# *Implementation Process of a Canadian Community-based Nurse Mentorship Intervention in HIV Care*

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*We describe salient individual and organizational factors that influenced engagement of registered nurses in a 12-month clinical mentorship intervention on HIV care in Canada. The intervention included 48 nurses and 8 people living with HIV (PLWH) who were involved in group-based and one-on-one informal mentorship informed by transformative learning theory. We evaluated the process of implementing the mentorship intervention using qualitative content analysis. The inclusion of PLWH as mentors, the opportunities for reciprocal learning, and the long-term commitment of individual nurses and partner organizations in HIV care were major strengths. Challenges included the need for multiple ethical approvals, the lack of organizational support at some clinical sites, and the time commitment required by participants. We recommend that clinical mentorship interventions in HIV care consider organizational support, adhere to the Greater Involvement of People Living with HIV/AIDS principles, and explore questions of professional obligations.*

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Stigma and discrimination toward people living with HIV (PLWH) continue to occur in health care settings; however, it is now more difficult to detect than early in the epidemic (Mill, Edwards, Jackson, MacLean, & Chaw-Kant, 2010). One factor perpetuating stigma amongst health care providers (HCP), including nurses, may be related to a lack of knowledge and educational preparation about HIV prevention and HIV clinical management and counseling (Ekstrand, Ramakrishna, Bharat, & Heylen, 2013; Mill et al., 2014). Furthermore, Mill and colleagues (2014) noted that opportunities for continuing education in relation to HIV care were lacking for practicing nurses. Providing health care for PLWH is influenced by prevalent societal attitudes, and beliefs and opportunities to engage in supportive and collegial learning opportunities (Vance & Denham, 2008).

To address this ongoing issue, we developed, implemented, and evaluated a mentorship intervention to increase nurses' knowledge about HIV care in two rural and two urban sites across Canada. The intervention utilized a mentorship intervention that brought experienced nurses and PLWH together with nurses who wanted to learn more about HIV nursing care. In this article, we discuss the process of conceptualizing and implementing the yearlong mentorship intervention across Canada. Specifically we: (a) describe the *development and implementation* of the mentorship intervention, (b) highlight the *strengths and challenges* that occurred during the implementation, and (c) provide *recommendations* for the future implementation of mentorship interventions with health care professionals in HIV care. Findings from our study related to HIV education for nurses are presented elsewhere (Mill et al., 2014), while quantitative and qualitative outcome changes in knowledge, attitudes, and practice will be presented in a future paper (Worthington et al., 2015).

## Literature Review

Countries that have been most successful in reducing HIV incidence and mortality are those that have recognized the need to address stigma and ensure access to services for all (Wiktor, Ford, Ball, & Hirnschall, 2014). Despite extensive efforts in HIV education, HIV-related stigma still exists in health care (Shah, Heylen, Srinivasan, Perumpil, & Ekstrand, 2014). Since the first global review of interventions to reduce HIV-related stigma (Brown, Macintyre, & Trujillo, 2003), two additional systematic reviews have been conducted to evaluate the impact of interventions to increase HIV knowledge, decrease stigma, improve infection control practices, and increase willingness by HCP to treat PLWH (Sengupta, Banks, Jonas, Miles, & Smith, 2011; Stangl, Lloyd, Brady, Holland, & Baral, 2013). Sengupta and colleagues (2011) reviewed 19 studies, including four interventions to evaluate nurses' willingness to provide care for PLWH. Of the 19 studies reviewed, 14 reported a reduction in HIV stigma; however, only two of these studies were rigorously designed and had used valid and reliable tools to measure a reduction in HIV stigma. Stangl and colleagues (2013) systematically reviewed 48 studies completed during the previous 10 years; 11 interventions were conducted with HCP and, of those, three were with nurses (Pisal et al., 2007; Uys et al., 2009; Williams et al., 2006) and one with nursing students (Yiu, Mak, Ho, & Chui, 2010). Interventions included combinations of organized education courses and other informal learning methods, some coupled with opportunities to interact with PLWH. Stangl and colleagues (2013) concluded that, although progress had been made in stigma intervention, more studies to evaluate interventions to reduce stigma were needed.

Uys and colleagues (2009) conducted a stigma reduction intervention using nurses and PLWH to co-facilitate the sharing of HIV information in health care settings in five African countries. This intervention was well received and "led to understanding and mutual support between nurses and people living with HIV and AIDS" (p.1065). Despite well-documented evidence of HIV stigma and its impacts (Lowther, Selman, Harding, & Higginson, 2014), limited research has described interventions to help minimize HCP-generated HIV stigma, and even less research has specifically focused on nurses in HIV care in North America. In addition, the lack of educational preparation and continuing education as well

as the absence of clinical mentoring in this area have been shown to be barriers to adequately preparing nurses to care for PLWH (Mill et al., 2014; Relf et al., 2011).

### Mentorship Interventions

The terms mentoring, precepting, supervising, facilitating, and teaching are often used synonymously. According to the Canadian Nurses Association (2004) guide to preceptorship and mentoring, the definition of mentorship is "either informal or formal in structure, usually focused in broader learnings, career development and personal and professional growth through a consultative approach over a longer term" (p. 13). This definition of mentorship emphasized a one-on-one relationship that occurs through the assignment of mentor and mentees. Others (Copley & Nelson, 2012) have used group interventions, with multiple individuals who have different skill sets and expertise, to mentor students. Despite this, there remains a paucity of research to explore the use of mentorship interventions in nurses in the Canadian context.

The World Health Organization (2014) recommended "training, mentoring and professional support for providers serving key populations" (p.6) to address stigma and discrimination issues. This is particularly important in the context of integrating HIV into areas of chronic care and/or integrating HIV care with other blood-borne viral infections.

### HIV Mentorship Interventions

The Canadian HIV/AIDS Mentorship Program (Throop et al., 1998) was successfully implemented in the late 1990s, when interested physicians paired with specialized physicians working in HIV care. While the program was well received, time commitments, as well as differences in regional accreditation programs, limited the success of the program. In 1997, the Canadian Association of Nurses in AIDS Care created a network of nurses working in HIV care who were available to mentor others in the province of Quebec (Paquin & Lambert, 2000). The program continues to operate with continuing success (D. Sylvain & K. Tremblay, personal communication, September 18, 2013). More recently, a mentoring intervention that included PLWH working alongside clinical mentors to coach rehabilitation professionals was implemented and evaluated (Solomon et al., 2011). Solomon and colleagues (2011) noted that having both a clinical mentor and a PLWH mentor was critical to the program's successful outcome.

### Mentorship Intervention Development

Recognizing the shift in adult education to lifelong learning, researchers are now considering the use of informal learning opportunities to help professionals acquire or improve job-related skills through different training pathways (Nilsson & Rubenson, 2014). Our mentorship program was based on transformative learning theory as it paralleled the tenets of mentoring and lifelong learning (Mezirow, 1997). Three broad concepts have been identified as essential in transformative learning: experience, critical reflection, and development. More recently, transformative learning has been described as learning that is more than the acquisition of new knowledge and skills, and as something that involves a different "capacity within the learner" (Illeris, 2014, p.5). Transformative education holds the possibility of addressing underlying attitudes and stigmatizing practices.

## Method

### Principles for Community Engagement

We developed a community-based intervention of clinical mentorship for registered nurses in HIV care. PLWH worked alongside expert nurses to mentor nurse mentees. Community-based research emphasizes engagement of community partners in all aspects of the research process from inception and design to dissemination of findings (Caine & Mill, 2015; Israel, Eng, Schulz, & Parker, 2013). The inclusion of PLWH as researchers and advisors and as participants and guest speakers ensured that the research was guided by the principles of Greater Involvement of People living with HIV/AIDS (GIPA; Nyblade, Stangl, Weiss, & Ashburn, 2009; Syed, Sulaiman, Hassali, & Lee, 2013). GIPA principles have been widely recognized as good

practice in programming and policy that involves and acknowledges the rights of those affected by HIV to have opportunities to contribute in the decision-making that affects their lives. Engaging PLWH alongside nurses was also regarded as participatory and inclusive, and emphasized education as a democratic practice. Further, it was postulated that the civic engagement of individuals, in this case nurses and PLWH, most affected by health disparities were more likely to produce evidence-based findings that would, in turn, lead to positive policy changes (Cacari-Stone, Wallerstein, Garcia, & Minkler, 2014).

Evidence from knowledge translation studies has suggested that didactic education and dissemination approaches have limited impact on changing clinical behavior. Providing case-based experiential learning can increase student ability to think critically and apply didactic knowledge to clinical patient care (Wyles, McLeod, & Goodfellow, 2013). Therefore, building on research by Mill and colleagues (2009) and the experiences of the Canadian Working Group on HIV and Rehabilitation's pilot initiative on HIV mentorship (Solomon et al., 2011), we designed a multiple mentoring approach (Copley & Nelson, 2012) for the study. We recruited both nurse and PLWH mentors to work with less experienced nurses in order to increase their capacity to provide comprehensive HIV care for PLWH in Canada. PLWH mentors were identified and recruited through local AIDS Service Organizations (ASO) partners.

The study was conducted in two urban and two rural communities (rural was defined as a population $<$ 75,000) across Canada. We implemented a 12-month intervention at three sites and a 6-month intervention at one site. The intervention was collaboratively designed by participants at each site, a community advisory committee (composed of ASO members and PLWH), and research team members (including academic researchers, a PLWH, and clinicians). Three 2-day face-to-face workshops (0, 6, 12 months) at three sites, and two workshops (0, 6 months) at one site were conducted. At the first workshop, relationship-building activities, discussions of case vignettes, and listening to guest speakers from various disciplines were included. In between workshops, groups of two mentors (one nurse, one PLWH) and four mentees met on a monthly basis (2–3 hours) to continue to meet the learning needs based on suggestions of both mentors and mentees. These meetings included education sessions with interprofessional guest speakers, working on case studies facilitated by mentors, or participating in onsite visits to community service organizations. The mentoring process and topics of discussion were group led. Over the course of the 12 months, participants (including nurse and PLWH mentors and mentees) were involved for an average of 100 hours and were paid $175 for each 2-day workshop to partially compensate for taking time off of work and other participation costs (e.g., parking, childcare). Continuing education credits (3-credit course) were provided to participants by the University of Alberta if 100 hours of participation were completed.

We used an exploratory evaluation design, including in-depth interviews and survey questionnaires with nurse and PLWH mentors and nurse mentees to collect data on strengths and challenges of the mentorship intervention. Data collection took place at the beginning, during, and immediately after the intervention. We explored nurses' HIV education background, their experiences with the care of PLWH, and their knowledge of HIV; these findings have been reported elsewhere (Mill et al., 2014; Worthington et al., 2015). In addition, using content analysis, we analyzed e-mails, field notes, and meeting minutes from research team conversations to identify strengths and challenges during implementation of the mentorship intervention. The findings from this analysis are the focus of this article.

## Ethical Considerations

Ethical approval for the study was obtained from the Health Research Ethics Board at the University of Alberta, at each co-investigator's affiliated institution, clinical agencies and health authorities involved at each site, and as required from the partner ASOs. Written informed consent was obtained from all participants. In addition, the research team developed and signed *Principles for Research Collaboration* to outline ethical and authorship principles to guide our research collaboration. The criteria outlined by Meleis (1996) were used to enhance the rigor and

credibility of the project. These criteria included contextuality, relevance, reciprocity, awareness of identity and power differentials, empowerment, communications styles, time, and disclosure.

### Data Collection to Obtain Information on Process

We documented discussions from nine research team meetings and four community advisory committee meetings. In addition, as we negotiated the ethical and administrative approval with each site, we kept an e-mail trail of our discussions with various decision-makers and administrators. Following each of the 11 site-specific workshops, we de-briefed with members of the research team who had participated in the workshop. These de-briefing sessions were audio-recorded and transcribed. We analyzed meeting minutes, e-mails, and de-briefing session field notes to identify strengths and challenges during the implementation of the mentorship intervention and have included these reflections here. The qualitative content analysis required us to be immersed in the data as a whole, to continually read the data, and to be open to emergent themes. It was key to have an in-depth understanding of the context of the data. The unstructured nature of data analysis allowed us to consider diverse viewpoints, including emotional reactions (Hsieh & Shannon, 2005), with the ultimate aim to create themes.

## Results

### Participants

The participants included 40 mentees (38 female, 2 male), eight nurse mentors, and eight PLWH mentors working in small groups (on average, four mentees, one nurse mentor, and one PLWH mentor). Nurse mentees worked in a range of clinical areas, including community or public health, sexually transmitted infection clinics, prisons, long-term care, acute care, and mental health. Seven of the eight nurse mentors had specialized in HIV care for more than 10 years, and the majority had a bachelor's degree and worked in a hospital HIV clinic. Seven of the eight PLWH mentors had been living with HIV for more than 10 years. Six (15%) of the 40 mentees withdrew from the intervention prior to completion, citing challenges with meeting times and shift work. One mentee became ill and two moved to a different province.

### Strengths of Intervention

We implemented the clinical mentorship intervention from 2011 to 2013. Prior to and during the implementation, we encountered significant strengths and challenges. Strengths included (a) the integration of education theory; (b) the involvement of PLWH as mentors; (c) the opportunity for reciprocal learning between mentors and mentees, as well as PLWH and nurses; and (d) the commitment from community organizations, including ASOs, the Canadian Association of Nurses in AIDS Care, Canadian Working Group on HIV and Rehabilitation, and Canadian AIDS Treatment Information Exchange.

*Integration of education theory.* The mentorship intervention was based on mentoring and adult learning theory, reflective of transformative education. Transformative education was emphasized in all aspects of our intervention to help address the underlying attitudes and stigmatizing practices that PLWH encountered when accessing health care. As we developed workshop agendas and promoted topics of discussion amongst participants who met on a regular basis, we facilitated activities that touched upon their lived experiences. Some parts of these experiences were focused on access to HIV care and experiences with nursing care. The focus on personal and professional experiences provided mentors and mentees with the time needed to critically reflect individually and as a group. In relation to transformative learning in practice, participant motivation and strong engagement with the learning process was key. Transformative learning is important to successful learning outcomes that are easy to recall, to think about, and to apply to a variety of practice situations and to develop competencies in relationship to the specific problem in question (Illeris, 2014).

*Involvement of mentor PLWH.* Throughout the study, we paid close attention to the meaningful

implementation of the GIPA principles, which was particularly demanding when PLWH faced increasing challenges in their daily lives. One of the co-investigators and one community advisory member passed away of AIDS-defining illnesses during the research project. The impact was felt not only by research team members, but also by participants. In one of his last communications with the research team and participant group, the gravely ill co-investigator wrote:

> Please send this to the group that I am doing well, love and miss you all and I am well on the path to wellness. The Mentorship Project, I am very passionate about and thrilled to be part of the research team. (E-mail communication, May 2012).

The team member passed away 2 months after writing this message.

Despite benefits, involving PLWH as mentors also proved challenging because few nurses had worked with PLWH in meaningful and relevant ways in their daily practices. Some of our PLWH mentors faced personal health challenges or economic instability, which precipitated, at times, moving in and out of their roles as mentors. Others faced challenges of role clarity and feelings of vulnerability. One PLWH mentor commented on her initial experience joining the study: "Like I felt that there was a big sign over me or something over my head that pointed me out and everybody was watching me now. I was very—I guess you'd say I got very self-conscious of myself" (Urban PLWH mentor).

Over time, the approach shifted to more meaningful inclusion of PLWH. A rural PLWH mentor felt that her perspectives and experiences were valued during the mentorship project:

> For many, many years, we were treated like little tokens … and if we accessed them [HIV health services], then that meant funding dollars. I don't know if I should call it grassroots or to the human side of it, that's what these guys [nurses] have shown me, "Oh, yeah, I'm human! Okay, you can actually touch me!" (Rural PLWH mentor)

Overwhelmingly, both nurse mentors and mentees valued PLWH mentor openness, courage, and sharing of life experiences during the study to help them understand the perspective of PLWH.

*Opportunities for reciprocal learning.* Mentors and mentees consistently shared that they had developed a strong, tight-knit group based on building collegial and trusting relationships. Participants commented that they learned from each other over time regardless of whether they were in the role of mentor or mentee. A nurse mentor commented on the value of having a PLWH mentor being a part of the learning process:

> I think she [female PLWH] was instrumental. We learned so much from her … we can read clinical guidelines all day long and learn from that, but it's that personal experience. And lots of times in clinical practice, we may have the odd client who is open and wanting to teach us, but that doesn't happen very often, so I think it was completely instrumental to have [PLWH mentor] there. (Rural nurse mentor)

Another nurse mentor reflected that mentoring others gave her increased confidence in her own knowledge and that the group gave her the validation she needed in her daily practice:

> Sometimes we don't really feel like we know very much, but then being in this role [nurse mentor] in the group has validated my knowledge and my experience, so I think that carries through when I go to work. It's important to have confidence when you're dealing with people that are in crisis, and I feel—like, it's good to have the support so that I can feel better capable in my daily job, and this group has given me that. (Urban nurse mentor)

*Long-term commitment by partnering organizations.* Support from the Canadian Association of Nurses in AIDS Care, Canadian AIDS Treatment Information Exchange, and ASOs was critical for recruitment of participants and in sustaining participant commitment. The tremendous support of the local ASO staff, who encouraged PLWH to enroll as mentors and provided ongoing support, was particularly helpful to ensure that PLWH remained in the study when they encountered challenges. A nurse

mentor believed that her participation in our study connected her to the local ASO in ways that she would not have discovered on her own:

> One thing I should also add that's really been beneficial is I feel that I've made a connection to [local ASO]. I don't know how or why, but it wasn't established before, so that's a really good piece that's enhanced my role, because now I feel a lot more confident about how and who and when to refer people, and knowing people that actually work here makes it even easier. And it's such a good facility; even just having the physical space here has been a really good thing. (Urban nurse mentor)

## Challenges in Implementation

Primary challenges that were encountered during the implementation of the intervention included (a) institutional challenges and (b) the need to develop interventions that reflected the political contexts specific to geographic areas.

*Institutional challenges.* A major challenge was the need for multiple ethical approvals. Sixteen ethics applications were submitted across Canada in order to implement the intervention research study across the four sites. Considerable delays in obtaining ethical approval in our multisite research project affected the timeline of the 3-year project. At the rural sites, the ethics process tended to be much simpler; having the principal investigator's home institution ethics approval was sufficient to gain access to sites where nurses worked. The time required to complete the ethical and administrative approval process at health authorities was influenced by a variety of complex and intersecting variables, including the sociopolitical environment. In addition to sociopolitical shifts in the framing of HIV, the role of nurse managers as gatekeepers to participation and obstacles to obtain ethical approval to advertise and recruit nurses impacted the implementation of the research.

*Lack of organizational support at sites.* While several attempts were made to implement the project at two additional sites, a combination of conflicting political agendas (such as whether HIV was seen as an important or urgent issue to address), a lack of leadership support, and a perceived lack of opportunity to work with people affected by HIV yielded no uptake at these sites. Obtaining administrative approval to advertise our project at some clinical sites proved difficult. For example, recruitment from a potential pool of public health nurses was hindered at a large urban site. The administrators at that site made the decision that learning about HIV care was not relevant for public health nurses working for the health authority. We wondered if this decision was based on an assumption that HIV was a chronic condition. Some public health nurses were puzzled by the need to prove that learning about HIV care was relevant to their work. As one mentee shared: "My manager just felt it wasn't directly applicable to my work, which is not correct; we're public health generalists out here, we are responsible for knowing about sexual health and communicable diseases" (Urban mentee).

At another urban site, several highly politicized and large-scale HIV projects may have kept HIV disease, treatment, and care at the forefront of service delivery; nurses in that community from diverse work settings were keen to learn more about HIV treatment and care. Yet in the same city, administrative gatekeepers considered that too much research related to HIV occurred at particular clinical sites and denied our request to access potentially interested nurses. After many months of communication with officials during the application process, the ethics officer gave us the final answer:

> I'm sorry [Health authority] has denied your request. Approval for these types of research projects is at their discretion, and if they decide they do not want [their] nurses to participate, we [Ethics office], are unfortunately unable to offer any other solution. (e-mail correspondence)

We found that community size played a role in the ability of interested nurses to join the study. At rural sites, manager support was particularly high: "My manager's extremely—oh, my God, she's awesome! She's extremely in for education, and if you have to be away from the clinic, that's fine; clear your calendar and go … Education is great" (Rural mentee).

Nurses at some urban sites had nonsupportive managers when they asked if they could join the study. One of the nurse mentees went to great lengths

to get her workshop attendance approved as a professional development day: "I originally used vacation hours [to attend the workshop] … to request time off, and I had to speak to my professional union" (Urban mentee).

Other structural challenges for nurses to participate were related to the flexibility of their positions and their workloads. Another consideration was whether or not they worked in health care settings that allowed staff to change work hours or days. "I mean, being able to send somebody for training when you don't have somebody going to work tomorrow isn't going to happen" (Urban mentee). We also found that mentees from larger urban centers had much more difficulty negotiating meeting times and had the least flexibility in arranging their schedules. When we asked participants what the most difficult aspect was of participating in this mentorship project, one mentee responded:

> It is a little more challenging for me to … have that kind of chunking of time … it affects clinical practice and [pause] you know, we all say we're busy, and I think if you believe in something strongly, yes, you can find time, but we've faced cuts to our staffing. (Urban mentee)

One of the nurse mentees who worked in a specialized community health center shared that several of the nurses in her office were interested in joining the mentorship project; however, she relayed what she was told by the manager:

> "You can't all attend because you need to be in the office to cover for each other." So it's a sense of a very traditional nursing role where you have to cover your patient load or cover for each other's work … So I don't think it was the content that was the concern, I think it was the time and the coverage … (Urban mentee)

This nurse, on the other hand, believed that the nurses could have worked the coverage out among themselves. We wondered if this was an issue of lack of decision-making autonomy or lack of support for HIV-related time for professional development activities.

*Need to tailor intervention to fit political context.* At the start of the program, the research team conceptualized the intervention to be identical at each site. Over time we realized this was not feasible and that the delivery of the intervention was impacted by attitudes of nurse and PLWH mentors, mentees, and the sociopolitical nature of HIV care in different parts of Canada. In some regions of Canada we were told that HIV was simply not an issue; yet we were well aware that clients who were from these regions had been required to travel to large cities to access care. Following a community consultation with decision-makers at one site, it was suggested that a combination of low HIV prevalence rates, the integration of HIV services into more comprehensive interventions of service, including sexually transmitted infections and blood-borne pathogens, and sociopolitical environments, had hindered the implementation of the intervention.

Our findings also suggest that without a local champion who was familiar with and could navigate local organization politics, as well as motivate the mentorship groups, mentors and mentees were likely to form weaker links with each other. This champion could be a research team member, a participant, or a decision-maker/stakeholder who believed in the research objectives and eventual outcome. Relationships between mentors and mentees, as well as PLWH and nurses, were fundamental for learning. Following the implementation of a mentorship program with rehabilitation professionals, Solomon and colleagues (2011) suggested that a skilled facilitator was essential to promote the process of learning and to foster the relationships between mentors and mentees that are required to ensure successful mentorship for all involved.

## Discussion

Based on our experiences over the course of this study, it was necessary to shift our perspective on how we viewed the mentorship process. An individual's decisions about his or her learning needs were influenced by, and embedded in, the organization work environment. Who decided what learning and knowledge counted and where? The answer to this question was not consistent across Canada. At times, nurses did not have personal agency to

decide what continuing education opportunities interested them (Mill et al., 2014). Political understanding of workplace learning impacted both the ethical approval process to conduct research and recruitment efforts for our project. When defining workplace learning, it is important to understand the organizational context within which learning occurs. Fenwick (2008) recognized that learning and working could no longer be considered in discrete silos, but rather, as two different views of the same reality.

The use of transformational learning theory enabled us to consider learning as a social process and to understand that sociopolitical conditions can facilitate or impede learning (Mezirow, 1997). We found that HCP participating in learning communities could share and create knowledge that supported continued learning. This behavior added a social dimension to their reflection and has been described by others as critically reflective workplace behavior (de Groot, Endedijk, Jaarsma, Simons, & Van Beukelen, 2014). The nurses who participated in our study endeavored to make their practices more evidence based, and explored and constructed meaning collaboratively in an effort to decrease the stigma and discrimination that their clients received in their health care.

Canadian registered nurses are accountable for providing competent nursing care, which means they must maintain and continuously enhance their knowledge, skills, and attitudes to meet client needs in an evolving health care system (Canadian Nurses Association, 2015a). Despite this requirement, many variables within organizations dictated what nurses could and could not do to enhance professional development. The process of creating a continuing education credit at the University of Alberta to provide formal educational recognition for nurses, and providing honoraria to attend workshops were not the principle motivators for nurses to join and complete the intervention. Interestingly, when asked what had motivated their participation, none of the participants mentioned continuing education credit; instead, motivation was intrinsic and responded to a need to adequately care for patients living with HIV. Successful creation of the continuing education credit as a recruitment tool and retention strategy was viewed as a major accomplishment for the project but was a lengthy and time-consuming process.

In addition to sociopolitical shifts in the framing of HIV, the role of nurse managers as gatekeepers to participation and obstacles to obtain ethical approval to advertise and recruit nurses created significant delays in the project. We observed that knowledge was enacted and improvised within situational contexts and organizational structures. Nurses in the study had little autonomy to negotiate continuing education opportunities that interested them. At times, gatekeepers at the organizational level influenced what was considered relevant learning for nurses. Health care research gatekeeping as defined by Lee (2005) is the process of permitting or denying access to a selected research site. Health care researchers understand that access to a research site, which may include patients and HCP, is an important ethical issue in a research proposal. Researchers should, therefore, anticipate the possibility of gatekeeping; in our study, obtaining ethical and organizational approval were complex processes that were both time and resource intense.

Important considerations for successful HIV mentorship program interventions included ensuring support from managers and educators who could play an instrumental role in facilitating access, as well as confirming a supportive organizational structure. A Canadian Nurses Association (2015b) position statement recommended that employers of nurses have the responsibility to maintain quality practice environments that allow access to professional development opportunities. To ensure that issues of HIV stigma are adequately addressed in nursing care, additional supports, including accessible mentorship interventions, are warranted. To achieve their intended outcomes, we recommend that clinical mentorship interventions consider political contexts and organizational support, adhere to GIPA principles, and consider questions of professional obligations.

## Disclosures

The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

## Key Considerations

- Researchers, clinicians, and educators may use the process of implementing the mentorship intervention to enhance the capacity of health professionals to work in HIV care.
- Important considerations for successful HIV mentorship program interventions include supportive managers and educators who play instrumental roles in ensuring access and a supportive organizational structure.
- Having a local champion/skilled facilitator who understands the local political context, promotes the process of learning, and fosters relationships between mentors and mentees, is vital for a successful mentorship program.
- Clinical mentorship interventions should consider political contexts and organizational support, adhere to Greater Involvement of People Living with HIV/AIDS principles, and consider questions of professional obligations.

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