed in the Mentoring Job Aide

To be found on the SAMU Website samumsf.org
What is Mentoring?

To make sure we all speak the same language, here is a little introduction on basic concepts of mentoring.
1. Definition of Mentoring

MSF mentoring activities are all based on a common understanding of mentoring. The SAMU’s clinical mentoring framework is built on the definition as follows:

“Mentoring is a personal learning relationship outside of hierarchies and operations. A mentor (an experienced person) allows a mentee (a less experienced person) to gain and develop knowledge, abilities, and maturity in a specific position or a professional area that they share.”

It could be depicted as seen below. We will discuss its and its consequences throughout this guide.

It is often compared to coaching (which does not require a common field of practice, and aims at individual fulfilment of a person’s potential), or to supervision (which entails a hierarchical contractual relationship). There is some possible overlap between supervision and mentoring activities (see Chap. 2).

For further definitions of Mentoring vs Coaching, refer to the Oslo Hub Website (mentoring-coaching.msf.org) or to the summary of OCB L&D on OOPS

1 For those of you interested to go beyond this guide, this definition is based on publications by David Clutterbuck. It differs from the US common understanding of mentoring which is closer to sponsorship.
2. Mentoring as an approach to develop competence

Mentoring is one approach to building competence of individuals. It is one of the most powerful training modalities, since it offers possibilities to address all foundations on which we build skills.

- It can provide learners with appropriate technical theoretical knowledge (e.g. clinical, patient support, lab...) through didactic trainings ('classroom' trainings - PEDAGOGY) in order to fill a knowledge gap (Δ).
- It also provides opportunities to guide them in applying this knowledge to their work environment (TRANSFER of knowledge into competencies).
- It also provides regular back-and-forth processes between theory and practice, along with opportunities for reflecting on on-the-job experience and sharing it with others (concept of reflexivity).
- The aim of increasing the competence of several individuals in a facility, is that it will have a broader impact, on the health of patients in general (EFFECTS).
3. Mentoring definition in practice: it takes time

This definition of mentoring implies the following:

- We mentor **individuals**, not facilities. Chap. 2 details how mentorship fits into an MSF-MoH partnership.

- The main vehicle for learning is the **relationship** between mentor and mentee. If you face any issue with implementation, frame your solutions to promote long-term, personal and confidential relationships. Mentors and mentees need time to establish a rapport and maintain their relationship. Although providing standards is hazardous, it is usually considered that an average contact ratio of 4 to 6 hours per week over an average of 12 weeks would be **ideal** to meet our understanding of clinical mentoring. More than half of this time should be spent in side-by-side provision of care and optimising opportunities for learning.

- It is a long-term process with a beginning and an end, **focused on specific learning objectives**. Even if several cycles are anticipated, the relationship should not fall into routine, aimless visits.

---

**Idea from Gutu (& Roma & Embu) - The Substitution Option:**

Providing additional staff to substitute for the mentee while he/she is being mentored was done in Gutu because of the workload caused by then new ART-initiation activities in already busy health-centres. This took the burden off the remaining consulting staff. Where the workload is perceived as disproportionately high, a substitution scheme increases:

- the quality-time mentors can spend with their mentees
- the likelihood of acceptance and support from the rest of the clinic

(see diagram showing the staff distribution for the substitution model in Appendix 9).

The provision of additional HR in a clinic might however

- lead to absenteeism of the non-mentored staff
- increased attractiveness, with patients clustering in clinics on ‘MSF days’
How Does Mentorship fit into the MSF-MoH Partnership?

In several contexts, MSF chooses to partner with other actors (usually the Ministry of Health) in order to support existing or implement new activities. This approach aims at increasing access to healthcare (by increasing coverage) and improving the quality of care, while fostering sustainability. It is often considered as an option for exit strategy, handing over activities to MoH but ideally should be an integral part of any MSF project from the inception of the project.

Although it involves fewer expert MSF staff, it is by no means a ‘light’ intervention, as you will come to see for yourself.
1. MSF Activities within the partnership

The first aim of MSF intervention is to provide care to patients. The partnership usually delegates the direct care to the partner, but include a variety of activities, from building rehabilitation to pharmacy supply, and more often than not involve plans for capacity-building of the staff. Training staff or providing diagnostics or medications will all contribute to improve the patient’s health.

2. Support facility performance

Several interventions can be used in a partnership to improve the overall the quality of patients’ care i.e. the performance of a facility. MSF usually implements a combination to increase chances of success. Many involve capacity-building of individual staff (mentoring, coaching...), while others are more ‘systemic’ interventions (supportive supervision, algorithms, m-health, dashboards...).

‘Supportive’ supervision² encompasses activities aimed at a facility (rather than individuals) that will promote an environment auspicious for adequate service delivery. It focuses on the conditions required for proper functioning of the clinic and clinical team.

Each intervention requires staff with a specific skill-set.

‘Quality Improvement’ is a set of interventions that would assist HCW to identify and solve problems of poor or inadequate performance.

This guide will include some tips on performance-enhancing activities beyond mentoring (M&E, dashboards), considering how intertwined all of it is.

---

² The WHO ‘Supportive’ supervision differs from MSF’s ‘Formative’ supervision which describes a line-manager’s approach to capacity-building of individual staff members.
3. Role & Responsibilities of MSF teams in a partnership

Capacity-building of MoH staff can be done in various ways. As stated above, mentoring is one of the most evidence-based approaches to clinical education of healthcare professionals. It is often compared to supervision.

As a partner, MSF will rarely have hierarchical managerial relationship with MoH staff that is necessary for actual supervision. MSF is more likely to implement mentorship, with activities that will overlap with supportive supervision.

The potential for overlap is summarized in the figure below:

**Fig 1. Supervision vs Mentoring – Potential overlap of activities**

Mentors need to keep in mind that a crucial aspect of mentoring is to promote a nurturing relationship with the mentee. When incorporating supportive supervision activities, clinical mentors should take a different approach than the DoH. They should keep in mind that the goal of these activities is to improve the clinical environment rather than to audit the quality of care. It is thus best to have separate visits from the DoH Supervision Team. Within the MSF team, mentors should not participate in supervisory activities such as facility performance evaluation in a facility where they routinely mentor.

This is not merely a semantic debate. Although clinical mentoring and supportive supervision overlap considerably, the activities are different enough that they would require specific skill sets. MSF staff will need to be recruited (hopefully), trained but mostly supported accordingly, for these activities to be performed adequately.

The theoretical concepts underlying both supervision and mentoring are summarised the Mentoring Job Aide.
4. Timeline of a partnership

Each partnership is a project on its own, going through several phases. Each phase may require presence of different staff, and with various intensity.

Any active mentoring in a facility will belong to an ‘intensive support phase’ for that specific facility. However once mentees are deemed autonomous, facilities shouldn’t be abandoned.

A ‘maintenance support phase’ could consist of any activity fostering continued education, maintaining a culture of learning in the facility (e.g. monthly case discussions, CME facilitated by the former mentees...). This progressive withdrawal of the support should help maintaining:

- Regular back-and-forth processes between theory and practice (reflexivity)
- Keep former mentees in a stage where they “know that they do know” (self-confidence).

Other activities carried out within the MSF – facility partnership should not be affected whether active mentoring is underway or not, and thus should continue as planned during a maintenance support phase.

5. M&E and the partnership

The achievement of a project's operational objectives depends on many factors. Training and mentoring contribute to it, but they are not the only factors. Many organisational and contextual parameters also come into play. It is therefore often difficult to measure the direct link between training/mentoring activities and the achievement of a project’s operational objectives.

It correlates that entry and exit criteria from a partnership should not be worked solely around the mentorship, since several activities may contribute to the objectives.

Monitoring of the mentoring activities and their impact will feed and can be included into the monitoring of a project’s objectives (log-frame).
Success Factors of Mentoring Programmes

Success factors could also be considered as pre-conditions to programme implementation. The majority of them should be addressed, even minimally, to ensure the likelihood success, i.e. skill development of staff, while preventing MSF mentoring teams’ frustrations.
The 8 factors listed below are an opportunity to review a few ‘theoretical’ concepts underlying the framework.

<table>
<thead>
<tr>
<th>Curriculum planning &amp; structuring (opening/closing + Objectives)</th>
<th>Selection &amp; training of Mentors</th>
<th>M&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation (or at least certification)</td>
<td>Other Factors ?</td>
<td></td>
</tr>
<tr>
<td>Support &amp; involvement of the leadership MSF &amp; partner</td>
<td>Formalisation by contract</td>
<td></td>
</tr>
<tr>
<td>Prior communication &amp; briefing w/ partner at all levels</td>
<td>Share results / feedback on process w/ all levels of partner organisation</td>
<td></td>
</tr>
</tbody>
</table>

All of them should be proactively investigated to ensure the likelyhood of skill development of staff, success of the partnership and last but not least, prevent MSF teams’ frustrations.

Mentoring should not be an "underground” and poorly structured activity! (i.e. mostly sacrificed in favour of daily tasks). Paying close attention to these success factors should contribute to it.

Some may not be fully sorted by the time mentorship starts. They should however all be regularly re-addressed (accreditation, M&E). Others absolutely require thorough polishing prior to initiation (Curriculum structuring, recruitment and training of mentors, prior communication at all levels within MSF and partner organization).

As such, they are not pre-requisites to mentorship implementation. They are merely the most efficient mitigation measures MSF can implement. They are meant to compensate for context-related issues that might hamper the partner’s and the mentees’ motivation to change.

Most of the following factors have been identified through evaluation & lessons learned from past and current mentoring activities. They are further corroborated by literature review as well as quality criteria retained by the EMCC (European Mentoring & Coaching Council). Further factors could be identified through your project: make sure to create opportunities to learn from your experience, and share with others!

Usefulness beyond mentoring

These success factors, although identified for mentoring programmes, would be as important to consider for any other type of support to partner facilities.

Challenges to mentorship implementation commonly identified by mentoring teams are summarized in the mentoring Job Aide

---

3 Motivation towards education will depend primarily on whether mentees’ primary needs are met or not (hierarchy of needs). For example, lack of regular income for HCW is difficult to mitigate without a more substantial (and less sustainable) interventions such as payment by performance. It makes mentoring less likely to succeed and more complicated to implement.
1. Curriculum planning and structuring

Structuring a curriculum is the most essential step when considering implementing any kind of training. The following steps can guide you through the process:

1. The first step is the identification of healthcare needs to cover. This needs analysis should highlight what issues are related to lack of knowledge or competence of healthcare workers, and those related to more logistical or managerial matters.
2. Once training needs are collated, it is important to identify the healthcare cadres that need to be targeted by the mentoring programme, and the specific tasks they should be able to perform (which de facto will become the learning objectives).
3. Then sequences of the curriculum and their duration (weekly, bimonthly, etc.) can be laid out.
4. It is fundamental that the mentorship has a clearly identified starting and ending point, so that both mentees and mentors can take stock of their achievements within a definite timeframe.

2. Prior communication

Define a communication strategy for the mentoring programme to formalise the activity of mentoring, make it official and transparent, to foster buy-in at all levels.

With whom? Mentoring activities should be known and understood by all players involved (MoH at all levels, other NGOs working in the catchment area).

When? Use any and all opportunities to communicate. To wrap-up this communication process, plan on opening and concluding sequences of the programme, involving supervisors, mentors, mentees and management.

Content? What is mentoring, the objectives and expectations (e.g. remove any financial compensation), defining roles and responsibilities of participants and their supervisors.
3. Mentor recruitment and training

3.1 Selecting Mentors

Ideal mentors are **experienced peers** to their mentees, matched in culture, language and qualification. Whenever this cannot be achieved, potential barriers to communication should be explored when building a relationship with the mentee.

More importantly, mentors should have skills in 3 domains:

- Good technical skills and experience, whether they are clinicians, counsellors, lab-techs or pharmacists to ensure their **legitimacy**
- Communication skills (ability to enter into a personal, constructive relationship)
- Teaching skills (or willingness to develop them)

**Technical expertise & experience**

- Whatever the field (HIV/TB/SRH/NCD...) a mentor can hardly be legitimate if not more experienced and more knowledgeable in that field than their mentees. This includes:
  - Knowledge of guidelines & SOPs
  - Work experience
  - Problem-solving capacity (in patient management)

**Communication skills**

- Active listening in order to identify actual needs and the ability to nurture a confidential and respectful relationship is paramount
- Capacity to give constructive feedback to mentees (including in the presence of patients).
- Helpful attitudes would include being: respectful, non-judgemental, open-minded, patient, confident but with ego kept under control...

**Teaching skills**

- This framework implies a fair amount of teaching to small groups of adult, this implies yet another set of competencies. These include:
  - Being conversant with adult learning principles
  - Designing learning objectives
  - Being comfortable speaking to a group of people
  - Group management
  - Time management
  - IT skills

---

An example of Mentor Job Description can be found on the SAMU website Mentoring Resources
3.2 Training Mentors

All mentors cannot have all the required skills from the start. They need to be legitimate technicians (clinicians, counsellors, lab-techs...) with the appropriate range of soft skills. They should therefore be supported in both clinical and pedagogical skills. Several options are listed below:

- **Technical proficiency:** Mentors should remain conversant with latest guidelines through:
  - Clinical trainings organised regularly
  - Access to updated guidelines and SOPs
  - Opportunities to maintain minimal hands-on experience

- **Teaching and communications skills** can be addressed through a formal *Training of Trainers-Mentors (ToT-M)* that can be organised at any time during the programme implementation.

- Weekly meetings of mentors are encouraged to create a peer-to-peer learning environment. It should provide mentors with opportunities to learn from each other in all 3 domains. Mentor’s self-evaluation sheet assessing his/her mentoring practices, successes and challenges should feed these weekly / bi-monthly discussions (see Appendix 5)

- Supervision from the line-manager (NAM/MAM/PMR) is of paramount importance in all 3 domains

---

**Idea from Kinshasa HIV Project:**

To ensure PHC nurse mentors and IPD doctor mentors stay very much in touch with latest practices, a rotation system between the CHK and the decentralization team has been implemented. It is a potentially very powerful system, hit a few hurdles:

- the need to synchronise the rotations with mentoring curriculum in order not to break the mentor-mentee relationship half-way through the curriculum
- the admin-related potential change of contract or salary

---

In the HIV/TB field, the following are therefore offered (see the SAMU website)

1. SAMU HIV/TB clinical and programmatic training
2. Remote technical support and/or SAMU site visits

---

4. Support and involvement of the leadership

Discussions and negotiations with different stakeholders will be necessary during the mentorship. Initial and continued support and willingness from the ‘hierarchy’ on both sides (at project and country level) will thus be essential.

- MSF: support and involvement of the whole team (PMR, FieldCo, Medco)
- MSF/MoH programme (district) directors and health centre supervisors.

This will enable discussions on topic as broad as Patient management protocols or as focussed as HR allocation and retention. It should help foster future geographical scale up.
5. Accreditation

Mentees need to see there is something for them to gain in the process. It is always worth asking prospected mentees what they would wish for, it is the best way to foster buy-in (motivation). Recognition and accreditation of the curriculum by the national health authorities helps tremendously. When accreditation is possible, it considerably reduces the obstacles often encountered in the implementation of the mentorship. Many national programmes have their own guidance/mentoring systems. It is advisable to explore how our activity can be recognised within the existing systems of accreditation.

As a halfway measure, **MSF certification** can be of value. Criteria for granting a certificate of competence have to be clearly set before the initial briefing of mentees. It can include minimum standards for:

- **Attendance** (e.g. 85%)
- **Knowledge** (post-test result, e.g. 80%)
- **Practical skills** (last observation, e.g. 80% based on the 3-points scale)

**Idea from Khayelitsha**

The training programme developed in Khayelitsha to facilitate task-shifting of HIV-patients’ management to nurses in the 2000s was a major contribution when the NIMART (Nurse-initiated and managed anti-retroviral therapy) accredited programme was rolled-out in South Africa a few years later.

NIMART and its accreditation made the programme one of the biggest, most sought after and successful accredited mentorships, now translated into NIM-DRTB and other programmes in the country.

6. Formalisation by contract (legal or symbolic)

Establish contracts at all levels of responsibility:

a. **MSF/MoH**: at the director level (Agreement Protocols - MoUs)
b. **MSF/MoH**: at the clinic and hospital level
c. **MAM/Mentors’ supervisors**: at the level of the nurses/doctors in charge of health facilities, department heads, etc.
d. **Mentor/mentee**: symbolic Mentoring Agreement
   - Ensure **commitment** and explores **motivation** of the mentees, i.e. their **willingness to be mentored** (desire to learn new skills and abilities, participate in discussions and being receptive to constructive feedback).
   - Define and clarify each person’s roles and duties
   - Define confidentiality parameters and other foundations for trust
   - Provide mediation clauses in the event of problems developing

7. Sharing Results – Reporting Progress

Organise and **communicate** the progress and results of the mentoring programme for all levels of partners involved:

- At the level of MSF and MoH (district) management → dashboards and quarterly reports
- At the facility (clinic and hospital) level → dashboards
- At the individual (mentor/mentee) level → handbooks
8. Monitoring and Evaluation

The mentoring M&E system intervenes at four different levels, for which specific tools can be implemented:
1. The mentee
2. The mentor-mentee relationship
3. The mentor
4. The effectiveness (‘impact’ in lay terms) of the mentoring training programme on the operational objectives of the project, i.e. programme indicators

8.1 Of mentees: progress in their clinical knowledge and skills

Several parameters can be monitored with different tools, for different purposes:
- **Pre/post-test** → progress in knowledge (if pre- and post-test available)
  - achievement of minimum standards of knowledge (if post-test only)
- **Attendance** → commitment of participants
  - monitoring of mentors’ activities
  - should include monitoring of other healthcare workers’ absenteeism (collateral damage)
- **Mentoring observation grid** → individual competence in the workplace
  - assess implementation of knowledge and attitude
  - progress in competence if an initial evaluation was done
  - is a proxy to availability of services
- **File reviews** → is a retrospective analysis of unguided consultations
  - can serve as preparation of future consultation = training method
  - can assess quality of documentation
  - not always applicable, if several consultants are involved for each patient

8.2 Of Mentors

- **Mentor’s self-evaluation** → reflection on own confidence to perform tasks
  - identify own gaps for improvement
- **Supervision of Mentors** → assess performance both technically and pedagogically
  - require careful briefing of mentees and patients
  - see tool in Appendix 5
8.3 The mentor/mentee relationship

The success of a mentoring programme depends significantly on the quality of the relationship between mentor and mentee. This aspect is often underestimated and therefore overlooked (e.g. limited time with each mentee, frequent changes of mentors or mentees...).

- Mentoring Agreement → identify commitments and expectations
- Feedback (mid-course & final) → checking on adequacy of the relationship
- Quantifying the relationship → frequency & duration of visits

8.4. The impact of mentorship on operational objectives of a project

Lastly, it is important to make the connection between the objectives of the mentoring programme and their contribution to the operational objectives of the project.

This involves showing the connection with the project log-frame (selecting a few key indicators for monitoring the performance of the programme). These are best drawn up in collaboration with the MSF project coordination early in the development of the mentoring programme.

It is interesting to choose a mix of process and outcome programme indicators. It helps to measure the impact of a mentoring programme both at facility level (work of healthcare workers) and on patients’ health.

- **Process indicators**
  
  depict performance of a facility in providing good quality services. Intuitively, process indicators would depend more **directly** on mentoring activities, since they are mostly related to healthcare providers’ activities.
  
  e.g. **Proportion of active HIV+ patients having VL done at 12 months of ART**

- **Output indicators**
  
  should always be considered with regards to input, but greatly depend on the patient’s access to and use of services when expressed in absolute numbers.
  
  e.g. **Number of patients on ART**

- **Outcome indicators**
  
  are the most relevant when assessing if a project reaches its objective when measured through routinely collected data. The impact of the mentoring programme on outcome indicators is more **indirect**, since they also depend on patients accessing the services and their adherence to the care provided.
  
  e.g. **Proportion of HIV+ on ART with VL < 1000 copies/mL**

To be pragmatic, almost no indicator should be added for mentoring purposes only. Having mentees trained can indicate availability of services, and autonomy of a facility is paramount when monitoring the possibility of exiting a partnership.
Operationalizing a Mentorship Plan

Practical Steps & timeframe

Here are a few more pragmatic tips on steps to take when a project moves forward with mentorship: what to do, when to do it, and tools to help do it.
The delivery of mentorship should be considered along the same steps as any training or project – the steps of a training/project cycle. For the sake of clarity, it is summarized into three pillar phases: preparation (or planning phase), implementation (doing phase) and evaluation (check and act to plan phase).

**Preparation Phase**

**Duration:** 3 weeks to 3 months, depending on
- prior partnership,
- mentoring experience of the team

Applies whenever planning a new mentoring partnership (new mentees, new content, new facility).

**Evaluation & Follow-Up**

**Duration:** 2 weeks to 2 months
Always applies, to decide whether to remain in same facilities, move on to others or start mentoring mentors for handover

**Follow-Up**

Continue monitoring
Less intensive support or new cycle

**Evaluation**

Indiv. achievements
Impact on prog. objective

**Needs Analysis**

Healthcare Needs
Training Needs

**Design**

Identify Target
Learning Objectives
Select Mentors
Agreement

**Development**

Session Plans
Training material
Teaching/Job Aids

**Implementation**

Opening & Closure
Conduct classroom & on-the-job sessions

1. Opening
   1/2 to 2 days
   • Selection of mentees
   • Briefing on Mentoring
   • Programme presentation
   • Pre test knowledge

2. Implementation
   (6 to 12 weeks)
   • Alternate didactic & on-the-job training
   • Follow-up of learning process
   • Follow-up of the mentor/mentee relationship

3. Closing
   1 day to 1 week
   • Post test (knowledge)
   • Final evaluation of competencies
   • Feedback
   • Certificates

Each phase is further detailed in following pages.
1. Preparation (Needs Analysis, Design & Development)

Laying the foundations for a mentoring programme is probably the most important step. Several key questions are outlined below to support doing this work in a systematic way.

1.1. Needs Analysis

Any learning experience offered needs to start with a careful analysis of the learning needs. A comprehensive learning needs analysis is therefore the critical first step in the development of a mentoring curriculum.

We need to state here that the starting point remains the medical project objectives from which we assess corresponding individual training needs (e.g.: if our medical target is treatment initiation: we will then assess training needs of clinicians in treatment initiation, not in OI management).

The more comprehensive the initial analysis is, the greater the likelihood of a successful outcome. This is best conducted collaboratively with the local staff in the project. Such an analysis needs to take into account the following:

1. The **health needs** of the population and the nature of engagement with those needs as outlined in the *project log-frame*
2. Whether mentorship would actually address the real problems (i.e. is the primary need actually training or programmatic or organisational / structural?)

For the purpose of assessing the learning needs to be met through mentorship as a training programme, we will assume that the initial work has already been done, the need for a *clinical* training has been deemed appropriate.

1.2. Design Phase

1.2.1. Identify target group(s)

In order to structure a curriculum, the following questions need to be considered: Who should be able to perform what responsibilities, where in the facility and when?

1. What is the **target group** for the mentoring?
   
   e.g. can basic counselling be addressed by training a group of experienced nurses, or should there be a curriculum dedicated to lay-cadres?
   
   This has a significant impact on how the training will be structured. This is a direct consequence of a core principle of adult learning: adults are generally uninterested with content that is not useful to them on a daily basis.

---

**Idea from Nsanje**

The use of a *schematic drawing* depicting patient flows helped identify the various points of care and which cadres was needed for each station. It enabled the team to segregate tasks, identify pitfalls (cadres intervening at the beginning and the end of a patient’s visits in different locations) and structure a specific curriculum for each cadre.
2. The next step is then to define the more detailed learning needs: what tasks do we want the target group(s) to be able to do? The information can be gathered in a number of ways:
   - Meetings with the clinicians to hear of their learning needs
   - Discussions with local medical managers regarding their observations
   - The use of a variety of tools in health centres:
     - Job description (if any)
     - Observation of consultations
     - Evaluation of a set of files in a health centre (on a pre-established set of criteria).

3. While carrying out the observation, mentors should also assess
   - where the mentoring will happen, what space is available (are consultation rooms big enough, is there space for teaching groups, are there chairs, black-boards, should the patient flow be re-organised?), and
   - when it will happen. It is useful to ask the future mentee when they would be most available for classroom teaching, or when specific consultations (ART Clinic, TB day, ANC days...) are happening.

Ultimately, a curriculum will be designed for each HCW cadre identified (Nurses, COs, MDs, Counsellors), and the tasks they should be performing. No side-by-side training can happen if we do not know whom to aim it at, and where and when it can happen.

In parallel, all prior communication at all levels of the MOH can be carried out, and agreement formalised into MoUs.

1.2.2. Develop curriculum

In order to design a mentoring curriculum, it is essential to formulate learning objectives (LOs) for each topic carefully. It will ensure the curriculum is oriented towards what the trainees need rather than towards what we think we should teach them (see an example of curriculum in Appendix 1).

---

**Idea from Eshowe**

When an activity needs to ‘handed over’ through mentoring, the easiest process is to sit with the staff actually performing these activities/tasks and proceed in 3 steps. After visualizing the tasks to be performed, help the team identify the necessary knowledge to be imparted, or the attitude with which the tasks should be performed.

<table>
<thead>
<tr>
<th>1. Activities</th>
<th>Intermediate Learning Objective</th>
<th>Perform Screening &amp; Diagnosis of TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Tasks</td>
<td>Specific Learning Objectives in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• applied skills and</td>
<td>Systematically ask 6 TB screening</td>
</tr>
<tr>
<td></td>
<td>• behaviour</td>
<td>questions to all HIV and Diabetic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>patients</td>
</tr>
<tr>
<td>3. Knowledge</td>
<td>Define Knowledge to be imparted</td>
<td>Document TB screening in ART Card</td>
</tr>
<tr>
<td></td>
<td>in order to be able to achieve</td>
<td>for all PLWHA</td>
</tr>
<tr>
<td></td>
<td>those tasks</td>
<td></td>
</tr>
<tr>
<td>Behaviour</td>
<td>Define Behaviour to be outlined</td>
<td>List common signs and symptoms of</td>
</tr>
<tr>
<td></td>
<td>and promoted for the patients'</td>
<td>TB in HIV and/or diabetic patients</td>
</tr>
<tr>
<td></td>
<td>benefit</td>
<td></td>
</tr>
</tbody>
</table>
The process of writing up learning objectives is core to structuring a curriculum. It is important to use active verbs when formulating them. See the Job Aids for further tips.

### 1.2.3. Identify mentors

**Mentors** are usually identified at this stage. It is then paramount to confirm they are conversant with the tasks identified, the SOPs and guidelines being written.

**Communication with facilities** and potential mentees should also start at this stage, with proper briefing of all stakeholders.

#### Ideas from Embu

As a new project, the Embu NCD mentorship was able to undertake a thorough preparation phase. The following preparation was carried out over 3 months, while waiting for MoUs and drug-supply:

- Mentors were *specifically recruited* for their experience in NCDs or/and in mentoring / teaching. They then participated in a one-week *NCD training* followed by a 6-days ToT-M.

  The activities then started with a 3-months ‘*embedment*’ of all nurses and clinical officers in the facilities involved in the first phase of the mentorship. These initial 3 months gave the whole team specific insight into their MoH colleagues’ capacity. It also came as an early warning for absenteeism, seeing how a few HCW then did not show up for work, seeing patients were going to be attended by the MSF team.

  Even though not all mentorship programmes are new, it is sometimes best to take a step back and ensure this preparation phase is properly addressed.

### 1.3. Development of tools and training material

The observation grids are a direct product of these learning objectives collated into coherent curriculum.

The specific learning objectives will also be used to develop training material for:

- Classroom didactic teaching sessions, directed at small groups of adult learners (interactive). Teaching methods will need to take into account logistical constrains (scarcity of electricity, projectors)
- Work-place training, either:
  - Side-by-side mentoring (role-modelling, observation and feedback...)
  - Case studies when conditions do not present often (e.g. CMV retinitis in PHC)
  - File reviews to address specific population (e.g. HIV+ adolescents)

The initial production of these teaching materials can be time consuming, but if properly done, only minor tweaks would be needed when the curriculum is repeated in other facilities for example.
2. Implementation

Learning objectives define the content of mentoring sessions. Each (weekly) session is usually structured around 1 didactic classroom teaching session and one or more bedside mentoring moment(s). These sessions focus on one activity (intermediate learning objective) and a series of responsibilities (tasks and attitudes - specific learning objectives). The succession of these sessions will constitute the mentoring curriculum.

If staff availability is limited (turn-over, night shifts etc.), or if the curriculum is too extensive, the sessions can be grouped into a succession of ‘chapters’ (or module, the name is of little consequence).

The mentoring curriculum is spread into coherent units, the length of which depend mostly on:

- The attention span most suitable before mentoring falls back into routine visits (mentees are less likely to perceive their achievements when the curriculum drags beyond 6 months).
- The probability of mentees and mentors remaining available.

Whenever the objectives are complex /broad enough, they should be spread over several modules so that no unit spans more than 12 weeks.

It is important to plan fulfilment of the curriculum within a timeframe, for both mentors and mentees to be able to appraise their progress and achievements. Opening and Closing steps help in formalizing the timeline.

**OPENING STEP**

It can be an extensive and political event, or a basic agreement on continuing activities for a subsequent ‘chapter’.

**DURATION:** This is an important stage of the mentorship, which may last 0,5 to 2 days.

**ATTENDANCE:** presence of MSF managers and MoH supervisors is essential, with both mentees and mentors!

**OBJECTIVES:**
- Officially begin the mentoring programme
- create a shared dynamic
- Present the system to mentees
- Perform an evaluation of mentees’ clinical knowledge (pre-test)
- Record mutual expectations of mentees and mentors (and dispel misconceptions)
- Sign mentoring agreements (mentor-mentee)

**FORMAT:** can either be a centralized half-day training with drinks and snacks up to a week-long training with official ceremony at the end: it will depend need for visibility, buy-in or acceptance.

**IMPLEMENTATION STEP (6-12 weeks)**

Succession of alternating didactic ‘classroom’ and practical, on-the-job mentoring sessions.

- The classroom teaching sessions (45 to 90 min) take place in each partner health centre. They target all staff including the mentored staff. They generally take place after the morning consultations (when the work load is less). It is recommended that they be scheduled on the same day of each week and at the same time to establish this activity as part of the health centre’s routine.
- Side-by-side mentoring sessions involve only selected mentees, should take up to 75% the time spent in the facility

Methodologies should be interactive, with theory that introduces exercises and clinical cases. As much as possible, stick with methodologies taking the existing knowledge of participants into account. See the Yellow Section of the Mentoring Job Aide
CLOSING STEP

**Duration:** 1 to 2 days  
**Attendance:** identical to opening phase  
**Objectives:**
- Make the end of the mentorship official  
- Collect feedback on the process from mentors and mentees  
- Submit the results of the knowledge and skill evaluation (post-test + mentoring session observation)  
- Award certificates/diplomas

---

**Ideas from Conakry**

Implementation of the mentorship for PHC doctors follows an original 3-steps schedule:

I. Mentees first attend the ‘Basic Clinical HIV/TB Training’ facilitated by the mentoring team and their supervisors (1 week)
II. The second step is an ‘internship’ in the MSF-led HIV consultation at Matam HC (3 weeks)
III. The mentorship is then taking place is each mentees’ heath centre (12 weeks)

It gives mentees an exceptional opportunity to consolidate their acquired knowledge and experience. It permits them to review certain chapters, reflect on existing practices, and review what they have learned. In short, it represents exceptional training potential for mentees. It is however important to take the following constrains into account:
- The number of mentees who can do the internship simultaneously is limited by the number of MSF consultation in the ‘reference’ centre  
- The internship needs to be structured around specific objectives as well (active observation)  
- Staff facilitating the training or leading consultation during the internship need to be trained in mentoring skills
3. Programme monitoring, evaluation and follow-up

Several tools have been developed to document individual and programmatic data.

3.1 Mentee and mentor logbooks – individual M&E tools

The monitoring and evaluation tools for each individual follow-up amount to a few documents. In the interest of practicality and clarity, they have been grouped into two handbooks, for both mentee and mentor.

Mentee handbook (see an extract in Appendix 2)

This serves as the mentee's "learning passport" and is the central tool of the system. It centralises all mentor/mentee interactions and training.

It is a "double entry" handbook, which follows the technical (clinical) training aspects on the one hand, and the mentor/mentee relationship on the other.

Mentees may what they learn here as well as questions or problems encountered when not accompanied by their mentor. Mentors may write summaries of mentoring sessions as well as recommendations and other information useful for mentees' development. This handbook is essential to a successful outcome of the programme.

Mentor handbook

Mentors have their own "mentor handbook" in which they summarise the progress of each of their mentees. It enables them to capture a baseline and final assessment of their mentee’s competence. These can be used (anonymized or aggregated) for activity management purposes.

Mentors can also document their own successes and challenges, which they may decide to share with the rest of the mentor team and their supervisors. The tool is there to encourage self-reflection. It is thus not to be captured in any way, and its use may decrease over time, as mentors acquire more experience.

Some tools mostly aim at giving mentor/mentee opportunities to reinforce and pay close attention to the quality of the relationship (usually underestimated) or self-reflection. They are not meant for control purposes, whether a relation is good or not, or if mentors are doing a good job or not for example.

Technical SOPS or memos (algorithms, referral criteria etc.) can be compiled in a separate section of this handbook or as a separate booklet.

Evaluation & Safe Space

Mentees who feel constantly under hierarchical supervision often tend to show what they know how to do well, and to remain silent about their areas for improvement, often perceived as weaknesses.
3.2 Monitoring Mentoring activities

Monitoring mentoring activities implies the following:

- Are ‘pre-conditions’ fulfilled (number of MoH staff in clinic, agreements...)?
- Is the mentoring being done? (i.e. attendance monitoring, graduation of mentees)
- Does it have an impact?
  - Positive, on the projects’ medical objective
  - Negative (absenteeism or resentment of other staff for example)

Individual data can be collected from the mentor’s handbook. All this individual ‘parameters’ should remain as confidential as possible (identity of mentees should not be divulged beyond mentoring programme managers). They are not directly included in any dashboard or a facility performance-based evaluation.

For programmatic use, they can be collated in a database provided data is anonymous (e.g. code for each mentee, data entry by mentor). It can then be used in its aggregated form to monitor the mentoring activities. This follow-up is usually necessary and useful to the activity manager (see Example in Appendix 3).

**Idea from Embu: the mentee-retention cascade**

To monitor for the sustainability of the activity, it is interesting to transpose the ‘cascade’ approach to the retention of mentees in a facility. Loss of mentees between the initial number intended, the number having completed the mentorship, then the number of former mentees still practicing in the facility 12 months post ‘initiation’ could facilitate greatly discussions with the MoH when discussing mitigating measures. It also would give a better picture of the potential for lasting impact in the catchment area.
3.3 Sharing results on the process and impact of the mentorship

The most important role of M&E is to be used to further improve activities in the future.

The selected programme indicators should be shared on a regular basis with all stakeholders of the mentorship (e.g. quarterly meetings at facility level). This process can be used to foster ownership of the results. ‘Competition’ between facilities can also help emulate the ones lagging behind, but it should be used with caution and in a way adapted to the context.

The aggregate mentoring progress and programme indicators can be presented in the form of a dashboard. It can either depicting progress in one facility over time, or compare several facilities at a given moment in time (see several examples in Appendix 4). Alternative visual formats could be created in order to facilitate information transfer.

3.4 Mentorship follow-up

Depending on the result of the evaluation process, the future steps in the MSF-facility partnership will be decided. The way forward after a first ‘cycle’ depends on learning and operational achievements, as well as strategic choices. It can include either of several possibilities (or a combination thereof), outlined in the graph below.

If further needs are identified within the same facility (lack of individual progress, non-achievement of objectives, change of objectives e.g. new guidelines...), further intensive mentoring can be organized in that facility.

Or there is a need for geographical expansion, and the same curriculum can be implemented in other facilities.
When indicators are deemed satisfactory for the facility, the intensive support should be weaned off. The partnership can move on to a *maintenance phase*, during which mentors can do less frequent visits, structured around CME or case discussions.

**Idea from Nsanje**

Since the M&E team is collecting all patient-centred data in an electronic database, this information can be used for CME. To help structure the *maintenance phase visits* and improve patient care, the M&E team is producing 6 different lists of ‘patients of interest’ (e.g. children with 1 high VL 1x/month), with a specific recurrent deadline for each (e.g. 2nd Monday of the month). The mentors can then use these lists to frame their discussion during visits, and follow-up on their recommendations regularly.

It thus is important to take the time to thoroughly evaluate a cycle before moving on to the next (this evaluation is foundation work for the preparation phase of a next cycle).

**Further Mentoring Cycle**

- **Remain in same facilities**
- **New facilities, new mentees** (increase coverage, test replicability...)

**New mentees (HR turn over or decision to train 100% of staff...) - Repeat cycle 1 (adapted) content & method**

**Same mentees - Change content**

- Cycle z = More advanced level of care, change in management / SOPs / guidelines...
- Cycle z = mentoring mentees to become future mentors of their peers / colleagues (exit strategy)

**Same mentees become mentors**

**Repeat Cycle x in content & method (adapted from 1st cycle’s experience)**

**Idea from Mutare**

Zimbabwe has integrated the need for HIV mentorship in its own guidelines. The MSF team, based on the experience acquired in Gutu, is involved in mentoring the MoH mentors. It still requires a structured curriculum that will focus on imparting HIV expertise as well as the teaching and communication skills required. It is however important to monitor how sustainable the MoH mentoring will be after MSF departure (availability of transport to various facilities etc.)
4. Management of mentoring activities

4.1 Who is managing (supervising) mentoring activities?

Whenever mentoring activities are to be carried out, teams should carefully consider who within the medical team will manage the mentoring activities. Several questions can guide the reflection:

- **PMR direct supervision vs NAM/MAM middle-management?**
  
  Considering the many and diverse responsibilities of PMR, they should probably not have to directly supervise such a team unless mentoring is the only activity being carried out in the project.
  
  This delegation of responsibilities requires delegation of some decision-making power. It will still require PMR or FieldCo involvement when it comes to meeting ‘higher-level’ stakeholders.

- **Activity Manager’s profile?**
  
  Technical expertise vs management skills? Considering the NAM/MAM will have to carry out supervision of mentors (including assessing & supporting their clinical as well as their teaching and communication skills), it would help if the supervisor is skilled in these 3 domains as well. It is probably useful to balance her/his profile with the strengths and weaknesses of the mentoring team. Whenever several activities in the project require middle management, it is easier to allocate technical/clinical expertise to a separate cadre (differentiate managerial supervision from formative supervision).

4.2 What does supervising mentoring activities mean?

The following activities should be considered:

- **Administrative management of a team of mentors**
  - Including creating a safe-space for peer-learning for mentors

- **Review of teaching material produced by the team and/or participate in its conception**
  - Review of the pedagogical aspects (learning objectives, methodologies...)
  - Review of the technical content

- **Each Mentor should benefit from formative supervision at least once-a-month in order to:**
  - Help them fine-tune their mentoring competencies
  - Identify problematic relationships

- **Monitor context of the mentoring activities, for example:**
  - Document ‘collateral damages’ triggered by the mentoring programme (non-mentored staff absenteeism etc.)

- **Managers also usually monitor and supervise other activities carried out within the MSF – health facility partnership (e.g. pharmacy supply, lab activities...)**

- **Evaluation of operations (impact) in supported facilities. Shielding mentors from being involved in evaluation processes helps maintain the mentoring relationship as a safe space.**

- **Assess logistical issues hampering implementation of new knowledge**

Examples of tools potentially useful for a Mentoring Activities Manager can be found on the SAMU website in a supervisor’s-dedicated folder
Frequently Asked Questions

The questions gathered here are the ones without clearly identified solutions, that could be relevant for most (current) projects undertaking mentorship activities. They might touch on challenges faced daily by mentoring teams. We welcome new queries and contributions whenever you feel other options should be considered.
1. FAQs on mentoring

The ‘mentoring’ label is being used in a variety of contexts. Here are a few queries you might still have about this concept.

1.1 What is the difference between mentoring and coaching?

Where mentoring is a relationship between 2 people working in the same professional field, coaching does not involve this common ground as a necessity. Coaches will mostly ask powerful questions or facilitate reflection on different perspectives so that coaches can come up with their own solutions and develop their full potential.

Mentors can and should use coaching techniques to strengthen their mentoring soft-skills.
Likewise, supervisors can use mentoring and/or coaching techniques to undertake formative supervision.

1.2 How strict are we on the application of mentoring theory?

This guide emphasizes approaches that stick as closely as possible with an ideal mentoring relationship. A relationship that promotes a safe space for learning is the bare minimum.
To create trust in the safe-space, mentees will need to be empowered, repeatedly challenged on their view of training that contrasts with usual cultural approaches in many contexts. The absence of hierarchical link and confidentiality are key in enabling the safe-space.
It does not mean that confidentiality can always be strictly enforced. More often than not, mentoring activities managers will have knowledge of specific mentees achievements or challenges. It is their responsibility to protect the safe space created by the mentors as much as possible, by not divulging pieces of information mindlessly.

1.3 Is mentoring alone enough?

Mentorship is often misconstrued as all activates within a partnership. It is only one piece of the partnership puzzle. No capacity-building, whether through classroom trainings, or mentoring will achieve much if the environment is not conducive to the implementation of the new knowledge/skills. That is the reason why supportive supervision, drug supply or logistic support etc. usually need to be added to the plan (For example, a supervisor might need to intervene to allow for an improvement of patient flow).

1.4 How strict are we on the implementation of this framework?

As stated before, this guide is very much a collection of lessons learned from the field. Teams should not feel constrained by it. It is merely tips that pave the way for teams wanting to implement mentorship. Nevertheless, many recommendations contained in this guide could be relevant for partnerships that do not involve mentoring. Do whatever you can...

1.5 Can all partnerships be labelled mentorship programmes?

Mentorship requires individual companionship, side-by-side time oriented towards learning. It is in essence a training activity in the work-place. It should be distinct from supportive supervision, when only activities targeted at the whole facility are implemented, even if some classroom trainings are sometimes organized.
1.6 Is the aim of mentoring sustainability or ‘replicability’?

**Sustainability** can be considered at 3 different levels

- Sustainability of the patient’s care, which will depend on many factors, including drug-supply, patient’s empowerment to demand care, and the long-term effect of the capacity-building of HCW. This would be included in an advocacy strategy.
- Sustainability of the mentorship is admittedly restricted to the long-term effect on competence of the individual mentees. It might need to be repeated, simplified etc.
- **Replicability** of the mentoring programme would be the possibility for the MoH to undertake a similar programme and possibly scale it up nationally. It will depend on the usual barriers of HRH and logistics means at hand.

It is a crucial debate, but this guide is not intended at addressing it. These issues should be discussed during the initial exploration steps of the project.
2. FAQs on Curriculum

2.1 Can a curriculum be extremely ‘short’?

As long as mentees and mentors have the time to establish a learning relationship, a curriculum can be as short as you want. To promote the back-and-forth between theory and practice, to not be too much of a burden to a facility and to ensure the relationship develops, our intuition is that a minimum of 6 weeks of once-weekly contact should be considered.

A short curriculum increases the chances of mentees completing it.

Consider that simpler the better, provided minimum standards are being met.

2.2 How can we ensure the curriculum is not too ‘heavy’?

A curriculum will be as long and thorough as the care that we want to delegate to our partner. The more complex the guidelines, the more extensive the package of care, or the higher the standards of care, then the more complex and long the curriculum will be.

The curriculum should be framed around the project’s objectives. However tempted HCW may be, if a project’s objectives are focused on PMTCT for example, there is no reason to train mentees on every single aspect of OI management.

The package of care (i.e. guidelines and SOPs) is also a strategic decision that will need to be thoroughly discussed before the curriculum can be designed.

Once a curriculum is very long, it is probably wise to divide it into modules. For example, IPD doctors could benefit from a 1st module on emergencies in HIV (life-threatening OIs) and a 2nd module on chronic management of HIV (ART monitoring, strategies for retention into care). A quick evaluation in-between modules should be done. It would also allow mentees to complete modules separately.

2.3 Can we mentor facility managers?

Mentoring facility managers is often considered as a ‘mitigating measure’ when mentorship programmes face challenges related to poor HRH management (e.g. paediatric champion not on duty on paediatric ART Days, too many nurses on leave at the same time) or other organizational issues in a facility.

Mentoring facility managers on how to do supervision and supportive supervision seems like a good idea. However, the needs go beyond training managers. Many challenges are related to structural issues primarily. The other issues are as follows:

- To mentor facility-managers, the MSF projects would have to be legitimate holders of facility-management expertise in order to create adequate curriculum
- Mostly projects would need mentors who would be legitimate managers, having experience in the management of facilities.

We are not sure these conditions could be met in the field currently. It is an area where mentoring of managers and mentoring on specific aspects of healthcare will eventually intersect.
3. FAQs on mentees

3.1 How can we address mentees turn-over?

We have seen time and again mentees leaving programmes for multiple reasons (transfer out of the catchment area, study leaves etc.) This turn-over touches on issues much broader than medical education, and is closely related to what motivates HCW. Considering we cannot impose any long-term retention within a facility, we can only try for mitigating measures:

**Step 1:** ask mentees what would they would want from the programme, and what would make them stay.
- Accreditation – a diploma that could be valued within the DoH
- Incentives, or payment by performance: be very cautious considering all the possible contra-productive collateral damages
- Something else?

**Step 2:**
- Prior negotiation with DoH to minimize staff-rotation
- Sequencing programme in short cycles to promote completion

*Note:* Let’s not contribute to this turn-over by recruiting the best mentees to become MSF mentors as we often did in the past 😊

3.2 Can anybody be a mentee?

Only HCW wanting to join a mentoring programme of their own free will, as an informed consent, should be considered as mentees. This means that people should not be coerced in any way. It also entails that HCW partaking to substance abuse should be considered with caution.

There should be no limitations related to the capacity to read and write, provided the curriculum does not involve documentation of care. The main consequence will be that teaching methods will need to be adapted accordingly.

3.3 Can HCW refuse to be mentored, and how do we address it?

Yes, obviously. In that case, it is worth checking that the induction and on-boarding of potential mentees have been done thoroughly. A few steps should be taken:
- Ensure they received the appropriate information on the programme (see below)
- Ensure their hierarchy at facility and district level supports the programmes and participates to its presentation
- Investigate reasons for the refusal, and consider if they can be mitigated
- If there is more than 1 possible mentee, approach others.
- If there are no other possibilities, you are probably better off selecting another facility.
3.3 How should we deal with a ‘poorly motivated’ mentee?

Labelling mentees ‘not-motivated’ is a dangerous and too much of an ‘easy’ answer to impressions of failure. It is worth to check and where possible address:

- Was the mentorship not imposed to them?
- Are his primary needs (for basic income, food and sheltered) perceived as covered?
- How did we introduce mentorship to them?
- They are clearly informed on what they can expect:
  - Was it properly stated there is no link with evaluation?
  - Is there expectation of increased work-load because of the mentorship?
  - Can he expect to gain something out of the mentorship?
- Is the curriculum structured enough to see what they will learn?

If all these aspects were addressed, then a discussion with their hierarchy can be undertaken.

3.4 What happens if a mentee leaves?

The first step is to ‘investigate’ and document the reasons for departure, to learn then adapt the programme.

Depending on when the mentee leaves the structure, there could different solutions:

- If less than half the curriculum has been conducted, it could be reasonable to enrol another mentee and start anew. Unless a mentee is exceptionally brilliant, it is not appropriate to try and ‘catch-up’ with the others by going through multiple sessions in 1 day (that would decrease the likelihood of long term development of competence).
  - Either the same curriculum is provided at the planned rhythm. It should be discussed in light of the cost (need for cars etc.) that it will create to have visits prolonged in the facility for a single mentee.
  - Another option could be to propose that the new mentee attends an ‘accelerated’ induction by being mentored full-time in a ‘model’ facility where more patients care being attended to, and thus opportunities for learning are multiplied.
- If mentees leave a facility after completion of the curriculum, a simpler version of the curriculum, focussing on maintaining the current cohort rather than including all competences required to enrol new patients could be considered.
- If departures become so recurrent that it jeopardizes the project’s objectives, it raises more fundamental questions. The initial choice of doing mentoring should be challenged, rather than consider that mentoring does not work....
Appendices – Examples of Tools for Implementation

These appendices are examples extracted from or proposed to actual mentoring programme. These are mentioned merely to help the team in designing their own tools, adapted to the context.
All the tools or extracts presented below are the ones deemed of most interest to project managers. Some tips on how to adapt and use the tools can be found in superposed text-boxes.

1. Example of a mentoring curriculum
2. Example of a mentees’ performance follow-up spreadsheet (Observation Grid)
3. Example of a mentoring activities follow-up spreadsheet
4. Example of a Clinic Dashboard
5. Guide for the (weekly) mentoring team meeting
6. Mentor’s Supervision tool
7. Chronogram example
8. Example of substitution model

All the tools can be found in their full Excel and Word format on the SAMU Website. A full set of mentees’ and mentors’ handbooks for both NCDs (for clinicians and PCS) and Advanced HIV Disease for Clinicians can be found there as well.
1. Example of a Mentoring Curriculum

MSF Mentoring Programme Overview
Advanced HIV Care for Nurses
at Primary Healthcare Level
Eshowe, South Africa

General objective:

Improve skills of nurses in the management of Advanced HIV patients at primary healthcare level in 2 sub-districts in KZN, SA

Intermediate Objectives (I.L.O.)

Module 1 Detection & Documentation of O.I.s and RoTF in HIV Patients (Refresher)

<table>
<thead>
<tr>
<th>Week</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Document HIV WHO staging &amp; perform systematic standardized physical examination</td>
</tr>
<tr>
<td>2</td>
<td>Perform systematic TB Screening and Diagnosis of PLWHIV &amp; IPT</td>
</tr>
<tr>
<td>3</td>
<td>Perform systematic STI screening and diagnosis in PLWHIV &amp; Family Planning</td>
</tr>
<tr>
<td>4</td>
<td>Detect Treatment Failure and its causes</td>
</tr>
<tr>
<td>5</td>
<td>Manage treatment failure - EAC</td>
</tr>
<tr>
<td>6</td>
<td>Manage Treatment Failure - switch to 2nd line</td>
</tr>
</tbody>
</table>

Module 1 Implement Advanced HIV PoC Testing of Advanced HIV Patients - Study Protocol

<table>
<thead>
<tr>
<th>Week</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Identify Patients with Advanced HIV</td>
</tr>
<tr>
<td>8</td>
<td>Perform Necessary investigations for Advanced HIV Patients</td>
</tr>
<tr>
<td>9</td>
<td>Manage a Positive TB LAM Result</td>
</tr>
<tr>
<td>10</td>
<td>Manage a positive CRAG LFA result</td>
</tr>
<tr>
<td>11</td>
<td>Manage a negative TB LAM and negative CRAG LFA</td>
</tr>
<tr>
<td>12</td>
<td>Intensify Viral Load Testing in Advanced HIV Patients</td>
</tr>
</tbody>
</table>

Week 8 Specific learning objectives

<table>
<thead>
<tr>
<th>Week 8</th>
<th>I.L.O.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>K</td>
<td>List 4 methods for screening for TB as per MSF’s “Advanced HIV Study” protocol (WHO Questionnaire, GeneXpert, Sputum Culture &amp; DST, TB LAM)</td>
</tr>
<tr>
<td>8</td>
<td>K</td>
<td>List 3 steps required in TB LAM testing</td>
</tr>
<tr>
<td>8</td>
<td>K</td>
<td>List 5 steps required in CRAG LFA testing</td>
</tr>
<tr>
<td>8</td>
<td>K</td>
<td>Name 3 possible outcomes for a CRAG LFA/TB LAM test</td>
</tr>
<tr>
<td>8</td>
<td>AS</td>
<td>Demonstrate how to perform TB LAM test</td>
</tr>
<tr>
<td>8</td>
<td>AS</td>
<td>Demonstrate how to perform CRAG LFA test</td>
</tr>
<tr>
<td>8</td>
<td>AS</td>
<td>Performs Reflex Testing to all identified Advanced HIV Patients as per SA guidelines + Advanced HIV Study Protocol (VL, TB Screening, Crypto screening)</td>
</tr>
<tr>
<td>8</td>
<td>AS</td>
<td>Refer identified Advanced HIV Patients to Study Nurse</td>
</tr>
<tr>
<td>8</td>
<td>B</td>
<td>Explain PoC tests results to patient in a non-frightening, supportive manner</td>
</tr>
</tbody>
</table>

Note: Each activity represents an intermediate learning objective for mentees. Each of these I.L.O.s is divided into specific learning objectives for knowledge (K), Application of Skills (AS) of in terms of Behaviour (B). Broad I.L.O.s lead to more S.L.O., making the curriculum heavier and more complex to implement.
## 2. Example of a Mentees’ Observation Grid & performance follow-up

### Using a 3-points scale
- Meaning of the scores usually needs to reminded to mentors regularly (‘easy’ scores of 3)
- Means that an average score of 50% for a given ILO is unacceptable – passing rate should be 80%

### Scoring system of individual criterion
- 1: unacceptable perform., unexplained abs.
- 2: acceptable but should be improved
- 3: Good, no need for further improvement
- Blank: Not Applicable

### Using the Observation Grid

Opportunities to observe or check on the mentees’ performance might not arise every week. Systematic assessment would also make using the tool very cumbersome. Hence possible ‘blanks’ every now and then in an observation grid. Mentors should focus on:
- Baseline assessment
- First implementations after initial didactic training
- areas identified as weaknesses
- final ‘evaluation’

### Table of Observations

<table>
<thead>
<tr>
<th>Mentee</th>
<th>Mr X. Y.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centre</td>
<td>K. PHC</td>
</tr>
<tr>
<td>Programme</td>
<td>Management of Advanced HIV at PHC</td>
</tr>
<tr>
<td>Starting Date</td>
<td></td>
</tr>
<tr>
<td>Closing Date</td>
<td></td>
</tr>
</tbody>
</table>

#### Mentee’s Performance (3-weekly)

<table>
<thead>
<tr>
<th>Week 7</th>
<th>ILO</th>
<th>Identify Patients with Advanced HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>Define Advanced HIV disease for both adults and children according to WHO</td>
<td>1 2 3</td>
</tr>
<tr>
<td>K</td>
<td>List at least 10 opportunistic infections that are associated with Advanced HIV</td>
<td>2 2 3</td>
</tr>
<tr>
<td>K</td>
<td>Classify OIs depending on level of immunosuppression (CD4 &lt;200 and CD4 &lt;100)</td>
<td>1 1 2 2 3</td>
</tr>
<tr>
<td>K</td>
<td>Identify 2 groups of patients who will need PIMA testing when they attend clinic as per MSF Advanced HIV study protocol</td>
<td>3 3 3 3</td>
</tr>
<tr>
<td>AS</td>
<td>Analyse and interpret PIMA results to identify Advanced HIV patients</td>
<td>3 3 3 3</td>
</tr>
<tr>
<td>B</td>
<td>Demonstrate empathy and understanding when welcoming back patients who have defaulted treatment</td>
<td>2 2 3 3</td>
</tr>
</tbody>
</table>

#### Week 8 I.L.O. Perform Necessary investigations for Advanced HIV Patients

| K      | List 4 methods for screening for TB as per MSF’s “Advanced HIV Study” protocol (WHO Questionnaire, GeneXpert, Sputum Culture & DST, TB LAM) | 1 3 3 3 |
| K      | List 3 steps required in TB LAM testing | 1 3 3 |
| K      | List 5 steps required in CRAG LFA testing | 1 3 3 |
| K      | Name 3 possible outcomes for a CRAG LFA/TB LAM test | 1 3 3 |
| AS     | Demonstrate how to perform TB LAM test | |
| AS     | Demonstrate how to perform CRAG LFA test | |
| AS     | Performs Reflex Testing to all identified Advanced HIV Patients as per SA guidelines + Advanced HIV Study Protocol (VL, TB Screening, Crypto screening) | |
| AS     | Refer identified Advanced HIV Patients to Study Nurse | |
| B      | Explain PoC tests results to patient in a non-frightening, supportive manner | |
## 3. Example of Aggregate database for follow-up of mentoring activities

<table>
<thead>
<tr>
<th>Health Centre</th>
<th>K. PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme</td>
<td>Management of Advanced HIV at PHC</td>
</tr>
<tr>
<td>Starting Date</td>
<td>15/02/18</td>
</tr>
<tr>
<td>Closing Date</td>
<td></td>
</tr>
<tr>
<td>Last Update</td>
<td>July 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mentoring Total Score %</th>
<th>85</th>
<th>&gt; 80%</th>
<th>Good prospects for success</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>60 - 80%</td>
<td>Possibilities, requires more effort but going in a promising direction</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>50 - 60%</td>
<td>Risk of Failure, in need of multi-level intensive support</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>&lt; 50%</td>
<td>Requires thorough assessment &amp; commitments before moving on</td>
<td></td>
</tr>
</tbody>
</table>

### Target

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
</table>

| Mentoring General | Total Number of staff (clinicians) | 4 |
|                  | Number of Clinician Mentees       | 4 |
|                  | Number of Counsellor Mentees      | 0 |
|                  | Number of mentee having graduated | > 80% |
|                  | Attendance of mentees             | < 10% |

| Clinicians | Document HIV WHO staging & perform systematic standardized physical examination |
|           | Perform systematic TB Screening and Diagnosis of PLWHIV & IPT |
|           | Perform systematic STI screening and diagnosis in PLWHIV & Family Planning |
|           | Detect Treatment Failure and its causes |
|           | Manage treatment failure - EAC |
|           | Manage Treatment Failure - switch to 2nd line |

| Advanced HIV Protocol | Identify Patients with Advanced HIV |
|                      | Perform Necessary investigations for Advanced HIV Patients |
|                      | Manage a Positive TB LAM Result |
|                      | Manage a positive CRAG LFA result |
|                      | Manage a negative TB LAM and negative CRAG LFA |
|                      | Intensify Viral Load Testing in Advanced HIV Patients |

| Counselling | Conduct EAC Session |
|            | Conduct counselling for 2nd line switch |
|            | Facilitate support group meeting |

| Lab | Equipment (PIMA, pipettes, fridge) functional |
|     | Adequate stock of Advanced HIV Specific consumables |
|     | External Quality Assessment on PoC tests |

| Pharmacy | CTX-INH available in all HC |
|          | Number of stock-outs refilled by MSF |< 5%|
## 4. Example of a Clinic Dashboard – follow-up of impact

### NCDs, Kiritiri HC

<table>
<thead>
<tr>
<th>Domain</th>
<th>Operational objectives</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td><strong>Impact on Community Health / Outcome indicators</strong></td>
<td>Proportion of pregnant women screened for DM</td>
<td>&lt; 75%</td>
<td>75 – 95 %</td>
</tr>
<tr>
<td></td>
<td>Proportion of newly diagnosed DM patients with RBG &gt; 200 started on treatment</td>
<td>&lt; 70%</td>
<td>70 – 90 %</td>
</tr>
<tr>
<td></td>
<td>Proportion of DM Patient with HbA1c &lt; 7,5% at 6 months</td>
<td>&lt; 70%</td>
<td>70 – 90 %</td>
</tr>
<tr>
<td></td>
<td>Proportion of DM Patients still in care after 12 months of treatment</td>
<td>&lt; 70%</td>
<td>70 – 90 %</td>
</tr>
<tr>
<td><strong>Availability of service</strong></td>
<td>Mentees (Clinicians &amp; PS) attend mentoring sessions</td>
<td>&lt; 60%</td>
<td>60 – 80 %</td>
</tr>
<tr>
<td></td>
<td>No absenteeism by either mentees or other staff</td>
<td>&gt; 20%</td>
<td>10 – 20 %</td>
</tr>
<tr>
<td></td>
<td>DM patients have HbA1c @ M3 after DX</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Good quality service</strong></td>
<td>Triage identifies patients for NCD screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of DM patients screened for TB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of HTN patients having CV risk calculated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DM complications referred to level 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Free MoH</strong></td>
<td>No NCD drugs stock-out</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All staff on MoH pay-roll</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Using a Dashboard

Targets for each ‘activity’ can be set with reference to the literature, after discussion with referents, and should be in keeping with targets set in the log-frame. Most importantly, as with any indicators, numerators and denominators should be clearly defined, and as much as possible not based on estimates.
### Nsanje HIV Project Dashboard

#### Domain: Site Checklist

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # Site visits | site visits | # site visits | # site visits | >80% | ± 10% | ± 50% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

#### Domain: Mentorship

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # graduating mentorship | mentors | # mentors | # mentors | >60% | ± 10% | ± 50% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

#### Domain: Mentorship Tool Score

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # mentorship visits per facility | visits | # visits | # visits | ± 10% | ± 50% | ± 70% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

#### Domain: Prevention

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # of MTCT cases identified | cases | # cases | # cases | >90% | ± 10% | ± 70% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

#### Domain: Pre-Treatment

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # patients enrolled in care | patients | # patients | # patients | >100 | ± 50% | ± 70% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

#### Domain: Treatment

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # of TB cases | cases | # cases | # cases | >90% | ± 10% | ± 70% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% | ± 90% |

#### Domain: TB

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # of patients initiating TB treatment | patients | # patients | # patients | >80% | ± 50% | ± 70% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

#### Domain: Stock Availability

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # of TB cases | cases | # cases | # cases | <10% | ± 50% | ± 70% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

#### Domain: Treatment Effectiveness

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| # patients with access to antiretroviral treatment | patients | # patients | # patients | >80% | ± 50% | ± 70% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

#### Domain: Mortality

| Indicator | Source | Numerator | Denominator | Target | J | K | L | NDH | TRIN | LULW | NDAM | MBEN | CHID | TENG | NYAM | PHOK | KALE | SORG | MASE | SANK | MANH |
|-----------|--------|-----------|-------------|--------|---|---|---|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| % of patients in the catchment area | patients | # patients | # patients | >60% | ± 50% | ± 70% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

**Using a Dashboard**

Indicators that are systematically ‘Non Applicable’ should be thoroughly investigated, explained and/or discarded when not relevant.
5. Guide for the (weekly) mentoring team meeting

Core purpose of this tool is to facilitate Communication, Accountability and Nurture within a team of mentors.

Opening:
Quick check of all mentors to get an overall sense of how people are feeling – discouraged, positive etc.:  

Mentors evaluate themselves - positive and potentially corrective
(Refer to mentor’s daily reflection documents)
Clinical knowledge e.g.: Not being able to answer questions from mentees Encountering problems with patients that they don’t know how to manage:

Presentation skills: Lessons learnt/challenges: adult learning principles, key messages, methodologies, presentation techniques, feedback methods and actual feedback given:

Mentoring skills: Eg Problems with mentees that they need help with: an unmotivated mentee, someone doing something badly, handling repeated mistakes that the mentee is not learning from
Their own challenges – review training checklist – verbal and non-verbal communication, communication skills (active listening, reflective listening, summarising), barriers to communication

Management/Admin challenges
Management problems? E.g.: Poor support from the nurse-in-charge, in-house staff issues affecting the mentoring process

Admin problems. E.g.: filing of results issues, patient flow / triage issues

Wrap-up and closure
Solutions and way forward
# 6. Mentors’ Supervision Tool

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Health Centre</th>
<th>Starting date</th>
<th># contacts/ week (average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total number of mentees**

### Evaluation scale

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>Not Applicable / Performance not demonstrated</td>
</tr>
<tr>
<td>1</td>
<td>Poor performance, meets few of the basic expectations, needs to work extensively on own practices</td>
</tr>
<tr>
<td>2</td>
<td>Unsatisfactory performance, meets some expectations, needs improvement.</td>
</tr>
<tr>
<td>3</td>
<td>Satisfactory performance, master practices but can improve to make it stable over time</td>
</tr>
<tr>
<td>4</td>
<td>Excellent performance, meets expectations of consistent effectiveness, exemplary master of the trade</td>
</tr>
</tbody>
</table>

## A. Technical (Clinical) Competence

<table>
<thead>
<tr>
<th>Score</th>
<th>Comments/ Specific Observations:</th>
<th>Understanding of HIV screening strategies <em>(can explain HCT/VCT, index testing, reminds HCW when not done during 1st visit...)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Master MSF protocols <em>(knowledge &amp; understanding)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Viral Load / RoT Failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- PMTCT/ EID</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Transfer to community groups</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Knowledge of ARVs &amp; anti-TB drugs <em>(side-effects, drug interactions...)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multidisciplinary approach <em>(can explain roles of PS, calls on PS team regularly, starts of discussion...)</em></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Systematic medical history taking <em>(TB/STI screening, MST, 4 PMTCT pillars...)</em></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Systematic physical examination of a PLWHA <em>(CD4 &lt; 100)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(can remind / demonstrate steps...)</em></td>
</tr>
</tbody>
</table>

### Using the Supervision Tool

The purpose of the tool is to remind supervisors to pay attention to all 3 aspects of mentors’ necessary skills. As is often the case, the supervision could require both the technical referent and the line manager, if the later does not possess the necessary technical knowledge. The ‘Technical Competence’ Part of the tool should be adapted to the curriculum taught by mentors. The example provided is targeted for basic HIV management, but should differ within an Advanced HIV Disease-type curriculum.
### B. TRAINING SKILLS

<table>
<thead>
<tr>
<th></th>
<th>Score</th>
<th>Comments/ Specific Observations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Clear Learning Objectives</strong></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Interactivity</strong> <em>(method choice, valuing &amp; building on participants’ knowledge...)</em></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Group management</strong> <em>(...)</em></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Time management</strong> <em>(...)</em></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>Clear Key messages</strong> <em>(review L.O., hand-out ...)</em></td>
<td></td>
</tr>
</tbody>
</table>

### C. COMMUNICATION SKILLS

<table>
<thead>
<tr>
<th></th>
<th>Score</th>
<th>Comments/ Specific Observations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Established a trustful relationship with mentee</strong> <em>(mentee asks questions, seems comfortable...)</em></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Uses non-verbal components of active-listening</strong> <em>(not looking at phone, visual contact with patient/mentee...)</em></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Uses Verbal components of active listening</strong> <em>(affirmative, reflective, summarizing statements...)</em></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Checks that messages are properly received</strong> <em>(checks understanding, requests mentee to think aloud...)</em></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>Uses thinking-aloud technique to demonstrate process / method</strong></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Maintains patient-centred attitude when intervention during consultation is necessary</strong> <em>(without creating fear etc.)</em></td>
<td></td>
</tr>
</tbody>
</table>
| 7 | **Gives constructive feedback**  
   - Asks permission  
   - Chooses the right time  
   - Balances positive / negative  
   - Specific Observations  
   - Proposes action points | |

### D. POINTS OF ACTION

<table>
<thead>
<tr>
<th></th>
<th>Score</th>
<th>Signatures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>..................</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>..................</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>..................</td>
</tr>
</tbody>
</table>
### 7. Example of Mentorship Chronogram

**Mentorship activities 2018-2020 with 2 teams** (IPD = 1 MD + 1 nurse + 1 Counsellor + 1 data capturer / OPD = 1 nurse + 1 Counsellor + 1 data capturer)

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th></th>
<th>2020</th>
<th></th>
<th>2020</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hosp 1</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td></td>
<td>IPD Cycle 1</td>
<td>IPD Cycle 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hosp 2</td>
<td></td>
<td></td>
<td></td>
<td>IPD Cycle 1</td>
<td>IPD Cycle 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC 1</td>
<td>OPD Cycle 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC 2</td>
<td>OPD Cycle 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC 3</td>
<td></td>
<td></td>
<td></td>
<td>OPD Cycle 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ad Hoc</td>
<td>Eval. OPD Cycle 1</td>
<td>Eval. IPD Cycle 1</td>
<td></td>
<td></td>
<td></td>
<td>Evaluation of mentorship, review ops</td>
</tr>
</tbody>
</table>

**Legend:**
- **Black**: Baseline evaluation & Assessment
- **Dark Grey**: Teams Embedment (work alongside MoH colleagues)
  Polishing of curriculum training materials
- **Light Grey**: Intensive Support Phase, i.e. Mentoring 2x/week
- **White**: Maintenance Support Phase (CME, case discussions 1x/week to 2x/month)
- **White**: Follow-up Phase - M&E / data Collection
- **White**: No MSF presence
8. Diagram: structure of the mentoring programme and M&E time

Module 0
OPENING

Thematic week 1
Training session 1
Presentation 1
Mentoring at work
Observation 1

Thematic week 2
Mentoring at work
Observation 2
Training session 2
Presentation 2

Thematic week 12
Patient file
review

CLOSURE process

Technical training

M&E Competencies
Pre-test knowledge
Initial evaluation of competencies
Mentee logbook

M&E Inter-personal relationships
Initial agreement
Mentor/mentee
Attendance form
presence/absence
Attendance form
presence/absence
Intermediate feedback form
Mentor/Mentee
Final feedback form
Mentor/Mentee

M&E Impact on project outcomes
Initial joint clinic
needs assessment
MSF/MoH clinic

Key indicators - project logframe

ToT mentoring
Mentors

Logbook
Mentor

Weekly follow-up meeting
Mentors

Self-evaluation
Mentors

Sitrep

Project dashboard

Registers

Conclusion
Recommendations
Mentors

Final joint clinic evaluation

Technical training

eg: SAMU HIV/TB (Sr)
9. Example of Substitution model

EXAMPLE OF SUBSTITUTION MODEL FOR A FOUR-PERSON MENTORING TEAM

Clinic nurse  MSF mentor

Nurse clinic manager  Selected mentee  MSF mentor  Clinic nurse