# AIDSRelief Ethiopia

## A sustainable approach to strengthening continuity of HIV care and treatment services by linking hospitals to health centers

### Background

HIV treatment and care services at the health facility level are usually fragmented and fail to provide continuity of services down to the community level. Hospitals, health centers and community level support are not systematically linked. Health providers working on HIV care and treatment at the hospital and health centers do not have an established relationship and communications; these disconnects hamper HIV patients' follow-up and transfer, and increases the lost to follow-up (LTFU) rate. Moreover, though the national mentoring guideline recommends that hospitals mentor health centers, this approach is rarely implemented.

### Approach

AIDSRelief implemented its care delivery model that links hospitals, health centers and the community, at St. Luke hospital and its surrounding five government health centers. The hospital works closely with health centers that serve as satellite sites; this approach establishes a formal link among the health providers at these facilities through mentorship. This approach included setting up a hospital based mentorship program for the health centers, following the nationally supported decentralized mentoring approach, and instituting community based treatment support (CBTS).

The AIDSRelief program provided hospital health staff with necessary training including a training on mentoring using the national mentoring guideline; other guidelines and tools such as pre-site visit checklist, one-to-one mentoring checklist, chart review forms, and site debriefing form; and one–to-one mentoring for hospital staff to have sufficient skills and confidence to mentor health center staff once a month. These mentorship activities targeted all staff involved in comprehensive HIV services, with an emphasis on HIV care and treatment, PMTCT and CBTS. Activities at the health center level include the hospital mentor and the health center staff conducting a one-to-one observation of HIV patients, client record review and review of patients' registers. Discussions occurred on complicated cases, and treatment approaches. In the early stages, the AIDSRelief technical staff conducted joint visits with the hospital staff to the health centers to provide the necessary guidance; as the hospital staff became more confident in the tasks, the AIDSRelief technical staff reduced the amount of support provided.

To ensure sustainability, AIDSRelief coordinated these activities with the hospital administration and the government zonal health department. All players were involved in the planning and implementation process, and understood the commitment required of them. The hospital enabled its staff to take time off on a monthly

AIDSRELIEF CRS CATHOLIC RELIEF SERVICES INSTITUTE OF HUMAN VIROLOGY 1996 UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE Futures GROUP

basis for the mentoring assignment and the zonal health bureau had its zonal mentoring staff participate in this exercise.

Resources required from the hospital were the time of the health staff and transportation to the health centers. AIDSRelief provided technical assistance focusing on mentorship, training and clinical updates, and per-diem for the hospital staff.

## Lessons learned

As a result of this effort, St. Luke has built a mentoring team that provides support to health centers with minimal support from AIDSRelief. The St. Luke mentoring team began supporting four newly initiated ART health centers in the last six months, with 222 patients on care, of whom 137 patients on ART, and no patients lost to follow-up. HTC and PMTCT services are strengthened; 19,040 individuals are tested, of whom 1,666 are pregnant women. Fourteen new HIV-positive pregnant women were identified, of whom 86% (N=12) were initiated on prophylaxis to reduce risk of mother to child transmission. With the support of hospital mentors and case managers, the referral and linkage of ART patients has been successful in ensuring that patients who reside in the vicinity of the newly initiated ART health facilities continue their treatment in the nearby facility; 42% of the cumulative ever started on ART at the four health centers are transferred in from other facilities.

Moreover, the linkages of the health facilities enabled experience sharing among health center and hospital staff, and ensured the provision of high quality client care at the health centers by building the skills of health center practitioners who were new to providing such services. This approach becomes even more important as more health centers are planned to initiate ART. The exchange also facilitated sharing of resources including forms and drugs, and improved referral linkages between the facilities. Including a community intervention as one component of the mentorship increased the health centers' ability to reach out to their communities through a structured approach with adherence case managers and supporters. This approach is more successful as patients live closer to health centers than the hospital.

Success of such an endeavor requires high commitment and buy-in of the hospital management, as well as the involvement and support of the zonal health department. The integration of zonal level mentors has also strengthened the relationship between the hospital and the health centers. The Roomier Regional Health Bureau has adopted the AIDSRelief linkages of health facilities approach through mentorship throughout its region. This model is replicable and the necessary guidelines and tools developed by AIDSRelief are currently being reviewed and adapted by the region. Challenges included turnover of trained mentors, insufficient expert staff at the hospital, and increased workload at the hospital while its staff conducted mentorship and limited hospital authority over the health centers for administrative support.

Based on AIDSRelief Ethiopia's experience, the mentorship by hospitals to health centers and reaching out to communities is a model that is replicable by other health facilities. This approach builds local capacity to provide such mentorship, and minimizes the responsibilities of international implementing partners such as AIDSRelief, leading to a more sustainable health care delivery model. Hence, implementing partners should focus on targeted efforts of building technical mentorship packages and linkages of services in collaboration with government health departments as a means to build local capacities, to transfer necessary technical skills and to ensure ownership of the HIV care and treatment program by government counterparts.