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# Cost implications and benefits of using Roving Mentor Teams to strengthen HIV and TB clinical management in public sector primary care clinics:

a district scenario in an urban district with a fully established District  
Clinical Specialist Team (DCST)

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**A mentor empowers  
a person to see a  
possible future, and  
believe it can be  
obtained.**

**- Shawn Hitchcock**



# 2009 WAD Speech set in motion the rapid expansion of ART, mostly through NIMART

Speech declaring huge expansion of treatment marks final break with stance of predecessor Thabo Mbeki



“In order to meet the need for testing and treatment, we will work to ensure that ***all the health institutions in the country are ready to receive and assist patients*** and not just a few accredited ARV centres. Any citizen should be able to move into ***any health centre and ask for counselling, testing and even treatment if needed.***”-

*Address by President Jacob Zuma on the Occasion of World AIDS Day, Pretoria Showgrounds, 1 December 2009*

# Root cause of FPD's approach to Health Systems Strengthening



**Question**

**"Why do we consistently fail to implement very good policies?"**

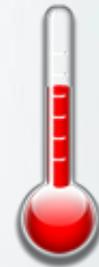
**Answer:**

**Breakdown in process of translation from policy to implementation**

-2009 review commissioned by Minister Barbara Hogan



**Policy**



**Health Outcomes**



**Breakdown in flow**

**Policy → Strategy → Operational Plans →  
Budgets → HR allocation → M&E →  
Implementation → Health Outcomes**

# FPD's RMT model is a product of the transition of SA ART program and a strategic focus on HSS

## Previous SAG focus:

### SA model of HIV care and treatment:

- Centralised
- Hospital -centred
- Doctor-driven
- Stand-alone ART clinics

2010/11

Shift

## Current SAG focus:

### SA model of HIV care and treatment:

- Decentralised
- PHC-centred
- Professional nurse-driven
- Integrated into PHC package

## Previous FPD focus:

### Direct service delivery:

- Focus on scale up of dedicated ART clinics
- Train & Second health care workers, data clerks etc. in direct service delivery roles

2012/13

Shift

## Current FPD focus:

### Technical Assistance\*:

- Focus on in scale up & integration of NIMART into PHC package
- Train, mentor and provide TA to strengthen HSS & scale up NIMART

# FPD developed the Roving Mentor Team (RMT) to support rapid scale up of the NIMART program

## Purpose:

- To support clinic-based learning of NIMART nurses through compilation of a 'portfolio of evidence' (POE) in line with the nationally prescribed "*Green Book*".
- To foster an enabling environment for PHC, HIV & TB in-service integration & rapid scale up of NIMART



## Structure of the roving mentor team:

- **Clinical mentors (Dr)** focus on ongoing development of prevention mentors in NIMART, SAG doctors, adolescents & paediatrics & complicated cases & ICSM
- **Prevention mentors (PN)** focus on HTS, NIMART mentorship, TB/HIV integration & using data & ICSM
- **Health Information Systems Mentors (HISMs)** focus on tier.net, DHIS, file integration, data validation & reporting & presentation & ICSM
- Supported by team of advisors (**MCH, TB/HIV, Community, SCM, M&E**)

# There was significant investment in developing clinical mentors

Mentor Course Requirements	Duration (days)	
	PN	Dr
1. NIMART/HIV mgt*	5	3
2. HCT	2	-
3. PMTCT	3	1
4. Adherence	2	-
5. TB*	2	2
6. STIs	1	-
7. IPT	1	-
8. IMCI	11	-
9. Palsa plus/PC101	1	1
10. Paediatric HIV*	3	2
11. Tier.net & stationery	3	3
12. Mentoring*	3	3
<b>Total</b>	<b>37</b>	<b>15</b>

## Practical experience –

- Nurse mentors- in-training worked under the supervision of an experienced clinical mentor x 6 months

## Assessment of mentors—

- Signed off logbook of 80 cases (based on Green Book); revised to 26 cases
- 10-12 Objective Structured Clinical Examination (OSCE) to test clinical & mentorship skills
- Tests

## Ongoing skills development

- Quarterly skills development workshops
- Policy updates, as needed
- New trainings (e.g. PC101, ICSM)

\*Recognition of prior learning is taken into account



# Data sources

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- **Costs of RMT:** Quantitative data analysis of financial data exported from FPD's ACCPAC system for costs linked directly to Roving Mentor Team expenses
  - All FPD expenditure is tracked per grant, per province and district, per building block, per department and per project
  - Financial data for January-March 2016 for one district were extracted and analyzed and projected into an annual cost & one-off investment
- **Benefit of RMT:** A mixed methods approach was used including:
  - DHIS pivots
  - quantitative data from internal M&E
  - qualitative data from mentee satisfaction surveys and semi-structured interviews. Satisfaction was measured on five-point likert scale and mentee experiences were transcribed verbatim.
  - qualitative data from “panel of experts”

# Costs of the Roving Mentor Team: a district scenario in urban district with 8 teams

Scenario: 1 RMT (1 clinical mentor, 1 prevention mentor, 1 information coordinator) supporting to 8-12 facilities in the geographic catchment area

## Initial set-up costs:

	1 team	1 district (x8)
Training of RMT*	R 85 800	R 686 400
Identifiable gear	R 6 750	R 54 000
Laptop	R 45 000	R 360 000
Vehicle	R 338 865	R 2 710 920
Tracker	R 5 884	R 47 072
<b>One-off</b>	<b>R 482 299</b>	<b>R 3 858 392</b>

### General notes:

- \*Training costs as a per-participant proportional contribution of total training P&L
- Est. 20% increase for rural district
- Salaries align with SAG OSD
- Excludes operational budgets for:
  - Training/workshop budget for SAG staff
  - Stationery & consumables
  - Other troubleshooting budget

## Annual operational costs:

	1 team	1 district (x8)
<b>Transport</b>		
Registration & licensing	R 600	R 4 800
Insurance	R 22 026	R 176 208
Tracker subscription	R 2 808	R 22 464
Maintenance budget	R 10 000	R 80 000
Travel costs	R 25 000	R 200 000
<b>Total Transport</b>	<b>R 60 434</b>	<b>R 483 472</b>
<b>Personnel</b>		
Salaries	R 1 535 144	R 12 281 151
Fringe benefits	R 297 357	R 2 378 859
Medical insurance	R 40 060	R 320 480
<b>Total Personnel</b>	<b>R 1 872 561</b>	<b>R 14 980 491</b>
<b>Other recurrent costs</b>	<b>R 2 250</b>	<b>R 18 000</b>
<b>Training &amp; skills dev</b>	<b>R 39 600</b>	<b>R 316 800</b>
<b>Sub-Total</b>	<b>R 1 974 845</b>	<b>R 15 798 763</b>
<b>Supervision / overhead</b>	<b>R 148 113</b>	<b>R 1 184 907</b>
<b>Total</b>	<b>R 2 122 959</b>	<b>R 16 983 670</b>

Source: FPD ACCPAC system & historic burn rates



# Benefits of Roving Mentor Teams (1/2)



- Provided weekly structured mentoring & supervision at facility level
  - Provide mentorship to a total of 452 NIMART trained nurses (avg. of 5,5 per facility)
  - Supported a total of 241 (avg. 3 per facility) achieve “competency” as per NIMART POE & graduation [source: internal M&E]
- Supported district to rapidly scaling up number of initiating sites (Q1 2012→Q2 2016)
  - # sites initiating adults increased from 56 (66%)→ 85 (99%) of sites
  - # sites initiating paedes increased from 34 (40%)→ 85 (99%) of sites
  - Avg # adults initiated new on ART increased from 1350 → 2250 per month
  - **93% of all initiations now take place at primary health care level** [source: DHIS]
  - Succeeded to get Local Authority clinics to initiate

# Benefits of Roving Mentor Teams (2/2)



Dimension of satisfaction survey [mid-term evaluation]	SCORE (max 5.00)
Mentoring met my main expectations	4.18
Effectiveness of my relationship with my mentor	4.68
Mentoring made me feel more positive about managing HIV in PHC	4.63
Mentoring made me more confident about managing HIV in PHC	4.60

- Evidence that NIMART nurses are increasingly knowledgeable, experienced, independent; mentorship evolving to managing complex cases – advanced HIV disease, ‘treatment failure’, children, abnormal biochemistry results [mid-term RMT evaluation, 2014]

[Source: Mid-term Evaluation]



# Comparison of RMT to DCST: Costs & Roles

	1 DCST team
Total Transport	R 73 000
Total Personnel	R 10 490 000
Other recurrent costs	R 50 000
Training & skills dev	
<b>Sub-Total</b>	<b>R 10 613 000</b>

	1 RMT	1 district (x8 RMT)
Total Transport	R 60 434	R 483 472
Total Personnel	R 1 872 561	R 14 980 491
Other recurrent costs	R 2 250	R 18 000
Training & skills dev	R 39 600	R 316 800
<b>Sub-Total</b>	<b>R 1 974 845</b>	<b>R 15 798 763</b>

- Composition: 1 “Specialist” team of 7
- Ratio: 1 DCST covers 85 facilities
- Focus: priority clinical portfolios (e.g. MCH, O&G, EMS...)
- Approach: District systems
  - Conduct gap analysis & provide TA & problem solving
  - Develop TA strategies & lead/conduct training interventions
  - Conduct audits/ QA / supervisory visits

**GAP: Lack footprint on the ground to provide long-term 1-on-1 support**

- Composition: 8 “Generalist” teams of 3
- **Ratio: 1 RMT: 8-12 facilities**
- Focus: PHC from NIMART perspective (including integration of PHC, TB, MCH, HCT, HIV, Chronic)
- **Approach: Service provider & facility program**
  - Provide in-service training
  - **Develop individualized mentorship plans**
  - **Provide structured & routine clinical & data mentorship & persistent follow-up**
  - Trouble shoot / QIP → develop & track implementation of plans & change over time
  - **Supplement DCST strategies & plans with in-facility presence & PHC clinical audits**



# Conclusions & recommendations of HIV & TB clinical mentorship

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- SAG NIMART mentees, facility staff, DCST & DHMT value the support and role of the multi-disciplinary “generalist” roving mentor team
- RMT are a good complement to SAG District Clinical Specialist Teams (DCST)
  - Add HIV and TB and M&E expertise
  - Have facility-level skills development & change management mandate
    - Ratio of 1 RMT: 8-12 facilities per RMT (FPD has 6-8 teams per district)
    - Focus on structured mentorship, skills transfer & facility-level systems reorganization
    - In-facility presence & persistent follow up (dose & duration) to see plans to fruition
- The roving mentorship model is dynamic and has evolved in terms of:
  - Scope & level of technical expertise,
  - Intensity & duration of mentorship
- Lessons learned and cost analyses from PEPFAR’s roving mentor teams should be used to inform longer-term SAG strategies and budgets to manage change regarding policies/new strategies and maintain high quality, integrated clinical care at PHC level

# FPD Roving Mentors and TA team thank you for the opportunity to share our model

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