



TECHNICAL REPORT

Pilot of the Hhohho Regional Coordination Agency

MARCH 2015

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CDC	U.S. Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CME	Continuous Medical Education
CMS	Central Medical Stores
CMT	Clinical Mentoring Team
CTX	Cotrimoxazole
DOTS	Direct Observed Treatment, Short-course
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation

EHCP	Essential Health Care Package
FP	Family Planning
GKOS	Government of the Kingdom of Swaziland
HCI	USAID Health Care Improvement Project
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
ICAP	International Center for AIDS Care and Treatment Programs
IHM	Institute for Health Management
M2M	Mothers to Mothers
MDR-TB	Multi-drug-Resistant Tuberculosis
MDT	Multidisciplinary Team
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSH	Management Sciences for Health
NCLS	National Clinical Laboratory Services
NERCHA	National Emergency Response Council on HIV and AIDS
NGOs	Non-Governmental Organizations
NSF	National Strategic Framework
NSTS	National Sample Transportation System
NTCP	National TB Control Program
OIs	Opportunistic Infections
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PIHTC	Provided-initiated HIV Testing and Counseling
PMTCT	Prevention of Mother-to-Child Transmission
POC	Point of Care
PSI	Population Services International
QI	Quality Improvement
RCA	Regional Coordination Agency
RCMT	Regional Clinical Mentoring Team
RHMT	Regional Health Management Teams
SADC	Southern African Development Community
SCMS	Supply Chain Management Systems
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SID	Strategic Information Department
SNAP	Swaziland National AIDS Program
SOP	Standard Operating Procedure
SRHU	Sexual and Reproductive Health Unit
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
URC	University Research Co., LLC
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

EXECUTIVE SUMMARY

The Paris Declaration, developed and endorsed at the Second High Level Forum on Aid Effectiveness (2005), lays out a roadmap to improve the quality of aid and its impact on development. The Declaration lays out five fundamental principles to make aid more effective: ownership, alignment, harmonization, results, and mutual accountability. In order to leverage these five tenets to improve the health sector, host countries should take ownership in the development of interventions, with Ministry of Health (MOH) leadership over health policies, strategies, and coordination of technical assistance. Interventions should be aligned with national priorities so that donor investments in the health sector can be properly managed to achieve better health outcomes based on a platform of mutual accountability.

In this spirit, PEPFAR's goal in Swaziland is to provide financial resources and technical support to the MOH to ensure delivery of high-quality services to patients and clients at service delivery sites, while at the same time strengthening the capacity of the health system to achieve this goal in a sustainable way. As part of its mandate, PEPFAR and its HIV care and treatment partners in the country, including the International Centre for AIDS Care and Treatment Programs (ICAP), the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Mothers to Mothers (M2M), Management Sciences for Health (MSH), and University Research Co., LLC (URC), have initiated a coordination strategy to better orient their technical assistance efforts to support MOH leadership in improving clinical mentoring to support the delivery of quality health services.

The Regional Coordination Agency (RCA) was formed by the Regional Health Administrator for Hhohho, along with the PEPFAR Care and Treatment lead, the Chiefs of Party of PEPFAR-supported implementing partners, and clinical mentors, for the purpose of coordinating PEPFAR support for the implementation of the Essential Health Care Package, HIV Package of Care, and other priority programs of the Government of the Kingdom of Swaziland and PEPFAR.

This report serves to outline the processes of implementing the Hhohho RCA and clinical mentoring activities, highlighting the steps taken to prepare for implementation; implementation of the pilot; and challenges, successes, and recommendations to strengthen the approach. The authors hope that the results from this pilot will shed light on similar models to be implemented by the MOH and PEPFAR through its implementing partners in other regions.

1. INTRODUCTION

On August 27, 2012, the Regional Health Administrator for Hhohho, along with the PEPFAR Care and Treatment lead, Chiefs of Party, and mentors came together to launch an innovative partnership to improve coordination and implementation of HIV clinical mentoring in the region as a pilot to inform the MOH policy on clinical mentoring approaches for the country. Under the auspices of the PEPFAR Regional Coordination Agency (RCA), a team of mentors from the MOH and its partners was commissioned to develop an implementation approach that would facilitate a coordinated, MOH-led clinical mentoring team. At the launch, stakeholders agreed that the pilot RCA would be utilized as a means to coordinate PEPFAR support for the implementation of the Essential Health Care Package (EHCP), HIV Package of Care, and other priority programs of the Government of the Kingdom of Swaziland (GKOS) and PEPFAR. In addition, a presentation was given describing the role of the RCA within the Regional Clinical Mentoring Team (RCMT) concept, and the process of developing key indicators and deliverables for tracking implementation was initiated.

As decentralization of health care progresses, services become systematically more accessible to those in need. With an uptake in service utilization, a strong emphasis on improving the quality of service provision must be maintained to ensure that health care workers are adequately supported. As a result, clinical mentoring is, and will continue to be, a critical priority for both PEPFAR and the GKOS. The RCA and RCMT pilot in Hhohho was undertaken in an effort to ensure that the decentralization of TB and HIV services to primary health care clinics and related community linkage programs is not detrimental to the quality of service provision.

This report serves to outline the processes of implementing the Hhohho RCA and clinical mentoring activities, highlighting the steps taken to prepare for implementation; implementation of the pilot; and challenges, successes and recommendations to strengthen the approach. Hopefully the results from this pilot will shed light on similar models to be implemented by the MOH and PEPFAR through its implementing partners in other regions.

1.1 Background

Swaziland embraced a shift towards primary health care (PHC) and its concepts in 1983. With this came the introduction and roll-out of a basic package of preventive and curative services geared towards health promotion and accessible at a decentralized health site. Between 1991 and 2000, due to the emerging epidemic of HIV and rising incidence of TB, the implementation strategy shifted once again, this time to a more selective form of service delivery, mainly addressing these two diseases in addition to malaria.

Since 2000, there have been reforms to the PHC system focused on improving delivery of services. These reforms have included the decentralization of financial management and administration by the regional health management teams and facilities; a focus on community-based care; a renewed emphasis on task shifting and sharing; and strengthening of referrals and linkages between the community, primary, secondary, and tertiary levels of care. The reforms were also intended to enhance the ability of the Ministry of Health to effectively deal with emerging health challenges as well as to further modernize approaches to governance and management to facilitate responsive, equitable, and financially viable health services.

MOH guidelines for the operation of decentralized health services in Swaziland (Draft No.4, 1990) state that the Regional Health Management Team (RHMT) is responsible for planning, budgeting, monitoring, and supervising all health facilities and services within the region, for both government and mission (non-profit or religious) run facilities. The RHMT is headed by a specially trained Regional Health Administrator who supervises assistant health administrators (hospital administrators in the region). The RHMT is a key juncture within the health system where national strategies are converted into actions and where horizontal relationships are established with other agencies and sectors covering the same geographical areas.

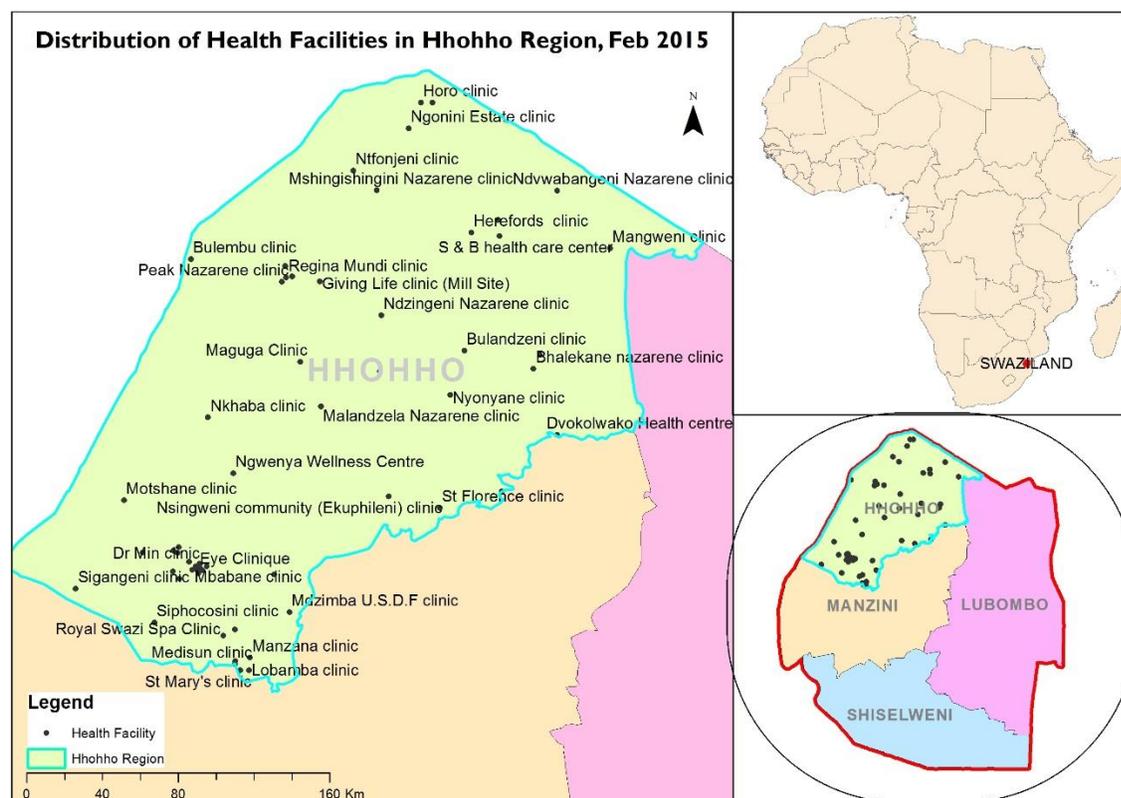
1.2 Hhohho Health Services

1.2.1 Population and health facilities

The Hhohho Region is one of four in Swaziland, located in the high veld with a population of 289,797. According to the Service Availability Mapping Report (SAM 2010), a total of 71 out of the 265 health facilities in Swaziland are located in the region. Figure 1 shows the location of the main health facilities in Hhohho. The following is a distribution of health facilities across the Hhohho Region by type:

- 1 National Referral hospital and 1 Regional hospital
- 2 health centers
- 2 public health units
- 4 clinics with maternity
- 49 clinics without maternity
- 10 specialized facilities

Figure 1. Map of Health Facilities in the Hhohho Region



1.2.2 TB and HIV situation in Hhohho Region

The HIV epidemic exhibits some degree of regional heterogeneity in the country, with the prevalence rate among those aged 2 years and older ranging from 16 percent in Shiselweni to 21 percent in Hhohho. The regional differential is especially marked in the case of older adults, as 8 percent of the population age 50 years and older is HIV-positive in Shiselweni compared with 15-17 percent in the other three regions. The HIV prevalence rate for the Hhohho Region is 29% among 15-49 year olds, and adult HIV prevalence in the Hhohho Region is 42.9% (11th national sero surveillance 2008). Among TB patients, estimates of dual infection with HIV in the Hhohho Region is 72%, with a national co-infection rate of 79.6% (11th national sero surveillance 2008).

1.2.3 Policy and guiding documents

Health care and treatment in Hhohho are guided by the following policies and guidelines:

- National Health Policy
- TB/HIV decentralization guidelines and plan
- The National Health Strategic Plan
- The Essential Health Care Package
- National Guidelines on the Comprehensive HIV Package of Care for Adults and Adolescents in Swaziland 2010
- National Tuberculosis Control Guidelines 2012
- PMTCT Guidelines 2010
- National Supervision and Mentoring Framework

Table 1 below defines the package of care for clinical mentoring teams as provided for in the National Guidelines for Comprehensive Care for PHCs.

Table 1. Package of Care for HIV Clinical Mentoring

Clinical	Psychosocial	Preventative
<ul style="list-style-type: none"> • HIV testing and counseling, including early infant diagnosis • Baseline assessment • Use of ART drugs in adults and adolescents • Clinical and laboratory monitoring • Assessing and managing common symptoms of HIV, including pain • Screening, preventing, and treating tuberculosis (TB) • Cotrimoxazole (CTX) and fluconazole prophylaxis • Cancer screening and treatment • Services for sexual and reproductive health (SRH), including family planning (FP) • Assessing and managing mental health conditions • Transitioning from HIV care to HIV care and treatment • Palliative care 	<ul style="list-style-type: none"> • Adherence preparation and assessment • Ongoing adherence counseling and support • Psychosocial assessment • Ongoing psychosocial support • Counseling and support for disclosure – that is, a client’s sharing his or her HIV status with others • Community support, including access to support groups • Counseling on substance use and abuse • End-of-life support for the entire family 	<ul style="list-style-type: none"> • Primary prevention • Positive prevention • Nutritional education and support • Counseling on hygiene, sanitation, and safe water

1.3 The Regional Coordination Agency

The purpose of the RCA is to facilitate an efficient and strategic approach for PEPFAR's support to the implementation of the EHCP, the Comprehensive HIV Package of Care, and other priority programs of the GKOS/PEPFAR. Basic principles of the RCA include:

- In line with the draft National Supervision and Mentoring Framework, the responsibility for conducting supportive supervision and clinical mentoring of health services falls within the scope of the RHMTs.
- With the emerging disease burden and the goal of achieving universal access to critical services, PEPFAR and its partners, with engagement of the RHMT, acquired a role of building the capacity of the RHMT to provide high quality supervision and mentoring.

1.4 The Clinical Mentoring Team

For the pilot, all existing clinical mentors fielded by PEPFAR technical assistance partners were formed into one pool that was then absorbed into the Regional Clinical Mentoring Team (CMT), which is part of the RHMT. The Regional CMT was coordinated by the Regional Clinical Advisor, the focal point for coordination of technical support among GKOS, PEPFAR, and other development partners in the region. The Regional CMT was expected to conduct approximately two technical site visits per month to each facility. All partners in the region continued to support the facilities and the RCMT/RHMT mentors in their respective technical areas. All partners in the region also continued to provide support for logistics (e.g., vehicles and telephones). With ongoing partner input, the RCA had the responsibility of working with the Regional CMT to coordinate technical inputs, region-specific logistics, as well as respective work plans and schedules for mentoring and supervision.

1.5 Objectives of the Pilot

The pilot launch of the CMT in the Hhohho Region was conducted in a joint manner between the RHMT, PEPFAR, and technical assistance partners. The pilot was carried out with the following objectives:

- To provide leadership in implementing the concept of the RCA and Regional CMT
- To build the capacity of the clinical mentors to provide high quality mentoring
- To develop and pilot tools for regional clinical mentoring
- To document achievements, challenges, and lessons learned
- To provide regular updates to the PEPFAR regional and facility coordinating committees

2. IMPLEMENTATION AND RESULTS

2.1 Pilot Design and Implementation

2.1.1 Conception meeting

Plans for the regional pilot were solidified during a conception meeting that included representatives from PEPFAR, the Hhohho RCA, URC, ICAP, M2M, EGPAF, and the MOH. Through the inception meeting, regional partners reached a consensus on the most efficient method for coordination of regional activities. The pilot design included one lead PEPFAR agency--in this case, URC for Hhohho Region, structured meetings for planning and feedback, three mentorship multi-disciplinary sub-teams with overall lead MoH clinical mentor, and a

monitoring and evaluation system. The group agreed that the clinical mentoring pilot should focus specifically on training; supporting facilities through the provision of phones; reviewing and finalizing the terms of reference for the RCA; and developing implementation modalities and a road map.

2.1.2 Launch of RCA activities

Following a series of meetings, the Regional Health Administrator (RHA) officially launched the Hhohho PEPFAR RCA on August 27, 2012. In attendance were representatives from PEPFAR-supported agencies, Country Directors, and regional mentors from M2M, ICAP, URC, and EGPAF. In her opening remarks, the RHA mentioned that coordination of partners has been a challenge for Swaziland in the past; she applauded this initiative, including the work of the Regional CMT in mentoring facilities and improving health outcomes. She further mentioned that this exercise will assist the RHMT to improve their planning and capacity to implement, monitor, and report results. The PEPFAR RCA should empower the region to take a stewardship role in enhancing its accountability for resources used and results derived.

2.1.3 Mapping of sites

Partner-supported sites were mapped by updating a previously developed matrix according to technical area supported, availability of support phones, and support agency. It was recommended that facilities be supported to deliver the comprehensive package of HIV care and improve access to lab diagnostics, male circumcision and others.

2.1.4 Planning meeting with Hhohho mentors

After mapping the sites, the team of mentors, comprised of representatives from the 4 PEPFAR-funded agencies, operationalized RCA activities by forming three sub-teams and clustering facilities to be monitored accordingly.

2.1.5 Orientation workshop for mentors

An orientation workshop was held on the 8th - 12th October 2012 to standardize clinical mentoring tools and activities. Fifteen regional clinical mentors participated, representing URC, ICAP, M2M, EGPAF, and Regional MOH counterparts such as the MOH CMT, Sexual and Reproductive Health Unit (SRHU), National TB Control Program (NTCP), the Strategic Information Department (SID), and the Swaziland National AIDS Program (SNAP).

2.1.6. Clinical mentoring activities

The joint clinical mentoring teams visited 40 sites, working with staff using a number of approaches including: one-on-one clinical management observation, review of clinical cases, facilitation of case discussions, specialized trainings, audits of patient records and registers, and participation in facility quality improvement (QI) and multidisciplinary team (MDT) meetings.

2.1.7 Trainings

During the visits listed in Table 2 from November 2012 – May 2013, a number of trainings were conducted and supported by the RCA in collaboration with the following partners:

- **PACT:** Grants management training, 29-31 October 2012, 26 participants
- **URC:** TB quarterly review meeting, 31 October-2 November 2012, 61 participants

- **EGPAF:** Provider-initiated HIV testing and counselling (PIHTC) standard operating procedures orientation, 6-8 November 2012, 35 nurses trained in 17 health facilities. Few nurses attended as compared to the 60 nurses expected.
- **URC:** On-site TB management training at Lobamba Clinic, 20 November 2012, 6 nurses
- **URC:** On-site TB management training at Ezulwini Satellite Clinic 21 November 2012, 4 nurses trained
- **M2M:** Pre-service training for mothers to mothers, 5-23 November 2012, 7 nurses trained
- **ICAP:** Cluster meeting for Piggs Peak Hospital, Mkhuzweni Health Center with the supported clinics, 23-24 November, 43 health care workers
- **EGPAF:** PIHTC for Mbabane Hospital, 26-30 November 2012, 19 nurses from 18 departments (25 nurses were targeted)
- **URC:** On-site TB management training at Ntfontjeni, 4 December 2012, 4 nurses trained
- **M2M:** In-service training for mentor mothers, 3-5 December 2012, 30 participants
- **EGPAF-PMTCT:** Early Infant Male Circumcision training for six health facilities; 35 health care workers from 3 facilities. Some health facilities cancelled the trainings due to staff shortages.
- **MSH/Systems for Improved Access to Pharmaceuticals and Services (SIAPS):** Training on Pharmaceutical and Laboratory Supply Chain Management

Table 2: CMT Planned versus Completed Visits

1st Week of the month	3rd Week of the month	Comments
13 - 15 November 2012	27 - 29 November 2012	Successfully visited
December 2012	December 2012	No visits
15 – 17 January 2013	29 – 31 January 2013	Successfully visited
12 – 14 February 2013	19 – 21 February 2013	Successfully visited
12 – 14 March 2013	19 – 21 March 2013	Successfully visited
April 2013	23-24 April 2013	Successfully visited
14-16 May 2013	May 2013	Successfully visited

2.1.8 Phone support

Each clinical mentoring team developed a Standard Operating Procedure (SOP) for phone support in health facilities to increase patient follow-up and tracing to promote adherence to TB and HIV treatment and reviewed the current reporting tools. In all, 36 facilities were provided phones, and 39 units/departments within these facilities were provided airtime. A systematic report and monitoring mechanism for airtime usage was developed and implemented.

2.1.9 Monitoring RCA activities

The teams used technical logs to document and report on each facility visit, detailing the mentoring activities conducted during the visit. Paper-based technical log copies were completed and filled by the CMT, guided by the MOH supervision book. The technical logs were then entered into the database by the monitoring and evaluation officer for each sub-team, although generating web-based reports was difficult on many occasions. Original copies of the

technical logs were kept by CMT Clinical Advisors, who also made copies for the various agencies.

The team conducted monthly feedback and planning meetings to develop and share team performance, develop monthly calendars, and share notices on upcoming trainings.

Monitoring and evaluation activities of the pilot phase were guided by a monitoring and evaluation (M&E) plan informed by activity objectives. The use of pre-existing recording and reporting tools and methods of data collection was emphasized. Regional clinical teams were able to track activities implemented, identify and document lessons learned, gaps identified, and corrective actions.

Collectively, the M&E team was able to set targets to measure and assess whether a selected CMT team was achieving its intended outcomes. On a monthly basis, the M&E team and CMT team leads were able to compile a monthly report. M&E and CMT team members were able to participate in monthly dissemination and sharing sessions.

A number of tools, including the technical log, clinical mentoring checklists and airtime log, were also used to ensure that teams were tracking and effectively using resources. At the output level, the M&E teams were able to measure the combination of inputs and activities to quantify the direct results of the CMT team's activities at supported health facilities. Output measurement indicated whether an activity planned by the clinical mentor teams was successfully conducted and documented properly.

Because the pilot phase was implemented over a six-month period, the M&E teams were not able to measure outcomes directly linked to CMT activities. In this case, "outcomes" were defined as the intermediate effects of the clinical mentoring activities on facility health care workers and patients; this includes specific changes in knowledge, skills, attitudes, systems, level of functioning, patient treatment outcome, and client satisfaction. A positive outcome for mentoring health care workers would be a demonstrated improvement in the HCW's ability to diagnose and treat a specific disease. It was also requested that each agency select two outcome indicators to track.

2.1.10 Capacity building for mentors

Mentors were trained on key technical areas and mentoring methodology in collaboration with SNAP and were given post-tests. Those who did not achieve the minimum score were required to be re-trained in HIV/AIDS and TB clinical management.

Technical directors from various organizations in the partnership introduced "mentoring of mentors" at a meeting in January 2013. Tools were developed for assessing the capacity and competency of nurse mentors, and a timeline for technical directors to conduct joint visits with the teams was set to occur once a month.

3. SUCCESSES, CHALLENGES AND RECOMMENDATIONS

3.1 General Challenges and Recommendations

Air time: Phone support

Call logs used for verification of air time usage at the facilities need to be compiled on a regular basis and this was a challenge initially. To address this, a new SOP was developed which eliminated the use of call logs to verify and instead air time verification forms were developed to

be completed by mentors during every visit to facilities. Quarterly airtime usage forms will be collected by the regional sub team leads and used to compile the quarterly reports.

Vehicles

Due to the number of mentors in each team, the regional clinical mentoring team requires a 7-seat vehicle to transport the mentors to and from the facilities, which can be problematic. Additionally, some mentors expressed an unwillingness to sign indemnity forms. To address these challenges, waivers from signing the indemnity forms were made, and, when available, each supporting agency agreed to provide a 7-seat vehicle to transport the mentors.

Maximum participation by all parties

There was a noted absence of mentors due to other assigned duties. However, continuous lobbying with the MOH, RHMTs, and the relevant agencies to support the mentors is ongoing, and this has improved attendance.

Competing with individual agency reporting mandate

Mentors indicated that the different reporting requirements and needs of the various partners has negatively affected the amount of time spent at each facility. This has also affected the consistency and level to which Regional CMT members can participate in joint clinical mentoring in supported facilities.

Apparent lack of support from top management in the agencies

This activity lacked full buy-in from several key supporting partners, who felt that the endeavor was detracting from their efforts in their area of service delivery. Thus, the activity was not implemented to its fullest capacity. Continuous engagement of all supporting partners and reassurance from PEPFAR regarding meeting of targets has helped to achieve buy-in from all the supporting partners.

Limitation in means of communication

MOH mentors experienced challenges in contacting facilities and agencies while travelling to and from the facilities. Supporting agencies were requested to provide mobile phones for the transport vehicles. This remains an ongoing issue that will need to be addressed in the future.

Documentation: Technical log and supervision book

A few of the facilities were not yet in the system for reporting using the technical log. These facilities should be entered as soon as possible by ICAP. Technical logs only allow for a small amount of information to be stored, so mentors could only document key findings, successes, and gaps. Timely entering of technical logs and prioritizing their entry on Fridays is a requisite and during the last week of the month, the team leads should make copies for agencies to aid in their report generation.

Content and process of clinical mentoring

There was a perception by health care workers (HCWs) at some facilities that mentors were not adhering to the proper clinical mentoring process. These workers stipulated that the mentors were focused largely on data collection, rather than mentoring to build capacity within the facility. A meeting of Technical Directors was convened to examine this particular issue and recommendations to resolve this were agreed, as follows: i) collect data on the competences of

the mentors and strengthen their capacity where gaps are found, and ii) technical directors should conduct joint clinical mentoring visits with CMTs once a month.

Improving the support process

During implementation of the pilot phase, a number of consultations with different stakeholders were held. Suggestions garnered from these consultations were taken into consideration, and relevant changes were implemented during the pilot to improve the support process and coordination of RCA activities. At the end of the pilot, interviews were conducted with key informants, who suggested the following to improve Regional Coordination Agency approach and Regional CMT activities:

- A policy meeting for Country Directors should be conducted to ensure a conducive political environment for mentors to work in.
- Feedback of CMT activities to RHMT Clinic Supervisors should be ongoing so that everyone is on the same page and so that they can problem-solve when necessary.
- Feedback of CMT activities with SNAP Senior Medical Officer should also be ongoing in order to receive guidance and directives and to troubleshoot issues.
- Clinical mentors should be attached to “mother hospitals” for practice on the two days they are not conducting joint supervisions to ensure their skills are kept up-to-date.
- Mentorship competences and skills mix (for HIV comprehensive care) should be strengthened at the visited facilities.
- The quality of mentorship monthly reports and documentation should be improved.

3.2 Successes, Challenges, and Recommendations: Mentor Perspective

Mentors participating in the Regional CMT activities were able to assess the pilot through a number of focus group discussions conducted by the CMT and participating health facilities at the end of the pilot phase. Mentors were able to critically reflect and review the regionalization process and approach on key areas of support, and were able to provide insight into which methods were successful and which challenges were encountered. Recommendations were made to enable the RCA to improve the current approach.

3.2.1 Key achievements and successes highlighted by the mentors

Trainings and capacity building

Mentors agreed that trainings were carried out in large part as expected, and those that were not completed were due to time constraints.

Organizational development, skills transfer

Mentors expressed a flexibility for members from one team to assist another team when the need arises, and help is requested. They agreed that teamwork was enforced and worked very well. Mentors also agreed that feedback from individual team members was crucial and discussed professionally.

Phone support

According to the mentor teams, key successes regarding phone support included: quarterly Airtime verification and improved airtime supply and distribution.

Additional achievements and successes:

- Availability of transport at all times; cost-effectiveness of transport use as opposed to carrying just one person for clinical mentoring
- Completed visits to all sites with baseline assessments now available
- Started quality improvement (QI) in select facilities
- Onsite trainings (Pre-ART, Intensified Case Finding, TB) were conducted
- Mentors were trained to ensure competence in all key areas of TB/HIV
- A planning matrix was introduced, improving planning greatly
- Coordinated visits have helped facilities cope better

3.2.2 Challenges highlighted by the mentors

- Emerging and competing activities from the different agencies resulted in incomplete mentor teams at times, forcing some trainings to be cancelled.
- Plans made by the mentors were at times overridden by plans made by their individual agencies.
- Incomplete reports were produced due to unclear indicators. There are many indicators from the different agencies, which need to be consolidated and shared.
- The zoning of facilities became a problem when issues are followed up by a different mentor team than the one that carried out the initial visit. This should be reported appropriately.
- Balancing the schedule for site visits was difficult due to the limitation in days available for mentor teams to support the many facilities and facility departments.
- Mentors were not always available for the joint clinical mentoring visit, and there were times when the team had only one person available for mentoring.
- It was unclear who was responsible for the collection of quarterly verification forms.
- It was difficult at times for mentor teams to communicate with facilities while traveling to/from the site. Airtime support in the form of mobile phones in each vehicle would help alleviate this issue.
- Call logs were incomplete, lacking information about the outcome of the phone calls.
- Due to unclear roles and confusion in the process for integration of strategic information in the Regional CMT pilot, M&E mentoring support in facilities was a challenge.
- The schedule and process of the pilot was to be implemented within the first two weeks of each month, hence the MOH mentors no longer felt productive in the final two weeks. This resulted in a lack of activities for MOH mentors, while the agency mentors continued with their routine project support to facilities and regions.
- Airtime support for the MOH mentors was not available for calling facilities when they require support.
- Facilities sometimes attempted to make calls when there was no airtime at all, thus causing a disruption in patient follow-up.
- Data collection activities on the behalf of individual agencies sometimes clashed with regionalization days.

3.2.3 Recommendations made by mentors

- Indicators should be clarified from all agencies as determined during the RCA orientation meeting.

- Facility focal personnel should be trained on call log indicators for reporting as PEPFAR requires.
- Facilities should be required to call specific members from the mentoring team when ordering airtime.
- M&E mentors should be trained on all mentoring approaches as many do not know what to do in facilities, especially with regards to proper tools.
- Agencies should share their schedules in a timely manner so that Regional CMT activities can be coordinated appropriately.
- The RCA and all other regional coordinators should be involved in planning meetings so that they can provide guidance on regional trainings and meetings.
- PEPFAR and other appropriate agencies should decide on coordinated work plans.
- Agencies should hire more personnel for mentoring support to reduce use of regional coordinators and agency officers who already have a full workload.

RHMT members were asked to reflect on whether regionalization is working, if yes, why and if no, why not. Responses included:

- ✓ *In general regionalization is good but there is a need to address all the identified issues. PEPFAR and agencies must go back to the drawing board.*
- ✓ *Yes, but request support from agencies for human resources and involvement in activities for Hhohho Region, from planning to implementation.*
- ✓ *The approach is fine only if we can share the plans with the agencies on time, and the two weeks is sufficient for the RCT. We need the provision of airtime to MOH mentors.*

3.3 Successes, Challenges, and Recommendations: RHMT Perspective

The members of the regional health management team (RHMT) critically reflected and reviewed the regionalization process and the approach of the RCA and clinical mentoring on a monthly basis and at the end of the pilot. Feedback was received from the following Hhohho RHMT representatives: the Clinic Supervisor, TB Regional Coordinator, AIDS Regional Coordinator, Clinical Advisor, and Regional SID Officer.

RCA and Regional CMT activities conducted and supported by RHMT members included:

Planning: Some RHMT members received schedules, and some participated in the planning process, although this was not consistent.

Feedback: Only a few RHMT members received written feedback reports, verbal feedback reports (briefings), or participated in feedback meetings.

Supervision: Limited to two members of the RHMT.

Training: Some members of the RHMT participated in onsite TB-related trainings.

Clinical mentoring: Two members of the RHMT participated in clinical mentoring.

3.3.1 Successes highlighted by the RHMT

- The integrated and comprehensive clinical mentoring team was comprised of members with varying expertise in TB, PMTCT, HIV care and treatment, and M&E, thus providing comprehensive support to HCWs and making it easier for facilities to integrate services.
- Receiving the schedule prior to visits resulted in less service disruptions by the various agency mentors in the facilities.
- The facilities have responded positively to the work of the CMT.

3.3.2 Challenges highlighted by the RHMT

- The size of the clinical mentoring team was sometimes larger than necessary, particularly for smaller clinics which would at times have only 2 nurses.
- The mentors' technical expertise varied from team to team, resulting in a lack of consistency in the information provided to facilities.
- Most of the mentors had other responsibilities affecting their availability for joint regional clinical mentoring.
- There were a large number of competing activities in the region requiring the participation of mentors, which took away from the time they could spend on this activity.
- Mentors often spent more time collecting data than on clinical mentoring.

3.3.3 Recommendations made by the RHMT

- There is need for greater involvement of the respective RHMT members in planning, training, and feedback on clinical mentoring.
- Agencies need to make mentors available on a more consistent basis.
- Stakeholders should review a comprehensive checklist and finalize the indicators to be tracked for clinical mentoring.

3.4 Successes, Challenges, and Recommendations: Health Care Worker Perspective

Health care workers (HCWs) - including 22 nurses and 8 doctors from 6 of the health facilities supported - provided feedback from their experience with the RCMT and how they benefited from the onsite training, phones and airtime support.

Activities and support received by HCWs in visited health facilities included:

Clinical mentoring: Most of the HCWs indicated that they received clinical mentoring from the team; however, they also indicated that the team should spend more time at each facility.

Feedback sessions: Each facility received feedback from the mentoring team with regards to any issues identified for follow-up.

Quality improvement projects: All facilities indicated that they were supported with QI projects, data review, and learning sessions at the facility and regional levels.

Training: Some facilities received onsite trainings and commented that improvements have been seen. One facility received support for all Continuous Medical Education (CME) trainings.

Airtime support: All facilities received adequate airtime support, which is reimbursed in a timely manner. HCWs indicated that they have followed all the instructions provided relating to airtime support.

Multidisciplinary team meetings: Some facilities were supported by mentors through attendance at their MDT meetings, although this was not consistent.

3.4.1 Successes highlighted by the health care workers

- HCWs thought that the participation of mentors in MDT meetings and CME trainings was positive.
- HCWs felt that they were supported technically and received the required assistance to help identify areas of improvement (QI project implementation).
- They felt that the mentors assisted greatly in proposed projects, for example, by assisting the nurses to be up-to-date with the latest information, practices, and guidelines.
- They also agreed that the mentors assisted in report writing and motivating the nurses, especially with positive feedback when they were doing something well.
- Mentors assisted in team building and were of a friendly nature and very encouraging.
- Some HCWs felt that they were satisfied with the efforts and attested that in 2013 they felt much more aware of issues and clinical updates than in previous years.

3.4.2 Challenges highlighted by the health care workers

- New processes were introduced in clinics without the mother facilities receiving a clear orientation and relevant information from the mentoring team, e.g., referral tools.
- Not all expected mentors came as expected, at the same time, or at all. As a result, the joint clinical mentoring pilot did not match the overall joint CMT approach.
- Some mentors came in the morning when the clinics were busy, and HCWs were therefore unable to make full use of their presence.
- One facility indicated that they never received proper clinical mentoring.
- The team members were not always present, hindering the mentorship process as those present may lack certain skills that a missing mentor possessed, thus leaving HCW unsupported in those areas.
- The time spent in one clinic was sometimes too short because the CMT was required to visit two or more clinics in one day.

3.4.3 Recommendations by the health care workers

- Facility multidisciplinary teams should be given the capacity to effectively carry out their functions.
- Mentors should capacitate each other so that each member's technical skills are distributed evenly amongst the team members (CMT) and in that way be transferred to the HCWs.
- Additional human resources (nurses) are required in project-supported health facilities.
- Create a schedule and share it in advance with facilities to allow both the team and nurses to meet on an appointed date.

3.5 Successes, Challenges, and Recommendations: RCA Partners

Representatives from URC, EGPAF, MSH, ICAP, and PACT provided feedback at the end of the pilot phase on their experience with the pilot. The agencies provided a cost estimation of the process and implementation of activities.

Key activities, support, and roles played by the RCA partners included:

Coordination: RCA partners facilitated an efficient and strategic approach for PEPFAR's support to the implementation of the EHCP, Comprehensive HIV Package of Care, and other priority programs of the GKOS/PEPFAR. Partners also worked with the RHMT and the CMT to coordinate regional work plans and schedules for mentoring and training.

Planning: All RCA partners participated in Regional CMT planning and RCA support.

Feedback and reporting: Partners provided regular updates to PEPFAR Regional and Facility Support Coordination Meetings on region-specific achievements and challenges.

Clinical mentoring: Partners provided disease-specific clinical mentors with expertise in TB, PMTCT, ART, and HTC to 40 health facilities in Hhohho Region.

Technical assistance: All partners were able to provide technical assistance through their staff (coordinators, advisors, and directors).

Infrastructure: Some partners were able to provide minor infrastructure renovation to support the process of the RCA/Regional CMT.

Training: All RCA partners provided and participated in the joint onsite trainings conducted within the health facilities.

Phone support and airtime support. URC took over all airtime support and coordination, which had previously been supported by a few different partners.

Management of pharmaceutical commodities and services: SIAPS supported facilities by identifying and designating staff to ensure that services and data for the ART program is captured accurately and in a timely manner.

Transport provisions: A number of the partners were able to provide transport for site visits, supporting onsite and regional trainings.

Other support included: Support for placement of a data clerk in Mangweni and Mbabane Hospital was provided.

3.5.1 Successes highlighted by the RCA partners

- There was synergy in the support given to facilities.
- There was immediate follow-up; issues were addressed, and gaps identified.
- Skills and expertise were shared between different cadres.
- Increased knowledge of other ongoing activities in the region implemented by other agencies.
- Facilities were visited and supported by different agencies at once.
- Resources were leveraged; for instance, one vehicle was used by different agencies to conduct joint site visits.
- Nurse mentors were coordinated during facility visits.
- Mentoring was multidisciplinary, i.e., also included M&E officers.
- Created an enabling environment for the planning and implementation of RCA activities among key stakeholders (RHMT, agencies, SNAP, SRHU, and NTCP).
- There was coordination in the development of calendars for CMT and in-service trainings.

- Mentors increased their capacity in the various HIV disciplines.

3.5.2 Challenges highlighted by the RCA partners

- No indicators were developed for the RCA as a whole; thus, each mentor had to track their agency indicator as it aligns to their work plan.
- Three teams were developed, but not all agencies were represented in each team, which made it difficult for mentors of other teams.
- MOH mentors were more oriented on care and treatment.
- HTC and PMTCT activities were not given the same priority as treatment and care in regional activities, as indicated in the monthly report. Some of the MOH mentors concentrated solely on care and treatment, meaning PMTCT and HTC issues were always secondary, even in the planning phase.
- Follow-up was an issue, as this had to be done outside the first two weeks of the month designated for regionalization.
- Some nurses felt that addressing every issue in one day was an overload of information/work.
- Mentors oftentimes could not separate their role in the CMT from their role in their specific agency, focusing too much on agency priorities.
- The difference in the number of sites supported by PEPFAR partners caused mentors from some organizations to be under increased pressure in the final weeks of the pilot to try and achieve the targeted number of site visits.
- Agency mentors were unable to schedule site visits for the weeks outside of regionalization because the regionalization meetings were scheduled during that time.
- Communication to facilities was not very clear, as most facilities were not aware of the Regional CMT approach, leaving the mentors the responsibility to try and adequately explain the pilot at the beginning of a visit.
- Planning was, at times, not problem- or objective-driven.
- There was a lack of validated tools.
- Reporting and dissemination of findings of the CMT activities to all relevant stakeholders was inadequate and unstructured.
- There was a lack of consensus on reporting needs and service indicators to track the performance of the Regional CMT.
- There was a limited use of data to inform planning for clinical mentoring.

3.5.3 Recommendations by the RCA partners

- All agencies should meet and develop indicators that will be tracked across the teams, aligned with the work plan.
- The Regional Clinical Advisor should coordinate agency site visits and regional activities to avoid flooding facilities with different agencies.
- Nurses should be consulted for feedback since they are one of the main beneficiaries of the Regional CMT activities.
- Planning should be done quarterly so as to help agencies plan for other activities.
- Mentors from the various agencies should meet regularly so as to provide feedback to each other.
- Partner roles and responsibilities should be clearly identified.

- Reporting needs/requirements for the MOH and partners should be clearly identified and structured in RCA clinical mentoring activities.
- The reporting template should be restructured to respond to the needs of facilities and the RCA.
- Mentors should be appropriately trained with a standardized methodology.
- A joint calendar for mentoring and feedback should be developed.

4. CONCLUSION

The pilot of the Hhohho Regional Coordination Agency in Swaziland created synergy in the support given to health facilities and greatly facilitated the immediate follow-up of issues and identified gaps in support from facility partners. Through this mechanism, skills and expertise were better shared between different cadres, and opportunities were found for resources to be leveraged in support of facility requirements. Stronger capacity building was seen through improved coordination of nurse mentors during facility visits. The results and recommendations from this pilot should inform the roll-out of similar models to be implemented by the MOH and PEPFAR through its implementing partners in other regions.

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