Kingdom of Cambodia

Nation Religion King

Ministry of Health

Standard Operating Procedure of Clinical Mentoring for Adult and Pediatric HIV/AIDS Cares and Treatments

National Center for HIV/AIDS Dermatology and STD

July 2020

Forward

In 2011, the National Centre for HIV/AIDS, Dermatology and STD (NCHADS) and partners joined together to develop a first Standard Operating Procedure (SOP) for Clinical Mentoring at Pediatric AIDS Care (PAC) sites in Cambodia. The SOP was launched in June 2012, implemented and first updated was done in late 2014.

The aim of this second updated SOP for clinical mentoring is to maintain and strengthen the clinical competency of health care providers at ART clinics to provide quality of care complying with the recent evolutions of the HIV and AIDS care and treatment globally and in Cambodia. Clinical Mentoring should support the national program to reach the national goal of 95:95:95 by 2025.

The Ministry of Health supports this mentoring initiative that will provide invaluable clinical skills for health care providers who are responsible for Adult and Pediatric PLHIV patients cares and treatments at ART facilities in Cambodia.

Phnom Penh, 20 October, 2020

Prof. ENG HUOT
SECRETARY OF STATE

Acknowledgments

National Center for HIV/AIDS, Dermatology and STDs (NCHADS) would like to express our profound thanks to all NCHADS staffs, all members of TWG for HIV Care and Treatment, and all mentors for their contributions. NCHADS also would like to thank development partners, including, WHO, US-CDC, CHAI, AHF, FHI 360/LINGKAGES, Sihanouk Hospital Center of Hope and Brown University for their technical assistance. We appreciate the participation of all these actors who have actively contributed to the successful development of the SOP for Quality Improvement through Clinical Mentoring in Cambodia.

NCHADS hope that this SOP will assist all mentors in providing quality service improvement for Adult and Pediatric HIV/AIDS Cares and Treatments in Cambodia.

Phnom Penh, 12 October, 2020

Director of National Center for HIV/AIDS

Dermatology and STDs

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For Adult and Pediatric HIV/AIDS Care and Treatment

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral drug
CBO	Community-based Organization
CD4	T-CD4+ Lymphocyte
CHAI	Clinton Health Access Initiative
CoC	Continuum of Care
CQI	Continuous Quality Improvement
D4T	Stavudine
EWI	Early Warning Indicators
Hb	Hemoglobin
HEI	HIV-Exposed Infant
LR	Linked Response
MCH	Maternal and Child Health
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NMCHC	National Maternal and Child Health Centre
NPH	National Pediatric Hospital
NGO	Non-Governmental Organization
OD	Operational District
OI	Opportunistic Infection
PAC	Pediatric AIDS Care
PASP	Provincial AIDS and STI Program
PLHIV	People living with HIV
SRH	Sexual and Reproductive Health
TWG	Technical Working Group
TB	Tuberculosis
UNICEF	United Nations Children's Fund
VL	Viral Load
WHO	World Health Organization

Contents

I. Introduction and background

1.1 HIV Program Context

HIV care and treatment services, especially providing ARV have rapidly expanded during the last seven years with treatment coverage over 80% of those patients in need of treatment. There are currently 69 Adult ART sites and 37 Pediatric AIDS Care (PAC) sites in Cambodia, providing ART care to 60,114 PLHIV across the country, among them there are 2,738 pediatric PLHIV by Q2 2019. The rapid expansion of ART services occurred from 2004 to 2010, leading to a large cohort of patients on ART for five to ten years who require assessment for treatment failure. Some treatment sites are well-established with experienced clinicians and high number of patients. Other sites are newly established or have lower number of patients and clinicians with less practical experience. Furthermore, the national program recently shortened the duration of the didactic component of its HIV clinical care training program.

As the HIV treatment cohort in Cambodia matures, the national priority has evolved from scale-up of AIDS Care services to improving the quality of care and treatment. The clinical mentoring approach will support the capacity development of newly established sites and targeted sites while fostering professional support relationships and referral networks between experts and sites. The approach will align with the Cambodian 3.0 initiative for achieving the elimination goals of zero new HIV infections, zero AIDS-related deaths, and zero HIV-related stigma; and supports the national goal of 95:95:95 by 2025.

1.2 Clinical Mentoring in the context of HIV care quality improvement approach

In Cambodia, there are a number of national activities and approaches which support quality of care at the ART clinics. These approaches include Supportive Supervision to address program management issues, Continuous Quality Improvement (CQI) to monitor and improve quality of care indicators, trainings and network meetings to build clinical competency. Clinical Mentoring is distinct from those approaches in that it focuses on on-site coaching to apply clinical competency. On the other hand, Clinical Mentoring will complement to the clinical training of new clinicians to build their clinical competency in the HIV care and treatment area. As new initiatives, approaches and guidelines are established, there is a need to provide ongoing support to adolescence and adult ART and PAC teams to continuously strengthen clinical skills and high-quality implementation of national treatment protocols and programmatic approaches.

Table 1. National quality improvement activities in Cambodia's HIV Program

No.	Activity	Purpose	Frequency	Format	Facilitator/ Recipient
1	Supervision	To support ART clinics to address specific issues/indicators during the supervision visit and follow-up visit	Every 6 months	Site visit	National program staff to Adult ART or PAC sites
2	Implement P-D-C-A cycle (CQI) on quarterly basis	To continuously review, analyses the root causes of the problems, develop improvement plan, and follow-up related to the performance of the clinic.	Every 3 months	Workshop	OD/PHD level COC teams and inviting the National Program
3	Clinical Training	Build capacity and knowledge on HIV care and treatment of health staff	Once at the start of work	Didactic and practical training	National to Adult ART and PAC teams
4	Clinical Refresher Training	Refresh the capacity and knowledge on HIV care and treatment of health staff	Periodic	Didactic training	National to Adult ART and PAC teams
5	Counsellor and Clinician Network Meetings	To provide clinical updates Peer review of HIV/AIDS cases	Semi-annually	Large group meeting	Nationally facilitated regional meeting for ART teams; Nationally facilitated meeting for PAC teams
6	Clinical Mentoring	To strengthen the clinical competency	Every month to targeted ART clinics	Mentor to Site (including clinicians, nurse counsellors)	National level to ART clinics Provincial mentor to their ART sites

II. Objectives of clinical mentoring

Clinical mentoring strengthens the clinical competency of ART teams including PAC and improves the quality of care provided to patients. The specific objectives of the clinical mentoring are:

- To strengthen clinical competency of staff and hands-on clinical skills for better quality of care of ART services.
- To mentor the application of clinical skills gained from the training provided by NCHADS.
- To strengthen and support the implementations of clinical guidelines, concept notes, and SOPs of the national program.
- To develop a pool of national clinical mentors to provide clinical supports to ART srevices in Cambodia.

III. Clinical Mentoring Approach

Clinical mentoring approach is set up as three stages: pre, per, and post mentoring.

3.1 Pre-Clinical Mentoring

3.1.1 Setting up a clinical mentoring system

A. National Clinical Mentoring Coordinator and Pool of Clinical Mentors

The National Clinical Mentoring Coordinator (NCMC) at the national level (one for adult care, and one for pediatric care) will be appointed by the National Center of HIV/AIDS, Dermatology, and STDs (NCHADS). The NCMC will propose a set of experienced clinical mentors and submit the proposed list of mentors to Ministry of Health for approval.

Below are minimum requirements to be a clinical mentor:

- well-trained on clinical management,
- well-trained on clinical mentoring techniques,
- has experience, skills and knowledge in the area of HIV related for at least 10 years,
- preferably the mentor is from a site with large cohorts of HIV-infected patients, national hospitals or NGOs.

As the clinical mentors will be providing on-the-job training to clinicians/health providers at sites, it is important that the mentors are themselves well informed and trained. The initial step will be to provide refresher training for the clinical mentors in accordance with the training needs below:

- Have there been any major changes in the HIV system which require training (e.g. updated HIV clinical management guidelines, introduction of new guidelines, new policies or new approaches)
- Do the clinical mentors require training on mentoring visit techniques and participatory approaches (e.g. problem identification, problem-solving, training adults, time management, two-way communication, coaching, on-site training, etc.)
- Are there areas that can be strengthened by clinical mentoring visits and will therefore require mentoring training.

B. Tools for Clinical Mentoring

The National Clinical Mentoring Coordinators will assure the availability of these tools to update clinical competency and skills of health care providers during the clinical mentoring visits. The tools include checklists and recommendation and follow-up forms (Annex 1-5).

B1. Learning materials and job aids to be used by mentors during clinical mentoring visits

In addition to the training of mentors, it is important to have the right tools available to assist mentors and to standardize the clinical mentoring system. A clinical mentoring visit is an excellent opportunity to provide on-the-job training to individual health workers or with health facility (ART clinic) staff as a team. As Mentors will be providing on-the-job training, it is important to have standard materials available that:

- Are specific and simple to the skills that need to be improved,
- Are practical with clear manual/instruction and further detail reference,
- Can be used to prepare for training,
- Mentors can refer to during training sessions,
- Health workers can use to practice and reference.

Health workers need simple, easy-to-follow materials rather than heavy reference guides or training manuals. For health-facility staff, materials with clear explanations on how to do a particular task, preferably with flowchart and algorithm, onsite coaching, practice exercises and case discussion, are the most useful. The Mentors needs to be well prepared and fully knowledgeable about the topic and materials.

Before conducting the clinical mentoring visits, mentors have to make sure they bring these job aids with them:

1. National HIV Clinical Management Guidelines for Adults, Adolescents, and Children
2. National algorithm for Viral Load testing, EAC, and follow-up the treatment efficacy,
3. Condition when to start/stop Cotrimoxazole.
4. Criteria for MMD,
5. Criteria for Same-day ART,
6. TPT algorithm,
7. Job-aid for Cryptococcus screening,
8. Management of ARV side effects,

B2. Clinical Mentoring checklist and forms

A checklist contains items to be checked at EVERY site visit. However, it should not deter the mentors from recording and following up on other critical issues that he/she has observed but that are not included in the checklist.

The information collected should help the Mentors to decide what corrective actions can be taken during the visit, and what issues need to be followed up for actions in the longer term.

3.1.2 Ensuring adequate resources for conducting Clinical Mentoring

When setting up a clinical mentoring visit system, NCMC needs to ensure that adequate resources are available. The following items should be included in the budget:

- Transport,
- Per diem,
- Drivers,
- Fuel,
- Logistics: checklist, job-aid, slides, flowchart, etc.

3.1.3 Planning regular Clinical Mentoring visits

Planning for Clinical Mentoring visits should be included in the quarterly/annual work plan. It is important to look at the data when planning for Clinical Mentoring visits.

The plan should indicate:

- **Where to conduct visits**. The most common criteria used for selecting priority ART clinics are but not limit to:
    - Newly ART service establishment,
    - Highest number of newly detected,
    - Highly missed appointment, LTF and/or ,High mortality rates,
    - High rate of Viral laod failure (including 3rd line patients),
    - High rate of OIs report,
    - Low performance rates, for example, percent viral load/CD4 test, percent patients on MMD, percent of patients on same-day ART, percent of patients on TPT and other OI prophylaxie,
    - Other criteria could include: areas with recent outbreaks, new staff who may need mentoring/training on clinical practices, good coverage in the past but drop in coverage or low coverage in the present.

- **When to conduct visits**. Once the prioritized ART clinics are set to be visited over the next quarter/year, the visit schedule need preparing accordingly. It is important to conduct the visit according to the plan. If the visit cannot happen as planned, the health worker/facility concerned should be informed in advance. It is important to monitor planned visits versus actual visits and record the reasons for not holding any visit as planned (e.g. lack of transport, competing priorities, etc.). The frequency of Clinical Mentoring visits will vary with the situation.

    - Problem-solving and motivation in staff will demand frequent visits if they are to result in improved performance.

    - New ART clinics or major changes in existing ART clinics (e.g. new staff, new responsibilities) will require frequent visits.

    It will be necessary, however, to undertake **at least** two visits per year to each ART clinic. When planning the schedule, ensure that adequate time is available.

- **What are the objectives to cover during the visit.** It is important to have a clear

understanding of the main objectives of the visit. This could include main tasks to observe, or main topics on which training should be given, etc. A review of previous visit reports, and checklist, can assist in identifying which topics to cover during the Clinical Mentoring visits. Prepare an agenda for the visit in advance. The agenda should include one or two issues that have already been identified as priorities.

Although certain training topics can be planned in advance, some training needs may become evidence during the visit or during discussions with health providers.

The objectives of the follow-up clinical mentoring visits will be identified at the end of the first visits.

3.2 During Clinical Mentoring visits

The process of Clinical Mentoring is to assure that the ART team provide 3R to HIV patients: Right diagnosis, Right treatment, and Right follow-up. During a Clinical Mentoring visit to the ART clinic, the Mentors should conduct the following main steps.

3.2.1 Collecting information

Mentors use Clinical Mentoring checklist (Appendix 1: Clinical Mentoring Checklist) and collect information using a number of methods including:

a. Observing the health-facility environment and the health worker giving health services,
b. Listening to health workers,
c. Reviewing the records,
d. Reviewing recommendations from past visits.

The following information will be collected at each visited site at the first visit:

a. Availability of guidelines/SOP/Job-aid: Mentors assure that the latest updated versions of clinical guidelines/SOP/Job-aid are available in the ART clinic and easy to access when needed,
b. Patient flow in the facility: The patient flow may vary from one clinic to another based on their local arrangement. At minimum, the patient flow should be as in Appendix 2 – Patient Flow at ART clinic,
c. Key clinical care components: Mentors will review patients' chart to assure the care and treatment of the patients at ART clinics following the valid latest updated National HIV clinical managment guidelines/SOP/protocol. Mentors will use the findings from the chart reviews to assess and feedback the health workers on their clinical competency as well. The following clinical information of adult patient care will be collected during the clinical mentoring visits:
    i. Percentage of patients re-tested before starting ART,
    ii. Percentage of patients initiated Same Day ART complied with the criteria,
    iii. Percentage of patients have been documented with EAC (either 1 to 3),
    iv. Percentage of patients switched regimen appropriately according to the national treatment protocol,
    v. Percentage of patients have been appropriated management due to ARV side effects,

vi. Percentage of patients with detectable viral load have viral load follow-up test,
vii. Percentage of patients with CD4<100 were prescribed Fluconazole,
viii. Percentage of patients with CD4<350 were were prescribed Cotrimoxazole,
ix. Percentage of patients have VL test documented,
x. Percentage of patients have VL test complied with the national algorithm,
xi. Percentage patients screened for Cryptococcus and receiving Fluconazole prophylaxis according to the national guidelines,
xii. Percentage of patients received TPT in accordance with national protocol.

For pediatric AIDS care, a slightly different information will be collected (Annex 1).

To ease the chart review processes, Mentors should ask the data entry clerk at ART clinic to generate list of patients with the preselected conditions, for example:

- List of patients newly enrolled during last month,
- List of patients with viral load >39 copies/ml,
- List of patients who are on 2nd or 3rd line regimen,
- List of patients with CD4<100,
- List of patients with CD4<350,
- List of patients on ART at least 12 months.

3.2.2 Identify main clinical challenges

Mentors use the information they collected regarding the key clinical components to evaluate the clinical competency of health workers at ART clinic against the National treatment protocol/guidelines/SOP and identify clinical gaps for improvement and on-the-job training.

3.2.3 On-the-job training

Once the clinical competency gaps are identified, mentors will provide relevant on-the-job training to health care workers accordingly. In case there are many areas need improving, mentors will provide coaching according to the level of priority.

3.2.4 Recording the results of the visit

At each ART clinic should have a "Clinical Mentoring Record Sheet". The sheet will record:

- Findings from the visit related to clinical indicators. It should record only the clinical indicators that have problem(s) or challenges.
- The gaps of clinical skills associated with the challenged clinical indicators. There may be many reasons/causes associated with the low performance of the clinical indicators, but there should be gaps associated with the clinical skills recorded.
- Actions taken during the visit to address immediately the clinical gaps. The immediate actions that mentors took during the clinical mentoring visits are part of clinical coaching or on-the-job training. Mentors should not let the health providers at ART clinics to complete the defiance activities without immediate correction. For example, mentors observe health care providers prescribe 6-month scripting for an unstable patient; or prescribe TPT for suspected TB patients.

  Actions that mentors took during the clinical mentoring include but not limited to training on a specific topic, explaining the job-aids, or demonstrating a clinical skill.
- Agreed follow-up actions. At the end of the visit, mentors and health providers at site

discuss the follow-up actions that need completing. The performance of follow-up actions will be served as indicators of success or failure of the clinical mentoring approach.

3.2.5 Conduct Out-briefing with the ART Team

At the end of the clinical mentoring, mentors will conduct an out-briefing with the ART Team at site of what are recorded in the "Clinical Mentoring Record Sheet", have mentor representative and ART Team representative sign on the book.

3.3 Post Clinical Mentoring visit

After each clinical mentoring visit, mentors must prepare a clinical mentoring report. The report is vital for convincing the importance of the clinical mentoring, planning corrective measures, i.e. trainings or refresher trainings to strengthen the clinical capacity of health care workers, and planning for future visits accordingly. The report will inform PHD, PASP, Team leader and his/her team, and partners of the situation in the ART clinic.

The Clinical Mentoring visit report should contain:

- Date of visit, name of ART clinic and its location,
- Mentees,
- Mentors,
- Summary of findings and comments on how well they are performed,
- Discuss each indicator in the clinical mentoring checklist that have the issues,
- Describe what immediate corrective actions were taken during the visit, and
- Describe follow-up actions.

The report should attach a copy of "Clinical Mentoring Record Sheet" that is kept at site. The report should be shared to site within seven working days.

IV. Monitoring and Evaluation

The monitoring and evaluation of the clinical mentoring approach is part of the clinical mentoring report that should be done and disseminated regularly every quarter. The monitoring and evaluation will show how effective the clinical mentoring approach is regarding clinical competency of health care providers to provide HIV care and treatment services complied with the national treatment protocol/SOP/guidelines, that reflect in the trend of the improvement of the clinical indicators measured in 3.2.1 c.

Four indicators below will be monitored to measure the effectiveness of the clinical mentoring:

a. Percent of follow-up actions that are completed by the ART Team,
b. Percent of clinical indicators have been improved,
c. Percent of ART clinics with clinical indicator improvement at 2nd Clinical Mentoring visit,
d. Percent of ART clinics with clinical indicator improvement at 3rd Clinical Mentoring visit

a. Percent of follow-up actions that are completed by the ART Team	
Definition	Number of follow-up activities that ART Team and Mentors agreed during the clinical mentoring visit completed by the ART Team, divided by total number of activities that need following up, multiplied by 100.
Purpose	To measure the achievement of the recommendations from the mentors.
Method of Measurement	Count the number of follow-up activities that ART Team and Mentors agreed during the clinical mentoring visit listed in the "Clinical Mentoring Record Sheet", then compute for percentage using numerator and denominator below.
Frequency	At next clinical mentoring visit
Numerator	Number of follow-up activities that ART Team and Mentors agreed during the clinical mentoring visit have been completed by the ART Team at each ART clinic visited by the mentors.
Denominator	Total number of activities that need following up listed in the "Clinical Mentoring Record Sheet" at each ART clinic visited by the mentors.
Disaggregation(s):	No
Source of data	Clinical Mentoring Record Sheet (Annex2)
Interpretation	The higher percent of completion the higher commitment of ART team to follow the recommendations from the mentors.

b. Percent of clinical indicators have been improved	
Definition	Number of clinical indicators that ART Team and Mentors agreed during the clinical mentoring visit improved by the ART Team, divided by total number of indicators that need following-up, multiplied by 100.
Purpose	To measure the improvement of the indicators that ART Team and mentors identified during the clinical mentoring visit.
Method of Measurement	Count the number of clinical indicators that ART Team and Mentors agreed during the clinical mentoring visit listed in the "Clinical Mentoring Indicator M&E worksheet", then compute for percentage using numerator and denominator below.
Frequency	At next clinical mentoring visit
Numerator	Number of clinical indicators that ART Team and Mentors agreed during the clinical mentoring visit have been improved by the ART Team at each ART clinic visited by the mentors.
Denominator	Total number of indicators that need improving listed in the "Clinical Mentoring Indicator M&E worksheet" at each ART clinic visited by the mentors.
Disaggregation(s):	No
Source of data	"Clinical Mentoring Indicator M&E worksheet" (Annex3)
Interpretation	The higher percent of improvement the higher clinical skills of ART team improved.

c. Percent of ART clinics with clinical indicator improvement at second Clinical Mentoring visit	
Definition	Number of ART clinics that have clinical indicator improvement at the second clinical mentoring visit, divided by total number of ART clinics that mentors visited for the second time, multiplied by 100.
Purpose	To measure the effectiveness of the clinical mentoring approach.
Method of Measurement	Count the number of ART clinics in "Clinical Mentoring Progress Report", then compute for percentage using numerator and denominator below.
Frequency	Quarterly
Numerator	Number of ART clinics that Mentors visited for the 2nd time in the reporting period have clinical improvement.
Denominator	Total number of ART clinic visited for the 2nd time in the reporting period.
Disaggregation(s):	No
Source of data	Clinical Mentoring Progress Report (Annex5)
Interpretation	The higher percent of ART clinic with clinical indicator improvement, the higher effective of the clinical mentoring approach.

d. Percent of ART clinics with clinical indicator improvement at third Clinical Mentoring visit	
Definition	Number of ART clinics that have clinical indicator improvement at the third clinical mentoring visit, divided by total number of ART clinics that mentors visited for the third time, multiplied by 100.
Purpose	To measure the effectiveness of the clinical mentoring approach.
Method of Measurement	Count the number of ART clinics in "Clinical Mentoring Progress Report", then compute for percentage using numerator and denominator below.
Frequency	Quarterly
Numerator	Number of ART clinics that Mentors visited for the 3rd time in the reporting period have clinical indicator improvement.
Denominator	Total number of ART clinic visited for the 3rd time in the reporting period.
Disaggregation(s):	No
Source of data	Clinical Mentoring Progress Report (Annex5)
Interpretation	The higher percent of ART clinic with clinical indicator improvement, the higher effective of the clinical mentoring approach.

Annexes:

Annex 1: Clinical Mentoring Checklist

Clinical Mentoring Checklist
(Adult ART and Pediatric Clinic)

Visit Type: First visit □ Follow-up visit □ Visit Date (MM/DD/YYYY): ……../……../……..
Site Name: …… **Site ID:** ……..
Co-operation with NGO: Y□ N□
Service: Adult with Pediatric Y□ N□ OD name: …..……
Province/city: ……..
Mentor (s) name: ……

Total members/staff of team	Site Staff present
- Team Leader: ……	- Team Leader: ……..
- Physicians: …….	- Physicians: ……...
- Nurse Counselors: ……	- Nurse Counselors: …….
- Triage staff: ……	- Triage staff: …….
- Data entry Officers: ……	- Data entry Officers: …….
- Pharmacy staff: ……...	- Pharmacy staff: ……
- Blood collectors: …….	- Blood collectors: …….
- Community Action Counselor (CAC): ……...	- Community Action Counselor (CAC): ……...
- Community Action Worker (CAW): ……..…	- Community Action Worker (CAW): …….
- Facility based worker (FBW): ……..	- Facility based worker (FBW): ……...

Section 1: Adult Care & Treatment	1	2	3	4	Comments
1.1 National guidelines/SOP/Job aids for adult care and treatment are stored in the clinic and easily accessible: (OI/ART/HCV/PEP/MMS/SDART/VL monitoring/TPT) **Scoring:** 1: None is available 2: A few is available 3: More than half 4: All are available					
1.2 Patient flow in the clinic: **Scoring:** 1: No clear flow 2: Have flow, but not indicated 3: Have indicated flow, but patients not follow 4: Have indicated flow and well organized and appropriate					

1.3 Appropriate COVID screening at entry to facility? Covid warning signs in the clinics? Masks, hand sanitizer, hand washing available? Social distancing observed? **Scoring:** 1: None is available 2: One or two are available 3: Three are available 4: All are available					
1.4 Private, soundproof, counseling area available. **Scoring:** 1: None is available 2: One is available 3: Two are available 4: All are available					
1.5 Initiation of ART in accordance to national guidelines/SOP *Check 10 ART files/charts by randomly selected among new patient*					
1.5.1 What proportion of newly diagnosed clients have a CD4 test (baseline CD4) at the time of ART initiation? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.5.2 What proportion of patients receiving re-testing HIV diagnosis before initiated ART? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.5.3 What proportion of patients initiated Same Day ART complied with the criteria? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.5.4 What proportion of all newly initiating ART with TLD? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.6 Enhance Adherence Counselling (EAC) and the management of virological failure. *Check 10 ART files/charts of patients with viral load >39 copies/ml*					
1.6.1 What proportion of the patients have been documented with EAC (either 1 to 3)? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.6.2 What proportion of patients with detectable viral load have viral load follow-up test according to guidelines? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.7 Switching the ART regimen due to treatment failure appropriately according to the national treatment protocol/guidelines					

Check 10 ART files/charts of patients who are on 2nd or 3rd line regime					
1.7.1 What proportion of patients switched regimen due to treatment failure appropriately according to the national treatment protocol? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.8 Management **of ARV side effects appropriately according to the national treatment protocol/guidelines** *Check 10 ART files/charts of patients who have experience of ARV side effects.*					
1.8.1 What proportion of patients had ARV side effects have appropriately management according to the national treatment protocol? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.9 Percent patients screened for Cryptococcus and receiving Fluconazole prophylaxis according to the national guideline *Check 10 ART files/charts by randomly selected patients with CD4<100*					
1.9.1 What proportion of patients have CD4 counts <100 screened for Cryptococcus? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.9.2 What proportion of patients with CD4<100 were prescribed Fluconazole? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.10 Eligible patients receiving Cotrimoxazole prophylaxis according to the national guidelines. *Check 10 ART files/charts by randomly selected patients with CD4<350*.					
1.10.1 What proportion of patients have CD4<350 were prescribed Cotrimoxazole? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.10.2 What proportion of these had follow-up CD4 every 6 months until CD4>350 and cotrimoxazole stopped? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.11 Patients with Viral Load (VL) tests monitoring according to the national guidelines. *Check 10 ART files/charts of patients who have been on ART at least for 12 months*.					
1.11.1 What proportion of patients have VL test documented at 6-month ART and yearly thereafter? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					

1.11.2 What proportion of patients have VL test complied with the national algorithm? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.12 Percent patients receiving TB preventive (TPT) therapy according to the national guidelines. *Check 10 ART files/charts by randomly selected*					
1.12.1 What proportion of patients have been screened for TB signs and symptoms? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.12.2 What proportion of eligible patients for TPT have received TPT? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
1.14 Percent patients get MMD according to the eligible criteria *Check 10 ART files/charts by randomly selected*					
1.14.1 What proportion of patients get ≥3MMD complied with eligible criteria? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
Total Section Score (84/84) =					

Main clinical challenges

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Proposed actions to address the main clinical challenges

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Follow-up Action

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Section 2: Paediatric Care & Treatment	1	2	3	4	Comments
2.1 National guidelines/SOP/Job aids for paediatric care and treatment are stored in the clinic and easily accessible (OI/ART/HCV/PEP/MMS/SDART/VL monitoring/TPT) **Scoring:** 1: None is available 2: A few is available 3: More than half 4: All are available					
2.2 Eligible paediatric patients are on ART according to national guidelines/SOP. *Check 10 ART files/charts by randomly selected among new paediatric patients*					
2.2.1 What proportion of pediatric patients initiating ART within 01 week from enrolment at PAC clinic? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.3 Enhance Adherence Counselling (EAC) and the management of virological failure. *Check 10 ART files/charts of patients with viral load >39 copies/ml*					
2.3.1 What proportion of the patients has been documented with EAC (either 1 to 3)? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.3.2 What proportion of patients with detectable viral load have viral load follow-up test? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.4 Eligible paediatric patients receiving Cotrimoxazole prophylaxis according to the national guidelines. *Check 10 ART files/charts by randomly selected paediatric patients*.					

2.4.1 What proportion of patients were prescribed Cotrimoxazole complied with the national protocol? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.5 Patients with Viral Load (VL) tests monitoring according to the national guidelines. *Randomly check 10 ART files/charts of patients who have been on ART at last for 12 months*.					
2.5.1 What proportion of patients have VL test documented? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.6 Switching the ART regimen due to treatment failure appropriately according to the national treatment protocol/guidelines *Check 10 ART files/charts of patients who are on 2nd or 3rd line regimen*					
2.6.1 What proportion of patients switched regimen due to treatment failure appropriately according to the national treatment protocol? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.7 Management of ARV side effects appropriately according to the national treatment protocol/guidelines *Check 10 ART files/charts of patients who have experience of ARV side effects.*					
2.7.1 What proportion of patients had ARV side effects have appropriate management according to the national treatment protocol? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.8 Percent patients receiving TB preventive therapy (TPT) according to the national guidelines. *Check 10 ART files/charts by randomly selected*					
2.8.1 What proportion of patients have been screened for TB signs and symptoms? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.8.2 What proportion of eligible patients for TPT have received TPT? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					
2.9 Paediatric patients are assessed growth and nutritional monitoring. *Check 10 ART files/charts by randomly selected patients if 4 items are assessed BMI, High & Weight, Mid-upper arm circumference (MUAC), Growth curve plot*					
2.9.1 What proportion of patients were assessed the 4 items at the last clinical consultation? ☐ <60% ☐ 60-79% ☐ 80-89% ☐ ≥90%					

Total Section Score (48/48) =
Main clinical challenges ……. …… ……
Proposed actions to address the main clinical challenges ……. …… ……
Follow-up Action ……. …… ……

Annex 2: Clinical Mentoring Record Sheet

Finding	Clinical gaps	Follow-up Actions	Responsible	Timeframe

Annex 3: Template of a Clinical Mentoring Report

- Date of visit, name of ART clinic and its location,
- Mentees,
- Mentors,
- Summary of findings and comments on how well they are performed,
- Discuss each indicator in the clinical mentoring checklist that have the issues,
- Describe what immediate corrective actions were taken during the visit, and
- Describe follow-up actions.

Annex 4: Clinical Mentoring Indicator M&E worksheet

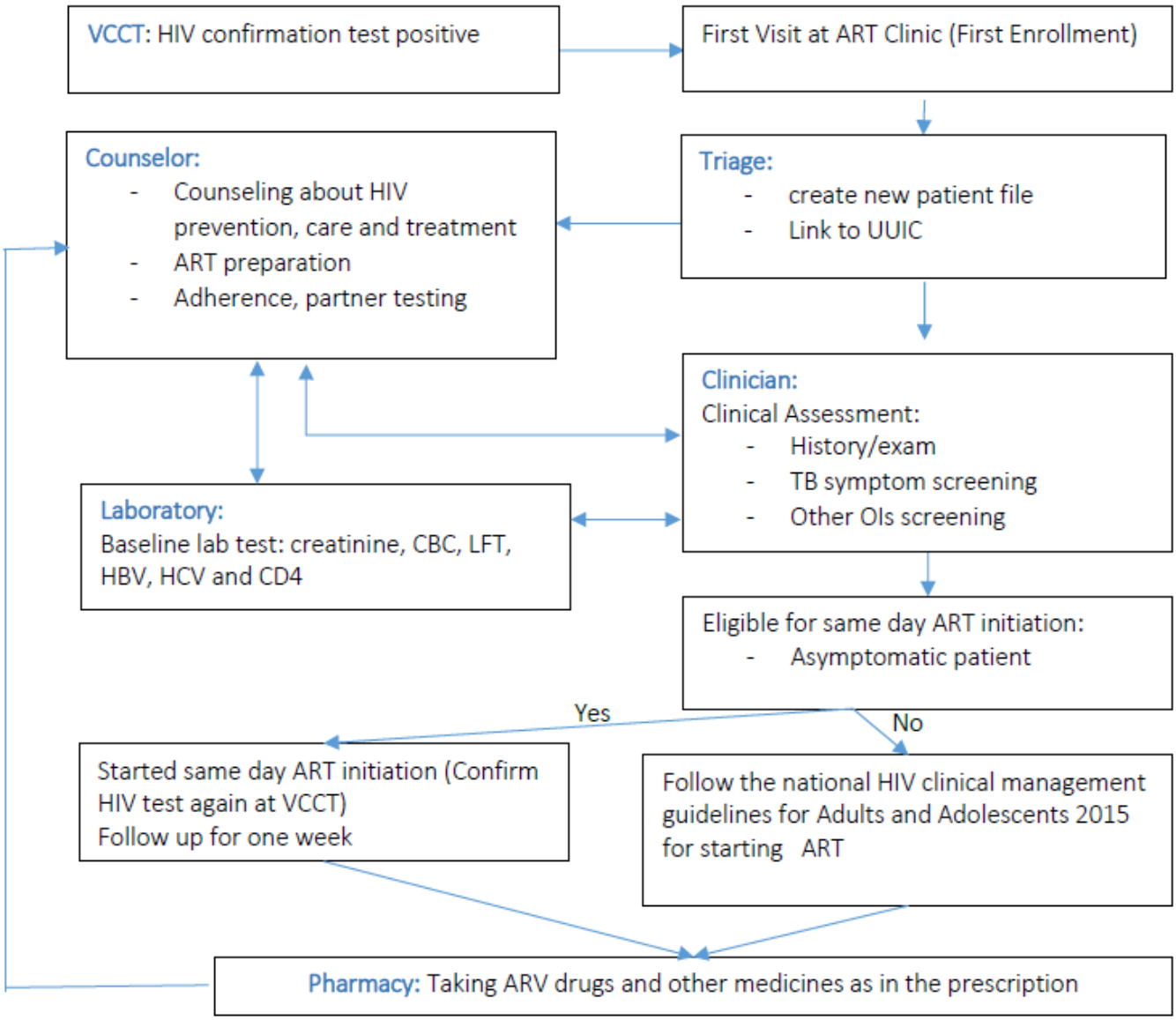
Indicator	% at the 1st CM visit	% at the 2nd CM visit	% at the 3rd CM visit

Annex 5: Clinical Mentoring Progress Report

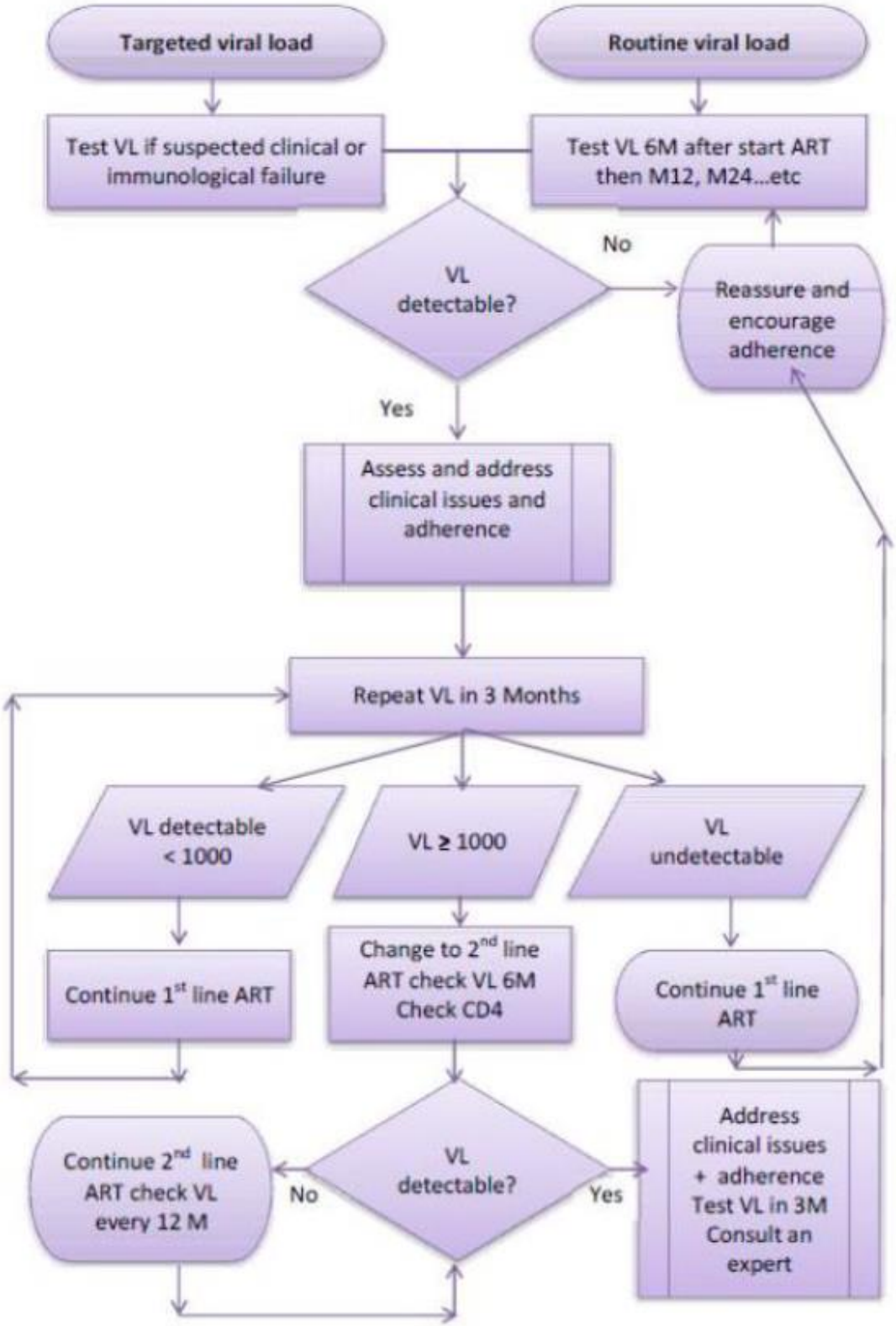
List of ART clinic	Clinical Indicator Improvement at 2nd CM visit		Clinical Indicator Improvement at 3rd CM visit	
	Yes	No	Yes	No
1				
2				
3				
4				
5				

Appendixes:

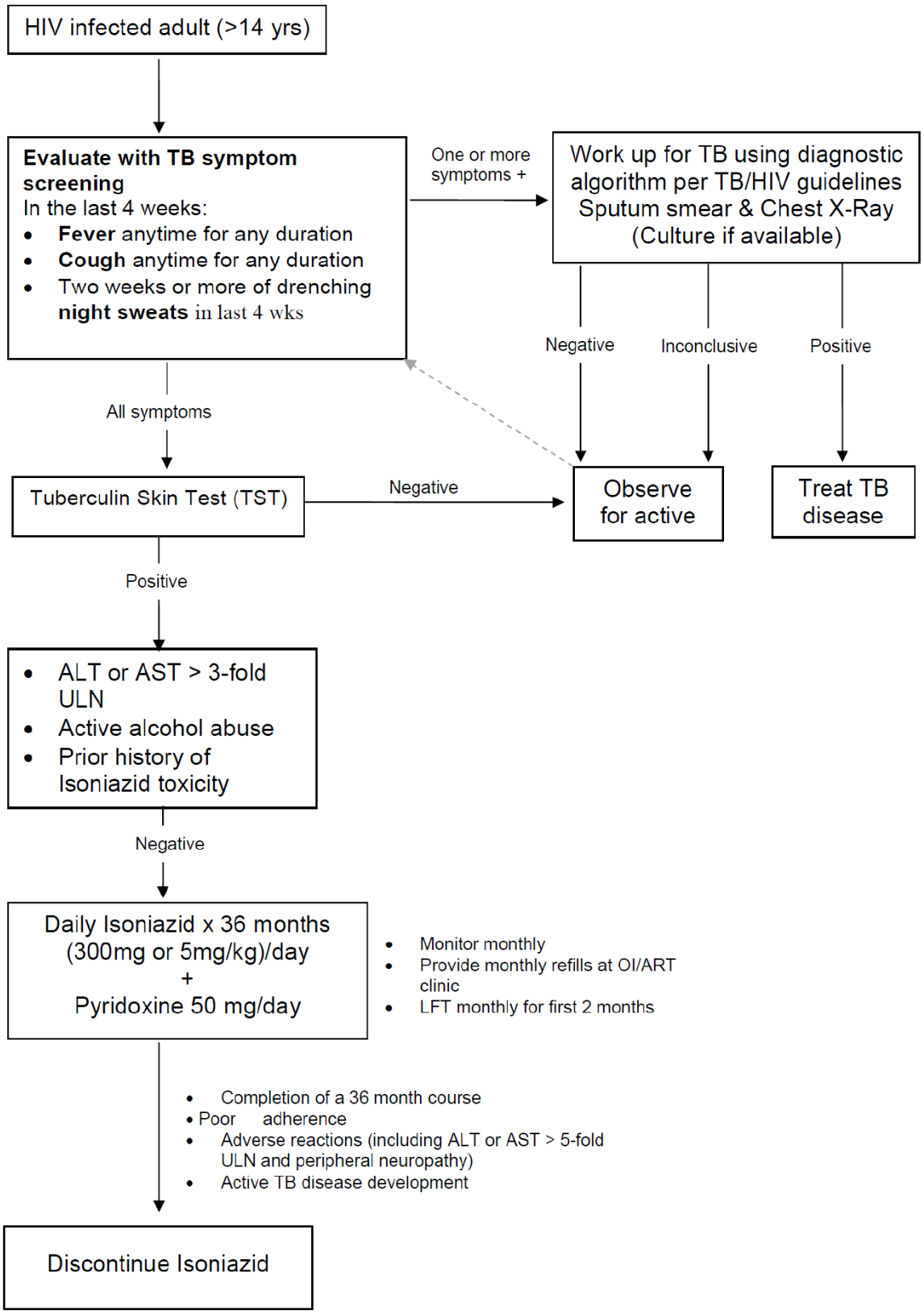
Appendix 1: Patient Flow at ART Clinic



Appendix 2: National Viral Load Algorithm

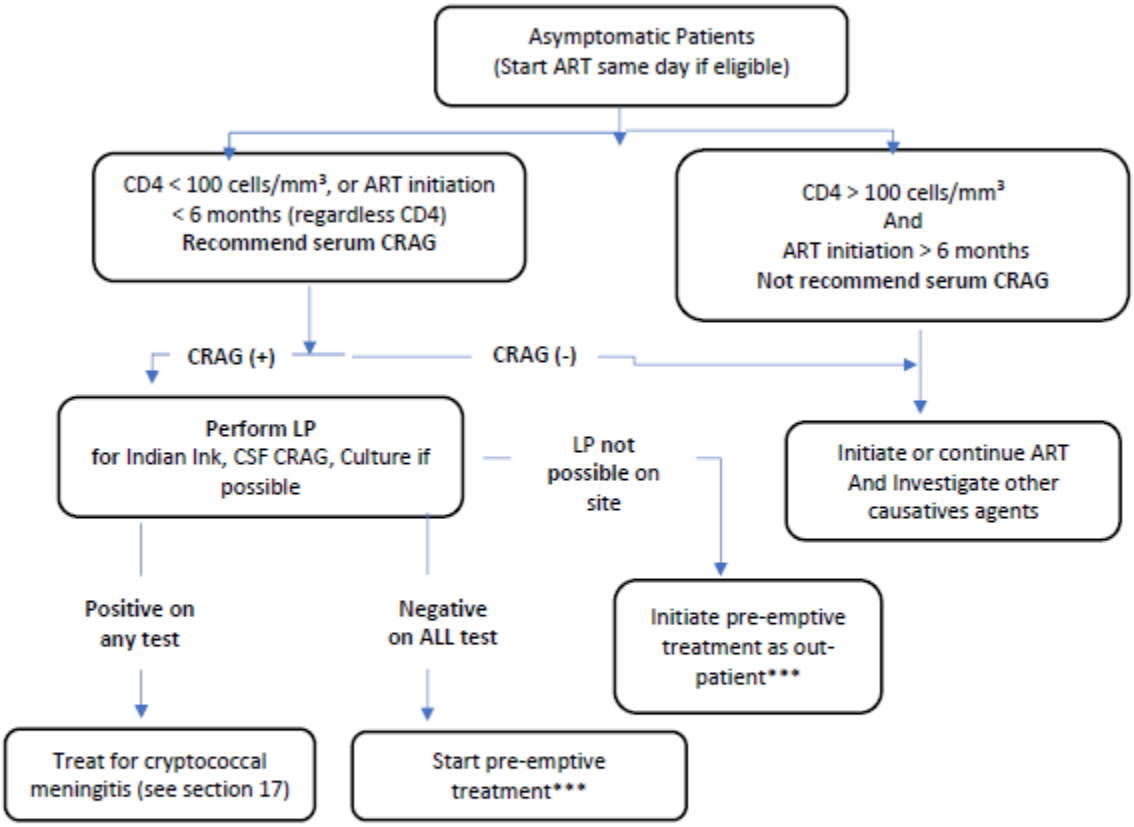


Appendix 3: TPT Algorithm (since 2010)



Appendix 4: Cryptococcal screening for asymptomatic patients

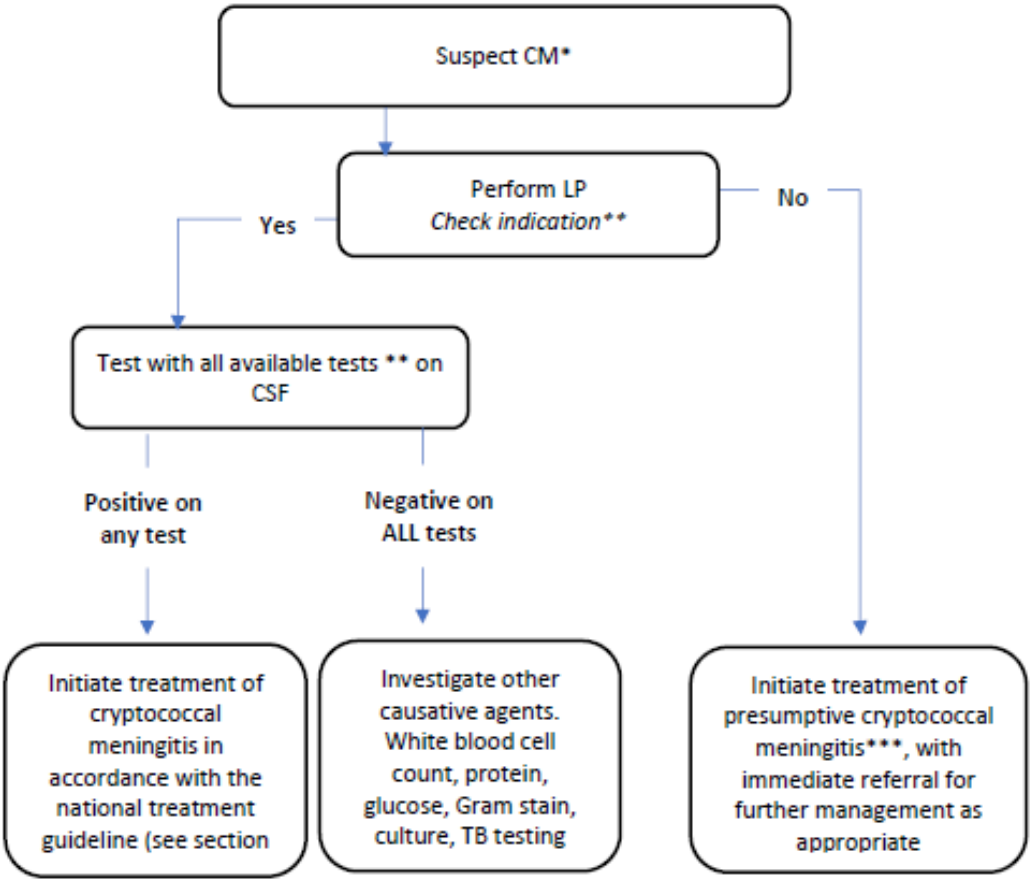
Figure 4: Cryptococcal antigen screening for asymptomatic patients



***Start pre-emptive treatment:
Fluconazole 12mg/kg oral daily for 2 weeks; then 6-12mg/kg for 8 weeks and followed by maintenance of fluconazole 6mg/kg with maximum dose of 200mg daily until CD4 > 100 cells/mm³ in 2 consecutive measurements of 6 month apart

Appendix 5: Cryptococcal screening for patients suspect cryptococcal meningitis

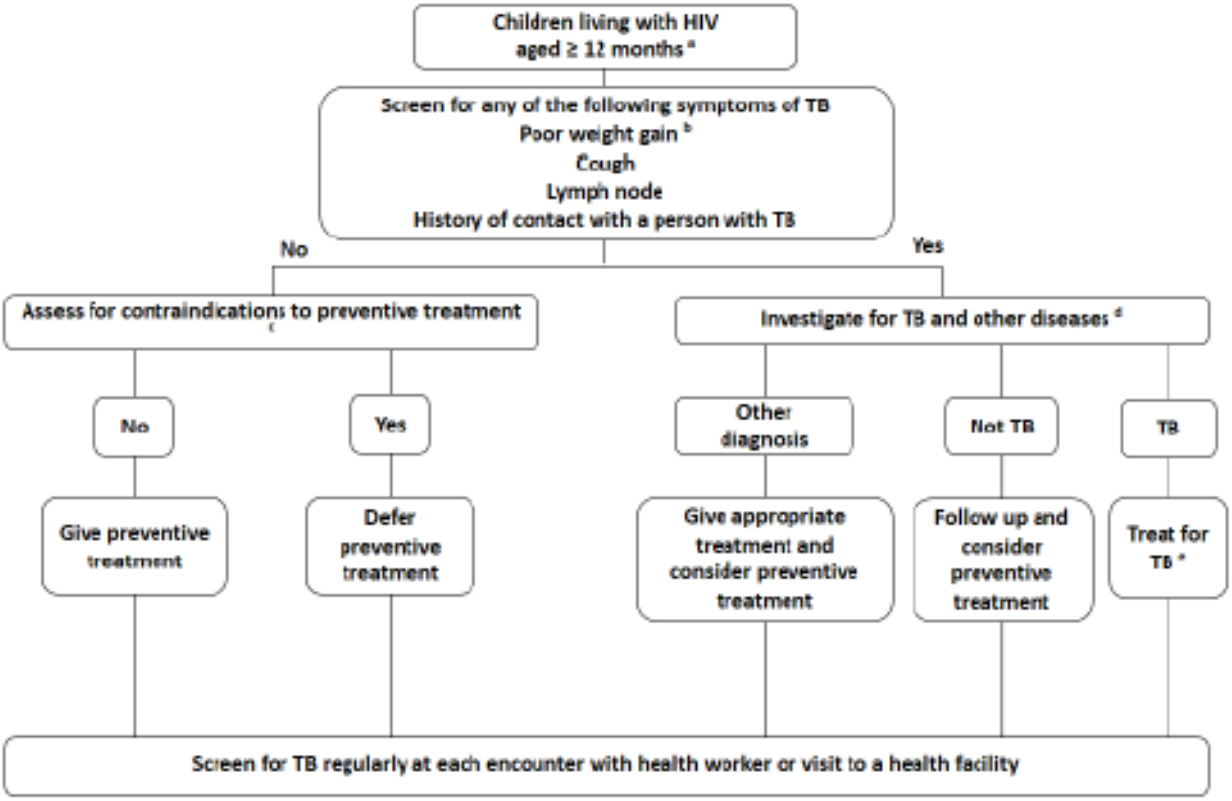
Figure 5: Cryptococcal antigen screening for symptomatic patients



*Headache, neck stiffness, sensitivity to light, seizures, fever, convulsion, blurred vision
** Contraindications consist of focal nervous system signs (excluding cranial nerve VI palsy) or recurrent seizures and, where possible, confirmed by computed tomography. Raised intracranial pressure does not contraindicate lumbar puncture in (suspected) cryptococcal meningitis. Other contraindications include major spinal deformity and patient refusal after fully informed consent was sought.
**all available tests include CRAG, Indian Ink and culture and result provided within 24h
*** provide Fluconazole 12mg/kg one dose and promptly refer the patient to RH where LP and management are able to provide.

Appendix 6: Algorithm for TB screening in children with HIV aged ≥ 12 months

Algorithm for TB screening in children living with HIV aged ≥ 12 months



Appendix 7: Tuberculosis Preventive Therapy regimens

Drug regimen	Doses	Considerations
Weekly isoniazid and rifapentine for 3 months (3HP) for all PLHIV > 2 years	**Isoniazid:** When INH is used in the 3 HP regimen it is advisable to use the following: • Individuals aged 2–11 years: isoniazid: 25 mg/kg • Individuals aged ≥ 12 years: Isoniazid: 15 mg/kg **Max dose: 900mg daily** **Rifapentine:** 10.0–14.0 kg = 300 mg 14.1–25.0 kg = 450 mg 25.1–32.0 kg = 600 mg 32.1–50.0 kg = 750 mg > 50 kg = 900 mg Plus vit B6 25mg daily	12 doses. The drugs should be issued to align with ART schedule
Daily INH for 6 months (6 H) for children 12-24 months, and for infants aged < 12 months only if in contact of a TB case	Isoniazid: • Children: 10 mg/kg (range: 7–15 mg) **Max dose: 300mg daily** Plus vit B6 25mg daily	180 doses