

**DEFAULTERS TRACING AND RETENTION OF PEOPLE LIVING
WITH HIV/ADS (PLWHA), HOW FAR DO PEER PERFORMS THIS
DUTY?**

**A CASE OF BUNAZI HEALTH CENTRE IN MISSENYI DISTRICT
COUNCIL**

**DEFAULTERS TRACING AND RETENTION OF PEOPLE LIVING
WITH HIV/AIDS (PLWHA), HOW FAR DO PEER PERFORMS THIS
DUTY?**

**A CASE OF BUNAZI HEALTH CENTRE IN MISSENYI DISTRICT
COUNCIL**

By

LEVITAS REVELIAN RWAZO

**A Dissertation submitted to the School of Public Administration and Management
for the Partial fulfillment of Master Degree in Health Systems Management at
Mzumbe University**

2015

CERTIFICATION

We, undersigned, certify that we have and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled ***Defaulters Tracing and Retention of People Living with HIV/AIDS (PLWHA), How Far Do Peer Performs This Duty?? A case of Bunazi Health Centre in Missenyi District Council, Kagera Region , Tanzania***, in partial fulfillment of the Requirements for award of the Masters degree in Health system Management of Mzumbe University.

Mr. Deogratias Faustine Mpenzi

Signature

Major supervisor

Signature

Internal Examiner

Signature

External Examiner

Accepted for the Board of School of Public Administration and Management

Signature

DEAN/CHAIRPERSON

DECLARATION

AND

COPYRIGHT

I, Levitas Leverian Rwazo, hereby declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature

Date

© 2015

This dissertation is a copyright material protected under the Berne Convention, the Copyright Act 1999 and other International and national enactments, in behalf, on intellectual property. It may not be reproduced by any means in full or part, except for short extracts in fair dealings, for research or private study, critical scholarly review or disclosure with an acknowledgment, without prior written permission by Mzumbe University, on behalf of the author.

ACKNOWLEDGMENT

First of all I would like to thank God for His Grace, Mercy and everlasting love towards me and my family. As human being it was impossible to accomplish the hard task I had a head of me without His guidance. May his blessing be with all who supported me in one way or another to accomplish the task.

The accomplishment of this work has been contributed by many generous individuals whom their inputs led to this valuable product. This Dissertation is a result of these individuals and it become impossible to acknowledge their contributions by mentioning everyone individually by names, positions, though few among them need to be mentioned below.

I am pleased to convey my sincere thanks to my supervisor Mr Deogratias .F. Mpenzi for his constructive guidance throughout research work process, and he was greatly committed to ensure that I finish this study and present it as required. The supervisor frequently read the manuscript and advice accordingly from the early stage of proposal development up to the dissertation stage with very critical observation.

Further acknowledgment goes to my Employer for allowing me to pursue the studies and associated support during my study. I further convey my appreciations to my District Medical Officer Dr Zabron Masatu my fellow staff particularly Mr Flavian Nturwa, and Jusline Bukuru for their great support and tireless cooperation regardless of many duties, responsibilities and commitments they had.

Also I would like to express appreciation for the encouragement, moral and material support from my beloved husband, Mr Dominic Ntikarejo, our daughter Hellen and our son Brian, lovely parents Mr & Mrs Leverian Rwazo and all family members, without forgetting to mention Ednata Kaumbya France, who encouraged me to accomplish the programme.

Lastly I express my appreciation to the management of Bunazi Health centre, Kassambya, Kyaka and Minziro wards for allowing me to collect data from their health facility and community members.

I ask all of you to receive my sincere appreciations. I remain solely responsible for any errors and misinterpretation in this work.

DEDICATION

This dissertation is dedicated to my beloved Parents, and to my beloved Husband and our children.

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Ant Retroviral Therapy
CTC	Care and Treatment Centre
FBO	Faith Based Organisation
HIV	Human Immune Deficiency Syndrome
ICAP	International care and treatment of people with AIDS programme
IPD	In Patient Department
MAPEC	Missenyi AIDS and Poverty eradication Crusade
MOHSW	Ministry of Health and Social Welfare
NACP	Nation AIDS Control Programme
NGO	Non Government Organization
OPD	Out Patient Department
PE	Peer Educator
PMTCT	Prevention of Mother to Child Transmission
PLWHA	People Living With HIV AIDS
TADEPA	Tanzania Development and AIDS Prevention
VCT	Voluntary Counseling and Testing
VHW	Village Health Workers
WHO	World Health Organization
HBC	Home Based Care

ABSTRACT

The study principally intended to assess the role of peer educators in defaulter tracing and retention of people living with HIV/AIDS at Bunazi Health Centre in Missenyi District. The study was motivated by defaulting trend of PLWHA already on ART. The general objective was to assess the performance of peer educators, government and partners in defaulter tracing and retention of People Living with HIV/AIDS (PLWHA) at Bunazi Health Centre. The specific objectives were; to establish the extent at which PLWHA lost to follow up ,to examine likely factors that cause PLWHA to default from their appointment dates ,to identify the ways used by peer educators, government and partners in tracing defaulters and emphasizing the use of ARVs and adherence to prescriptions and hence retention of PLWHA, to compare the trend of defaulters before and after introduction of peer educators program and to explore staff , community perception and support to PLWHA

The study employed descriptive design, purposive and stratified sampling technique was applied to get representatives sample of respondents were involved in the study. Data were collected through interviews, questionnaire, observation and documentary review. Data was managed at highly standardized procedures to ensure quality results. Coding, recoding, cleaning, processing and finally analysis and outputting of the results were conducted depending on the available software standards. SPSS statistical programme was used for data entry and analysis of quantitative data. The qualitative data was presented according to the findings in logical and sequential way so that conclusion can be drawn from them. The data was presented according to research question and research objectives, tables are used to present data.

The study showed that at Bunazi health centre PE reduces the rate of defaulting from 6.1% in 2011 to 4.5% 2014.The recommendations capitalize on the sustainability of peer educators' programme and close follow up of PLWHA at the community level in collaboration with VHW and HBC providers.

TABLE OF CONTENTS

CERTIFICATION	i
DECLARATION	ii
COPYRIGHT	ii
ACKNOWLEDGMENT	iii
DEDICATION	v
LIST OF ABBREVIATIONS	vi
ABSTRACT	vii
TABLE OF CONTENTS	viii
LIST OF TABLE	x
LIST OF FIGURE	xi
CHAPTER ONE	1
1.1 Introduction	1
1.2 Background Information	1
1.3 Statement of the Problem	3
1.4 Research Objectives	4
1.4.1 General Objective.....	4
1.4.2 Specific objectives	4
1.5 Research Questions	5
1.5.1 General question.....	5
1.5.2 Specific questions.....	5
1.6 Significance of the Study	5
1.7 Scope of the Study	6
1.8 Conceptual Frame Work	6
CHAPTER TWO	10
LITERATURE REVIEW	10
2.1 Introduction	10
2.2 Theoretical literature review	10

2.2.1 Definitions of important terms	10
2.2.2 Peer Education Policy and Regulation	11
2.3 Empirical literature review	15
2.3.1 Globally	15
2.3.2 Sub-Saharan Africa	16
2.3.3 Tanzania	17
2.3.4 Kagera	17
2.3.5 Missenyi	18
2.4 Research gap	18
CHAPTER THREE	20
METHODOLOGY	20
3.0 Introduction	20
3.1 Study design	20
3.2 Study area	20
3.3 Study population	21
3.3.1 Population studied and Study unit	21
3.3.2 Source population	21
3.4 Sampling and sample size	21
3.4.1 Sampling frame	21
3.4.2 Sample strategy/technique	21
3.4.3 Sample size and precision	22
3.5 Data and data collection techniques	22
3.6 Data management and analysis	23
3.7 Ethical considerations	23
3.7.1 Ethical issues	23
3.7.2 Consent and confidentiality	23

CHAPTER FOUR	24
PRESENTATION AND DISCUSSION OF THE FINDINGS	24
4.0 Introduction.....	24
4.1 Research findings	24
4.2 Demographic characteristics of respondent	24
4.2.1 The extent of loss to follow up for PLWHA.....	25
4.2.2 Factors that cause PLWHA to default from their appointment dates	28
4.2.3 Ways used by peer educators, government and partners in tracing defaulters and emphasizing the use of ARVs and adherence to prescriptions and hence retention of PLWHA.	32
4.2.4 Comparison of trend of defaulters before and after introduction of peer educators program.	37
4.2.5 Staff, community perception and support to PLWHA.....	41
CHAPTER FIVE	47
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS	47
5.0 Introduction.....	47
5.2 Summary	47
5.3 Conclusion	49
5.4 Recommendations	49
REFERENCES	51
APPENDICES	54

LIST OF TABLE

Table 1.1 Measurement of Variables Shown on the Conceptual Framework.....	Error!
Bookmark not defined.	
Table 3.1 Sample size and precision	22
Table 4.1 Demographic characteristics of respondent	25
Table 4.2 Lost to follow up as from 2010-2014.....	26
Table 4.3 Time missed ARV doses among PLWHA.....	27
Table 4.4 The safety of ARV among PLWHA	28
Table 4.5 why ARV is good/safe	29
Table 4.6 Factors that cause other PLWHA to default from their appointment dates	30
Table 4.7 Roles of peer educators	35
Table 4.8 Trend of defaulters before and after introduction of peer educators program	39
Table 4.9 Times missed appointment for the past 6 months among PLWHA.....	40
Table 4.10 Family members knows about HIV status among PLWHA.....	44
Table 4.11 Importance of informing family members about HIV status	44

LIST OF FIGURE

Figure 1.1 Conceptual Frame Work.....6

CHAPTER ONE

1.1 Introduction

This chapter gives the background information to the problem, the statement of the problem followed by general and specific questions, general objectives and specific objectives. The significance of the study was clearly shown, limitation of the study, scope of the study as well as the conceptual frame work.

1.2 Background Information

Human Immunodeficiency Virus (HIV), the virus that causes Acquired immunodeficiency Syndrome (AIDS), has become one of the world's most serious health and development challenges. It is estimated that 36 million people have died since the first cases were reported in 1981 and 1.6 million people died of HIV/AIDS in 2012. Current, about 35.3 million people worldwide are living with HIV/AIDS (WHO, 2013). While cases have been reported in all regions of the world, 95% of new infections occur in individuals living in low- and middle-income countries. Sub-Saharan Africa is the most affected region, with nearly 1 in every 20 adults living with HIV. Sixty eight percent of all people who are living with HIV approximately to 25 million in the world live in this region (WHO, 2013).

Notwithstanding with the world's HIV statistics, Tanzania is one of the countries hard hit by HIV/AIDS epidemic. According to NACP, 2012 recent reports from the Ministry of Health indicate that cumulatively about 600,000 have developed HIV/AIDS, and about 2 million people have been infected with the HIV/AIDS virus. HIV/AIDS has now become the primary cause of death among adults in the country and is decimating the most productive age group leaving behind misery, suffering and poverty. Following year after year increase of HIV transmission rate, one vital program were established in Tanzania through the Ministry of Health and social welfare (MOHSW) to enroll all HIV positive people so that to deal with them closely. Enrollment process at first dragged behind due to fear and stigma but with time increased.

Its increase was not in harmony with the increase of ARVs side effects, shortage and sometimes fake ARVs happened to enter Tanzania. Many people enrollees dropped out, and stopped adhering to prescribed medications and counseling and most health facility experienced a big gap between enrollees and number of visits as this intensified, donors, NGOs and faith based organizations earmarked this to be a severe health problem and a barrier against HIV war. Hence establishment of HIV/AIDS lost to follow up programs in Tanzania being supported by different sources nationally and internationally (UNAIDS 2012).

Peer education was a final resort by then to overcome this health problem. This strategy is speeding up and is thought to be only way in which patient-doctor relationship is highly monitored to mitigate all disparities in delivering HIV/AIDS related services. Peer educators, being the main source of information to PLWHA and link between facilitators (health facility and donors) were selected and trained to perform the duty assigned completely to them (NACP 2012).

Since the past years where peer educations prospered in Tanzania, there were marked reduction in HIV/AIDS infection and increased adherence to prescribed drugs and recommended counseling. In the Region due to several interventions put by MOHSW, the region authority, district authority, community and NGOs available in the region such as International care and treatment of people with AIDS programme (ICAP), Missenyi AIDS and Poverty Eradication Crusade (MAPEC), Tanzania Development Partnership (TADEPA) in collaboration with the health facilities, in 2010 the rate of HIV/AIDS infection were 19%, and reduced to 3.4% 2012. In which this was a very big good result of HIV/AIDS reduction in Kagera Region has been revealed. Thus, peer educators apart from tracing defaulters and emphasizing the use of ARVs has helped change behaviors among HIV positive people to stop unsafe sex and run for protective measures always hence reduction of transmission rates (Kwesigabo et al 2000). Notably, in Missenyi, the district comprises 35 health facilities in which there are 2 hospitals, 1 health centre and 32 dispensaries, in which they all provide services to PLWHA. Peer

educators programme were initiated to facilities with high volume of clients, only 6 facilities have Peer educators in Missenyi district.

Bunazi health centre being among facilities with this programme it was initiated in 2010. Since the start of this service the number of defaulter have been decreasing with time while the number of PLWHA enrollment has been increasing from time to time due to the presence of peer educators at the facility level.

1.3 Statement of the Problem

CDC (2011) suggests that the introduction of Peer educators' programme, has worldwide shown much improvement in adherence and retention of PLWHA at the health facility. Celletti et al (2010) shows that according to the study conducted in South African patients with adherence support were more consistent in picking up their medication, attaining a treatment pick-up rate of 95% compared to those without adherence support (67%; $p=0.021$). Rosen (2008) identified that in Zambia an improvement in retention of ART patients from 85.4% to 100% was reported 12 months after the introduction of adherence support workers. Nevertheless, a similar trend emerged in a randomized trial from Uganda that reported a two-fold difference in lost to follow-up rates at 24 months between patients who were supported by peer educators and those who were not (2.2% and 4.1% respectively). In Rwanda, a high rate of patient retention at 24 months (92.3%) was reported following the implementation of PE adherence support.

Recognizing the role of peer educators, the two NGOs, ICAP and TADEPA have come up with enthusiasm in facilitating projects against HIV/AIDS in Missenyi district whereby by 6 health facilities namely; Mugana Designated District Hospital (DDH), Kagera sugar Hospital, Bunazi Health Centre, Kigarama dispensary, Kajunguti dispensary and Ruzinga dispensary are benefiting from the project.

Before introduction of PE educators at Bunazi Health centre the rate of defaulter and non adherence were high and it was increasing as the goes on.

In 2008-2010 number of defaulters increased from 58 – 379, but it seems number of defaulters have been decreasing with time since the introduction of peer educators at Bunazi health centre.

Facility Quarterly Reports, (2008/2009 to 2013/2014) show that the problem of defaulters, retention and poor adherence to drugs by PLWHAs still exist at Bunazi Health Centre. This study intended to assess the performance of peer educators pertaining to defaulter tracing and retention of PLWHAs in relation to their responsibilities at the facility.

1.4 Research Objectives

1.4.1 General Objective

The main aim of the study was to assess the performance of peer educators, government and partners in defaulter tracing and retention of People Living with HIV/AIDS (PLWHA) at Bunazi Health Centre.

1.4.2 Specific objectives

- i. To establish the extent at which PLWHA lost to follow up
- ii. To examine likely factors that cause PLWHA to default from their appointment dates
- iii. To identify the ways used by peer educators, government and partners in tracing defaulters and retention of PLWHA.
- iv. To compare the trend of defaulters before and after introduction of peer educators program.
- v. To explore staff , community perception and support to PLWHA

1.5 Research Questions

1.5.1 General question

What is the contribution of peer educators, government and partners in defaulter tracing and retention of PLWHAs at Bunazi Health Centre?

1.5.2 Specific questions

- i. To what extent at which PLWHA lost to follow up?
- ii. What are likely factors that cause PLWHA to default from their appointment dates?
- iii. Which ways are used by peer educators, government and partners in tracing and retention of PLWHA?
- iv. What is the comparative trend of defaulters before and after introduction of peer educators program?
- v. What are the staff and community perception and support to PLWHA?

1.6 Significance of the Study

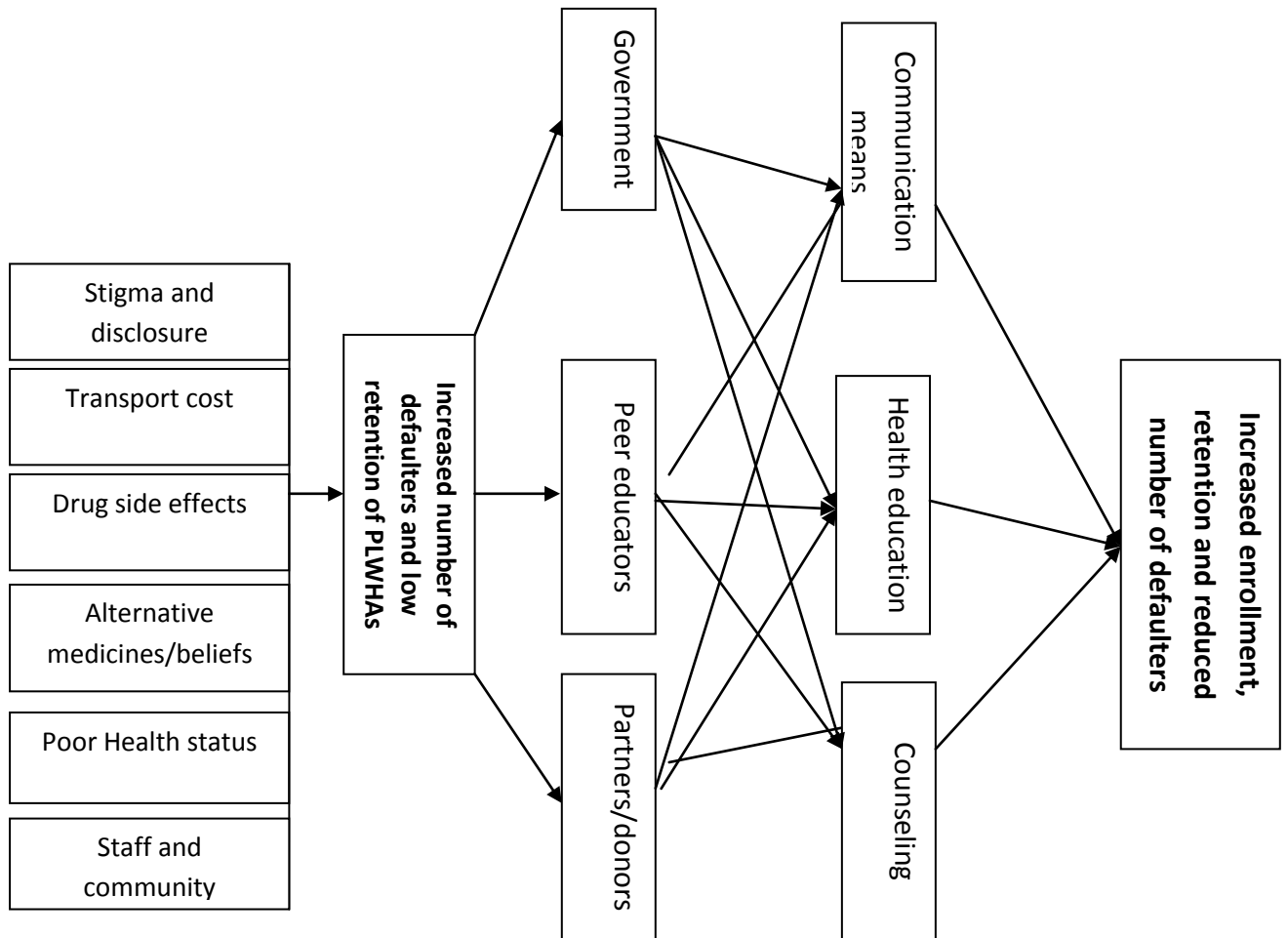
The study was suggesting proper measure to trace defaulters at Bunazi Health Centre and the district to funders in which the MOHSW in future might think of changing the current policy when other researchers make a study on a particular area, where by peer educators and PLWHA altogether will have to access a number of health services free of charge. More so, the study devises appropriate ways of reducing the number of defaulters and Lost to follow up in the community so that the health of PLWHA are promoted through prevention of new infection among PLWHA and preventing further spread of HIV infection in the community, avoiding some complications to patients/clients. Because when this problem is left unsolved might leads to undesired outcome, such as treatment failure, drug resistance, increased bed occupancy rate and drugs/supplies consuming rate, increased work load .Secondly this study significantly is the fulfillment requirement and justification for completion of masters degree.

1.7 Scope of the Study

The study was conducted at Bunazi Health Centre in Missenyi District and it involves PLWHAs, peer educators, CTC/VCT staff, community members from 6 identified villages and development partners collaborating with the district in fighting against HIV/AIDS.

1.8 Conceptual Frame Work

Figure 1.1 Conceptual Frame Work



Source: Researcher's construction, 2015

Table 1.1 Measurement of Variables Shown on the Conceptual Framework

VARIABLE	DEFINITION	MEASUREMENTS
Stigma and disclosure	<p>HIV related stigma refers to prejudices, negative attitudes and abuse directed to at PLWHA. Disclosure is the act of making something known or the fact made known.</p> <p>Due to stigma clients are not able to disclose their status hence increased number of defaulters.</p>	Frequency of PLWHA in VCT/PITC linked and attending to CTC at the facility from 2010 to 2014
Transport cost	<p>This refers to the costs incurred by patients when they attend clinics.</p> <p>Patients/client fails to attend to the clinic in the given date because they are not able to meet transport costs.</p>	Number of PLWHA failed to attend at the clinic during their appointment dates due to lack of transport costs
Drugs side effects	<p>Are unwanted or unintended effects from the drugs someone is using/taking among those side effects are vomiting, diarrhea, allergy etc.</p> <p>When someone develop severe side effect of drugs can decide to stop taking drugs</p>	Reported cases from PLWHA who developed/experienced drug side effects
Alternative medicines/Beliefs	<p>Is any medical treatment that is not part of conventional evidenced-based medicine in which it is not scientifically proved.(traditional medicines) Beliefs are assumption and convictions that are held to be true, by an individual or group of people regarding concepts, events, people and things. All these can lead to defaulting and treatment dropouts.</p>	Number of PLWHA attending to traditional hillers/not using ART due to Faith believes

VARIABLE	DEFINITION	MEASUREMENTS
Poor health status	<p>Is the impact of disease on patients function as reported by the patient, it is a range of manifestation of disease in a given patient including, symptoms, limitation of function and quality of life (Ambulatory and bed ridden patients).</p> <p>The health status of the patient is what will determine the attendance of the patient to the clinic in most cases those patients who are walking are only expected to be seen at the clinic, those ambulatory and bed ridden will not attend.</p>	Reported cases of PLWHA who are bed ridden/ambulatory by fellow PLWHA, Relatives, VHW and HBC
Staff and community perception	<p>The way you think or understand about someone or something, when staff or community have negative perception to PLWHA, the way they attend them and collaborate with them.</p> <p>When staff/community will have negative perception to PLWHA that is stigma and discrimination, PLWHA will continue not disclosing their HIV status, as a result there will be an increase in defaulting rate and new infection rate, they will not attend to the facility for VCT/PITC, instead of reducing prevalence rate of HIV/AIDS it will be increasing.</p>	Report from PLWHA about perception of health care workers and the surrounding community towards them

Source: Researcher's construction, 2015

The above conceptual framework illustrates the retentive process into three possible categories, as it is not the function of a single bullet measure but a couple of aspects integrating together into achieving desired goal. The government comes here as a stepping stone to all efforts directed to retaining PLWHA as it is obliged to provide

supportive policies, resources (human resource, financial as well as infrastructures); the facilitating NGOs/FBOs act as the intermediaries because they link the community to the government and other supporters (internal and external) thus need to properly address every single step to be in line with their targeted goals. PE they are working together in collaboration with Government and Nongovernmental organization so that they may deliver health related information and their experiences to their fellow (peers). The immediate and quick bullets that may lead to either success or failure in retaining PLWHA are thought to be the stigma and disclosure, long distance to health facility (lack of transport fee due to poverty), poor health status (ambulatory and bed ridden patients), side effects of drugs, alternative medicines and beliefs(traditions/faith).

Finally, when all these three levels will work together in collaboration they will reduce stigma and increase disclosure among the community and this will be measured through CTC 2 card(facility based document) where the client will bring treatment supporter and inform other members of the family, through health education and counseling they will be introduced to economic and social supportive groups where they will generate income through specific activities according to their localities. Through health education and counseling, staff and community they will perceive HIV/AIDS as other chronic disease not a diseases of people who misbehave, hence PLWHA will feel better than before and become good collaborator and follower on what will be advised.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents related literature on the knowledge, attitude and practice (KAP) about the peer education, the role and contribution of peer educators in defaulter tracing and retention of People Living with HIV/AIDS (PLWHA). This section also briefly summarizes key studies on the importance of peer education among PLWHA that have been undertaken several parts of the World including Tanzania

2.2 Theoretical literature review

2.2.1 Definitions of important terms

a) HIV/AIDS

HIV means Human Immunodeficiency Virus and AIDS refers to Acquired Immunodeficiency syndrome, but when it is HIV/AIDS it means there is virus and disease together (WHO, 2008).

HIV/AIDS Peers: are people who are alike in several respects: age, gender, interests, language, use of time, aspirations, social, and abilities, qualification and the disease they suffer from, HIV/AIDS (Celletti et al. 2010).

HIV/AIDS Peer educators: are HIV positive people who are capable of transmitting HIV information to their fellows PLWHA (Celletti et al. 2010).

b) Peer education- definitions

Peer education is the sharing of knowledge by someone who is either directly a part of the same social group as the individual with whom the knowledge is being shared, or who is of the same age, gender, race and ethnicity, occupation, socio-economic, and health status. But most importantly they inspire trust.

In relation to Human Immunodeficiency Virus (HIV), peer education is a less formal and more intimate approach to education that helps people who are unfamiliar with formal way of learning to be presented with knowledgeable peers (WHO 2008). This educational intervention occurs at various levels, depending upon where the person finds herself/himself within the continuum of HIV diagnosis and care.

As also Main (2002) discussed about it that a peer education program is usually initiated by health or community professionals, who recruit members of the target community to deliver that knowledge to the intended group in the community. The recruited group members' peer educators (PE) are trained in relevant health information and communication skills, the way of making their fellow PLWHA to live positively with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) through promoting health-related behaviors. Peer education has been operative in encouraging knowledge, attitudes and intention to change behavior in AIDS prevention (Sriranganathan, 2010).

Although this have been not the case because there are some peer educators who do not practice what they preach to their fellow, and in most cases this also might influence other unhealthy behaviors among PLWHA. In order the peer educator to influence her/his fellow to live and practice health behavior they should act as a role model in behavior change among their fellow and the community.

2.2.2 Peer Education Policy and Regulation

In order for any system to run smoothly there should a policy, guidelines and regulation. So the National AIDS Control Programme developed some of the policies and regulations to guide the peer education programme.

a) National HIV/AIDS policy

The government of Tanzania is committed to the prevention of HIV/AIDS and it has formulated the National policy on HIV/AIDS 2001 which is aimed at providing direction towards the improvement and sustainability of the health status of all the

people by reducing disability, morbidity, mortality improving nutrition status and rising life expectancy, The policy recognize that good health is a major resource essential for poverty eradication and economic development (MoHSW 2003).

b) Policy of peer educator in Tanzania

In order to achieve the desired goal, the MOHSW decide to put in place policy which guides the peer education program to perform their duty accordingly in peer educator's policy the MOHSW introduced goals , among those goals are as follows, Link the peer education program with other programme to form a comprehensive strategy, ensure quality control process in place, and evaluate the results of using peer educators including monitoring of activities, measuring the impact of education, consider incentives for peer educators to attract and retaining them. www.unicef.org/lifeskill

c) Regulations

Tanzania Commission for AIDS (TACAIDS) was first established by the announcement made by the President on 1 December 2000. The other step taken to establish TACAIDS was by the enactment of a law establishing Tanzania Commission for AIDS, Act No. 22 of 2001 by the Parliament. These steps were taken so as to ensure that the Government of the United Republic of Tanzania has an institution that is legally mandated to provide strategic leadership and to coordinate and strengthen efforts of all stakeholders involved in the fight against HIV/AIDS. (NACP 2000).

Apart from TACAIDS during the course of fighting against HIV/AIDS Tanzania as other country they introduce Peer educators programme after reviewing several literature and research about the contribution of peer educators in the trend of fighting HIV/AIDS.

d) Purpose of peer education programme

As the World Health Organization aimed at provision of equitable quality care to all PLWHA, but there were many patients who missed the health care services due to several factors, including inadequate health care workers which contributed much in long stay at the care facility, increased workload, out of stocks of drugs and medical supply, lack of knowledge about HIV/AIDS and social economic factors among PLWHA.

Inadequate recruitment and poor retention of skilled health professionals was regarded as the most serious obstacle for implementing the national treatment plan in thus far, the largely health care workers implementation of Ant Retro viral Therapy (ART) has become increasingly unable to bridge the gap between the ART clinics and the vast numbers of patients in need of treatment. Due to the mentioned above factors World Health Organization WHO (2008) elaborated more to why this programme of peer education was important, they promoted task shifting as a key strategy for overcoming human resources bottleneck. However, in a context of human resource for health shortage, the main goal of this program was to address the need for peer educators to actively engage with people living with HIV/AIDS in enhancing entry into HIV care, promoting antiretroviral therapy (ART) adherence, and facilitating long-term retention in HIV care. Contrary to the context-Bunazi health centre, task shifting in some circumstances can bring some confusion to the patients, at times PE might think that they can talk/practice anything concerning health related matters to their fellow peer, and because they are not professionals they can mislead their fellow if they won't be closely supervised. So supervision, directives and advice are very crucial so that knowledge of PE are clearly shaped, in doing so they will be so competent with some limitations in their work, they should be given job description through that they will assists in bridging the gap between the health care providers and PLWHA, by understanding challenges facing their peer groups in this era of HIV/AIDS.

Peer educator is the best person thought to disseminate new information and knowledge to PLWHA and can become a role model for them by practicing what he or she says. He or she can empathize and understand their emotions, thoughts, feelings and language, and therefore relate better to them. They are also able to inspire and encourage them to adopt health seeking behavior, especially HIV/AIDS preventive behavior for they are all sharing common weaknesses, strengths and experiences. In turn, peer educators who have increased knowledge and changed behavior are better able to deliver messages and conduct many activities with their peers. However, this has been so for years yet lost to follow up has always been a catch word in Missenyi district.

What seem would have worked here is diversifying the services to accommodate wide range of PLWHA health problems such like establishment of economic support groups, social support groups to mention but a few. Defaulters tracing movement at Bunazi health centre and in Missenyi district should be more polished to cater every person's desire and relinquish disparities among them. This will help them in their planning, setting developmental goals for their children and decrease the rate of orphanages in the community. Hence, peer education will be widened to catch many life aspects associated with PLWHA, record keeping of their works will be easy to monitor and manage that will aid clear reporting for further support requests.

As per social cultural factors is concerned, many people do trust those fellows with similar situation, so PLWHA will be free to have discussion about their opinion, worries, challenges and other social things in a safe environment with someone who relates to their situation, in which it will improve adherence to care and treatment because they may have a deeper understanding of what the client is experiencing. PE can play a role in community mobilization, decreasing stigma, and increasing support for PLWHA. They increase confidence in decisions making and take action able to empathize and understand the emotions, thoughts, feelings, and therefore connecting and relating more effectively. Communicates with their peers about a desired early health seeking behavior and risk reduction practice but also demonstrates it in her/his own life. Peer education programs can help both PE and PLWHA make positive changes in their behavior in order to take care of their personal health and that of their families (UNAIDS, 2010; Main, 2002; and CDC, 2011).

e) Importance of drug adherence and retention of PLWHA

Retention and drug adherence among PLWHA is a very important aspect of maintaining health of an individual. In the whole processes of counseling and testing, once an individual is diagnosed to be HIV positive need to adhere to medical counseling about how to live positively, avoiding new infection and protecting others from getting infection.

And if an individual is eligible to start ART as per National guidelines they are initiated on ART, and they should bear in mind that it is a lifelong treatment, no one should stop taking drugs. For many patients who have been practicing proper adherence of drugs, ART has transformed HIV/AIDS into a manageable chronic illness though still incurable disease. Thompson (2012) contributed to this issue that, the programme for ART should be durable, sustainable accessible and effective to all PLWHA. Because will assists in prevent of opportunistic infections, disease complications and deaths of PLWHA, all patients are advised to adhere to treatments, because when comprehensive care and patient self-management fail, patients discontinue treatment and develop rapid viral rebound, which significantly increases the risk of drug resistance and treatment failure, hence depression of CD4 counts which lead to opportunistic infection.

2.3 Empirical literature review

This part tells more on the related policies, guidelines and procedures entitled to the defaulter tracing retention of PLWHA and adherence to ART.

2.3.1 Globally

Prevention has helped to reduce HIV prevalence rates in a small but growing number of countries and new HIV infections are believed to be on the decline. In addition, the number of people with HIV receiving treatment in resource-poor countries has dramatically increased in the past decade. According to WHO more than a 30-fold increase in the number of people receiving ART in developing countries between 2003 and 2012, and almost a 20% increase in just one year (from 8 million in 2011 to 9.7 million in 2012). Though there some clients who do not turn up on the given appointments dates in which peer educators in most cases assets in tracing and retaining them. However, almost 19 million other people who are eligible for ART under new WHO 2013 guidelines still do not have access to antiretroviral drugs (WHO 2013).

2.3.2 Sub-Saharan Africa

More than two-thirds (70 percent) of all people living with HIV, 25 million, live in sub-Saharan Africa including 88 percent of the world's HIV-positive children. In 2012, an estimated 1.6 million people in the region became newly infected. As the number of newly infected with HIV increases there should be an intervention in which Peer Educators Programme have shown great improvement in fighting against HIV/AIDS (WHO 2012).

From other literature they describes the implementation and outcomes of an active defaulter tracing system used to reduce loss to follow-up (LTFU) among HIV/AIDS, receiving treatment at three Médecins Sans Frontières clinics in the informal settlement of Kibera, Nairobi, Kenya. Patients are routinely contacted by a social worker via telephone, in-person visit, or both very soon after they miss an appointment. Patient outcomes identified through 1066 tracing activities conducted between 1 April 2008 and 31 March 2009 included: 59.4% returned to the clinic, 9.0% unable to return to clinic, 6.3% died, 4.7% refused to return to clinic, 4.5% went to a different clinic, and 0.8% were hospitalized. Fifteen percent of patients identified for tracing could not be contacted. LTFU among all HIV patients decreased from 21.2% in 2006 to 11.5% in 2009. An active defaulter tracing system is feasible in a resource poor setting, solicits feedback from patients, retains a mobile population of patients in care, and reduces LTFU among HIV. www.ncbi.nlm.nih.gov 20/11/2014.

Despite these gains in HTC uptake and HIV chronic care enrolment, linkage of patients testing HIV+ to Pre- ART/ART services and retention of those patients in care remain major challenges. It is estimated that without intervention, less than 30% of people testing HIV+ will link to pre –ART care, while 6 - month retention among patients . ART is ~75% decreasing to ~35% by the fifth year in care. Anecdotally, follow –up of defaulting patients is sporadic and inconsistent at best (SNAP 2012).

Peer educators are seen as credible sources of information. This has been shown to be particularly effective amongst the youth population.

Peers and peer education are an important influence and approach in changing health behaviors. One of the beliefs of peer education is that it is cost effective. Peer education has been identified as a more economical way to deliver health training (Main, D. S. 2002).

2.3.3 Tanzania

Continuing high rate of lost to follow up in Ant Retro Viral Treatment programmes among people already on treatment, many study already done on this but according to the study done in randomly selected health facilities in Tanzania by Bupamba et al (2010) similar high baseline rate of attrition. The study was focusing on how to improve retention in care, and defaulter tracing over 18 months at 41 care and treatment centers (CTC) in Tanzania. Peer educators were given a task to follow up clients who had not returned to the clinic within two weeks after missing appointments in their homes. The results of the study shows that 3,949 clients were reported to have missed appointments or lost to follow up, the peer educators reached personally or confirmed the vital status of 2,820 of clients(69%) and they were returned to care. The primary challenge includes high numbers of incorrect address and inconsistency use of mechanism to detect early defaulters. Because of low rate of literacy, data entry system require intensive supervision ,however the results shows that due to visits of peer educators and phone calls to trace patients rates of lost to follow up were significantly decreased.

2.3.4 Kagera

In early 1980s, according to Dr Pius Tubei who was the Regional Medical officer in Kagera Region, the situation was worse in kanyigo, ward in Missenyi district, which recent statistics show that 3.2 percent of its people are currently living with HIV/AIDS. The region prevalence rate at the moment stands at 3.7 percent, almost half of the national rate of 7 percent (AJAAT, 2008). Due to that high rate of infection in Kagera region, as other facility/Authority they introduced the peer educator's programme in collaboration with other partners. Kagera region has witnessed the decline of in HIV

prevalence during the past two decades from 24% in 1987 to 4.7% 2009; this could be due to access to social capital, both structural and cognitive (Kwesigabo et al 2000).

Since the past years there were marked reduction in HIV /AIDS infection in the Region due to several interventions put by the Ministry of Health and Social welfare,(MOHSW) the region authority ,district authority, community and NGOs available in the Region such as International care and treatment of people with AIDS programme (ICAP), Missenyi AIDS and Poverty Eradication Crusade (MAPEC), Tanzania Development Partnership (TADEPA) in collaboration with the health facilities .In 2010 the rate were 19%, and reduced to 3.4% 2012 In which this was a very big good results of HIV/AIDS reduction in Kagera Region (NACP 2012). MOHSW and partners in collaboration managed to reduce the HIV prevalence in the Region mainly through health education, counseling and by the use of other means of communication through different medias so that the message is received by PLWHAS and the community. In 2010 they introduced the peer educators' programme in the region in which it shows some improvement of retention and adherence to treatment of some patients.

2.3.5 Missenyi

No study has been done to the importance and the role of peer educator in defaulter tracing and retention of PLWHA at the facilities in Missenyi district.

2.4 Research gap

According to several literature and study done concerning the importance of drug adherence to PLWHA, the MOHSW developed the policy of giving health services free of charge to all clients/patients with HIV/AIDS regardless the economical status of an individual in which this was regarded as a motivation to PLWHA to seek medical advice as early as possible, and attending to the clinic on the appointment dates but this has not been the case, patients/clients are not turning back on the appointed dates which lead to increased number of lost to follow up, defaulter and treatment drop outs while

there is low rate of enrollment and retention in care of PLWHA despite of counseling and other health services given. This study focused more on the assessment of peer educators, partners and government on their performance on tracing defaulters and retention of PLWHA at the facility. In assessing those three pillars the study looked more on the variables which might be the main factors(stigma and disclosure, drugs side effects, transport cost, poor health status, alternatives medicines/beliefs and staff/community perception) for the patients/clients not turning back on the appointment dates, defaulting and even to those who drop out from the treatment.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter contains the study methodology that was used by a researcher in collecting and analyzing data. It includes research design, study area, study population, sample and sampling procedure and data collection techniques and analysis.

3.1 Study design

Nature of research questions entails the need of both qualitative and quantitative data and borrows a comparative aspect. Therefore, descriptive study design was used since certain factors are being suspected to have relation to the research problem and a small scale cross sectional comparative design was employed. This is because; comparison assisted in the clarification as to whether peer educators, government and partners are having significant contribution on tracing defaulters.

3.2 Study area

Missenyi District Council is one of the eight local authorities in Kagera region. It covers an area of 270,875 hectares. It is situated on the West of Lake Victoria between 30⁰ 48' and 31⁰ 49' East and 1.00⁰ 00' and 1⁰ 30' South. On the Northern side, Missenyi District is bordering the Republic of Uganda on the East, Lake Victoria and a part of Bukoba District, on the South Bukoba District and on the West by Karagwe District. The District is composed of 2 Divisions namely Missenyi and Kiziba, subdivided into 20 Wards and 74 Villages Bunazi Health Centre is situated in Missenyi division, Kassambya ward and in Bunazi village.

3.3 Study population

3.3.1 Population studied and Study unit

HIV/AIDS positive population was subjected under study and study units were individuals using ARVs (all who have ever used drugs whether dropped or still on progress). The list of defaulters generated from which they were selected basing on distance of their residences from the health facility, non-defaulters, peer educators and CTC staff was studied.

3.3.2 Source population

Inclusion criteria: the main inclusion criteria for a subject to be involved in the study, must be HIV positive person and already on ARVs (dropped out or on progress) and CTC/VCT staff, and community members despite their HIV status.

Exclusion criteria: all HIV/AIDS negative people were excluded.

3.4 Sampling and sample size

3.4.1 Sampling frame

The study targets HIV positive population, peer educators, facilitating institutions and the specific health facility from which services are delivered to patients.

3.4.2 Sample strategy/technique

Depending on the too branched study in order to avoid biasness and to ensure validity probabilistic and non-probabilistic sampling techniques were used in selecting study units. Stratified sampling was dominated in probabilistic sampling while purposive sampling was taken from the non probabilistic category.

All mentioned groups were subjected to random sampling procedures and stratified sampling to groups with more than five units and according to their specified classes for example according to distance from home to the facility, they were singled out;

whereas groups with at most five units like workers in the VCT unit, purposive sampling was used.

3.4.3 Sample size and precision

Table 3.1 Sample size and precision

Sample frame	Total units	Sampled units	Sample percentage
Peer educators	6	6	100
VCT/CTC workers	8	4	50
Average defaulters	242	30	12.4
Average non defaulters	921	95	10.3
Total	1177	135	11.5

Source: Researcher's construction, 2015

Sampling techniques applied in obtaining units in each frame vary depending on the nature and purpose of respective category. Peer educators and VCT/CTC workers were obtained through purposive sampling because they possess specific information related to the study. To avoid bias in obtaining representatives for defaulters and non-defaulters, simple sampling technique were employed whereby all members in the sampling frame they had equal chance of being included in the sample. The techniques used to obtain 6 villages among 20 villages from which 3 of them peer educators operate also average defaulters and average non-defaulter reside.

3.5 Data and data collection techniques

Various data sources were employed to aid widened data pool and cross-checking of the data collection, thus triangulation. The nature of research questions fosters the use of extreme sources, primary and secondary sources. Primary sources of data include questionnaires which was administered to defaulters identified, non-defaulters, peer educators, healthy workers in the VCT/CTC unit, and the funding organization. In liaison with questionnaire; intensive interviews conducted with specific health workers and the facilitating organization, ICAP, defaulter, non defaulters and peer educators, alone and together.

More so, secondary source was used, and these include previous conducted studies in the same area to help a comparative aspect and hence strengthen triangulation.

3.6 Data management and analysis

Procedure for data management: data was managed at highly standardized procedures to ensure quality results. Coding, recoding, cleaning, processing and finally analysis and outputting of the results were conducted depending on the available software standards. SPSS statistical programme was used for data entry and analysis of quantitative data were done by descriptive statistics and presented in tables. The qualitative data was presented according to the findings in logical and sequential way so that conclusion can be drawn from them. The data was presented according to research question and research objectives, tables were used to present data.

3.7 Ethical considerations

3.7.1 Ethical issues

The research was designed in such a way that pays attention all community ethics and put human rights as a first priority. No harm was done to anyone involved in the study or not.

3.7.2 Consent and confidentiality

The consent was requested upon sensitization and introducing the study to the district authority, and health facility management where written both in Swahili and English consent form were handed to them for signification. Moreover, the study catches a very confidential health aspect, HIV/AIDs, where no one should disseminate information of a HIV positive person without her/his permit. Therefore, the study ensured high confidentiality preservation so as to not violate ones' confidentiality rights. The consent included assurance of voluntary participation, in this study the names of participants was not recorded for reference, only numbers were used. All the obtained information during and after the study were protected

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.0 Introduction

This chapter involves the presentation of research findings and the discussion based on research findings. The discussion in this chapter pertains to the role of peer educators in defaulter tracing and retention of PLWHA already at the facility. The study was motivated by increased number of lost to follow up and defaulters at the facility despite of free health services as per policy. In this chapter data from different sources are presented including those collected through various method and tools such as interview, questionnaire as shown in chapter three. This chapter provides the answer for research questions. Responses from different categories respondents provide the ground for presentation and discussions. The categories of respondents includes People living with HIV/AIDS already on Ant Retroviral Treatment, staff from Care and treatment clinic, peer educators and community members from identified villages served by Bunazi Health centre (catchment population).

4.1 Research findings

4.2 Demographic characteristics of respondent

Data was collected from 120 PLWHA at Bunazi Health Centre; respondents in this study were PLWHA on ART being good adherer or with poor adherence of drugs.

Most respondents were female n= 68 (56.6%) and n=52(43.3%) were males. The study revealed that the age of the majority ranged between 25-54 years were 103 represents (85.8%) in which respondents with age below 25 years and above 55years were 17 respondents representing (14.2%), More than half 83 represents (69.2%) of the respondents have primary education and about 32 represents (26.6%) of the respondents had attained secondary school education while 5 represents (4.2%) had not attained any

education level recognized in the formal schooling system. Among all respondents about 59 represents (49.2%) were engaging themselves in agriculture (self employment) while 61 represent (50.8%) respondents were dealing with other activities for generating income.

Table 4.1 Demographic characteristics of respondent

Variable	Frequency	Percentage
Male	52	43.3
Female	68	56.6
Age ranging 25-54 yrs	103	85.8
Age below 25 yrs	12	10
Age above 54 yrs	5	4.2
No formal education	5	4.2
Primary school level	83	69.2
Secondary school level	32	26.6
Agriculture (self employment)	59	49.2
Other income generating activities	61	50.8

Source: Research findings 2015

4.2.1 The extent of loss to follow up for PLWHA

Data were collected through questionnaire, interviewers guide and through discussions with different groups of the respondents also through documentary review from the past reports in comparison with current report of facility data base and patients files. VCT/CTC staff explained more about the defaulting rate in comparison with before the introduction of peer educators' programme in association with other factors.

From the research findings (Facility reports) it shows that, there were high rate of Lost to follow up at Bunazi Health Centre, the care and treatment services at Bunazi Health Centre were initiated in May 2008 in which the number of missed appointment and lost to follow up were increasing with time despite of services being provided freely, The number of defaulters top up with time, for instance, from 2008 through 2010 the number of defaulter at the facility level went up from 5-120 drop outs consecutively. But since the introduction of peer educators at the facility the number of miss up and lost to follow up have been decreasing with time from 2011 to 2014 the defaulters were 120-62

consecutively. Apart from retention of PLWHA at the facility also the number testing of HIV and enrollment increases. From the findings someone can think that this is not the problem because numbers of defaulters are not such high, but we should bear in minds that ART is quite different from other treatment, there should be no any miss up or defaulter of ART as the results could be fatal. The details are shown in table 4.2

Table 4.2 Lost to follow up as from 2010-2014

Year	Total patients/clients	Defaulters	Percentage
2008	106	5	4.7
2009	229	19	8.2
2010	410	42	10.2
2011	613	54	8.8
2012	748	61	8.1
2013	800	59	7.3
2014	857	62	7.2

Source: Research findings 2015

Time missed ART doses among PLWHA

The study done on the time from the last dose taken by the client, was projected to determine the level of which PLWHA misses ART which could tell why there are patients who changes clinical stages as per WHO (worsening condition) in every visits and explain treatment failure among PLWHA, the time taken from the last dose signifies poor adherence of drugs in percentagewise according to the number of days missed. The study shows that 12 respondents represents 10 percent missed doses for less than a week, 9 respondents represents 7.5 percent missed a dose less than a month, 7 respondents represents 5.8 percent who missed the doses for more than a month, 92 respondents represents 76.7 percent who never missed their doses. Detailed responses from the respondents involved in the study are shown in table 4.3

Table 4.3 Time missed ARV doses among PLWHA

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Less than a week	12	10.0	10.0	10.0
Less than a month	9	7.5	7.5	17.5
More than a month	7	5.8	5.8	23.3
None	92	76.7	76.7	100.0
Total	120	100.0	100.0	

Source: Research findings 2015

From other literature it shows that peer educators are of importance in tracing defaults, according to pupamba et al (2010), they explained the work done by peer educators in the research done in 41 CTC sites from Kagera, Kigoma, pwani and Zanzibar, the study were done over 18 months (Oct 2008 –Marc2010), the findings were as follows: 3,949 clients were reported to have either missed appointments or lost to follow up either reached personally or confirmed vital status for 2,720(69%) of listed clients of the traced by PE, 4411 (10%) had died and 2,309 (59%) were still alive. www.aidsmap.com/page/1/5/2015

In this objectives shows that the knowledge of good adherence of ARV has said to be the factor for good health among PLWHA, despite of good adherence of the clients it might be some reasons which might lead the client not to take doses at agreed time or day, this is quite different from those who misses appointments, this is having drugs at home but she/he have missed to take as it used to be, but even missing one dose it reduces the percentage in adherence because patients on ART should adhere 100 percent. As the percentage of adherence become decreasing then the immunity become decreasing hence increase the chance of opportunistic infections. From the findings it seems before the introduction of peer educators the rate of defaulting were high, as ART adherence is quite different from other drugs, once you stop taking ART you increase the chance of developing drug resistance which might read to treatment failure or

transmission of the virus which is more virulent that's why good adherence of ART are highly advised and supported.

4.2.2 Factors that cause PLWHA to default from their appointment dates

On this part data were from research tools used in the study from different groups; PLWHA on ART who are good follower/good adherer, CTC/VCT staff, interviewers guide among the department staff ,peer educators, community members from identified villages.

The safety of ARV among PLWHA

According to wiley-Blackwell et al (2010) they mentioned ARV side effects as a barrier to why PLWHA default from the clinic, some complains about body reactions, changes in their body shapes mostly being lipodistrophy, loss of adipose tissue. At Bunazi health centre this was not the case though some of them reported minor side effects of drugs which were tolerable. Apart from those minor side effects the study went into details to know if at all they are familiar with the safety of ARV or they are just taking them simply because they are infected and they don't have any alternatives. The study shows that all PLWHA they are familiar with the safety of ARV and used as it was prescribed by health care provider. Table 4.4 shows the details on the response of respondents on the safety of ARV.

Table 4.4 The safety of ARV among PLWHA

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	120	100.0	100.0	100.0

Source: Research findings 2015

a) Why ARV is good/safe?

The study went into details to know if PLWHA who are taking ARV knows the goodness/safety of ART, and if knows the functions of ARV in their body and this will motivate them not to skip their doses, missing appointments, defaulting or even drops

out from the treatments. Main intention of taking drugs are to kill or interfere the circle of intended agent in the body, in one way or another ARV as other medication the end results of its action are suppression/ reduction of viral load as a result immune status of an individual are improved through increased CD4 in which the chance for opportunistic infection are reduced. The study shows that ;36 respondents represents 30 percent knows that it reduces viral load, 32 respondents represents 26.7 percent knows that increase CD4 counts, 25 respondents represents 20.8 percent knows that it reduces chances of opportunistic infection, 27 respondents represents 22.5 percent they responded that all of the above. So from those observations the study reveals that there are other factors which cause PLWHA to defaulter as it was mentioned in the conceptual frame work, the findings are summarized in table 4.5.

Table 4.5 why ARV is good/safe

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Reduce viral load	36	30.0	30.0	30.0
	Increase CD4 counts	32	26.7	26.7	56.7
	Reduce chances of opportunistic infections	25	20.8	20.8	77.5
	All of the above	27	22.5	22.5	100.0
	Total	120	100.0	100.0	

Source: Research findings 2015

The study shows that, there are several factors which were the main causes to PLWHA to default from the treatment centre, as hypothetical reasons from the conceptual frame work, it mentions some factors which might lead client/patient fail to attend on the appointed dates as; distance from home to the health facility (lack of transport fee), ill health, stigma and disclosure, traditional and faith believes, improved health status and altitude of health care worker and the community. The study involved only 26 defaulters among 120 PLWHA on ART respondents. The analysis revealed that 14 respondents represents 53.8 percent was due to lack of transport fee, 9 respondents represents 34.6 percent was due to ill health, 1 respondent represents 3.8 percent was

due to traditional/faith believes, 1 respondent represent 3.8 percent was due to stigma, 1 respondent represent 3.8 percent was due to altitude of health workers.

Apart from those patients/clients who defaults their treatments, the study went into details to know what might be the cause of other patients/clients defaulting their treatment; the study was interested to know the views of their fellow patients/clients. Among the reasons given by clients why other PLWHA fails to meet the appointments dates were; stigma, lack of transport fee, ill health, this means some when ill cannot be in the position of going to the clinic and this is common to those who have not disclosed their status, otherwise someone would have collected his/her drugs, good health status of an individual, this means when an individual after taking drugs and gained immunity, become free from opportunistic infection they think that they are cured and decide to stop taking ARV as well as stopping visiting the clinic, traditional and faith believes. The study shows 43 respondents 35.8 percent were due to stigma, 25 respondents represents 20.8 percent are due to lack of transport fee, 26 respondents represents 21.7 percent are those with ill health, 11 respondent represents 9.2percent are due to weather conditions, 8 respondents represents 6.7 percent as traditional and faith believes 7 respondents represents 5.8 percent are due to improved health status, table 4.6 shows the findings

Table 4.6 Factors that cause other PLWHA to default from their appointment dates

Variable	Frequency	Percentage
Stigma/disclosure	43.	35.8
Ill health	26	21.7
Lack of transport fee	25	20.8
Weather(rain season)	11	9.2
Traditional/faith beliefs	8	6.7
When feel free from any infection (thinks that is cured)	7	5.8

Source: Research findings 2015

Apart from the effort put by MOHSW and implementing partners in improving ART adherence, (wiley-Blackwell et al 2010) In their study, they found that transport costs, time needed for treatment, and logistical challenges were barriers to treatment., transfer

patients reported that transportation costs influenced treatment retention. During their study, some of the patients reported that side effects (body shape changes) might be a contributing factor to default, although this was not reported as a major barrier to treatment. The use of traditional medicine was not a major theme in respondent reports, but it was mentioned as a contribution to their decision to stop treatment. This was quite different from Bunazi Health center as alternative medicine was among the hypothetical variable in which no one responded on it. But from their study, it seems common reasons for missing appointments included lack of transport, social problems, and travel out of station. Other patients stopped attending clinics once they felt physically better or with increased CD4 count. When tracked by volunteers, the patients would say they felt they no longer needed hospital services since they were feeling much better. Religious beliefs have also contributed to LTFs as some patients stopped attending clinics believing they would be healed by their faith, some religious leaders were advising patients not to take their ARV medication or to go for further tests. Stigma has also played a part in some regions where patients will not go back to CTC clinic where they initially registered after diagnosis, fearing to be seen by someone who might know them since they had not yet disclosed their status. Poverty has also contributed to LTFs as during rainy seasons, farmers focused on their farms and stopped attending their clinic appointments. Transport fees and accessibility for those who have to travel out of the village also been a deterrent to attending clinics, long waiting time and other health system concerns, among the issues reported were long queues, difficulty in booking appointments, difficulty tracking down paperwork or staff, too many patients at clinics, not enough time spent with providers, and clinics running low on medication.

www.ncbi.nlm.nih.gov 20/4/2015

Thus, from the findings, it seems the main factor for PLWHA defaulting from the appointment dates were stigma among themselves (PLWHA) and towards them from the community members and the surroundings, stigma seems to cover all reasons because if some could have been disclosed his/her status to some of family members they could even go for his/her ARV during the appointment dates when feel unwell.

Family members they could have been counseled him/her when seems not adhering to the prescribed drugs, meet the appointment dates even with improved health status, they could have contributed or make any some initiatives to make sure that he/she gets transport fee monthly. So in order to have people adhering to treatments/prescription we should make sure that knowledge about stigma is advocated to the whole community.

4.2.3 Ways used by peer educators, government and partners in tracing defaulters and emphasizing the use of ARVs and adherence to prescriptions and hence retention of PLWHA.

The modality used to get data was through questionnaire, interviewers guide, discussion and documentary review on the ways used by peer educators, Government and partner in the whole task of defaulter tracing and retention of PLWHA at Bunazi health centre, through discussion with VCT/CTC staff (Government employee) and peer educators. The study intends to know the ways used by those three pillars in making sure that PLWHA are traced and retained to the facility.

Government and partners in emphasizing adherence and retention

Government as the overall of all health services in the country, as its role of taking care of his people, they tried to develop the ways in which PLWHA could be retained on the care as ARV restore the function status of an individual living with HIV Due to HIV infection in which reduce the immune system of an individual leading to increased opportunistic infection, bed occupancy rate in the facilities increasing work load to the inadequate health care provider. on the way forward the problem, then task shifting thought to be the solution of reducing work load, the Ministry of Health in collaboration with implementing partners/Non Governmental Organisation (NGO), in task shifting they introduced the peer educators programme in which those peer educators have been giving health education to PLWHA during their routine visits at the facility, tracing defaulters and miss up patients/clients. Peer educators have been tracing defaulters through phone contacts in which partners have been providing vouchers for recharging their phones (PE).

Apart from tracing them, the Ministry of Health and Social welfare in collaboration with NGO supporting missenyi district they have initiated other CTC and mobile/outreach CTC in which some of the patients are shifted/referred to their nearby CTC/outreach from their domicile to reduce costs hence retention and good adherence to ART of PLWHA. In 2010 there were 4 CTC, 1 outreach and 2 refill sites whereby in 2014 there are total of 14 CTC and 1 outreach. The Government and partners through the support of Human resource/technical support, material support, capacity building among health care providers and training of peer educators, whom were chosen among PLWHA already on ART and trained on how they can reduce the work load at the CTC clinic which could be the barrier to PLWHA to come to the clinic due to long stay at the facility which increase stigma .The services to PLWHA were improved in which patients/clients were attended as per policy and guidelines. After the peer educators training they were assigned to perform some tasks which aimed in tracing of defaulters and retention of PLWHA.

The roles of peer educators

The study was interested in understanding the roles of peer educators in the era of HIV since the health sector in all departments they have scarcity of health care provider. Among the tasks given to peer educators was; giving health talks to their fellow PLWHA concerning adherence, nutrition education, safer sex, encouraging their fellow in living positively with HIV and the importance of disclosure, apart from above tasks they were mainly trained to trace defaulters through home visits, phone tracing and the use appointment book. Peer educators' traces defaulter and miss up by aid of appointment book by asking client whom they are used to attend on the same date.

In justification of home visiting by peer educators, the respondents reacted positively that peer educators have been visiting them to their homes giving support to the neediest patients/clients, the results were as follows, 89 respondent represent 74.2% are those who were followed in one way or another, 31 respondents represent 25.8 percent of those who have never followed by peer educators to their residence.

In most cases peer educators visits those with problems such as, those not show up during their appointment dates, who have problem with their families in disclosing their status, and those with had time in counseling/advising their partners. Because peer educators are taking ARV they are used as a role model in giving up their experience on ARVs being side effects and other findings that could be quite different from the already known from the literature/book (patients can present with other findings which are not documented in books). peer educators takes time to interact with their fellow PLWHA, giving them experience of living positively with HIV, experience of taking ARV and experience of living in the community which knows his/her HIV status comfortably.

Usually people trust those whom they have something in common, through health talks, giving experiences of ARV for long time, disclosing their HIV status to the community and being as a role model, PLWHA they usually become good adhere and remain at the facility and become good counselor to their fellow who are defaulting, stigmatizing themselves and those who are fearing testing of HIV. When clients/patients understand all of the above they will be retained at the facility and others will come for enrollment. The study was interested to know the roles of peer educator, and how did they assisted PLWHA in gaining knowledge pertaining to ART and its adherence, the study shows that about half of the respondents got the ART and adherence information about the importance of taking ART for the rest of their life from the peer educators. The study found that 50 respondents represents 41.7 percent are those who got this knowledge from the clinician, 50 respondents represents 41.7 percent are those who were educated by Peer educators, 20 respondents represents 16.7 are those who were educated by Nurses. The study went into details to asks more on the role of the peer educators if its known to PLWHA, it shows that 30 respondents represents 25 percent are those of health talks, 25 respondents represents 20.8 percents are of encouraging patients, 17 respondents represents 14.2 percent are those of defaulter tracing, 45 respondents represents 37.5 percent they are those responded all of the above, 3 respondents represents 2.5 percent are those of only 1 and 2, table 4.7 shows the details on the roles of peer educators.

Table 4.7 Roles of peer educators

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Health talks to the clients	30	25.0	25.0	25.0
Tracing defaulters	17	14.2	14.2	39.2
Encouraging clients	25	20.8	20.8	60.0
All of the above	45	37.5	37.5	97.5
Only 1 and 2	3	2.5	2.5	100.0
Total	120	100.0	100.0	

Source: Research findings 2015

According to (USAIDS 2010), as the number of lost to follow up increases, through PEPFAR the TUNAJALI program made a strategic decision to hire and deploy patient tracking coordinator(PTC) to track “lost” patients and reduce the emerging trend of missing appointments. The coordinators were located within the treatment centers, and at the end of each clinic day, the triage nurse provided them with a list of patients who missed appointments. PTCs then started tracking these patients from their first missed appointment. They initially attempted to contact patients by phone. They were able to reach some patients this way who provided valid reasons for why they were unable to attend clinic that day. Common reasons for missing appointments included lack of transport, social problems, and travel out of station. PTCs then rescheduled appointments for these patients and removed them from the missed appointments list. A final list of all missed appointments and those previously noted as LTFs but not yet traced were then compiled, printed out, and handed over to the HBC community volunteers and focal persons who would be more likely to know where the lost patients live and/or work. Another initiative used by some CTCs which has proven to work well was the introduction of “block appointments.” This system drastically reduced patient lost to follow up.

Patients also felt more involved with their health choices since they were given an option to select a time block that best suited them, thereby making them feel recognized and appreciated.

PTCs also went a step further by using clinic days to call out names of all LTFs during clinic times. This, too, was a success as they were able to get information on LTF patients' whereabouts from others who were attending clinic the same day, as some of these people were the missing patients' neighbors, friends, or fellow PLHIV support group members. PLHIV support groups have played a part in identifying lost patients within their support group through actively checking each other's CTC1 cards on their monthly meetings making sure that all members are attending clinics as required. Those seen to be going astray are referred to the group volunteer for more counseling and support so that they can continue with their clinic services, helping to reduce lost to follow-up in the process. PTCs have also used Regional hospital workers to track LTFs who might have been admitted in the regional hospitals with an illness or might be in the hospital deaths register list. PTCs also build and maintain key linkages between HBC program and the CTCs to ensure that timely follow-up is made to all PLHIVs registered at the CTCs in such a way that appointments are adhered to and retention rates meet the national standard of 95%. www.ncbi.nlm.nih.gov/start 21/4/2015.

The majority of transferred patients lowered transportation costs by changing clinic. Possible interventions to overcome financial barriers include providing stipends or vouchers to patients to cover transport costs. Additionally, a treatment plan designed to accommodate less frequent appointments and drug pick up, such as every 3–6 months, could reduce patient costs and reduce the time burden that ART places upon patients (wiley- Blackwell et al 2010).

From the finding it seems those three pillars are working in collaboration so that they reach the desired goal of bringing back all patients/clients who defaulted from the treatment and make sure that all enrollee and those coming after defaulter are retained at the facility. Through all intervention done/put in place by Government, Implementing partners and peer educators all people living with HIV/AIDS should adhere to the treatment and advice given to them. It's the purpose of the national that all PLWHA who are eligible to start ART should be initiated on ART as early as possible so that they may reduce the burden to the family, community, Health facility and the national at large.

When an individual start ART as early as possible, the function status will be restored, bed occupancy rate will be reduced, reducing the consuming rate of drugs and medical supplies hence increase the national economy through improved productivity of those PLWHA.

4.2.4 Comparison of trend of defaulters before and after introduction of peer educators program.

PLWHA on ART who were initiated ART at Bunazi health centre or those who were transferred in from other facility while on ART they were a source of data through questionnaire, interviewers guide with peer educators and VCT/CTC staff, and through documentary review.

The trend of defaulters of PLWHA at Bunazi health centre before the introduction of peer educators program was high, the facility started to provide CTC services in 2008 with a total of 106 Patients mostly being referred from Bukoba Regional Hospital, and from other health facility in the country.

Some services pertaining to HIV/AIDS were provided in the same room which was situated in the OPD building in which the area were not friendly to PLWHA due to inadequate privacy, inadequate space for provision of proper health services and some inconveniences in which patients have to move to other rooms for other services mixing with other patients who are not HIV positive. Health care workers regarded this as the main reasons to why the numbers of defaulters have been increasing, it was the same year when Implementing partners assisted the facility in constructing the CTC building in which all services are taking place because there are several rooms, and supporting the facility with providing Peer educators. Since the year 2011 the trend of defaulting have been decreasing with time, health care workers were not certain to what specifically reduced the number of defaulters because they occurred concurrently as a coincidence. From the study it seems the great contribution to reduce defaulters is the introduction of the peer educators, because some patients are still defaulting even on the presence of the CTC building, from the already seen factors.

Through documentary review/discussion with staff it shows that patients have been defaulting for long period of time even more than a year, because there were no way they could know all about the patients unless he/she come back again and tells them why she/he was not attending. Most reason was migrating to nearby country due to social economical reasons, feeling better and denying the HIV positive results. Due to those factors most people came back in critical condition, even in re -initiating of ART in most of patients were not useful and they ended on complications and losing life. But since the introduction of peer educators programme the frequency of missing appointments reduces, when an individual misses appointments there were some initiatives done to know why is he/she missing and tries to communicate with him/her through phone if at all is reachable, home visiting by PE /HBC providers. Through all this interventions PLWHA are not missing /defaulting for long time as before because they are being followed up.

In 2008 the facility had total number of 106 Patients with total defaulters 5 equal to 4.7%, the number of defaulters have been increasing with time, but shows a slight decrease on the introduction of peer educators, the trend were as follows 8.7%,10.2%,8.8%,8.1%, 7.3% and 7.2% from 2009 2010, 2011, 2012, 2013 and 2014 respectively. Table 4.8 shows the trend and the percentage of defaulting rate since 2008 to 2014.

Table 4.8 Trend of defaulters before and after introduction of peer educators program

Before introduction of Peer Educators at the facility			
Year	Total patients/clients	Defaulters	Percentage
2008	106	5	4.7
2009	229	19	8.2
2010	410	42	10.2
After introduction of peer educators at the facility			
2011	613	54	8.8
2012	748	61	8.1
2013	800	59	7.4
2014	857	62	7.2

Source: Research findings 2015

From the findings above the study was interested to know the frequency of defaulting among PLWHA after the introduction of peer educators, as we have seen that before patients could default even as long as one year. The study mainly focused on the period of six months retrospectively, patients/clients are required to attend at the facility in monthly basis

a) Times missed appointments for the past six months

The study was interested to determine the frequency clients' misses appointment for the past 6 months, the study shows that 96 respondents represents 80 percent never missed appointment for the past 6 months, 13 respondents represents 10.8 percent who missed once, 9 respondents represents 7.5 percent who missed 2 to 4 times, 2 respondents represents 1.7 percent who missed appointments 5 times and above. Table 4.9 summarizes the frequencies PLWHA missed appointment in the past 6 months.

Table 4.9 Times missed appointment for the past 6 months among PLWHA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	96	80.0	80.0	80.0
	1 time	13	10.8	10.8	90.8
	2 to 4 times	9	7.5	7.5	98.3
	5 times and above	2	1.7	1.7	100.0
	Total	120	100.0	100.0	

Source: Research findings 2015

According to USAID(2010), the study shows that the trend of defaulters have been decreasing since the introduction of TUNAJALI program which were situated in 4 Regions in Tanzania as a pilot area. They managed to track back defaulters, Dodoma Regional Hospital and Makole Health center, managed to track 60 percent of their patients within three months, reducing the number of LTFs among followed up patients by 50 percent and confirming the effectiveness of the tracking system employed by all PTCs and volunteers within the TUNAJALI program.

b) Peer educators help to improve ART adherence

A study conducted by Miyaho Bupamba et al (2010), from the Columbia International Centre for AIDS Care and Treatment Programme, showed similarly high baseline rates of attrition. The study, which looked at how to improve retention in care were based on defaulter tracing over 18 months at 41 care and treatment centres in Tanzania, with nearly 10,000 active clients on ART. Peer educators were hired to provide group and individual counseling, to facilitate referrals, and to conduct home-based visits. There were standardized criteria in selecting peer educators. They had to be HIV-positive, physically capable, willing and committed, and trained in the basics of HIV, behavioural risk reduction, treatment adherence and psychological support”. They conducted defaulter tracing for ART clients who had not returned to the clinic within two weeks after missing an appointment. “One of their tasks was to follow-up defaulting clients in their homes, to document their vital status, and to encourage them to return.

The results of the study indicated that 3,949 clients were reported to have missed appointments or to be lost to follow up. The peers educators reached personally or confirmed the vital status of 2,820 of those clients (69%) were returned to treatment centre.

Therefore, the findings shows that the trend of defaulter before the introduction of peer educators were high with long defaulting time even than a year among PLWHA, due to inadequate human resource at the facility there no way out they could make proper follow up to PLWHA who have defaulted though they knew the importance of ART adherence. So number of defaulting have been increasing with time till the introduction of peer educators which brings some difference in the frequency and rate of defaulting to some of the patients/clients. From these findings it seems peer educators are of great importance in the whole process of defaulter tracing and retention of PLWHA at the facility.

4.2.5 Staff, community perception and support to PLWHA

Through questionnaire, interviewers guide, discussion with PLWHA, staff and community on the perception and support to PLWHA it was the main data source for the study.

Due to stigma and discrimination against PLWHA and among themselves, these have been a great barrier to fight against HIV/AIDS. Initially when the mode of transmission was not clear to the community, the stigma rate was very high which lead to an individual once is diagnosed to be HIV positive not to disclose the information to anyone as the result transmission rates of new HIV infection increases. Also there were no specific staff for PLWHA as they were not free to attend / to be closer to them, there were shifts among HCW to attend PLWHA. In the community where the individual living with HIV/AIDS were coming from, there were stigma and discrimination to the extent that once the individual is diagnosed to have HIV was not regarded as a human being, they could not share utensils, clothing and even shake hands with him/her, they called them some discriminating names.

In the health facility once the individual tested HIV positive they were used to isolate them in which this were traumatizing patients psychologically. And all this could have been contributed to the increase of defaulters.

The study shows that health care workers are committed to their work and adhering to the policy of HIV/AIDS, they attend patients under patients right regardless of their HIV status, they are stationed to the clinic no rotation as in other department, so PLWHA are free to them because they are used to them. Before the initiation of ART clients/patients are asked to bring the treatment supporter who will remind the patients to take pills, come to pick drugs in case patients is not in the position to attend at the clinic. They take time to examine the patients as a whole and not a case of HIV as it was before, they can discuss and agree each other on the appointments date and sometimes to be given extra drugs/pills

Depending on the situation/problem of the patient.

The introduction of treatment supporter in the treatment of PLWHA in some extent has reduced stigma, because someone should expose his/her status even to one person, treatment supporter as a part of the community they support patients/clients in all aspects pertaining to HIV/AIDS services, being in their treatment follow up, social activities and psychological support. For this case community perception and support are of great importance in reducing the rate of defaulter.

This study also involved community members from six identified villages, Bunazi health centre as its catchment population it is saving about 20 villages, among those the researcher selected 6 villages with regards to the distance from the facility, high rate of defaulter from that village, and those with less defaulting rate. These villages identified are from Kassambya ward, Kilimilile ward, Minziro ward, Kyaka ward, and Mutukula ward. Those villages are Bunazi, Kassambya, Kilimilile, Minziro, Kyaka and Mutukula village. To this community members they were discussing about their contribution towards supporting PLWHA, their perception towards an individual with HIV, members in this group they said that, nowadays they regard PLWHA as their fellow but initially

they thought it was a contagious disease and they could not even share just a sit with an infected person, because of health education given to the community through different medias, people, school and other implementing partner they have realized that HIV is acquired but when you take precaution you can be free from HIV.

Some community members are blaming those PLWHA who infect others intentionally they regard them as killers and they don't even want to support them in anyway, because of stigma people are not ready to disclose their status they continuer infecting others, so the community members are advocating to their fellow who are HIV negative to remain negative by taking precautions and those who are already infected to keep the Virus by themselves. They are highly appreciating the service given by health care providers, Peer educators, Home Base Care Provider, and Village Health Workers towards PLWHA, they have said that they will be ready to give further support to PLWHA so long they have disclosed their status to them such as to go for the drugs at the clinic, taking care with great precaution when they become sick and to support them psychologically. The study went into details to know if some of family members/anyone in the community know the sero status of those respondents.

Family members knows about HIV status among PLWHA

Apart from education transmitted in community through different Medias, in school, collage and during visits in the health facility still there some people who can not disclose their HIV status to anyone due to stigma, in this era of HIV, stigma and discrimination are the main cause of increased new HIV infection, so encouraging and advising PLWHA to share their status with their fellow/ family members should be an ongoing counseling. The study shows that 111 represents 92.5 percent are those whom their fellow/family members knows about their HIV status, 9 respondents represents 7.5 percent they haven't disclosed their status to their fellows neither family members. Table 4.10 shows the responses from the respondent involved in the study on the particular question.

Table 4.10 Family members knows about HIV status among PLWHA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	111	92.5	92.5	92.5
	No	9	7.5	7.5	100.0
	Total	120	100.0	100.0	

Source: Research findings 2015

a) Importance of informing family members about HIV status

This was intended to find out the importance for the family members to know about the HIV status of an individual, as the study shown in previous analysis is that when you disclose your status to some of your fellow/ family members , they will assists in many aspects even during the appointments when the client is not in the position of attending due to several reasons they can go for his/her drugs, many clients knows the importance of telling their family members about their status but still they don't disclose their status. The study shows that 119 respondents represents 92.2 percent are those who see the importance of telling the family mebers,1 respondent represents 0.8 percent doesn't see the need of telling family members about his/her HIV status. Table 4.11 shows the responses of respondents on the importance of informing family members about their HIV status.

Table 4.11 Importance of informing family members about HIV status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	119	99.2	99.2	99.2
	No	1	.8	.8	100.0
	Total	120	100.0	100.0	

Source: Research findings 2015

The social support to PLWHA from the community

In 1980s to 1990s when the mode of transmission was not clear to the community, the stigma rate was very high which lead to an individual once is diagnosed to be HIV positive not to disclose the information to anyone as the result transmission rates of new HIV infection increases. In the community where the individual living with HIV/AIDS were coming from there were stigma and discrimination to the extent that once the individual is diagnosed to have HIV was not regarded as a human being, they could not share utensils, clothing and even shake hands with him/her, they called them some discriminating names. In the health facility once the individual tested HIV positive they were used to isolate them in which this were traumatizing patients psychologically. And all this could have been contributed to the increase of new HIV infection and defaulting rate, but nowadays when the education about HIV/AIDS is widely disseminated the rate of stigma and discrimination among the community have decreased to the minimal level. These supports are seen from different clubs and HIV networks in which people are free to integrate with their fellow community members being HIV positive or HIV negative.

Study done by Noriza et al (2015) shows that social support is the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network. These supportive resources can be emotional, financial assistance, informational or companionship and also intangible. Social support can be measured as the perception that one has assistance available, the actual received assistance, or the degree to which a person is integrated in a social network. Support can come from many sources, such as family, friends, pets, neighbors, coworkers, organizations, etc. Those who receive social support will feel relaxed and loved. This study will discuss the support carried out by the NGO, Komuniti Cakna Terengganu (KCT), to HIV-AIDS sufferers. KCT was established through an initiative from some. The focus of this study is to examine social support for HIV-AIDS patients and is limited to the role played by KCT. The objectives of this study are to analyze the views of patients with HIV/AIDS who received social support and to identify the obstacles faced by KCT in continuing support for the group.

This study used the qualitative method with two techniques to get data; Focus Group Discussion (FGD) and observation. 18 respondents were involved in two FGD sessions.

The study found that all patients are satisfied with the support given to them be it spiritual, informational or intangible. The programs are very effective and should be continued. www.mcser.org/journal 1/5/2015. Thus, health care staff, community perceptions and support towards PLWHA is a main factor for reducing or increasing defaulting rate of ART among PLWHA. Due to stigma towards HIV infection among the health care staff, community towards PLWHA and stigma among themselves(PLHWA), if there will be no any intervention towards the perception and support all effort of fighting against HIV/AIDS will be of no importance, In our community when we support PLWHA in all aspects being, health, socially, economically and psychologically the rate of new defaulting , stigma and infection will be decreased because even those with HIV infection they will be in the position of protecting their fellow from infecting them intentionally.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.0 Introduction

This chapter provides a summary of the study, conclusion in the line with the findings established during the study, recommendations and policy implications. The details are provided as follows.

5.2 Summary

Based on the findings from the study assessed the role of peer educators on defaulter tracing and retention of PLWHA at Bunazi health centre, it can be concluded that the efficiency and effectiveness of peer educators is primarily dependant on the support from Government (facility staff, drugs and medical supply and infrastructure), Implementing partner (donors).

The facility dealing with peer educators should develop the way of motivating them so that they continue assisting PLWHA as they are all moving on the same way towards improving their health physically and immunologically.

The problem identified which are likely to constrain good adherence include lack of transport fee, stigma, traditional/faith believes, ill health, improved health status as well as altitude of health care workers and the community. Apart from the above identified problems, there other problems which might lead to difficulties in combating this problem of defaulter though there are PE at the facility, this problem of some of PLWHA they give wrong names, wrong address which become impossible for the PE to trace them, sometimes PE meet with challenges of other clients are living in the area were even by the aid of bicycle they have problem to reach them mostly during the rainy season (hard to reach areas), after they have reached the area according to the address name and address given by the client they found that no one knows that person

(wrong names and address) due to stigma. Other clients were reached through phones, vouchers for recharging also were provided by partners, this were seems to be easy way for PE in tracing those client but the problem of it was unreachable phones which could be due to poor/lack of net work, wrong number given by clients, uncharged phones due to lack of power of any kind being electricity or generator in their locality.

The identified problems can be mainly solved by stigma reduction among PLWHA and the community, because when you disclose you HIV positive status anyone around you might be in the position of assisting you, for example if family members know about the status of the individual they will try their level best to find the transport fee as they will be aware of the importance of drug adherence or even encouraging those PLWHA to join in groups with Income Generating Activities so that they may cover those transport costs. When family members are aware of the status of the individual they will reduce stigma by cooperating with those PLWHA as a result even when they become ill they will go for her/his drug, apart from that when family members are aware they will advice those PLWHA to attend to the clinic even if their health status is improved, also they will counsel the individual Living with HIV to continue taking drugs even if is driven by traditional/faith believes.

The last problem are within health care workers and community at large to change their altitude towards those PLWHA so that we reduce numbers of those who miss appointment , defaulters as well as those who drop out from the treatment.

The study advices PLWHA to avoid giving wrong names and address to the clinic, this brings some problems to PE /HBC to trace them/visit them they do this simply because of stigma because PE are known and once they see him/her at their place they will be known that they are HIV positive.

From the findings it shows that the rate of defaulting at Bunazi health centre before the introduction of peer educators were high, the community, pLWHA and staff at large they are highly appreciating the efforts put by the Government and implementing partners for the introduction of this important programme.

5.3 Conclusion

Based on the findings from the study assessed the role of peer educators on defaulter tracing and retention of PLWHA at Bunazi health centre, it can be concluded that the efficiency and effectiveness of peer educators is primarily dependant on the support from Government (facility staff, drugs and medical supply and infrastructure), Implementing partner (donors). From the study done it has concluded that Peer educators have performed their duty of tracing defaulters and retaining PLWHA at Bunazi Health Centre. The facility dealing with peer educators should develop the way of motivating them so that they continue assisting PLWHA as they are all moving on the same way towards improving their health physically, socioeconomically and immunologically, this will reduce burden among families, organization and Nationally.

5.4 Recommendations

In order to promote good adherence of ARV at Bunazi health center and Tanzania in general, the following are recommended:-

- 5.4.1 Health education about the stigma reduction should be disseminated among PLWHA, Health care providers and the community at large, because from the study it shows that many problems/factors for defaulting arises due to stigma. This knowledge will improve the health status of PLWHA and reduces HIV new infection among the community.
- 5.4.2 There should be established and organized guidelines for peer educators so that they may work under good atmosphere abiding to their Job description which explain into details their Roles and Responsibility
- 5.4.3 Training for Peer educators its content and duration of training is not adequate not addressing all challenges expected to be found in the field, they should make sure that all peer educators should be capacitated and be competent with their daily activities. Because from the findings it shows that PE does not perform their duty effectively because they don't have enough knowledge on attending their fellow PLWHA.

5.4.4 Peer educators programme should be adapted to all facilities with CTC so that may reduce work load through task shifting to peer educators.

REFERENCES

- Ann Intern Med, 2000. 133(1):21-30.NIH (2006) HIV Treatment Adherence Research, available [10.1111/j.1365-3156.2010.02514.x](https://pubmed.ncbi.nlm.nih.gov/2010.02514/)PMCID: PMC3060335 (www.ncbi.nlm.nih.gov/start) 20/4/2015
- Association of Journalist Against Aids in Tanzania 2008 The prevalence of HIV in Kagera region
- Bupamba et al. “Ambassador for adherence “provision of highly effective default tracing and re-engagement by peer educators in Tanzania. Eighteen International AIDS conference, Vienna, abstract MAOE0303, 2010
- Celletti F, Wright A, Palen J, Frehywot S, Markus A, Greenberg A, et al. Can the deployment of community health workers for the delivery of HIV services represent an effective and sustainable response to health workforce shortages? Results of a multicounty study. AIDS. 2010;24 (Suppl 1):S45–57
- Center of Disease Control and prevention. New hope for stopping HIV CDC 2011
- Centers for Disease Control and Prevention, New Hope for Stopping HIV, Atlanta: CDC; 2011.
- Facility Quaternary reports 2008/2009, 2009/2010, 2010/2011, 2011/2012, 2012/2013, 2013/2014
- Kwesigabo G, Killewo J, Nyaryenkungu K, Sandstrom A, Bredberg-Raden U, Walls S, Mhallu F, Biberfed G, Prevention of HIV-1 infection in Kagera region of Tanzania 1987-2000
- Main, D. S. (2002). Commentary: Understanding the effects of peer education as a health promotion strategy. Health Education and Behaviour, 29(4), 424-426. doi: 10.1177/109019810202900403

Mediterranean Journal of Social Sciences ISSN 2039-9340(Print) ISSN 2039-2117(Online)Copyright © MCSER-Mediterranean Center of Social and Educational Research www.mcser.org/journal 1/5/2015

National HIV and AIDS Health Sector Research and Evaluation Agenda (2011-2015) on, <http://grants.nih.gov/grants/guide/pa-files/PA-07-338.html> 21/4/2015

Peer education and HIV/AIDS concepts, uses and challenges; Geneva UNAIDS 1999

Peer Education and HIV/AIDS: Concepts, Uses and Challenges. Geneva: UNAIDS; 1999.

Rosen S, Fox MP, Gill CJ: Patient retention in antiretroviral therapy programs in sub-Saharan Africa: a systematic review. *PLoS Med* 2008, **4**(10):e298.

Sriranganathan, G., Jaworsky, D., Larkin, J., Flicker, S., Campbell, L., Flynn, S., Janssen, J., & Erlich, L. (2010). Peer sexual health education: Interventions for effective program evaluation. *Health Education Journal*, *71*(1), 62-71.

Standard operating procedures February 2012 the National ART program patient linkage, retention and follow-up in HIV care (SNAP 2012)

Thompson MA, Mugavero MJ, Amico KR, et al. Guidelines for improving entry into and retention in care and antiretroviral adherence for persons with HIV: Evidence-based recommendations from an International Association of Physicians in AIDS Care panel. *Ann Intern Med*. 2012;*156*(11):817-833, UNAIDS.

Trop Med Int Health. 2010 Jun; *15*(s1): 48–54. Doi; [Wiley-Blackwell, John Wiley & Sons](http://www.wiley-blackwell.com)

World Health Organisation (WHO): *Treat, Train, Retain. Task Shifting. Global Recommendations and Guidelines*. WHO, PEPFAR & UNAIDS; 2008:96.

World Health Organisation WHO (2003). Adherence to long-term therapies: Evidence for Action.

APPENDICES

WORK PLAN

Figure 2.3: WORK PLAN

Task to be performed	Year/month										
	2014				2015						
	Sept	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July
Proposal writing	■	■									
Proposal presentation and approval		■									
Preparation of units of study			■	■							
Pilot testing of data collection tools				■	■						
Revision of study methodology					■	■					
Hiring and training of data personnel						■					
Actual field work						■					
Data collection						■	■				
Transformation of data into software						■	■				
Preparation for analysis								■			
Data cleaning								■			
Data recoding								■			
Processing and analysis								■	■		
Report writing								■	■	■	
Report submission								■	■	■	■
Report presentation											■

Source: Researcher's construction: (Rwazo, MHSM 2013- 2015)

BUDGET

Figure 2.4: BUDGET

The cost for research work will be Tshs. 5,600,000.00 as shown in the table below.

ACTIVITY	COST
Proposal writing	200,000.00
Proposal presentation and approval	600,000.00
Preparation of units of study	150,000.00
Pilot testing of data collection tools	300,000.00
Revision of study methodology	200,000.00
Hiring and training of data personnel	500,000.00
Actual field work	1,670,000.00
Data collection	300,000.00
Transformation of data into software	100,000.00
Preparation for analysis	20,000.00
Data cleaning	20,000.00
Data recoding	20,000.00
Processing and analysis	20,000.00
Report writing	500,000.00
Report submission	500,000.00
Report presentation	500,000.00
TOTAL COST	5,600,000.00

Source: Researcher's construction: (Rwazo, MHSM 2013- 2015)

INFORMED CONSENT FORM (ENGLISH VERSION)

PRINCIPAL RESEARCHER: LEVITAS RWAZO

INTRODUCTION

My name is Levitas Rwazo Masters student in Health System Management at Mzumbe University. I am conducting a research on the role of peer educators in defaulter tracing and retention of PLWHA at Bunazi health centre in Missenyi District. I would like to know various things about what you know about peer educators, PLWHA and the importance of good adherence to prescribed treatment to PLWHA on ART.

PURPOSE

The study aims to identify the possible factors which might lead to the patient/client to default from the treatment, drop outs and the role of peer educators in tracing and retaining the at the facility. This will help the community, facility, district and the national to sensitize and develop some strategies/policies for strengthening peer educators programme so that the number of enrollment and retention increase while decreasing the number of defaulters and drop outs in which this will reduce drug resistance, opportunistic infection, bed occupancy rate/drug and medical supplies consuming rate, hence improved health status of an individual.

PARTICIPATION AND PROCEDURE

You are free to participate or not to participate in this research. I will question you about your knowledge, attitude and practice in HIV/AIDS patients/clients in relation to adherence to treatment. This interview may take you up to 30 minutes. In case you don't understand a question please ask me to clarify more.

CONFIDENTIALITY

All collected information will be kept confidential and your answer will be part of many other interviewees that your anonymity is ensured. I will not inform anyone about your participation in this research. Your names will not appear in any oral or written report of this study, only identification number will be used.

BENEFITS AND RISKS

There are no direct benefits or risk for you being part of this research, however your contribution will help the community, facility, district and the National AIDS control programme to design and develop appropriate information resources to help community effectively to recognize the importance of supporting PLWHA to adhere to their treatment.

CONTACT

In case you need further clarification or follow up regarding this study contact the principal researcher – Levitas Rwazo , Mzumbe University P .O. Box 1 Morogoro Tanzania, Mobile 0784835698/0759571405

Email address : rwazolevitas@gmail.com

AGREEMENT

I I have understood the foregoing the information. I have had to the opportunity to ask questions about it and any question that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a subject in this study and understood that I have the right to withdraw from the study at any time without any way affecting me.

Signature of participant.....

Signature of researcher

Date

RESEARCH TOOLS

QUESTIONNAIRE (ENGLISH VERSION)

Assessment of peer educators performance on defaulter tracing and retention of PLWHA at Bunazi health centre

QUESTIONNAIRE FOR GOOD ADHERER AND DEFAULTERS

Identification number of participant	
Name of the interviewer	
Date of interview	
Village name	

Please circle the number of correct answer

Social-demographic status

1. Gender 1. Male 2. Female
2. What is your age in years
3. Marital status 1. Married 2. Single 3. Widow/widower 4. Cohabiting
5. Divorced
4. Level of education 1. No education 2. Primary 3. Secondary
4. Higher education 5. Other specify
5. What is your religion
6. What is your occupation? 1. Peasant (self employment in agriculture)
2. Fishermen 3. Small scale business 4. Others specify
7. When where you diagnosed to have HIV for the first time?
1. 1-2 years past 2. 3-5 years past 3. 5-10 years 4. >10 years past
8. For how long have you been taking ARV? 1. 1-2 yrs 2. 3-5 yrs 3. > 5 yrs
9. Who normally gives the information about ARV adherence?
1. Clinician 2. Nurses 3. Peer educators
10. Are peer educators important in the management of PLWHA?
1. Yes 2. No
11. What are the roles of Peer educators? 1. Conducts health talks 2. Tracing defaulters

3. Encouraging clients 4. All of the above 5. Only 1 and 2
12. Have you ever missed your ARV doses? 1. Yes 2. No
13. If yes for how long?
1. Less than a week 2. Less than a month 3. More than a month 4. None
14. Is there any problem when you skip your dose? 1. Yes 2. No
15. Can you share your ARV with some else who is HIV positive? 1. Yes 2. No
16. Do you think ARV is good for you? 1. Yes 2. No
- 17 Why ARV is good? 1. Reduce viral load 2. Increase CD4 3. Reduce chances of
Opportunistic infections 4. All of the above
18. Do you think ARV can cause severe side effects? 1. Yes 2. No
19. Have you ever missed appointments? 1. Yes 2. No
20. If Yes why missed 1. Lack of transport fee 2. Ill health 3. Tradition/faith beliefs
4. Altitude of health care workers 5. None
21. Why do you fellow clients miss appointments? 1. Stigma 2. Lack of transport
3. Ill health 4. Weather (rain season) 5. When free from any infection
6. Traditional/Faith believes
22. How many times you missed appointment for the past 6 months? 1. None
2. 1 times 3. 2 to 4 times 4. More than 5 times
23. Have you ever experienced ARV side effects? 1. Yes 2. No
24. Do you remember and practice adherence commands? 1. Yes 2. No
25. What exactly reminds you on taking your daily doses? 1. Family members 2.
Wall note
3. Phone alarm 4. Reminds myself 5. Keep the drug near the bed
26. Do peer educator come to your place for follow up frequently? 1. Yes 2. No
Do you think there is a need of PE follows up? Why
27. Do some/all family members know about your HIV status? 1. Yes 2. No
28. Do you think there is a need of telling them about your HIV status? 1. Yes 2.
No

Why

Please give your suggestion/views on how CTC services (reducing defaulters, increasing retention and improving adherence) can be improved in our facility.....

.....
.....

THANK YOU FOR YOUR COOPERATION

QUESTIONNAIRE (ENGLISH VERSION)

Assessment of peer educators’ performance on defaulter tracing and retention of PLWHA at Bunazi health centre

QUESTIONNAIRE FOR PEER EDUCATORS

Identification number of participant	
Name of the interviewer	
Date of interview	
Village name	

Please circle the number of correct answer

Social-demographic status

1. Gender 1.Male 2. Female
2. What is your age in years
3. Marital status 1. Married 2. Single 3 Widow/widower 4. Cohabiting
5. Divorced
4. Level of education 1. No education 2.Primary 3. Secondary
4. Higher education 5. Other specify
5. What is your religion
6. What is your occupation? 1. Peasant (self employment in agriculture)
2. Fishermen 3. Small scale business
4. Others specify
7. What do you understand by term peer educator?
8. Mention the qualities of good peer educators
9. What does the term “peer educator is a role model” to their fellow mean?
-
10. For how long have you been working as a peer educator?

11. Do you think this job is of any importance in preventing new HIV infection and
Improving health status of an individual? 1. Yes 2. No If yes how?
.....
12. What are community perception concerning this programme?
13. Can you identify/mention main reasons to why clients do not turn up on the
Appointment dates?
14. Which means do you use to bring them back to the treatment?
15. What is your reaction against those who do not show up even after you have
followed/visited them?
16. Since you have started these services how far have you reached to bring clients
Back and retain them according to the target given to you for the past six
months.....
17. Which indicators are used to test you performance?
18. What are challenges do you meet in your daily activities?
-
19. Which strategy do you have so that you improve your work?
.....
20. Please give your views? Comments on how can this programme be improved so
that we provide a quality care/service to our clients

THANK YOU FOR YOUR COOPERATION

QUESTIONNAIRE (ENGLISH VERSION)

Assessment of peer educators performance on defaulter tracing and retention of PLWHA at Bunazi health centre

QUESTIONNAIRE FOR CTC/VCT STAFF

Identification number of participant	
Name of the interviewer	
Date of interview	
Position/Desgnation	

Please circle the number of correct answer

Social-demographic status

1. Gender 1.male 2. Female
2. What is your age in years
3. Marital status 1. Married 2 Single 3.Widow/widower 4. Cohabiting
5. Divorced
4. Level of education 1. No education 2. Primary 3.Secondary
4. Higher education 5. Other specify
5. What is your religion
6. What is your occupation?
7. For how long have you been working at this department?
8. What are you daily duties?
9. Which criteria do you use to term clients are lost to follow up or defaulter?
-
10. What do you think might be the reasons for clients to default?
-
11. Since the start of peer educator programme have you seen any difference in the trend
of defaulting and retention for the past 3 years?
12. Do you think this programme have any importance in your daily activities?

- 1. Yes 2. No, Why?

- 13. How was the magnitude of the problem before and after the introduction of peer educators programme?
- 14. How does peer educator know the clients needs to be followed up?
- 15. How do you monitor the performance of the peer educator?
- 16. What are indicators for good performance of peer educators?
-
- 17. What are your tasks for those clients who return after defaulting?
-
- 18. Do you have action plan for supportive supervision for per educator at the field?
 - 1. Yes 2. No If Yes what are your main focus?
 -
- 19. What are strength/challenges of peer educators Programme?
-
- 20. What is your way forward?/opinion
-

THANK YOU YOUR COOPERATION

10. Do PLWHA have the same value in the community as any other member of the community?

1. Yes 2. No How?

.....

11. As a community member what are your contribution in assisting PLWHA to adhere to their

 Appointments/Treatment

.....

12. What is your perception towards PLWHA?

.....

THANK YOU FOR YOUR COOPPERATION

Assessment of peer educators performance on defaulter tracing and retention of PLWHA at Bunazi health centre

INTERVIEWER’S GUIDE FOR STAFF, PEER EDUCATORS AND PLWHA (GOOD ADHERERER TO TREATMENT AND DEFAULTERS)

Identification number of participant	
Name of the interviewer	
Date of interview	
Position/Designation	

1. What might be the cause of Lost to follow up and defaulting from the treatment among PLWHA?

.....

2. Why do PLWHA decide to shift to another clinic without any notification from the mother clinic?

.....

3. Why do PLWHA decide to drop out from the treatment while they know the end results of Stopping taking ART?

.....

4. Is there any problem which might arise when there is poor adherence to treatment?

.....

5. Do you think this health policy of free health services to PLWHA has any importance?

1. Yes 2. No Why?

.....

6. What are your suggestions?

.....

THANK YOU FOR YOUR COOPERATION