



Evaluation of the ASHM International Clinical Mentoring Model (ICMM)

Independent Evaluation by Darren Leitch | November 2018

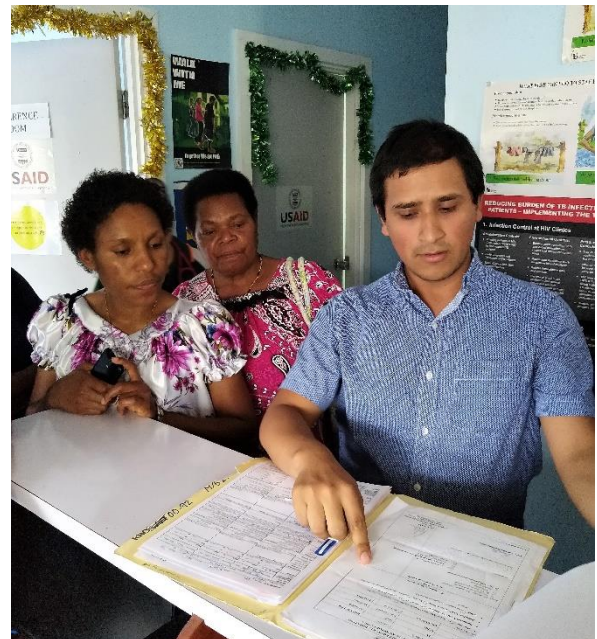
The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) International Program commissioned an independent evaluation of its International Clinical Mentoring Model (ICMM) in November 2018.

The evaluation explored the model's relevance, effectiveness, efficiency, impact and sustainability across three ASHM International projects: the Collaboration for Health in Papua New Guinea (CHPNG), the Sexual & Reproductive Health Integration Project (SRHIP) and the Pacific Sexual Health Workforce Capacity Building Project (PSHWCB).

The findings and recommendations of the ICMM evaluation will seek to strengthen ASHM International's clinical mentoring approach, programs and internal evaluation processes.

Evaluation Summary

- The ASHM International ICMM is an evolving model building localised and regional capacity for clinical mentoring in Papua New Guinea (PNG) and Pacific Island Countries (PICs). The model has built capacity in HIV, viral hepatitis, TB and STI diagnosis and treatment in high prevalence provinces of PNG and supported clinicians in low prevalence Pacific countries with technical backstopping and complex case management.
- The ICMM is filling a gap in effective in-service training in both PNG and the PICs.
- The ICMM is now maturing to build a local cohort of master mentors in PNG and support a regional network of mentors in the PICs that is linking isolated HIV clinicians to global best practice knowledge.
- The ICMM is providing a low-cost capacity building modality which cannot be matched by other capacity building modalities for its geographical coverage, the number of beneficiaries it reaches and the ongoing technical support it provides to mentees.
- The mentor program and the clinics it supports are reaching, and enabling treatment for, over 6,000 People Living with HIV (PLHIV) in PNG and expanding the number of ART prescribers in PNG and the Pacific.
- Despite impressive achievements the model is still fragile and still building the critical mass required to be sustainable. It faces challenges in terms of the capacity of some supporting partners in PNG and is vulnerable to external shocks such as health worker mobility, funding support and lack of validation of the model and endorsement by national health services.
- The ICMM needs to be better documented and validated as a cost-effective, high-impact capacity building modality. This will facilitate the potential integration of the model into national health planning and National Strategic Plans as an endorsed health workforce development strategy.





- There is an absence of data being collected through the model that can provide the evidence base to confirm the model's cost efficiency and effectiveness. Updating the unit cost analysis, calculating the return on investment and undertaking a cost benefit analysis of the model would help validate the model's value as a low-cost, high-impact appropriate development modality.
- Some improvements can be made to the operation of the model. Greater emphasis on skills-based training, particularly for mentoring skills, setting performance standards and defined deliverables, and better reporting to capture impact and the change effect would enhance the model.
- The policy agenda around gender and key populations are important elements of the model but need greater strategic focus and guidance to ensure practical implementation.
- As funding winds down on ICCM projects transition planning needs to commence, to consider options for sustaining the model. In parallel with this, ASHM International should look for potential partnerships in the public and private sectors that could help sustain investment in the model or support its evolution into a post-funding form.



Evaluation Recommendations

1. ASHM International and partners, the Catholic Church Health Service (CCHS) and the Oceania Society for Sexual Health & HIV Medicine (OSSHHM), should consider seeking to negotiate Memorandums of Understanding with national government departments, to bring national health ministries formally into the ICMM partnership model. This could assist with recognition and support for the model as a valued health workforce capacity building modality, and potentially provide access to funding that embeds and expands the mentoring model.
2. Accelerate the codification of the ICMM including documenting the process chain of mentor induction and training, and development of mentor guidelines to strengthen the documentation and validation of the model. Included in this process should be the setting of minimum performance standards and expected outcomes and deliverables from the mentoring process.
3. Seek to better articulate gender objectives at an operational level within the ICMM through development of a strategic plan to guide more practical training content and assist with defining operational approaches. Consider developing, as part of planned training packages, a unit on engaging men on sexual health and on gender-based violence, especially responses to sexual violence, given the prominence of the issue in influencing women's health-seeking behaviour.
4. Work with relevant community-based organisations to operationalise the key populations agenda of the ICMM and explore strategies for improved engagement with key populations within project health services.



5. ASHM International should undertake an analysis to validate the ICMM establishing unit costing, return on investment and cost benefit analysis data. Along with codifying the model, this will assist in confirming cost efficiency and effectiveness and support advocacy to attract further funding for the model.
6. Consider employing survey instruments and longitudinal measures to capture the change effect the mentoring model is creating in knowledge, attitude and clinical practice. Combined with the current systems level data being generated by the Clinical Mentoring Visit Reports, this could provide a means to measure the change effect that ASHM International clinical mentoring is engendering.
7. Start the process of developing a transition plan to define what form the ICMM may need to adopt in a post-funding environment. Seek to cultivate and develop partnerships with future potential funders, facilitators and enablers of the ICMM.

Evaluation Findings

Relevance

The ICMM is technically relevant to the needs of health workers and clinicians in PNG and the PICs. The ICMM sources, trains and deploys Australian, PNG and Fiji-based clinicians with substantial expertise in the diagnosis and treatment of HIV and STIs to serve as mentors to health clinic staff in PNG and HIV clinicians in public health settings in the Pacific. Mentees interviewed for the evaluation stated that ICMM mentors are appropriately skilled and experienced, have good communication skills and are able to provide high level technical support addressing mentor needs.

The ICMM has been adopted differently in PNG and the Pacific Island Countries (PICs), reflecting the different levels of health sector capacity and the differing profiles of HIV, STIs, viral hepatitis and TB in the two environments. Communication technology and health sector resourcing differences have also shaped the form of mentoring.



The ICMM is filling a gap for in-service training that is absent in PNG and limited in PICs. It is providing the only current means of exposure for frontline health staff in PNG to detailed current knowledge and practice in the diagnosis and treatment of HIV and other diseases.

The ICMM is supported by an extensive training program that provides technical knowledge of HIV, hepatitis, TB and STIs and mentoring skills. Drawing upon World Health Organisation (WHO) testing and treatment protocols, the training includes national HIV treatment guidelines, diagnostic skills and appropriate



Mentor Case Study: Mary

"I have to do it myself so that they see, and they follow me."

Mary completed the ICCM training six months ago. She is the team leader at a busy health clinic in Port Moresby, managing the drop-in clinic as well as the outreach program—a mobile clinic converted from an old bus.

"When we reach out to people at the markets, they tell us how busy they are and how they don't have time to come to the service," Mary says. "When they are sick it's too late to help them, so when the service is available at their doorstep, they take 15 minutes off from the market to come to the bus to do a test."

The mobile clinic has also allowed Mary to reach members of key populations, including sex workers, several of whom are now attending the clinic for regular testing and treatment.

While many of the challenges Mary faces at the clinic, such as fluctuations in the supply of medicines, are beyond Mary's control, learning how to mentor has helped her understand the different approaches she can take to mentoring the health workers in her clinic.

"There are different ways that you can mentor someone. Sometimes they see what you are doing, and they follow, but sometimes they listen to your instruction and they follow," she says.

"When I see that I'm managing elderly people... I got to literally fix it and then I say, now you're going to do this. So, after the training I see that approaches have to be different in the way we are approaching people so that people can accept what we are telling them, or what we want them to do."



treatment regimens. There is also a training component to accredit HIV prescribers. To date, 16 HIV practitioners from PNG and PICs had been accredited to prescribe ART under the ICCM.

The ICMM mentors are subject to training on mentoring skills and policy priorities including gender equity, child protection principles and the needs of key populations. All mentors are required to complete online modules in child protection principles.

There is a sense amongst some participants and partners that the training could be enhanced by being more skill-focused rather than its current strong theoretical content. Some stakeholders participating in the master mentor training would like to see more

focus on development of mentoring and communication skills to give practical techniques to mentors to facilitate effective peer-to-peer communication.

There is a clear need to create a sanctioned enabling environment for mentoring to take place in the workplace of public health services, particularly as local master mentor cohorts are built in PNG and the regional cohort matures in the Pacific. Part of the problem appears to stem from the fact that, at present, the ICMM largely operates outside of formal recognition as a valued and endorsed health workforce development strategy by national health authorities.



Effectiveness

The ICCM compares well against international criteria for clinical mentoring in both the PNG and PIC models. In PNG, mentors are dedicated to individual health clinics and their satellite clinics and a cohort of health personnel comprising nursing officers, community health workers and other medical support staff. This has allowed mentors to build strong and effective personal and working relationships over time with mentees, and develop a good understanding of their operating environment and resource constraints.

There is a strong sense amongst both mentors and mentees that mentor visits should be more frequent.

All mentors interviewed are able to articulate the goals and objectives of the ICCM. A consistent theme amongst mentors is that mentoring is about both building capacity amongst lesser experienced health professionals and providing them with collegial support to deal with the issues they face in interacting with a variety of patient types and needs. It is also seen as critical for building confidence in using technical skills and fostering team based approaches to health care.

There is strong consensus amongst mentors for the need for better definition and guidance around the role of a mentor and performance expectations. Operational manuals for mentors are seen as necessary by a number of informants to provide ongoing guidance and to define minimum performance standards.

There is a sense amongst a number of mentors and mentees that gender could be more practically focused within the training modules. A number of informants



Facilitator Case Study: Marcel

"I had a lot of questions this morning based on my talk yesterday... they've got a real passion for more information."

Marcel is a Melbourne-based doctor, and this is his third visit to PNG to run an ICCM workshop. He has been delivering some of the more clinical components of the workshop, teaching the participants more about some of the disease areas they are working in.

"There was a lot of interest in the hepatitis B talk that I gave. It affects such a huge percentage of people in Papua New Guinea—14 per cent have chronic hep B, which is huge, and they don't know much about it," Marcel said.

"They see patients with chronic liver disease, they know what jaundice is, they know patients die of liver cancer but they don't often know why. So I think that hep B talk puts that liver illness into context because it is going to be responsible for a lot of the causes of it."

Marcel has also been visiting course participants from his earlier workshops at their clinics, tracking their progress as mentors. It's his first time doing these follow-up visits as part of the ICCM program.

"I've seen two clinics and they're both very different in how they're set up... the health workers at all of them seem very competent," he said.

"It's great to see, one of the participants has been out to three clinics already to do mentoring follow-up, so they're definitely keen to get out there and impart their knowledge to others."



argued for the need to provide greater guidance on how gender consideration to improve service access for women and young girls can be articulated in an operational sense through service design and delivery.

Evidence from a survey of mentors found that the key population component is the least well absorbed element of the training modules and the least well realised element of the model in terms of practical implementation. Reducing stigma remains a challenge within health services in both PNG and PICs.

Efficiency

Against the key criteria of cost, impact and coverage, the ICMM model compares favorably against alternative capacity development modalities. It is difficult to identify any alternative capacity building modalities that could provide anywhere near the same level of coverage and cost efficiency.

The budget data provided for the three projects presented limitations in usefulness for analysing efficiency due to both a lack of specific cost detail and differences in budget presentation. Despite this, it is clear that the ICMM has a limited number of cost components, with consultant fees, travel costs and program management being the key cost drivers of the model.

Despite the challenges of attribution, it can be said unequivocally that the model is low cost and low maintenance compared to alternative modalities, and is run efficiently with a small but dedicated team of ASHM International program support personnel.

In addition to its low direct cost there are other elements that demonstrate the efficiency of ICCM as a development model. Some informants to the evaluation highlighted the practical cost efficiency of the ICMM as a development process that brings the expertise to the beneficiary in a workplace setting. For remote health professionals in isolated regions, the model is highly cost efficient compared to having to travel either domestically or internationally for training with the attendant transport challenges in both PNG and the PICs and the disruptive impact on patients, colleagues required to cover for the absence and the backlog of administrative workload. These practical elements of cost efficiency – the opportunity costs – reinforce the ICMM as an appropriate, low cost capacity building modality.

Impact

At an operational level improved quality of service has been manifest in the form of improved diagnostic capability and clinical skill leading to better treatment outcomes for patients. A number of PNG informants attribute improved abilities in syndromic diagnosis of STIs as leading to more appropriate treatment being administered at health clinics. Improved clinical examination skills of mentees and ability to interpret test results were reported as two key observed changes.





Mentor Case Study: Sylvia

"I have to be a good role model and work side-by-side with the staff."

Sylvia works in a busy hospital maternity ward as a supervisor, but she's a midwife by profession. She has come to Port Moresby for an ICCM workshop, to learn more about how she can support others in her workplace.

"As a supervisor I have to make sure the staff are turning up according to the schedule," Sylvia said.

"I'm taking care of three sections: the nursery for premature babies, the postnatal section, and managing labour and delivery inside the labour ward."

Sylvia's work puts a lot of pressure on her to be a leader and a role model under often challenging circumstances.

"The challenges I face is when there are more mothers coming in and I have few staff working with us, sometimes we are really overwhelmed with the workload we have... taking care of three wards is really a big challenge for me," she said.

She hopes that the skills she has learned at the ICCM workshop will help her to go back to her hospital and change things for the better.

"I am here to learn how to be a good mentor for the rest of my staff, so that they can learn from me," Sylvia said.



Reported improvement in note taking and record keeping have also been attributed to the mentoring process. This plays a key role in supporting better diagnosis and facilitating better patient engagement and referral options. Improvements in clinical skills has also enabled greater willingness of health workers to seek collegial advice on complicated cases. A number of informants cited better note taking and record keeping as facilitating case review discussions with colleagues on response and treatment options. This encouragement of a team based approach to health care is seen by informants as improving diagnosis and treatment responses and efficiency.

The greatest impact of the ICMM in PNG is being felt at the level of patient care in the contribution of the ICMM to increasing the coverage and reach of HIV testing and treatment services. The ICMM has rapidly expanded clinical capacity at supported health clinics. Over 6,000 PLWH patients are now receiving treatment and care through ICMM supported health clinics. This represents a significant increase in service capacity from 4,800 recorded in 2015 and accounts for 23% of all PLWH on ARTs in PNG, a remarkable achievement for a model of this size and cost¹.

The ICMM is providing critical technical backstopping and sharing experience in complex HIV case management for medical professionals operating in a low prevalence environment with limited exposure to HIV cases. With limited alternative peer support available in many PIC environments, the ICMM is providing a vital link for Pacific health professionals to gain access to specialised knowledge and technical expertise and experience in dealing with the management of complex cases. The ICMM is building stronger clinical

¹ PNG had 26,400 persons on ART in 2017 of the 48,000 estimated PLWH. Data from AIDS Data Hub

capacity in PICs and delivering technical support in an environment where alternative modalities would be more expensive or unable to provide the same range of coverage for the region.

A number of mentees identified greater confidence, both in technical skills and asserting professional opinion, as key outcomes of mentoring. This greater confidence is manifest in some by a willingness to guide other peer health workers in process compliance and correct procedure. This is a significant impact from the mentoring model in a cultural environment where peer-to-peer instruction or critiquing performance can be a sensitive and difficult issue to confront. A greater willingness to consult and discuss difficult cases with other colleagues was reported during the evaluation along with greater engagement in workplace discussions and team meetings, and enhanced communication and reporting skills.

The ICCM has helped to create a culture of learning that is otherwise absent from the PNG health sector. The mentoring model provides access to ongoing learning and professional development by facilitating health worker access to global trends and knowledge of the changing landscape of HIV and other diseases.

The ICCM encourages greater critical appraisal of processes and systems that are seen as inefficient and encourages thinking about workplace process improvement and how things can be done better. A number of informants spoke to the learning process from mentoring as a driver for cultivating more thinking about continuous improvement in health service quality.

Sustainability

Despite its impressive achievements, the ICCM remains fragile and vulnerable whilst it lacks good documentation of process and deliverables and whilst a critical mass of localised expertise which can sustain the model is still being built in PNG and consolidated in PICs. The model faces a number of further challenges with current funding of the ICCM model in PNG concluding in 2020. This will present challenges and opportunities for the design of the model to sustain in a post-funding environment. These challenges are recognised by ASHM International and are being addressed by investing in development of the master mentor cohort in PNG and the Pacific Island Countries.



The ICCM has become a victim of its own success by attracting high volumes of patients as the quality of health care service has improved and word of mouth has spread. Clinical health staff are chronically overloaded leading to burnout. This is a real risk to maintaining the master mentor cohort in PNG in particular, who are critical to the model's ongoing sustainability and replicability. This speaks to the wider issue of systems reform and the broader agenda that ASHM International and local partners (CCHS) could seek to prosecute in engaging and partnering with national government departments and ministries.

It is critical that transition planning starts immediately, to define and develop a strategy for how the ICCM could look in PNG and the PICs in a post-funding environment. Transition planning will need to consider how the model can be configured in the absence of continued funding, what form of technical support and management a post-funding model may need, how this could be supported, and defining and articulating the process steps to move the model from its current form to a more sustainable model for PNG and the Pacific.