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AIDSRelief Ethiopia

Community-Based Treatment Services (CBTS): The Ethiopia Experience

Background

Recognizing that facility-based services alone would be inadequate to respond to the wide array of needs that people living with HIV (PLHIV) may have, the AIDSRelief Care and Treatment Model incorporates Community-Based Treatment Services (CBTS) that provide the essential link between activities at the health facilities and those within the community. The goals of CBTS are to assist HIV patients to achieve optimal anti-retroviral therapy (ART) adherence and adequate viral suppression, and to maintain low rates of loss to follow-up (LTFU). CBTS is based on the principle of continuous patient and family engagement in care and treatment through structured treatment preparation for patients prior to ART initiation; home visits to support adherence and monitor medication side effects; early identification and clinic referrals of opportunistic infections (OIs) that impact mortality; a robust appointment system and same day follow-up for patients who miss clinic appointments; and supportive counseling to assist status disclosure and stigma reduction.

CBTS within the Ethiopian context

AIDSRelief Ethiopia currently focuses its support to care and treatment interventions at one hospital and five health centers in the West Shoa Zone of the country. By December 2011, 4,020 patients were enrolled in care and treatment programs, of whom 1,042 were on ART. CBTS activities have been embedded in the program since the beginning, with some modifications to conform to the Ethiopia Ministry of Health guidelines in the delivery of care to and treatment of HIV/AIDS patients. Linking services between the health facilities and the community is one of the most significant national challenges in rolling out HIV care and treatment programs. AIDSRelief CBTS activities help overcome this issue by highlighting the importance of community linkages of care and treatment programs and their essential role in providing extended quality care.

CBTS Structure and Implementation

CBTS activities provide necessary support to HIV patients through the efforts of adherence case managers, adherence supporters, and community volunteers.

The **Adherence Case Managers (ACMs)**—themselves mostly PLHIV affiliated with PLHIV associations—are primarily responsible for developing a tailored client- and family-centered care plan for patients on ART and those in care. Their work is supervised by clinic CBTS specialists. Each facility has one ACM who is responsible for managing the missed appointment system, tracking patients who might be lost to follow up, ensuring that

patients' CD4 tests are performed and recorded appropriately, and supervising adherence supporters, among other responsibilities.

Adherence Supporters (AS) complement the ACMs' roles, both at the facility and community levels. Like ACMs, they should ideally be PLHIV affiliated with an organization. At the facility level, AS provide structured treatment preparation to ART eligible patients and their family. Topics include basic information regarding HIV and AIDS, ARVs and side effects, and drug resistance. After preparation, the patient is assessed using a post-test in which a score below 80% requires an additional session of education and testing. Readiness is also assessed using a set of psychosocial-related questions. At the community level, AS carry out mobilization and sensitization campaigns, follow-up on patients who miss their clinic appointments, escort patients who need help to go to treatment facilities, and conduct home visits

A Case Study from An Adherence Case Manager at St. Luke Hospital

A 50-year old man came in to St. Luke hospital for an eye infection. He was very thin, weighing just 27 kg. He tested positive [for HIV] and his CD4 were at 80. He had dementia and couldn't remember to come to appointments. The adherence case manager questioned whether the man would be able to adhere to his medications.

After a couple of months of following up with him, through the case manager and community volunteers, the man brought in his family members, all of whom tested HIV negative, and he started on ART. He disclosed to his family and his weight returned. The adherence case manager reports, "He's doing all right now, and I see him every couple of weeks."

– Adherence Case Manager, St. Luke hospital

Community Volunteers (CVs), recruited from local PLHIV associations and the community, focus on providing home visits, LTFU tracing, awareness raising, adherence counseling, early identification and counseling for OIs, and referring pregnant mothers from the community to facility-based prevention-of-mother-to-child-transmission (PMTCT) programs. The community PMTCT efforts were devised to include referrals of pregnant women to the facility for HIV counseling and testing and, if HIV positive, these women are linked to PMTCT services. As of September 2011, 28 CVs—of whom 26 were PLHIV themselves—were providing services for approximately 971 patients, a ratio of 34 patients per CV.

Support group activities are conducted by CVs and AS. Topics such as positive living, early identification of OIs, and adherence and stigma are discussed and income generating activity opportunities are provided. Targeted support groups, such as pregnant women or mom-to-mom support groups, are also established. Discussions center on issues related to safe delivery, breast feeding, and general women's health issues.

CV, supervised by the AS, participate in monthly meetings where they discuss their cases and challenges at the health facilities' level; this occasion becomes a support group for the care givers, ensuring the CV issues are addressed. CV are also provided with a transportation stipend and are given tokens of appreciations such as T-shirts, umbrellas and boots.

Introducing the CBTS model

The introduction of the CBTS model to the clinic and the community was methodic and deliberate, starting with a clinic and then a community sensitization workshop in which the structures, functions, and processes of the model were unveiled. The workshop brought together community gatekeepers, religious leaders, PLHIV associations, community-

based organizations (CBOs), and local government, school, and health representatives. After these workshops, adjustments were made to the program to reflect the community and participant feedback provided during the workshops.

Successes

Loss to follow up rate: In the first four quarters of AIDSRelief program implementation, LTFU rates were relatively high and continued to increase gradually, reaching 53.1 LTFU per 1,000 patient-months of follow-up in the final quarter of 2010. Following CBTS start-up, the LTFU rate declined rapidly in the first quarter of 2011 to 47.3 LTFU. The retention rate at the primary site, St. Luke hospital, also showed a statistically significant increase from 74.8% in Q1 2009 to 79.6% in Q1 2011.

Baseline CD4+ testing rates: Everyone who tests positive at St. Luke hospital is referred to the ACM for counseling and same-day CD4+ testing, which has contributed to 88% of ART patients having had a baseline CD4+, the highest for any AIDSRelief country.

"Now that we have all the services available here in Dilela, it is much better for the patients. They can come here now and receive the care that we couldn't get when we were infected. "

– Adherence Case Manager, Dilela HC

Strengthened service linkages: Through referrals to AS, cross-directional linkages to other community-based programs supporting PLHIV in the area are taking place. Available community services include programs implemented by the Red Cross and the Oromia Development Association, who provide financial support and temporary shelter to PLHIV.

PMTCT outreach strengthened: CVs have been trained to seek out pregnant mothers in the community and refer them to the health centers to be tested. A feedback form is sent back from the health centers to help ensure the pregnant women were actually tested.

Impact of adherence counseling and support groups on patients: The introduction of a structured treatment preparation intervention has contributed to higher adherence rates: the overall patient crude retention is now estimated as 47.5% versus 34.4% prior to the program. Simultaneously, patient missed clinic appointments have reduced substantially. The discussions held during support groups have been shown to promote community-wide disclosure among pregnant women, which greatly enhances their ability to remain adherent to the medications.

"Before the AIDSRelief treatment preparation began, I was enrolled in the treatment program at the hospital, but I did not believe in taking the drugs. I would carry the drugs home, but I wouldn't take them. The people in the clinic were very surprised to see that I was not getting any better. Then after talking with the Adherence Manager, I was convinced about the need for the drugs. I have now started a mom-to-mom group to support other women to take their medicines, because it helps us to remain strong for ourselves and our families. It worked for me and I want it to work for them too."

– AIDSRelief Beneficiary

Challenges

Late ART initiation has a significant effect on treatment outcomes. One of the remaining challenges in providing ART is that of stigma, which causes many patients to provide false contact information and deny their identities. As many as 25% of pre-ART patients will reject AS phone calls. AIDSRelief experience shows that inviting patients to a clinic for a non-HIV related appointment may be a way to provide the patients with much needed, and often desired, support. Another challenge is getting asymptomatic pre-ART patients in the community to the clinic to initiate ART. The lack of transport and the long travel distances required to get to clinics have also been a challenge. This logistical challenge

also exists for CVs and AS making home visits and participating in other community-related activities. To help alleviate this problem, AIDSRelief procured motorcycles for ACM and bicycles for AS and CVs.

Lessons learned

The CBTS component has contributed enormously to the overall success of the program. The program has worked in harmony with the national goals of reducing loss to follow up and promoting scaling up. Key lessons learned include:

- Higher adherence rates can be attained through continuous engagement of patients and family through a structured care program provided by the CBTS model.
- Overall retention and minimal LTFU is achievable when there is a functional appointment system in place to track patients when they miss clinic appointments.
- The level of community stigma—and self-stigma among PLHIV—can be reduced and self-esteem increased by engaging patients and creating a comfortable environment for them to take responsibility for their own health
- Working with organizations of PLHIV has been essential to the success of the program.