Medecins Sans Frontieres Khayelitsha Clinical Mentorship Programme
Report and Toolkit

1. Background

In 2005, the World Health Organization (WHO) produced recommendations for clinical mentorship in resource limited settings, in response to the pressing need to scale up the provision of antiretroviral treatment (ART) for eligible patients.[1] The WHO document emphasizes the need for training and mentorship support of clinicians in order to decentralize services to district hospitals and primary health care centres; decentralization, in turn, not only leads to increased access to ART, but can promote long term adherence through proximity to care.

On World AIDS Day in December 2009, President Jacob Zuma announced South Africa's intention to increase access to HIV treatment and care by allowing nurse initiation and management of ART (NIMART). National clinical mentorship guidelines were finalized in January 2011, in order to provide guidance for provinces, districts, and sub-district management teams to develop and integrate clinical mentoring within the district health system.[2] The mentorship guidelines came at a time when 7492 nurses had undergone NIMART training nationally, with 23% (1745) initiating ART after training.[3]

Most recently, South Africa's National Strategic Plan 2012-2016 calls for all primary care, antenatal, and HIV/TB facilities to become fully functional as nurse-initiated ART, TB, and MDR-TB initiation sites for adults, children and pregnant women.[4] Implementation of this policy has been slow and practical steps for capacitating nurses is often lacking.

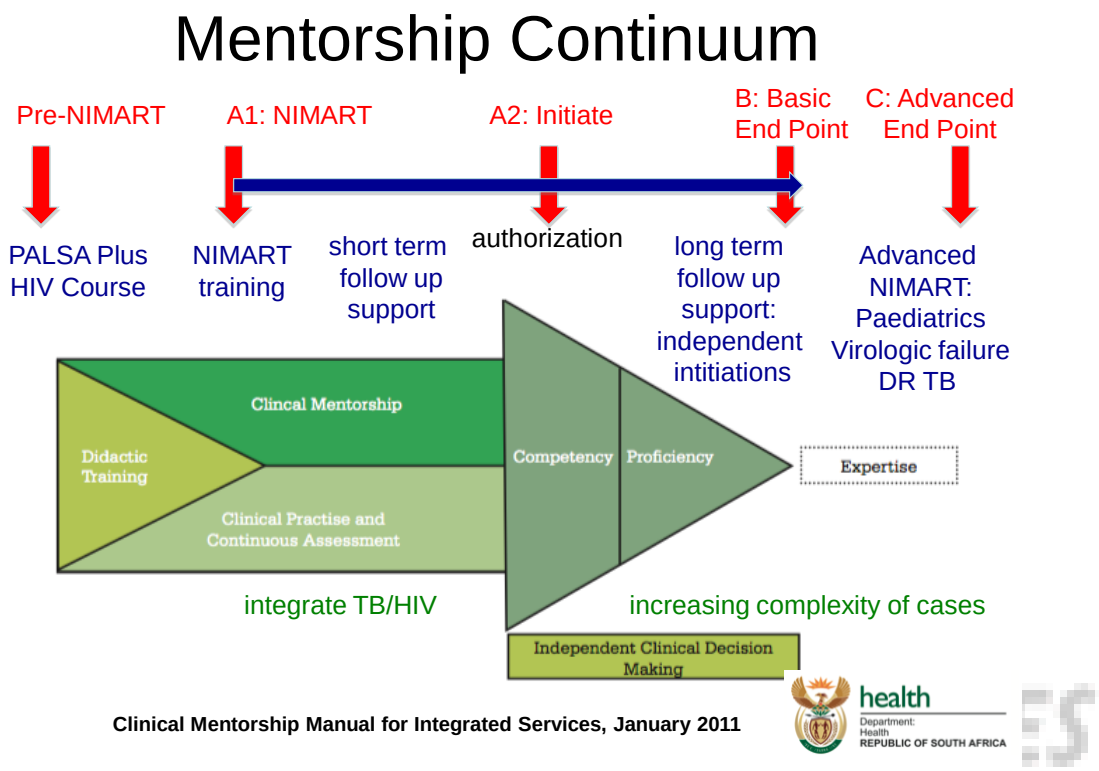
In February 2011, Medecins Sans Frontieres (MSF) Khayelitsha, in partnership with the City of Cape Town and the Provincial Government of Western Cape, designed and implemented a programme of mentoring nurses to initiate ART in stable patients. By December 2012, the programme has mentored 51 nurses (with 8 additional nurses pending authorization to prescribe ART), and has successfully scaled up the model of care suggested by the WHO, the National Department of Health, and the Western Cape's HIV&AIDS, STI, and TB (HAST) Directorate: namely, a health systems reorganization of HIV care to a nurse based, doctor supported ART service model. This report serves to describe the process of developing a clinical mentorship programme and the outcomes of the programme in Khayelitsha.

2. Steps in creating the mentorship programme

2.1 Define the purpose and process of mentorship:

A brief concept paper defining the need for mentorship of nurse initiations in Khayelitsha was developed, taking into account the national clinical mentorship and HIV treatment guidelines. The document is an example of the outline of a concept paper, including the background of nurse training and mentorship in Khayelitsha; the aims of the mentorship programme; the timeline of mentorship; clinical competencies; and measurable outcomes (Appendix 1). The concept paper creates an organizational framework for the programme, and forms the basis for discussions and partnership with

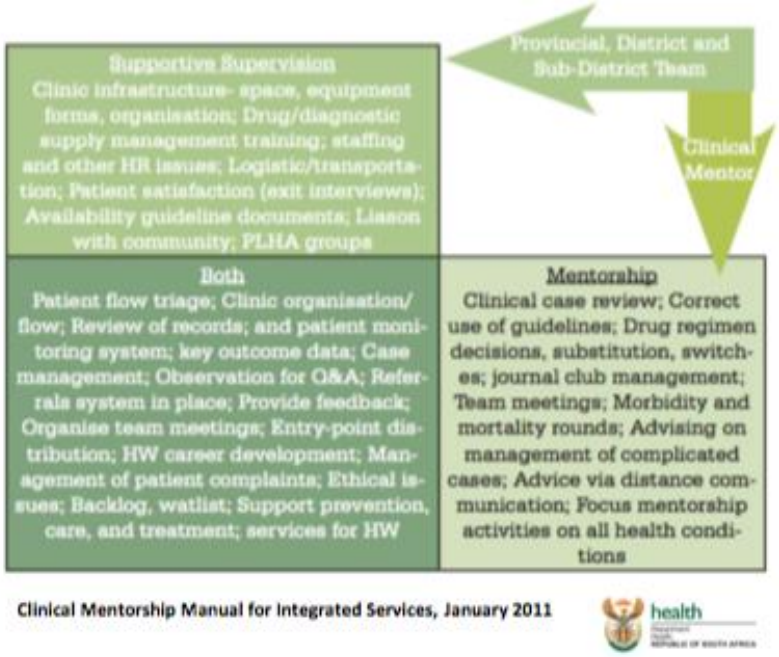
district management teams. This early partnership and regular communication with district and facility managers is crucial to the success of the mentoring programme, since it ensures the identification of appropriate nurse mentees and supports their time commitment for mentorship. The concept paper also provides the background for support from MSF project managers. Mentorship is not difficult to standardize, but requires programmatic support both from MSF and government partners; a simple continuum of the mentorship process is shown below, and can be modified according to timelines or programme requirements.



2.2 Select appropriate mentors:

The Western Cape Department of Health has outlined the requirements for either doctors or nurses to become mentors.[5] The criteria includes one year of clinical HIV experience, attendance at an HIV and mentorship training course, and the availability and enthusiasm for mentorship. Nurse mentors need to complete Palsa Plus training, and doctors must be familiar with Palsa Plus recommendations (Palsa Plus Clinical Guidelines provide standardized approaches to the primary care management of HIV and TB). A common obstacle encountered for new mentors is finding the time amongst other responsibilities for mentoring; this can be solved by strong leadership knowing the mentor's job responsibilities and creating the time, transport, and tools (guiding documents) for a mentor to be successful. The MSF mentorship programme, due to strong support from project managers, has employed one full time nurse mentor for NIMART mentorship.

The role of the nurse mentor was clearly defined from the beginning of the programme: a mentor is not substitutive for another clinician in the facility (the mentor does not provide direct patient care); the mentor's role is not supervisory, although some overlap in mentoring and supportive supervision does exist (see below); and the focus of mentorship is on management of HIV in the primary care setting. The nurse mentor is supported by an MSF doctor who provides clinical support, assists in the assessment of each nurse mentee, and evaluates the nurse mentor's performance.



2.3 Know the local training courses, treatment guidelines, and supporting mentorship documents:

Both mentors and mentees are required to have attended an HIV training course prior to being selected for mentorship. Since the course provides the foundation of HIV knowledge for clinicians, it is important to know what HIV training courses are available in the area, when they are held, and the content and quality of the courses. Similarly, a familiarity with country or provincial guidelines on adult and paediatric HIV, TB, and/or DR-TB is essential for the mentors in the programme. Lastly, some countries or provinces have clinical mentorship guidelines or requirements, which should be taken into consideration when designing an individual programme (Appendix 2). The South African mentorship guidelines include a tool to measure the performance of clinical mentors, which is a programme area of evaluation that is often overlooked.

The MSF Khayelitsha mentorship programme developed some additional mentorship documents, including a mentorship introduction/agreement letter for mentees (Appendix 3); a mentorship programme application form (Appendix 4); a mentee clinical competency checklist (Appendix 5); and a simple register for nurse mentees to track their initiations after the completion of mentorship (Appendix 6).

2.4 Select appropriate mentees:

The selection of nurses for mentorship to prescribe ART is often cited as a challenge for mentorship programmes, and yet it is critical for the establishment of efficient and successful mentoring. It is very important that the selection process include input from district/provincial management; facility management; the mentor; and the mentee. The mentee must be interested in participating in the mentorship programme, and have management approval for dedicated/protected time for mentorship visits. Nurses selected for NIMART mentorship in South Africa need to complete an accredited HIV/TB training course and have one year of clinical HIV/TB experience; just as importantly, the nurse mentee should be returning to a position in direct HIV/TB clinical care after mentorship. Remember, mentorship is a voluntary relationship: two parties enter into a contract and agree on a clear set of expectations and outcomes.

2.5 Schedule offsite and onsite mentorship visits:

Nurses selected for the MSF Khayelitsha mentorship programme complete one week (40 hours) of mentorship with an MSF nurse mentor in a centrally located high volume HIV clinic. Mentorship occurs through side by side case management, reviewing medical charts, case reviews of common HIV complications, or short in-service trainings. The MSF clinical mentor manager participates in a half day of mentorship at the end of the week, in order to assess the mentee's competency to initiate ART and decide with the nurse mentor if the mentee can be authorized. If further mentorship is needed, mentees are kept in the programme for weekly site visits up to three months (1 nurse [from 44 mentored] has failed to meet the competency requirements of the programme). If the mentee is competent to initiate ART, the nurse mentor conducts two half day mentorship sessions within two weeks at the nurse's facility, where practical obstacles to nurse initiation are identified and addressed. The most common barriers for newly authorized nurses to initiate ART are: poor management of the task shifting of clinical responsibilities for nurse initiation; lack of pharmacy support for nurse ART prescribing, usually due to poor communication; and too little support from the mentor during the initial post-mentorship period. These barriers are addressed during the nurse mentor's site visits to the mentee's clinic.

If a nurse mentee is unable to be away from her facility the one week of off-site mentorship, the same mentorship process can occur at her facility through scheduled one day visits over several weeks. This can be more difficult to schedule, since there is often little space and less staff availability for mentorship in the mentee's own clinic. The frequency, duration, and timing of a mentor's visits should be agreed upon in advance; the schedule should be respected by both the mentor and the mentee. The mentor should ensure that all necessary national treatment guidelines, the MSF "HIV Guide for Primary Health Care in South Africa," and other clinical references that the nurse can display by her desk for easy reference (WHO staging, creatinine clearance tables, ARV medication lists – see Appendix 7) are available during the mentorship process; the mentor should refer to them during mentorship so the mentee becomes

familiar with them. A mentorship logbook can be used to track the mentorship process (Appendix 8).

Western Cape Government Health requires a district level director to sign off a provincial authorization form once mentorship is complete and the mentor recommends the nurse for authorization. Other provinces or countries may not have established authorization criteria or authorization forms, in which case the mentor's organization (MSF, the Department of Health, and/or other NGOs) should work together with the nursing directorate to establish criteria for and documentation of the mentee's authorization. Once the nurse mentor has completed authorization, the MSF nurse mentor is available for phone consultations, and visits the mentee graduates once monthly to track the number of patients initiated by nurses and conduct case reviews on request from the mentee.

2.6 Monitor and evaluate the mentorship programme, and feedback results to programme managers and mentees:

The logbook (Appendix 8) or a simple file folder can be used to keep track of the documents involved in the mentorship process, including the mentorship agreement letter (copies of which should be given to the facility manager and the mentee), the mentee application form, copies of the mentee's training certificates (some provinces want copies of training certificates with the authorization form), the clinical competency checklist, and the authorization forms. Nurses in the Khayelitsha programme do a self-evaluation of their clinical competency before and after mentorship; in combination with the clinical competency checklist, the two evaluations are useful to determine if the mentee needs any further long term mentoring on specific topics.

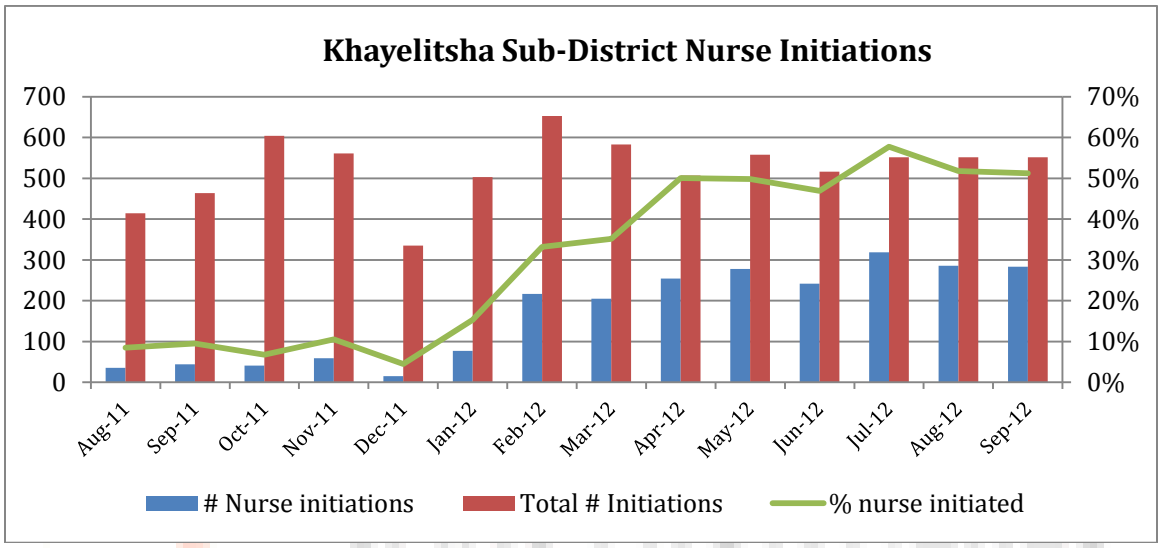
MSF keeps track of the nurses that have graduated from Khayelitsha's mentorship programme, and provides this list quarterly to the Department of Health. In addition, MSF began tracking the number of patients initiated by nurses in August 2011 by having nurses place a sticker of each patient they initiate in a simple register (Appendix 6). This information is now provided monthly as feedback to individual nurses, specific clinics, and Khayelitsha sub-district management. The data is a powerful tool to show nurses the impact their work is having: by September 2012, nurses were initiating over 51% of all patients starting ART in Khayelitsha. In smaller City Health primary health care (PHC) clinics, with less medical officer coverage than community health centers (CHCs), nurse initiations accounted for 77% of the monthly total initiations.

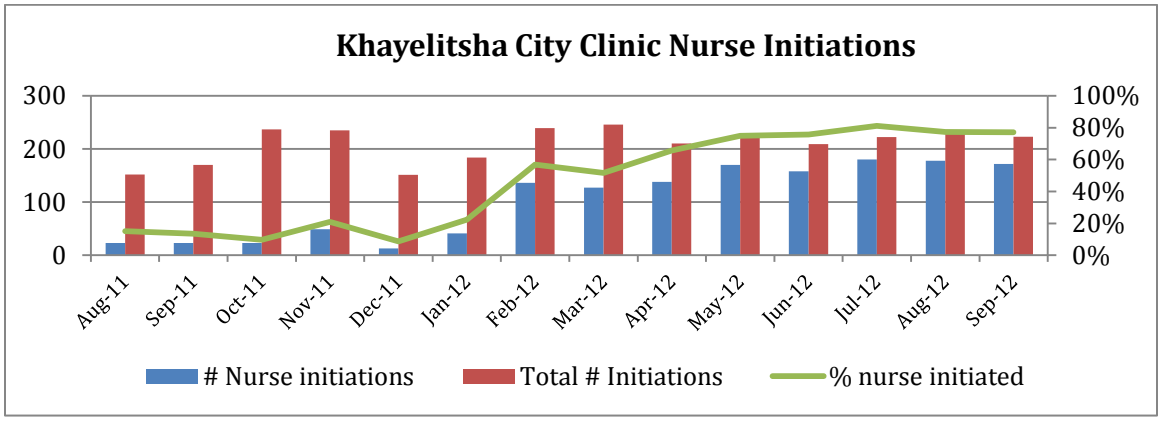
MSF organized a session with the nurse mentorship graduates to review this data and to hear their feedback about the programme. Mentors from other sub-districts in the Western Cape have agreed that feedback sessions with the nurses are very helpful for problem solving and providing support. The most frequent challenge that nurses state they encounter after they are authorized to initiate ART is "role conflict," or difficulty for themselves and other clinical staff members to adjust to the new role of the NIMART nurse. Occasionally, there will be resistance from pharmacists to accept a nurse ART

prescription, or pressure from other nursing staff against task shifting and nurse initiation of ART. The concerns raised in the feedback sessions are usually solved with a visit to the nurse's clinic, and communication with involved staff. Additional sessions are routinely planned in Khayelitsha, and include clinical updates and guideline changes in addition to the most recent data on nurse initiations.

Operational research to assess the characteristics of patients initiated by nurses and the quality of clinical care is currently underway in Khayelitsha. Preliminary data shows that nurses refer the same number of patients to a doctor before and after mentorship, but the percentages are small (1-2% of initiations); roughly 25% of patients see a doctor in the month prior to initiation; and nurses are superior to doctors in addressing adherence, performing WHO staging, and monitoring safely bloods.

3. Mentorship Programme Outcomes





4. Resources for Mentorship

Since its inception, the Khayelitsha mentorship programme has been staffed by one full time nurse mentor, and one part time doctor to provide management support and clinical oversight. With this minimal investment in nurse mentorship, 51 nurses have been authorized to initiate during the 22 months of the programme, and 8 nurses are pending authorization. The nurse mentor uses MSF transport to do clinic follow up visits; in government programmes, either a transportation allowance or government transport would need to be supported by management. The long-term impact of sustainable task shifting of ART initiation and management from doctors to nurses, in terms of cost and patient outcomes, remains as an important area of operational research across many models.

5. Summary

Clinical mentorship should be considered an essential component of the public health approach to universal access in resource constrained settings. It serves the following purposes:

- Supports the decentralization or introduction of ART services through task shifting and integration of care
- Allows for short initial basic trainings with simplified standardized guidelines
- Maintains and progressively improves the quality of clinical care of mentees
- Builds the referral network between primary care and district hospitals and between medical officers and nurses
- Motivates clinicians by providing effective technical backup, improving clinic efficiency, and providing an opportunity for professional development

The MSF mentorship model's strengths are:

- ✓ a nurse mentor foundation, with doctors as mentors only for complex case consultations and final authorization
- ✓ a partly mobile mentoring model, where nurses are mentored in their facilities after an initial week at a central high volume HIV clinic
- ✓ careful mentee selection criteria, done in close cooperation with and support from sub-district and facility management
- ✓ low programmatic resources – the programme is staffed by one MSF nurse mentor, with part time MSF manager support

Implementation of a simple clinical mentorship programme in Khayelitsha has led to nurse initiation of a majority of eligible patients, enabling medical officers to manage complex patient cases. This sub-district led, goal oriented approach is a successful pilot of translating nurse HIV initiation and management policy into practice, and could serve other health areas in southern Africa.

6. References

1. *WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy, and prevention in resource limited settings*, World Health Organization, June 2005.
2. *Clinical Mentorship Manual for Integrated Services*, National Department of Health, South Africa, January 2011.
3. ART Expansion Report, SL Diseko, National Department of Health. 5th South African AIDS Conference, Durban, South Africa, 9 June 2011.
4. South Africa's National Strategic Plan on HIV, STIs, and TB 2012-2016.
5. Circular H1 2012, *"Framework for Nurse Initiation and Management of Antiretroviral Therapy: Criteria for Mentors in NIMART,"* 3 January 2012.

6. Appendices

1. MSF Khayelitsha Project Clinical Mentoring Concept Paper
2. Clinical Mentorship Manual for Integrated Services, South African, January 2011
3. Mentorship Programme Letter of Agreement
4. Mentorship Programme Application Form
5. Mentee Competency Checklist
6. Nurse Initiation Register
7. Mentorship Programme Clinical Handouts
8. Mentorship Programme Logbook

7. Contact for comments or questions:

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