TECHNICAL REPORT

Exploring Peer Mentor Retention in Tanzania

NOVEMBER 2017

This technical report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Delphina Ntangeki, Faridah Mgunda, and Katherine Fatta of URC, and Sarah Smith Lunsford of EnCompass, LLC through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. The USAID ASSIST Project is made possible by the generous support of the American people through USAID. Funding for peer mentor activities in Tanzania was provided by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through USAID.

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For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

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ABBREVIATIONS

ART	Antiretroviral therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems
CHMT	Council Health Management Team
CTC	Counseling and testing center
HCI	USAID Health Care Improvement Project
HIV	Human Immuno-Deficiency Virus
MOHCDGEC	Ministry of Health Community Development Gender Elderly and Children
NGO	Non-governmental organization
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PSM	Patient Self-Management
QI	Quality improvement
RHMT	Regional health management team
R/CHMT	Regional and council health management teams
URC	University Research Co., LLC
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Introduction

Peer mentors, expert patients, and other non-clinical community-based workers are increasingly relied upon to be a bridge between the HIV patient community and the health facility. In Tanzania, where there is a critical health workforce shortage, the USAID Health Care Improvement (HCI) and later the USAID Applying Science to Strengthen and Improve Systems (ASSIST) projects supported the implementation of a patient self-management model in Morogoro Region, starting in 2011. The aim was to improve ART uptake among people living with HIV (PLHIV). Trained peer mentors were engaged to reach PLHIV in the community and connect them to facility-based services and educate them on the importance of adhering to treatment. Two years following the conclusion of ASSIST support, it was found that some peer mentors had continued in their role, while others had stopped. The objective of this exploratory study was to examine why some peer mentors were retained.

Methodology

Qualitative interviews were conducted with 21 peer mentors, 15 of who were still working in the role, and 16 health workers/facility management. Interviews were conducted by USAID ASSIST staff in Swahili. Data were captured by taking notes which was then entered into an Excel spreadsheet and content analysis was performed.

Results

Peer mentors were motivated by wanting to help their fellow patients, which was viewed as the most important aspect of the work. Only those retained in the position were motivated by a positive experience with treatment at the facility. Reasons for ceasing as a peer mentor included transportation difficulties, need to care for sick family, lack of salary/incentives, and personal age/illness. One respondent reported poor treatment from facility staff as pushing her to stop working as a peer mentor.

Facility staff felt that peer mentors relieved some of their workload by taking on some paper work and health education responsibilities, and recognized that peer mentors had access to patient communities that facility staff did not. Facility staff perceived those peer mentors who stopped working as lazy or uncommitted. Other reasons cited by facility staff included not being adherent to treatment, not understanding it was a volunteer position, finding paying work, and lack of transportation.

Recommendations for improving peer mentor initiatives included offering incentives, providing training and job aids, and offering a workspace at the facility and uniforms or identification.

Conclusions and Recommendations

Helping other PLHIV motivated peer mentors to start and continue working. Tensions in the peer mentor-facility staff relationship were noted on both sides, which may negatively impact peer mentor retention, while positive experiences at the facility was a reason for encouraging PLHIV to work as peer mentors.

Recommendations include:

- Providing support to peer mentors, including financial incentives, providing basic needs, and encouragement to practice self-care
- Ensuring that peer mentors understand fully the voluntary nature of the position
- Building a positive peer mentor-facility staff relationship that is based on respect and recognition

I. INTRODUCTION

Expert patients, expert clients, peer mentors, and other non-clinical community-based workers living with HIV have been increasingly viewed as an effective means of linking HIV patients with the health system and the services they need. Expert patients can help patients on antiretroviral therapy (ART) gain self-management skills and overcome barriers to adherence (Decroo, Van Damme et al. 2012). Peer mentors supporting HIV-positive pregnant women in South Africa were found to improve relationships with their partners, reduce depression symptoms, and increase exclusive breastfeeding of infants, but did not positively impact treatment adherence during pregnancy (Richter, Rotheram-Borus et al. 2014, Rotheram-Borus, Richter et al. 2014). Shifting tasks from clinical to non-clinical workers like expert patients and clients, can create space for clinical staff to see more patients in the day, improving efficiency in ART delivery (Kyakuwa 2009). In Malawi, expert patients also felt valued by their role model position (Tenthani, Cataldo et al. 2012).

Tanzania has an HIV prevalence of 5.1% among adults age 15-49 (Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC) et al. 2013). The country faces a critical health workforce shortage (Kwesigabo, Mwangu et al. 2012), which can negatively impact the quality and patient-centeredness of HIV services.

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) project supported the Tanzanian Ministry of Health Community Development Gender Elderly and Children (MOHCDGEC) to improve quality of anti-retroviral therapy (ART) and prevention of mother to child transmission of HIV (PMTCT) services using collaborative approaches. In 2011, ASSIST, under its predecessor the USAID Health Care Improvement (HCI) Project, started to implement patient self-management principles in Morogoro region to improve ART uptake among people living with HIV (PLHIV). Peer mentors were engaged as it was expected their knowledge, skills, and experience would be effective in increasing ART uptake.

In this initiative, the peer mentors were considered as people with firsthand experience in living with HIV and were ready to support others with the same condition in building their confidence in improving adherence to ARVs, keeping appointment to schedule clinics and working with patients to develop self-management skills. By disclosing their condition, peer mentors gained the trust of patients. In doing so, they were communicating with new HIV patients on how to deal with daily life and HIV as a chronic disease. They discussed the illness with patients, and helped them to overcome feelings of shame, giving their own examples. Peer mentors have also helped with the patient-provider relationship, making a more comfortable environment for patients to talk. The peer mentors kept patients on their strict ART schedule by explaining the importance of taking ARVs as prescribed, improving patients' self-management skills.

In 2011-2013, ASSIST trained health care workers and peer mentors on patient self-management, providing them with materials e.g. pocket guide, playing cards and guide for developing goals. Health care workers were asked to follow a given criteria for recruiting peer mentors. The criteria included:

- PLHIV on ART,
- Readiness to talk about their status,
- Good adherence to ARV,
- Able to read and write,
- Reliable and trusted in the community,
- Receiving HIV care services and living in the facility catchment area, and
- Willingness to support fellow patients through education and sharing experiences on living with HIV.

The RHMT explained the voluntary nature of being a peer mentor at the beginning of the program to attract individuals who were committed to the work and would be more likely to remain engaged over time. To avoid duplication and costs, most of the peer mentors/expert patients involved in the initiative were already home base care (HBC) volunteers and trained PLHIV therefore patient self-management training was additional content.

Peer mentors work under health care workers who continuously give peer mentors education and updates on HIV care and support peer mentors when delivering health education to fellow patients. Peer mentors also assist health care workers in non-medical task (i.e. filing, triage, packaging Septrine, checking patient's weight, and escorting/guiding clients to other health facilities' sections/departments). Such activities helped alleviate the health care workers' workload and streamline facility operations.

In some facilities, facility management provided tea and lunch to peer mentors on duty and the health care workers provided services to peer mentors and their families when they got sick. This was an effective means of supporting peer mentors and motivating them to continue working. The peer mentors working in military health facilities were given allowances as a motivation.

Health care workers and districts management in Morogoro Municipal and District Councils appreciated the work of peer mentors in contributing to improving the wellbeing of people living with HIV by influencing their retention into HIV care in the facilities they are working.

Two years after the conclusion of support by USAID ASSIST, some peer mentors had stopped working while others had continued on in their role, some even going so far as recruiting new peer mentors. This case study sought to examine why some peer mentors continued in their work while others ceased.

II. METHODOLOGY

A. Study Design

We used qualitative methods to understand decisions to either continue or cease working as a peer mentor in Morogoro Region, Tanzania.

B. Sample

The USAID ASSIST Project trained 55 peer mentors. USAID ASSIST staff in collaboration with regional and council health management teams (R/CHMT) through health care workers organized and requested peer mentors who are also working with other non-governmental organizations (NGOs) in HIV care to participate in the interview. Health workers and management personnel working in the program areas who interacted with peer mentors were also interviewed based on availability.

We theorized that there would be some differences in experience based on geographic location, so we sampled both peer mentor and health worker/management interview respondents to ensure geographic representation in urban, rural, and semi-urban settings.

C. Data Collection and Analysis

Semi-structured interviews were conducted with peer mentors, and health workers and management staff by USAID ASSIST Project staff in Kiswahili. Interview topics included recruitment and training, motivation to begin and continue working as a peer mentor, reasons for ceasing working as a peer mentor, collaboration with peer mentors, and recommendations for improving peer mentor initiatives. Data were captured using notes which were entered into Excel for analysis. Content analysis was performed in Excel.

D. Ethics

Informed consent was obtained from all adult respondents. Data collection was for evaluation purposes only and was not considered research, therefore the activity was exempt from ethics review.

III. RESULTS

A. Sample Characteristics

We interviewed 21 peer mentors, 15 (71%) of who were still fulfilling their role (table 1). Our respondents had worked an average of 4.3 years as a peer mentor and all had performed other work while being a peer mentor. This work included business ventures (10, 48%), working as a home-based care volunteer (HBC) or community health worker (CHW) (9, 43%), farming or other agriculture endeavors (11, 52%), or worked in local government (1, 5%), though the majority (17, 89%) were not paid for this work. Most respondents were female (16, 76%) and were an average 47 years old. Just under half (10, 48%) were drawn from urban settings, followed by rural (8, 38%), and semi-urban (3, 14%).

We also interviewed 16 health workers/management staff, over half (10, 63%) were nurses and most were female (12, 75%). Respondents were equally from rural and urban settings (6, 38% and 7, 44%, respectively). Respondents had worked an average of 9 years in their current facility and had spent an average of 3.2 years working with peer mentors. See table 1 for all respondent characteristics.

Table 1: Peer Mentor and Health Worker Respondent Characteristics

Characteristic	**N (%)**
Peer Mentors (N=21)	
Sex	
Male	5 (24)
Female	16 (76)
Age (average years)	47
Geography	
Rural	8 (38)
Urban	10 (48)
Semi-urban	3 (14)
Currently working as a peer mentor	15 (71)
Duration working as peer mentor (average years)	4.3
Performed other work	21 (100)
Type of other work performed	
Business	10 (48)
HBC volunteer/CHW	9 (43)
Farming	11 (52)
Local government	1 (5)
Payment for other work performed (N=19)	
Cash	2 (11)
In kind	0 (0)

Not paid	17 (89)
Health Workers and Management (N=16)	
Sex	
Male	4 (25)
Female	12 (75)
Age (average years)	44
Geography	
Rural	6 (38)
Urban	7 (44)
Semi-urban	3 (19)
Cadre	
Nurse	10 (63)
Clinical officer	3 (19)
CHMT	2 (13)
Data clerk	1 (6)
Duration working at facility (average years)	9
Duration working with peer mentors (average years)	3.2

B. Peer Mentor Perspectives

Peer mentors had many reasons for taking on the role (table 2). Interestingly, peer mentors who continued working reported positive experiences in care as a motivating factor for continuing to work as a peer mentor, while this was not mentioned by those who ceased working as a peer mentor.

Table 2: Reasons for becoming a peer mentor

	Peer Mentors Who Continued (N=15)	**Peer Mentors Who Stopped Working (N=6)**
Positive experience with treatment	3	
Previous volunteer experience	2	1
Wanted to help	10	4
Vacancy	1	
Wanted to be a member of a PLHIV group		1

Peer mentor respondents indicated that they were recruited by URC (9), health facility staff (5), or PLHIV group members (7). All respondents reported receiving some training for the role of peer mentor. Training

topics included managing client files including completing appointment and peer mentor registers, tracking patients lost to follow-up, interacting with and providing health education to clients on self-management.

The most important aspects of the role as peer mentor overlapped with the dominant reason for taking on the role: helping people within their community. This was described as “bringing hope to HIV patients” (respondent 1) and “giving people hope to fulfill their dreams” (respondent 12). Helping fellow patients included providing education, raising awareness about the importance of HIV testing and remaining in HIV care for life, encouraging safer sex behaviors, visiting and taking ARV for bed-ridden clients.

Personal growth was noted as a benefit – respondents reported learning about HIV, managing patient files and other documentation, and interacting with and counseling other patients. One respondent indicated that being a peer mentor built her self-confidence and placed her in a position to support her son who was also HIV-positive (respondent 6). Earning income or receiving incentives was another benefit of being a peer mentor (4) as well as the prestige afforded by the role (1).

In spite of feeling like they made a positive impact in their work as peer mentors, six respondents stopped working as a peer mentor (four ceased in 2014, two ceased in 2016). One respondent moved and was unable to pay for the transportation to continue providing services. Another respondent (male, 44 years old, urban) stopped working as a peer mentor because he had to begin taking care of his sick wife. Three other respondents indicated that the lack of salary or incentives such as food presented a challenge, however there were some internal inconsistencies in these respondents’ remarks. One respondent, a 61-year-old female who stopped working as a peer mentor in 2014, reported that she received bicycles and other incentives which was a motivating factor, but when asked why she stopped working she said she had reached retirement and there were no monthly incentives as a peer mentor; she was also unwell which contributed to her decision to stop working. Another respondent (female, 52 years old) developed other health issues (diabetes and high blood pressure). She needed to move to paying work so she could pay for food and transportation so she could remain in care. Only one respondent reported mistreatment by health facility staff as a reason for ceasing working as a peer mentor. A 43-year-old woman from an urban setting who stopped working in 2016, shared that she was subjected to bad language and unfair treatment, including being blamed for disorganized files, by health care workers at the facility.

C. Health Worker and Management Perspectives

Health worker and management respondents agreed that peer mentors aided in managing client files, weighing patients, providing health education and support in adhering to treatment, and tracking patients who had missed appointments and others who were lost to follow-up. All respondents in this category agreed that peer mentors were helpful and contributed to reducing health worker workload. One health worker felt that the addition of the peer mentors had resulted in increased HIV testing and reduced self-stigma among PLHIV (nurse, female, age 42, semi-urban).

The services offered by peer mentors and health workers were viewed by many health worker and management respondents as complementary. Health workers were not able go to the homes of patients, while peer mentors were and functioned as a bridge between the health workers and community. One health worker, a 60-year-old nurse in an urban setting, valued the peer mentors’ experience living with HIV. Their experience was complementary to the clinical information disseminated by hospital staff, though it was necessary to “observe them when providing health talks so as to clarify some issues” (nurse, female, age 60, urban). Advising and supporting peer mentors in counseling fellow patients was also an important aspect of the peer mentor-facility staff relationship. Health workers also occasionally provided peer mentors with a drink or air time as a means of encouraging them to continue working. Giving priority to peer mentors and their families when they were sick while providing health care services, was an effective means of supporting peer mentors and motivating them to continue working.

When asked why some peer mentors had stopped working, health workers and management contended that those who stopped were lazy and were not committed to their fellow patients or the job. These peer mentors were also not adherent to their treatment, according to one health worker (nurse, female, age 46, semi-urban). Another reason suggested was that some peer mentors are not invited to all the seminars which was demotivating. Not understanding the position was volunteer or finding paying work were two other reasons for peer mentors to stop working as expressed by health workers and management. Logistical challenges, namely transportation, also contributed to peer mentors ceasing in their role.

D. Respondent Recommendations

Both peer mentors and health worker and management offered suggestions for improving peer mentor initiatives (table 3). There was agreement that financial and non-financial incentives, training and other continuing education, job aids, and a physical workspace should be offered to peer mentors.

Two health workers suggested that the number of peer mentors be increased to cover the ART clinic days and reduce the burden on the existing peer mentors and give the peer mentors time to explore other income-generating activities.

One peer mentor respondent who did continue working as a peer mentor (female, 51-year-old, urban) was the only peer mentor who recommended that peer mentor programs should not be dependent upon donor funding. She expressed that peer mentors, when they started, agreed to work as volunteers and should continue as peer mentors even after USAID ASSIST support had ended.

Table 3: Recommendations for Improving a Peer Mentor Program

Peer Mentor Responses	Health Worker and Management Responses
Regular and timely incentives (financial and non-financial, including transportation and food)	Financial and non-financial incentives (tea, transportation, air time)
Refresher training, seminars, other forms of continuing education	Training, workshops, seminars
Uniforms or identity cards	
Materials (bags, reporting form), tools (transport or air time to find patients lost to follow-up) and job aids	Job aids
Space for preparing and submitting reports	Space for preparing and submitting reports
Non-donor dependent resources	

IV. DISCUSSION

This report presents the findings from a qualitative exploration into why some peer mentors continued in their work after the end of USAID ASSIST Project support while others did not. Two years following termination of USAID ASSIST support of the peer mentor initiative, it was learnt that some peer mentors were still seen working alongside health care workers.

Both current and former peer mentors we interviewed were motivated by a desire to help their fellow patients, in keeping with other research (Hussen, Tsegaye et al. 2014). However, positive experiences in care was only mentioned as a motivating factor by those peer mentors who continued in their work indicating that it may play a role in retention. One former peer mentor did share that negative interactions

with health workers influenced the decision to stop working as a peer mentor. Tensions in the relationship between health workers and peer mentors can also be observed in the health worker and management perspectives that those who did not continue working as peer mentors were lazy and not committed. Respectful relationships between health workers and volunteers like peer mentors should be cultivated. While we theorized that there would be differences in responses based on geographic location, this was not observed in our respondents' perspectives.

Logistical and financial barriers contributed to six peer mentors ceasing in their role. Peer mentors who spend their time working in the facility have less time for income-generating or other activities, putting strain on other areas of their lives.

While not a key finding in our interviews, research among peer mentors in other settings has found that peer mentors can experience secondary trauma through retelling their story when counseling HIV-positive members of their community, indicating the importance of developing self-care skills among peer mentors (Dhlamini, Knight et al. 2012). Expert patients in Ethiopia leaned on their spirituality and faith as well as their family and social networks to mitigate the psychological and economic impacts of serving their fellow HIV patients. (Hussen, Tsegaye et al. 2014).

While we did not examine the relationship between peer mentors and facility-based improvement teams, it is possible that improvement teams played a role in improving retention of peer mentors. When health workers recognize the importance of the peer mentors, improvement teams may integrate them in their facilities quality improvement teams to provide their opinion on the quality and problems encountered by patients (both at the community and facility level) in the HIV care processes.

With only about 20% of the recommended human resources for health positions staffed (Manzi, Schellenberg et al. 2012), peer mentors can offer a means of distributing the work and supporting health workers to provide HIV services (Tenthani, Cataldo et al. 2012). Health worker and management respondents we interviewed agreed that peer mentors alleviated some burden on their workload and were an asset. The peer mentor activities were part of a larger self-management model while yielded notable improvements. In a period of 30 months of implementation of the initiative (April 2011 through September 2013) about 64% of PLHIV contacts received information, education and got experience from the peer mentors about self-management aspect of HIV and coping with daily life challenges. Also 87% of ART patients were documented as having good ARV adherence status; 95% had stable clinical outcomes (no loss of weight of more than 3kg previous month, no opportunistic infections, and had functional working status). Of new ART patients, 85% were confident they could manage their clinic appointments, take ARVs according to given instructions, and engage in income generating activities; 88% of PLHIVs did keep their appointments (unpublished data). These successes could also have contributed to the feeling of responsibility to contributing to the improvement of other patients' health and making the initiative more important.

Clear explanation by regional health management at the beginning of the program about the initiative being voluntary could enhanced peer mentors decision on whether to join or not to join the program. The motive behind was the sustainability of the initiative. In order to avoid duplication and costs, most of the peer mentors/expert patients involved in the initiative were already home base care (HBC) volunteers and trained PLHIV therefore Patient Self-Management training was additional content.

Recommendations to offer salary or regular incentives to peer mentors move these type of initiatives from volunteer services to formalized employment. Doing so may afford peer mentors greater legitimacy in the eyes of the PLHIV community (Kielmann and Cataldo 2010); however, other actions, such as providing an identification card or uniform as suggested by some of our respondents, may also aid in their acceptance. We did not examine the wider PLHIV community's perception of the peer mentors, so it is unclear whether the peer mentors' legitimacy was contested.

V. CONCLUSION & RECOMMENDATIONS

Two years after the end of USAID ASSIST support of a peer mentor initiative in Morogoro region, Tanzania, almost two-thirds of peer mentors continued providing services to their fellow patients. The motivation to help others existed across both those who continued and those who ceased in their roles, but a positive experience with treatment was only present among those who continued. Health workers were appreciated of peer mentors who not only reduced their work loads, but were able to tap into both their social networks and their experience to gain access to PLHIV and encourage their uptake and retention on ART. Based on the experience in Morogoro, we make the following recommendations:

- As health facilities increase their reliance on volunteers, especially in settings with a high patient-provider ratio such as Tanzania, programs should look into covering some basic needs to support those who are ready to volunteer. Peer mentors should also be encouraged to practice their own self-care.
- Peer mentor initiatives could be institutionalized by including any incentives as a budget item. Conversely, peer mentors should understand and agree to be volunteers.
- Facility management and health workers need to create a conducive and supportive environment to retain peer mentors. Incorporating peer mentors into the improvement team at the facility may increase retention. Additionally, space in the facility to complete paperwork and uniforms or nametags would give peer mentors recognition and legitimacy.

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