The Challenges and Prospects of Community based antiretroviral treatment Service: The case of Akaki-kaliti health facilities in Addis Ababa

A Thesis Submitted to Addis Ababa University School of Social Work in Partial fulfillment of the requirement of Masters of Social Work

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Declaration

I, Arest Mamo declare that the "research titled the Challenges and Prospects of Community based ART Service the case of Akaki-kaliti health facilities in Addis Ababa" is submitted to partial fulfillment of the requirement for Master's Degree in Social work complies for the regulation of the University meets the conventional standard for originality and quality.

Arest Mamo Abdi _____

Approved By

Advisor_____ Signature_____Date_____

Internal examiner _____ Signature_____Date_____

External examiner _____Signature_____Date_____

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Abstract

The research is aimed to assess the Challenges and prospects of community based antiretroviral treatment in Government health facilities at Akaki-Kality Subcity, Addis Ababa. The study used qualitative research method and case study as a research design. Primary source of data has been gathered through twelve in-depth interviews where Participants of the study Stable patients who were enrolled in community based ART service; seven key informants who were ART Nurses and medical director from each health facilities. One FGDs and observation has been conducted. Purposive sampling technique has been used. Thematic data analysis was applied. The finding of the study revealed that community ART service encompasses with an activities like health assessment, education and counseling, adherence support, peer psychosocial support, drug refills and referral linkage. The participant responded that community based ART is cost effective and relived the workload of the provider and saved their time, has decreased frequent visits to the clinic, felt comfort, moreover the group members has been empowered and involved in different saving and credit schemes and also different social support activities; However, challenges mentioned by participants were fear of Stigma and discrimination, luck of trust on quality of the service, the issue of confidentiality and shortage of human resource. The findings of this study will have an implication for further research, policy makers and planners who work on the area.

Key words: Community based ART, task shifting, decentralization

ACRONOMYS

AIDS	Acquired immune Deficiency Syndrome
ART	Anti-retro viral treatment
CAG	Community ART refilling group or Community ART Adherence group
CBART	Community Based Anti-retro Viral treatment
CHW	Community health workers
DSD	Differentiated Service delivery
EPHI	Ethiopian Public Health Institution
FHAPCO	Federal HIV Prevention and Control office
HAPCO	HIV Prevention and Control Office
HEP	Health extension Program
HIV	Human Immune deficiency Virus
IAS	International AIDS Society
MOH	Ministry Health of Ethiopia
MSD	Mahaberehiwot for social development Organization
PEP	Post exposure Prophylaxis
PCAD	Peer lead Community ART distribution
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PREP	Pre exposure Prophylaxis
SSA	Sub Saharan Africa
UHEW	Urban health extension workers
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organization

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CHAPTER ONE

Introduction

1.1 Background of the Study

Human immune deficiency Virus (HIV) infection continued a prime health problem all over the world. More than 88 million people have become infected and 42.3 million have died with AIDS related diseases since the start of the epidemic; (UNAIDS 2023). Globally by the end of 2023, 39.9 million people are living with HIV and1.3 million become newly infected; (UNAIDS2023).

Ethiopia among Sub-Saharan countries as the most affected and shares a great amount in 2023 an estimated 605,235 People living with HIV/AIDS and a total of 10,063 AIDS related deaths have been accounted. Despite there is a progress on HIV mitigation there is still new infection about 7,428 in 2023 (EPHI2023).

The nation has adopted the global 95–95-95 goal i.e. diagnosing 95% of PLHIV, providing ART for 95% PLHV and 95% of PLHIV get virally suppressed) targeted by 2025 is part of strategies designed to eliminate HIV/AIDS epidemics by 2030. (UNAIDS, 2021) Moreover, world health organization recommends treating all HIV Positive individuals with antiretroviral drugs on the onset of diagnosis. (WHO.2016) because immediate treatment with ARV drug reduces morbidity and mortality of people Living with HIV (PLHIV)

Ethiopia has witnessed an immense improvement over the past two decades in reducing HIV prevalence and AIDS related deaths with here is a free antiretroviral treatment provided in all government health facilities.(FHAPCO 2018). The number of clients who are receiving ART has

remarkably increased from time to time with rapid scale up of ART program throughout the country. However in countries with a limited resources would be difficult to accommodate all the PLHIV's need on health facility based program unless and otherwise different mechanisms is implemented.(WHO,2017).

Ethiopian government adopted differentiated care service delivery on ARV treatment to reduce the burden on health facilities. Community based antiretroviral treatment which was started since 2018 in Addis Ababa and Gambela as a pilot where the prevalence rate is high. Community based ART service delivered with the help of one assigned health professional or with Peer Lead PLHIV so that they can get their ART drugs at community level in their locality with their preference. (PEPFAR 2020)

The study attempts to explore the existing service delivery; Challenge and prospects of Community based ART in Akakikaity Subcity Addis Ababa where Community based ART delivered with the help of one assigned health professional or with Peer lead community ART delivery.

1.2. Statement of the Problem

UNAIDS, Reports indicated about 30.5 million people were accessing antiretroviral treatment globally (UNAIDS 2023). It is with all possible responses including decentralization, task shifting of HIV care and treatment services. Despite the increasing availability of antiretroviral treatment, many individuals who are living in resource-limited set ups continue to face significant barriers to accessing and adherence to treatment and lifelong retention. Community based ART aims to address these challenges but the implementation and sustainability hindered by various factors. (WHO, 2020).

Tom Deccro et al (2013) studied that Community-based antiretroviral therapy programs can overcome barriers to retention of patients in resource limited countries in sub Saharan African countries and revealed that community based antiretroviral service made more accessible and affordable to the patient, they suggested however some challenge need to be overcome such as community based program has to be owned by embedded by community, there has to be supportive environment to ensure task shifting to lay cades and long-term vision of from government and international donor.

Similarly Bemelmans etal (2014) conducted a study on community supported models for care on PLHIV in sub-Saharan African countries, it was assessed from patient and health system perspectives resulted to benefit both by reducing the burden of the health system and the patient in conclusion separating ART delivery from clinical consultation would benefit both the patient and the program. The successes of community ART models depend on support and resources, flexible and reliable drug supply, access to quality clinical management, strong monitoring system and supported by lay worker cadres.

Rasschaert. F,etal (2014) conducted a study on assessment of community ART therapy Group models in tete, Mozambique, has witnessed that Community ART group (CAG) models resulted active patient involvement and empowerment also cost effective and time saving, it created certainty ART access and mutual peer support resulting in better adherence to ART treatment, it also generated reorientation health service toward community and strengthened community actions.

Balcha etal (2011) conducted a research on barriers of antiretroviral treatment in Ethiopia in Oromia region has found on his study that financial constraints like transportation, sociocultural

factors like lack of community support impended adherence to treatment, is also a barrier to retention on the program. Disclosure, community support and decentralization of ART to primary health care unit to enhance retention in care and treatment.

Assefa *et al.,* (2011) has conducted on the outcome of antiretroviral treatment program in Ethiopia he has found out retention of patient in care as a major challenge and varied from place of they have studied they suggested that programs that provide Comprehensive service can address the social, economic and contextual barriers which hider regular follow upon impact on patient retention in care. on the other hand Belay *et al*., (2021) studied on patients' preferences for antiretroviral therapy service provision As the result that patients' preference of ART services depended on their characteristics and values in getting the service has great impact in achieving treatment success and retention in care for better quality of care and treatment.

Previous studies focused mainly on treatment outcomes and overcoming the barriers of antiretroviral therapy; they did not focus on routine implementation of community-based antiretroviral treatment models. As far as my reading, there is no research conducted on challenges and prospects of community-based antiretroviral treatment in Ethiopia. Thus, this study attempts to examine the challenges and prospects of community-based ART services in the case of Akaki Kality health facilities in Addis Ababa, Ethiopia.

Objective of the study

1.3.1 General objective

- The general objective of the study is to assess the challenge and future Prospects of community based ART program in Akaki –kality Subcity, Addis Ababa, Ethiopia..

1.3.2. Specific Objective

1. To identify the community based ART services in Akaki sub-city in government health facilities.
2. To assess the effectiveness of community based ART service in Akaki kality Subcity health facilities.
3. To identify the challenges of community ART service/program in Akakikaliti Subcity
4. To assess the future prospects of Community based ART service in Akaki kality Subcity.

1.4. Research Questions

1. What are the services of Community based ART are provided in Akaki Kality Subcity health facilities, Addis Ababa?
2. What is the effectiveness of community based ART services provided in Akaki kality Subcity, Addis Ababa?
3. What are the challenges Community based ART services in Akaki kality Subcity, Addis Ababa?
4. What is the future prospect of community based ART Service in Akaki kality Subcity, Addis Ababa?

1.5. Significance of the Study

The study may help to identify the community role in Prevention, care and treatment of HIV and shows how the community ART would be helpful for policy makers, planners who are working in this area. It insights that Social workers play a crucial role in mitigating HIV and increasing effective allocation for resources on ART scale up using public health approach. The government will also benefit from this study as the findings will help to mobilize the community in preventive HIV infection and associated negative influences. Further, the study will have

immense significance to future researchers, as it will reveal the challenges and opportunities of Community Based ART Services.

1.6. Scope of the study

The scope of this research is limited with time and geographic matters. This study have assessed Community based ART models with adult PLHIV who are on antiretroviral treatment and enrolled in community based ART (HEP-CAG, PCAD). The study focused on PLHIV who are in ART enrolled in the group and attended for at least eight ART refilling sessions and ART nurses, Pharmacist, health extension workers. Thus, the study covered bordering area of Addis Ababa those who reside in Akaki Kality sub city selected health facilities. The researcher used individual those who reside in Akaki Kality community receiving ART in the area.

1.7. Limitation of the Study

The Study mainly emphasizes small scale implementation of Community based ART models CAG and PCAD and mainly concentrated on implementation, a challenge and future opportunities was assessed. Though, the area of the study is limited in one Subcity Akaki kality the rest sub cities in Addis are not included.

1.8. Conceptual Definitions

- **Stable patients:** Stable patients "are those who have received ART for at least one year and have no adverse drug reactions that require regular monitoring, no current illnesses or pregnancy, are not currently breastfeeding, have good understanding of lifelong adherence and evidence of treatment success (i.e. two consecutive viral load measurements below 1000 copies/mL). In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts

above 200 cells/mm3,an objective adherence measure, can be used to indicate treatment success." (WHO,2016)

- **Adherence** according to WHO "the extent to which a person's behavior – taking medications, following a diet and/or executing lifestyle changes – corresponds with agreed recommendations from a health care provider.''(WHO,2016)
- **Viral Suppression:** defined having less than <_1000copiesof HIV virus per milliliter of blood.(WHO,2023)

1.9. Organization of the study

The study structured in to five different sections starting from introduction. also general back ground of the study ,statement of the problem, objective of the study, the resarch scope, significance of the study, and also the limitation of the study included in chapter one. the second chapter reviews both conceptual issues explains the definitions of ART, community based ART models conceptual framework and experiences of CBART of different countries benefits, challenges and prospects of Community based ART. Chapter three explains description of the study, research design, sampling techniques, method of data analysis; Chapter four elaborates finding of the study and chapter five and data presentation, discussion, conclusion, Social work implication and recommendations.

CHAPTER TWO

LITERATURE REVIEW

This chapter will examine concepts and perspectives pertaining to community based antiretroviral treatment service delivery that is differentiated by two approaches, focusing on the effectiveness of community based ART, challenges and experiences of research conducted in Africa countries.

2.1Antiretroviral Treatment

Antiretroviral treatment is a combination of three drugs used to treat HIV infection. It works by inhibiting the virus to replicate in human body. The treatment regimen for HIV patient called HAART (Highly active Anti-retro viral therapy) it is designed to supress the virus to undetectable level and improves the immune system even though it need lifelong treatment. The drug used for preventing Mother to child transmission of HIV(PMTCT) when provided to the mother and infant for preventing the child to be infected . In addition, ARV drugs also reduce the transmission HIV among sero-descordant couples and for the people who are exposed to HIV (post exposure prophylaxis (PEP) and Pre exposure prophylaxis. (WHO, 2016)

ART has essentially improved the treatment for HIV and markedly decreased morbidity and mortality caused by HIV infections. Studies shows that there no known cure yet for AIDS still under research to find the cure for HIV/AIDS (Ginenus etal, 2019)

2.2 Differentiated Care

Differentiated care for HIV is a client based approach where it adapts the service with the preference of different group among people living with HIV. It reduces burdens by providing

differentiated care and treatment tailored to the Client. Therefore; the health system can relocate resources to PLHIVs' need. It provides an opportunity for the client who are stick to the treatment and for those who find difficult to initiate ART and stay in care with the suppressed viral load due to access to treatment barriers. (International AIDS Society,2016)

2.2.1 The need of Differentiated ART delivery

The health system is under lots of pressure therefore, ART delivering system will have to be re-examined. On the other hand to enhance the health system efficiency and out comes, Differentiated ART Deliver (DSD) Improves the quality of care and access to treatment of PLHIV and also supports "treat all" all positive people with recommendation of WHO. In order to achieve the required viral suppression in ART service delivery is initiation, retention in care and adherence. To attain the goal to reach 95-95-95, although there are about25 million PLHIV is on ART the treatment coverage has to be increased in order to end AIDS by 2030. there for its time to deliver differently based on the need of the client (IAS 2015).

2.2.2 Models of differentiated ART delivery (DSD)

Differentiated ART delivery is categorized in to four i.e., facility based, out of facility based, healthcare managed and client managed ART group. The first one is facility based ART refill model the client get refilled with the medication without getting clinical consultation and by pass all the clinical staff. Such as Appointment Spacing and fast track refill models in Malawi. The second one is Out of Facility based Model where both clinical consultation and ART drug refill provided outside the health care facilities. The model include community pharmacy, outreach model and home delivery (e.g PODI model in DRC, CDDP in Uganda).The third one is

Healthcare managed group model healthcare workers mange the group where the medication provided in group within the health facility or out of health facility such as Adherence clubs in South Africa, Teen clubs in Swaziland, MACs in Kenya).the forth one client managed client themselves mange the group get the drug refilled for themselves outside the health faculties for instance CAG in Mozambique and CARGS in Zimbabwe.)(IAS 2016)

2.2.3. The Four building blocks of DSD

The building blocks are the foundation of the models, which provides location for **where** question, **who** is providing care for service provider? **When** is care provided implicate (time of visits and frequency, **what** is provided (service package, drug) in differentiated ART delivery.

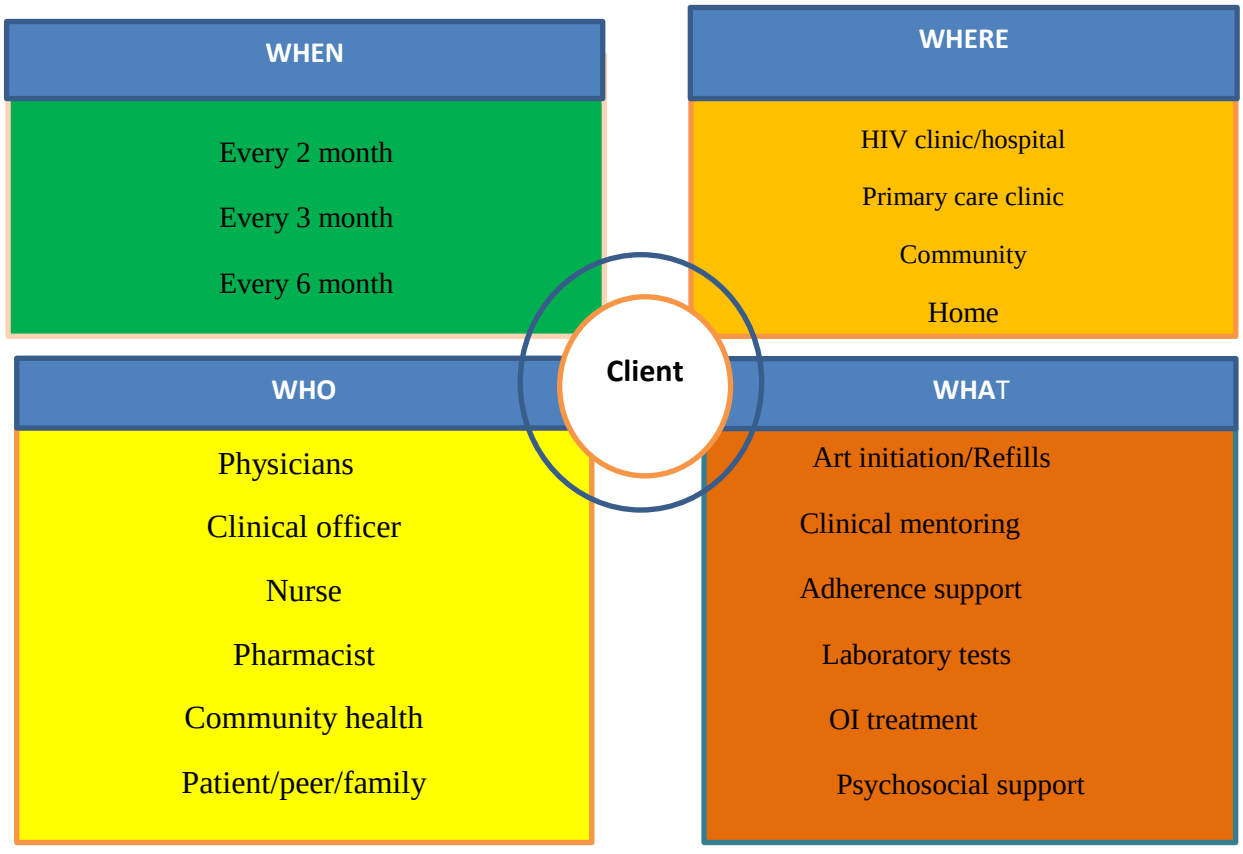

Figure 1 the building blocks of differentiated service delivery adapted by International AIDS society

2.3. Differentiated service delivery in Ethiopia

Ethiopia has decentralized and shifted the task ART delivery from hospitals to health center and from physicians to nurses provide initiation and ART refill. The patient had to come for general health assessment and ART refill every three month. The service was only facility based rather to differentiate. based on WHO recommendation 2016 test and treat all the situation urged that FMOH to decide to pilot differentiated service delivery and started appointment spacing as one option the patient could get their ART refill every six month continued had launched community based ART to CAG and PCAD has adopted started to implement models in full scale, urban Health care worker managed (UHEP) Community based ART has been piloted in Addis Ababa and Gambela since of 2018(PEPFAR, 2020)

2.3.1 Health Extension Professional Managed Community ART refill group

Health extension professional managed community based ART group was piloted in Addis Ababa and Gambella using urban health extension professionals (UHEP) and continues to scale up and working all over the country. This model uses health extension professionals (HEP), who have roles in HIV testing and other care provisions among the package. CAGs are self-forming groups comprising of stable clients on ART living in same locality that have a shared understanding. Each group member contains six to ten individuals'. The CAG members share experience about living positively with HIV, and are empowered to offer and receive peer psychosocial support and follow-up. (MOH, 2020).The group members, with the help of health professionals, they select team leader to coordinate communication between group members and health extension professionals. The drug refill every three months each CAG will have one community refill in between health facility visits that will happen every six months. Clients can

be referred or return to health facility at any points in the cycle for any issues arises (HOPE Project,2020)

2.3.2 Peer Lead Community Based ART distribution (PCAD)

The peer lead community based ART distribution (PCAD) groups are self-forming PLHIVs members who are stable patients living in the same locality. the group members turns to pick up ARV at health facility and distributes, among the other group members in the community.(Nowell,etal,2017) In PCAD they manage their own health and take action with the support of community and facility based health workers and get clinical evaluation and lab monitoring with their schedule. The group member select peer leader to coordinate communication among group members and health workers to get ongoing adherence assessment and support at community level. The group member share experience among them on how to live positively with HIV and empowered to offer peer psychosocial support and follow up with the help of health professionals. The peer leaders get coached by the health workers to conduct adherence assessment and monitoring of other event among other groups. Clients informed by health works to return at any time between the schedules if they feel to get to the health facility. the health workers identify clients who live same community link to peer leader so that they can join the group. (HOPE project in Ethiopia 2020).

2.3.3. Eligibility Criteria for Community based ART group

According to WHO requirement Community based ART (CAG/PCAD) is applicable for those who are stable patients “as those who have received ART for at least one year and have no adverse drug reactions that require regular monitoring, there is no current illnesses or pregnancy, who are not currently breast feeding, have good understanding of lifelong adherence and clients

who have evidence of treatment success (i.e. two consecutive viral load measurements below 1000 copies/mL). In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 200 cells/mm3, an objective adherence measure, can be used to indicate treatment success." The following PLHIV who are on AR can enrol in community based antiretroviral models. Such as Clients who are 18years of age, who consent to participate in UHEP CAG or PCAD, have received ART for at least one year and have no adverse drug reactions that regular monitoring and still first regimen, have no current illness or pregnancy and or currently breastfeeding, have good understanding of lifelong adherence, have evidence of treatment success and current viral load measurement below 1000Copies/ml (HOPE project Augus2020)

2.4. Health Belief Theory

There is a variety of health behaviour theories constructed with preventive stand point towards the disease mind. The design of most of these interventions models and theories adapted from different disciplines. (Glanz et al, 2014). Behavioural scientists working for US Public health service developed health belief model in 1950s and remains today is one of the most widely applied theoretical models and used by health professionals and psychologists. (Rosenstock, Strecher, & Becker, 1988).

Health belief model originally developed to explain peoples' participation in programs to detect disease and their behaviours in response to diagnosed illness. The health belief model predicts whether and why people take action to prevent, detect, or control health conditions. The model applies to behaviours with the potential to reduce risk of developing a disease as well as the effects of existing diseases (e.g drug adherence)(GodfreyH1952)

Health belief Model (HBM) was developed to address the behavioural problems that evoke health concerns. it postulate the probability of an individual of engaging in health behaviour is determined by his/her perception. The model organizes and assess individual behaviour in relation to their health conditions with the following six contracts: Perceived susceptibility (individual's perception risk of becoming ill, realizing for unwanted outcome); Perceived severity (individual's beliefs about the seriousness of health conditions and the potential consequences) perceived benefit (individual belief that good thing that could happen from undertaking that specific behaviours) Perceived barriers (individual's difficulties and cost in performing the recommended behaviours); Cue to action (exposure of factor that trigger for an action) self-efficacy(individual's confidence to perform the new health behaviour).

The six health determinants identified by HBM provide useful framework for designing long and short term health behaviors (Galnz, 1995) Health Belief model has been applied in diverse context, from chronic disease prevention to health education and promotion to evaluation of the effectiveness of community based interventions.

2.5Experiences on CBART

2.5.1. African Based studies

2.5.1Experiences of Médecins SanFrontières (MSF)

Médecins SanFrontières is a pioneer organization to start Community based ART and developed continuum of strategies ranging from health service-driven to client driven options is used to optimize long-term ART delivery. it implemented on eight African countries such as the Democratic Republic of the Congo, Guinea, Kenya, Lesotho, Malawi, Mozambique, South Africa and Zimbabwe different strategies have now been applied to scale up community based

ART. Each of the strategies used separate clinical consultations at the health facility by a trained nurse or doctor from the dispensing of ART (refills).

MSF works with local networks of people living with HIV to establish community ART distribution points, bringing medication delivery closer to patients' homes, free of charge. These distribution points are managed by people living with HIV who are trained to provide ART refills, adherence support and follow-up of basic support and follow-up health assessments The experience was ART delivery is provided by a lay cadre or patients, either in-group or individually, at a health facility or in the community; thus, it is no longer linked by space or time to the clinical consultation. These strategies generally target stable patients on ART. while there is no agreed definition of "stable" in this context, patients generally are considered to be stable. (UNAIDS,2015).

2.5.2. Sub-Saharan Africa

Tom, *et al*., (2013) Community based antiretroviral therapy programs to overcome barriers to retention of patients and decongest health services in sub-Saharan Africa. According to them, they evidence that Task shifting along with community participation has the potential to address the workforce gap, decongest health services, improves ART coverage ,and to sustain retention of patients in care the evidence supporting different models of community based ART in sub-Saharan Africa was reviewed. in Uganda and Kenya community health workers or volunteers delivered ART at home in Mozambique people living with HIV/AIDS self-formed community based ART group to deliver ART in community.

These Community based ART programs made treatment more accessible and affordable. on the other hand they suggest that to achieve some major challenges community program need to

be driven and owned in the communities and the other one there has to be enabling environment to ensure task shifting to lay staff like PLHIV and finally, commitment of national and governmental and international donors is required, Exploration of cost effectiveness and sustainability to ART models is needed.

2.5.3. Specific Country Evidence

The other evidence obtained on community based ART, Tete-Mozambique on stable patient participated ART provision peer support through Community ART groups (CAG).Tom, Freya, Barbara, Daniel, and Nathan (2014) assessed the evolution of CAG model implementation. they found that counsellors supposed to monitor the group and eligibility criteria according to the patient needs the expected output from the CAG the benefited on saving cost and time, improved treatment outcomes, model offered to them that there is mutual adherence support and protective environment, developed health seeking behaviour and improved awareness on HIV/AIDS, decreased stigma. They concluded that the CAG model concluded that empowerment and better treatment outcome.

Vandendyck *et al*. (2015) evaluated Community ART group(CAGs) in Nazareth Clinic rural Lesotho, a facility in rural Lesotho. In CAG stable patients take turn to collect their antiretroviral treatment. among 596 stable patients 199(33%) had joined CAG. one year retention among CAG members 98.7%.they suggested that being the member had reduced their time effort money spent to get monthly refill; induced peer support, enhanced adherence, Socioeconomic support empowered members to deal with stigma .resulted feeling of relief or comfort .health workers confirmed that there is increase openness about HIV about workload reduction.

.2.6. Effectiveness of Community based ART services

Community Based ART (CBART) overcomes the challenge related to both ART initiation and retention. Strategies like decentralization and task shifting have shared the workload over large number of health facilities and different levels of medical workforces. It aims also to decongest health services and sustain adherence for patients over long term and increase the capacity of the ART to increasing case loads.(Tom,etal,2013)

Studies assessed the reliability of community based ART with separated ART Clinic to clinical consultation. And presents its benefits, it has divided to client and to health system perspectives. The major success of community based ART delivery is reducing financial and time associated with frequent clinic visits.it encourages community based peer support, the social interaction social support created among them improved their adherence to treatment involved them to additional accountability mechanisms to ensure continuity and quality of care. (Ware etal,2009, Bemelmas.etal 2014) the other one is health system outlook which reduced clinic contacts required for clinically stable patients and refocusing resources toward managing sick patients with complex clinical problems is s key objective, with perceived reduction of staff workload and improvement in quality of care and program (Tom Decroo. etal2013)

2.7 .Challenges of Community based ART

There are two main challenges of CBART (Tom, *et al*., 2013). As per their study, they have described that patients refused to involve in Community ART program, due to stigma. It has been suggested that support and involvement of CHW in HIV care reduced stigma. and being part of peer groups has been found to lessen the perception of social stigma. Second, task shifting and community engagement may come at the cost of lower quality of care. the other one is task

shifting to community health workers and PLHIV is restricted by the level of knowledge and skills required to exert defined medical tasks Though the result of community based models that bring care of population that would not otherwise have had access should not be matched with the result of conventional care.

The most significant indicator for quality of care for a patient with advanced AIDS is survival. Provision of ART will always come first when compare helpfully with no treatment, as this is the only effective clinical intervention for reduction of mortality among PLHIV. this was demonstrated in Uganda where CBRT program implemented without scheduled routine clinical visit led to reduction of mortality among PLHIV, and their dependent HIV with uninfected children, that otherwise would have had difficulty in Accessing HIV care (Mermin, *et al*., 2008).

The accomplishment of community ART models depends on sufficient, reliable support and resources, including a cadre of lay workers, a flexible and reliable medication supply, access to quality clinical management and a reliable monitoring system for patient care (ideally containing viral load). The models also require on-going evaluation and further adaptation in order to reach more patients who are at high risk of loss to follow-up (UNAIDS, 2015). Thus, Community-based service delivery has been a central part of the response to HIV. To meet the UNAIDS targets to end the AIDS epidemic by 2030, adapting ART delivery systems to meaningfully include community-based services will be indispensible. These community systems must be resourced and scaled up, but accomplishing scale requires more than that: it demands a transformation in how community-based services are linked and integrated with health systems.

Conceptual Framework

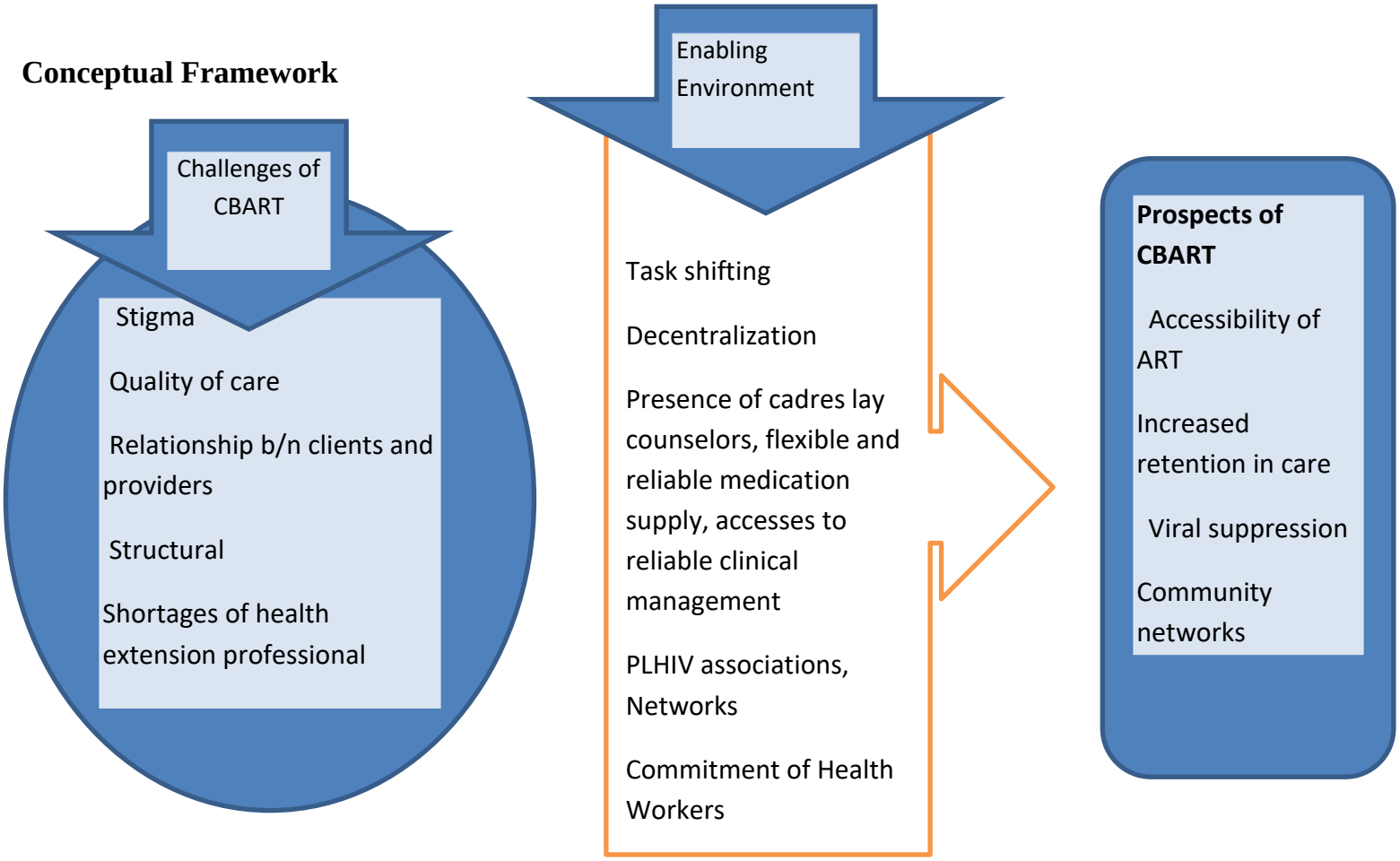

Figure 1.Conceptual framework

Sources: Adapted from (Tom *et al.*, 2011 and Yihalem *et al.*, 2021).

The conceptual framework includes the challenges and prospects of community based ART that also included service provision, players or involved persons and data collection system. The challenges are provider-driven developments of health services and health environment challenges including investments in health service.

CHAPTER THREE

RESEARCH METHODOLOGY

This section of the research elaborates about philosophical stance, research design, sources data, and sampling techniques, methods of data analysis, quality assurance and ethical consideration.

3.1Research Paradigm/Philosophical stance

Researchers in qualitative study embedded on philosophical stance to decide on the issue and bring their personal set of belief on the study (Creswell 2007) Social constructivism as a view guides the study emphasizing individual understanding of the world and develop subjective meaning of their experience, meaning is directed to the object or things. The meaning varies and leads the researchers have to look for the complexity of views rather narrowing of meanings to few ideas, always subjective meanings. (Creswell, 2014)

Considering the nature of social constrictive perspective, the researcher draws the following points that influenced the study participants discussed carefully on the challenge and prospects of community based ART services in a given area, and secondly it allowed participants to express their feelings and understand there situation, challenges which they are facing regarding of being HIV positive, involving in Community ART services and the data collection were flexible and the participants expressed their feelings without any blocking of their ideas.

3.2. Research Design

A research design is a setup of parameter for data collection in manner that aims to combine applicability to the research purpose with economy procedures Creswell, 2009). The study used qualitative research method been employed in selected health facilities where community based ART are being implemented. It mainly focused in describing on the characteristics of Community based ART in Adds Ababa and service getting in Akaki Kality Subcity in particular.it also characterized with cross-sectional study design According to Creswell (2012) points out that cross-sectional study design is applied when the researcher needed to collect data at one point at a time.

According to Kumar Case study in one of qualitative exploration to an in depth, intensive study of phenomenon, which requires personal observation and explores, institution, social unit, community or any group.(kumar,2006).in addition, case study deals with the process that takes place an intensive investigation of a particular unit under consideration. it studies also the behavior pattern in a given unit. Furthermore it allowed the researcher to get holistic and meaningful characteristics of contemporary phenomenon of real life event desires to understand complex social phenomenon(Kotari1995,Yin2003) Therefore the researcher explored and have got detailed information on challenge and prospect of community based ART.

3.3. The Study setting

The study carried out at Akaki kality which encompassing a total area of 118.1 km2 and an estimated total population of 255,384.(Ethiopian statistics authority2022 projection) .The sub city located at the southern part of the capital city bordered by Bole ,Lemikura and Nifas Silk sub cities. The study is conducted in a health facilities there are five health centers and northern west part of Akaki Kality Sub City and one hospital ie. Tirunesh Benjing Hospital. The researcher used qualitative approach that is focused with subjective assessment of implementation/service delivery, challenges and future prospect of community based ART program in Akaki-Kaliti Sub-city, Addis Ababa. Mahaberehiwot for social development organization (MSD) is one of a local implementing partner working on Family focused HIV care and treatment. The local implementing partner provides technical and logistic support in implementing ART models in collaboration other stake holders in the Subcity.

Community based ART group refill (CAG) and peer-lead community ART delivery (PCAD) implemented in all government health institutions in the Subcity in one hospital named Tirunesh bejing, Akaki, Saris, Kaliti, Gelan and Delfrea Health centers. For the purpose of the data collection focused on high load health centers has been used i.e. Saris health center with people on ART 1600, kality health center 1611 and Akaki health center 1538.(AAHB October report 2016 EC)The data which was found from Akaki Kality Subcity HAPCO there are a total of 6463 people currently on Anti-retroviral treatment of which 106 of them are in Community based group17 Group in (CAG) and 34 Peer lead ART groups (PCAD) are formed and accounts a total of 312 group members which is around 5% people living with HIV are in community based group in the Subcity source (MSD Report on March2024)

3.4. Sampling Technique

Krueger and Neuman (2006), stated that the main purposes sampling technique in qualitative research is to gather specific cases, events, or actions that can clarify the depth understanding of a certain phenomenon. The researcher used a purposive non probable sampling technique to select potential participants, the item for the sample selected deliberately by the researcher or when the researcher is mainly interested in the result from individual(David&Robert,2007)Non probability sampling technique used People living on HIV(PLHIV) who are on ART and Community based group member and residing in Akaki sub city are the primary participants and key informants who are working in health centers and hospitals , HAPCO in the sub city and other concerned offices has been interviewed with prepared semi-structured interview guide.

3.4.1. Sample size

The study used total of 25 participants, twelve in-depth interviews and seven FGD from 312 CAG/PCAD group members who were attended more than eight group sessions. And also there were six key informants who are working in a Subcity offices and health institutions. The sample size determined by on the basis of theoretical data saturation which (the point in data collection when new data no longer bring additional insights the research questions. (Mack, Woodsong, Macqueen, Guest & Namey, 2005)

3.5. Participant's inclusion Criteria

Participant's selection criteria of PLHIV who participated in the study are

1. PLHIV who are taking antiretroviral treatment, (ART) and who are Stable.

2. Participants who's Age is 18 and above

3. Participants who are a member of Community Based ART (CAG/PCAD) lead for two years or eight group session.

3.6. Methods of data Collection

The source of data used in the study is primary source data. Such as, interview, focus group discussion, and observation have been used to elicit in-depth information regarding the issue under the study. Secondary sources data were reviewed from different sources. the data collection process of the study described as follows:

3.6.1. In-depth interview

An In-depth interview was conducted for People living with HIV (PLHIV) whose age 18 and above. Face to face interview was conducted. 15-45 minutes spent for each interview, in quite place where a convenient place selected to the participants. The study used semi structured interview guide with an open ended questions to understand the issue from the participant perspective. Besides, As Creswell (2007) stated open ended questions will better allow the researcher to listen the perspective of participants than the question form closed ended one. The interview was applied for 12 PLHIV who are taking ART and a group member of CAG/PCAD from different health facilities in Akakai kality Subcity.

3.6.2. Key informant interview

There were a total of six key informants who were from Subcity HAPCO, and ART Nurses and urban health extension nurses at Healthcentr and woredas level. Face to face Interview was conducted with prepared semi structured interview guide as a tool of data collection got I got

information about services on community based ART and also challenges and prospects of community based ART.

3.6.3. Focus group discussion

The study used focus group discussion the ideal each group of focus discussion is 6 to12 participants, because as stated if a group is too small, one person in group would dominate, if it's too big it may be difficult to manage the group and get reliable information Stewart et al. (2007) Therefore, in this study, FGD has been conducted for one group which had seven (7) members in the group. One of the group members was as a moderator for the discussion conducted among the group the researcher was guiding the discussion accordingly. The members in groups were all PLHIVs taking ART and involved on Community based ART (CAG/PECAD) from health facilities in Akakikaity Subcity.

3.6.4 Observation

Observation conducted with prepared check list while participants interacting in CAG, PCAD group sessions, I have observed the physical set up, the situation of the clients, the level of interaction among them and with health extension nurses and peer leaders during their drug refilling session.As Creswel(2007) stated, contexts are important for understanding what the participants would say ,it is essential to understand the context beside the participant address. Furthermore, the observation served as an additional technique that complement the information obtained through interviews and documents review.

3.6.5. Document review

The researcher has reviewed documents like implementation manuals on UHCAG/PCAD, assessment tools, reports ,logbooks found from health centers and Subcity Health office, Community based ART log books, assessment similar documents, annul, reports have been reviewed to assure the comprehensiveness of the study.

3.7. Methods of Data Analysis

The data has been collected through qualitative methods; And analyzed qualitatively through non-numerical examination and interpretation of data for the purpose of discovering underlying meanings and patterns of relationships (Nowell, et al., 2017)). Hence, the data collected from informants or participants through observation, in-depth interview was transcribed and coded. The information obtained through written notes and audio records was carefully listened and categorized to determine the common themes. Thus, four major themes were formed which are the first one is identifying service of community based Antiretroviral treatment, effectiveness of community based ART services, challenges of community based ART and prospects of Community based ART. The result Observation, the interviews, and reviewed documents supports and are in line with research objectives and are thematically analyzed in order to answer the research questions.

3.8. Quality Assurance

The quality of the study enhanced with the following employed mechanisms. First the researcher used appropriate methods of data collection instruments which are consistent with research type and perspective. Second developed appropriate data collection protocols, which brought the required data matches to the objective of the study. As(Babbie, 2008,),suggested that credibility

is assurance of whether the qualitative data that was collected is a true picture of what is being studied the researchers intended to employ flexible research methods or multiple methods of data collection which so called method of triangulation. This is to explain about a particular concept from different perspectives which can assure credibility of the data. in addition, the researcher engaged with participants and had prolonged time of attachment in order to get a true picture of the study. Furthermore, peer debriefing of a study conducted with the colleague experts of research methods, those are out of research group, to get constructive reflection on the issue is a supportive means to assure credibility of the issue under the study.

3.9. Ethical consideration

The ethical considerations has been taken in to account are the following major issues. Primarily on approval of letter from School of Social work, Addis Ababa University to communicate concerned offices. Secondly, in social research most ethical issues such as protecting participants from harm, securing informed consent, and right to privacy has been considered. In line with the above points, for informed consent a great attention was given. Before the data collection starts, the participants were informed about the purpose and objectives of the study. Every participant voluntarily participated in the study requested to give written consent after the explanation of research objectives and goals. They were informed as they have free choice in deciding whether to provide the required information or not. Likewise, the issue of confidentiality has been given a serious attention. There was no naming of the individual, which means that the participant remained anonymous throughout the study. Therefore, there is no any attempt that threatens or harms the participants' confidentiality.

CHAPTER FOUR

Findings

In this chapter the finding of the study will be presented, there are four major themes and divided in to sub themes. the first one is services delivered on community based Antiretroviral treatment, effectiveness of community based ART services, challenges of community based ART and future prospects of Community based ART will be discussed.

4.1. Characteristics of research participants

The characteristics of research participants were about12 Community ART group members participated through in-depth interviews, Six ART providers, (Health Officers, Nurses) participated in key informant interviews, FGDs incorporated of both members of community ART groups (CAG) and Peer lead Community (PCAD) group members.

Table 4.1.1 Socio-demographic characteristics of research Participants

No	Code	Sex	Age	Marital Status	Religion	Education level	Sources of income	Years taking ART for
1	001	M	60	Married	Orthodox	2th	Unemployed	13yrs
2	002	F	50	Married	Orthodox	2th	Factory worker	17yrs
3	003	F	40	Married	Orthodox	8th	Employed	14yrs
4	004	F	37	Single	Orthodox	illiterate	Self employed	6yrs
5	005	F	46	Widowed	Muslim	5th	Self employed	13yrs
6	006	M	57	Single	Orthodox	5th	Employed	7yrs
7	007	M	41	Married	Orthodox	2th	Employed	5yrs
8	008	F	40	Married	Orthodox	9th	Employed	17yrs
9	009	F	38	Widowed	Protestant	9th	Employed	15yrs

10	010	M	62	Married	Orthodox	Diploma	Employed	12yrs
11	011	F	61	widowed	Orthodox	2th	Unemployed	15yrs
12	012	F	85	Widowed	orthodox	illiterate	Retired	16yrs
13	FGD-01	F	35	Widowed	Orthodox	4th	Self employed	13yrs
14	FGD-02	F	40	Widowed	Orthodox	8th	Factory worker	14yrs
15	FGD-03	F	43	Married	Muslim	illiterate	Self employed	5yrs
16	FGD-4	M	50	Married	Muslim	4th	Factory worker	8yrs
17	FGD- 5	F	40	Married	Orthodox	10th	Unemployed	7yrs
18	FGD -6	F	50	widowed	Orthodox	illiterate	Self employed	17yrs
19	FGD-7	F	46	Widowed	Muslim	5th	Self employed	13yrs

Participants who are involved in Community based ART (CAG/PCAD)(March 2024)

Table 2. Data presentation on Key informants

No	KII	Sex	Age	Education	Position	Marital status
1	KII.1	F	55	BSC degree	Subcity HAPCO Head	Married
2	KII.2	F	35	BSC degree	Akaki kality HC	Married
3	KII3	M	38	BSC degree	Kality HC	Single
4	KII4	F	35	BSC nurse	Saris HC	Married
5	KII5	F	28	Masters	MSD	Single
6	KII6	F	25	Diploma	Kality HC	Single

in this section all the participants profiles has been examined such as sex ,age, Marital status, Religion, education, their sources of income and years on Art treatment also presents. As indicated above background information in the table of resarch participants who have been involved in the interview were 25 and are regarding gender compositions six of them are Male and the rest nineteen are females. the age group of participants it falls between 25 up to 85 . Regarding marital status five of them are single, eight of them are widowed and the rest 12 are married regarding their religion as indicated 11 of them are orthodox Christian and 2 of them Muslim and the rest one is protestant.

4.2Community based ART Service provision

4.2.2 Participants' situation receiving the Services

All participants in in-depth interview and FGD has described they have been on ART and all of them are stable they do not have serious health issues and spent for some years since they started antiretroviral drug. Most of them are active workers employed and self-employed.

> *Client 001one said that I have forgotten the day I knew my status because it was very long time and am familiarized on taking the drug. I only remember it while I go to ART clinic for lab checkups but here in the community distribution we discuss even beyond our sickness. The other responded that (code 002) said that I only remember while I meet group the drug refill time because we as group are like families we discuss beyond our assignment.*

4.2.1 Community based ART service implementation process

Key informants from the study responded about the services provision and how community based ART started in their facility respondents explained about the process of community based ART: Community based service delivery on Anti -retroviral treatment with two existing models

one with urban Health extension supported group (UHA_CAG) or the other peer lead group. The service has been started in the Subcity at high client loaded facilities and continued to other by now all the facilities are performing the service in all health centers. the respondents on key informant added that, The health professionals or ART providers in the clinic following the procedure do the first initiation to the client based on the inclusion criteria so that they could get the service at community nearby, they adjust their appointment date prescribe the drug. the respondent added lastly that pharmacist pack and label the drug. The group leader or the Health extension nurse collect the drug from pharmacy distribute to the group with the place they agreed. Each of them (the provider, pharmacist and the health extension worker or Peer lead) has tracking books where the drug distribution performed at community ART distributers (Urban extension nurses or peer leaders) client assessment and distribution of their drug distribution health assessment check list.

Key informants have responded about how the service provided to the client;

> *KI 01 reported that the provider in facility do the client initiation for stable clients and based on the inclusion criteria the mapping with the client after getting their consent using assessment check lists. they use the eligibility criteria as Stable clients, whose age is above 18 are selected will form the group Community ART refilling Group(CAG) as self-forming group formed in the health facility where the health extension nurse distribute the drug doing the health assessment.*

The other KII participant Code (004) stated as follows

> *"We provide Anti-retroviral treatment to the client as one treatment and care option for stable clients with suppressed viral load based on the inclusion criteria provided, in order to minimize their frequent visit to the clinic. After getting the*

consent from the client we make an adjustment to their appointment so that they can take ART drug on same day."

The other KII06 informant responded that *KII03 said that "we provide service community the first one initiation from whom are in conventional care to involve them as group when they come to us self-forming group a minimum of 5 to 10 so they can get to know each other and come at their appointment and we let them to choose where suitable place to get their drug for they can easily take their medication nearby to their living area during distribution adherence counseling is provided, discussion experience sharing also conducted."*

One participant on the in depth interview said that

"I have joined CAG group with the initiation of health professionals. I work as volunteer in the community and also a group leader to distribute the drug to my members. I am stable and I provide awareness in the community for people like me so the nurse at the clinic oriented me that to for the group and create CAG we did that so we are eight in group we take the drug every three month and we are all stable."

Community based ART include some service components during drug refill, adherence support provided among the group, psychosocial support or peer support and education and peer counseling, health assessment ,experience sharing among the group. Moreover they are involved in different economical support activities like saving and credit among them and referral and linkages to get different socio economical services which is provided during drug refill.

4.2.2Adherence support

Adherence support provided for the patients while they meet to take their drug, the provider assess the client adherence and also peer support, they use some reminders systems, it's all they

share during their group meeting, and home base visits helped the individual to retain in the treatment. The peer leader does adherence assessment and link to health facilities if any health issues arise. *"I have joined the group with initiation of the community volunteer, she supports me so much with my sickness, and told me because I am stable so I can join the group. We are six in group and we gather at her house monthly having tea and coffee, we discuss on out how to take the drug, about safer sex, on how to take our drug, side effect of the drug, wife also taking ART drug after I got tested for HIV. The experience I got from my group member made me to discuss openly with my family."*

on the other hand participants 002on FGD *said that "we got all the service we got our ART drug, got medical assessment from health extension nurse , counseling about the drug, we share experience among our group, we discuss about drug interactions".*

Disclosure is one of the issues raised to the family or to whom very significant to the members has witnessed that they have disclosed to their family because they have realized that by disclosing he have benefited a lot. The respondent said on code 08 said that;

> My *family didn't know my status while I used take my medication though the Nurse always advise me on benefits telling to my family. Since I joined the group I have got the courage to tell my family. We had abstained from sex for a long time because my wife has denied. Ours level of viral load status very minimal and suppressed. The nurse has told us that the level of the virus in our body has been suppressed so can my wife can have safer sex because our GOD father advise us to stay together. My children all know about our HIV status they support me very much. We discuss openly with our family.*

4.2.3. Education and counseling

Education and counseling is provided to the client by nurses or peer leaders related to their health so that they can cope up with their life and adhere to the drug. They share their life experience among them and Helps the client to understand the importance of treatment adherence.

> *Participant (007) said that "I meet the group two times in a year, we gather in a group with the assistance of our group leader and community health extension nurses. We are five in number first we discuss health issues on our health and share to health extension nurse, if we have some issues to solve among ourselves it can be financial or other then we discuss on our health issues with the nurse."*

4.2.4. Health assessment and drug refill

Drug refill one the main and final task after assessment and education and counseling session they refill the drug to each client based on the label on the written on package one of the group leader from research participants(004) responded that;

> *Being an HIV positive and also I work as a volunteer in the community supporting the needy who are HIV positive. My group member chose me as a group leader so that I can coordinate and take ART drug to them, we are six in number. I collect drug from the health center distribute to them at a place we agreed to meet every three month.*

4.2.5. Peer Psychosocial Support

Peer to peer psychosocial Support exhibited in both CAG and PCAD group members during peer support the group share valuable information about their medication. Peer support fosters sense of belonging and the member who may feel isolated during the treatment

> Participant code 007 said that *while "I meet my group I feel relieved. on the contrary, every time while I come to ART clinic I feel that someone may notice that am taking HIV drug so now I come here only two times a year for laboratory investigation and medical consultation because I am very stable, sometimes I forgot that I am HIV positive what reminds me is when I come to ART clinic, being in a group made me feel at ease".*

On one hand peer support improves adherence to treatment because group members who maintained and adhere to their ART regimen is an encouragement to others and share experience to other how they managed the side effects of the medication *"Before I was coming to health facility every month but now I come to health facility only once , we have monthly contribution like "ikkub" we collect it while we meet to take our drug and some body from the group in need, the same goes like that and we are very close to each other to share our problems. The other participants said that*'' *Our group leader call us group member a day before our appointment to collect our drug, we come here at the place where we agreed every three month to get our drug and if we have any compliant. The organization (MSD) provides us some materials like we got some times face mask, sanitizing materials*. the other participants add that group peer leader added that'' *we are six in a group the members are all struggling for life as I am the group leader we are very attached to them they call me other than our appointment. We are the same we are on the same status we are families".*

4.2.6. Referral and linkage

Community base ART do referral linkage back to the clinic if there is any health issues arises and refer to them they can get social services to different associations and NGOs GOs so they

can get the social support they need. Clients who do not show up for drug distribution they are traced timely by peer leader and community volunteers.

4.3. Effectiveness of Community based ART service (CAG/PCAD)

Participants on FGD and interviews has responded on how effective community based antiretroviral treatment as they compare to the facility based ART. They provided points on how they chose community ART such as being involved in the program has reduced frequent visits to the ART clinics, its cost effective, participant felt comfort while getting refilled with ART drug.

4.3.1. Reduced frequent visits to the clinic/health center/hospital

Being involved in community based antiretroviral treatment group has gave them relief from frequent visits to the health facilities *"I knew my status in 2000 in E.C because of my illness and I have started Anti- retroviral treatment at Zewditu hospital treated stayed for some years and transferred me to Akaki health center which is near to my place because of the location the hospital was far I wake up in the morning at 4 to reach there and get treatment. I will no longer worry about waking up early going far the my peer lead will bring me at home because I won't go far because of my leg due to last car accident happened to me five years ago.''*

4.3.2. Cost -effectiveness

Community based ART reduced the work load of health providers and also transportation cost for the patients while they come to the clinic, Participants stated that they have benefited being involved in the group of saving time and also minimized cost of transportation.

> *KII4 said that Community ART models helped the health provider to provide the service tailored to the client we used to take more time doing clinical consultation with our client even if they are stable. But now they do not need to come to the clinic*

unless they feel sick to come to check up because of the peer leaders or the health extension nurse distributes their drug at community at their place.

Regarding cost and time off for work Participants on interview said that

I won't cost no more for transportation the health extension worker always brings me the medication in the community where we agreed to meet 45 years old the other respondent I don't need to ask permission from my supervisor at every ART clinic appointment my peer leader brings me my medication at my place I won't worry any more. the other participant on in-depth interview *reports that Before. I was taking from health facility I come to the health clinic monthly so that I cost for transportation now I come to health facility two times a year. and I get my group in the community with no cost. I feel very comfortable with my group to collect from them. Our group leader collect from health center and distribute to us. It's very accessible near to my home and feels safe because people will not see me every time at ART clinic.*

One of the respondents in FGD responded that:

I used to bring my medication from hospital which is far from home they changed to take from Health center which is a bit far and now I take easily around my home and I don't need to worry about traveling cost and recalling my appointment date peer leader call me on the day of the distribution sometimes if I don't make it to meet my group she will bring me at my place.

4.3.3 Group interaction and feeling comfort.

We used to go to the health facility to take our medication since we started CAG the medication the service itself come to us and we feel comfortable we discuss on our problems to therein the group.

> *I feel very comfortable taking my medication from my peer and among my friends I almost forget my sickness we talk about more on our problems while receiving my drug. We discuss about the medication side effects doses, said one of CAG members.*
>
> *I feel good we share information experiences to each other I just understood that not only me was HIV positive so there are other people who share like me. I am very close to my group members we share information, we talk about anything we want other than about life and challenges.my friends are very supportive. Taken from FGD 005*

Participant's II from KI stated that CAG is very necessary and supportive for client whom are stable and who fulfills CAG requirements, because it provides them a support for group and makes them very interactive during every CAG session and also the medication is accessible by the health extension worker or peer leaders.

4.4 Challenges Community based ART

Participant in in-depth interview and FGD has responded on major challenges in receiving Community based ART Services, those were less acceptance and commitment of the program, fear of stigma and discrimination, the issue of confidentiality, expectation on some sort of support among clients, luck of trust on the quality of the service, shortage of urban health extension workers to deliver the service.

4.4.1 Less acceptance and Commitment to cascade the service

Community based ART is implemented in collaboration with international organization along with Ministry of health and other stakeholders; however it was not easy to accept the program and as one option model. they said that there are a lots of office work load to accomplish so that the health professionals in the interview complained about the burden of paper work to be filled in ART clinic Some respondents among ART providers said that as far as we do the routine assessment and drug refill preparation got complained despite it minimizes the work burden in the health center has many record book and paper works to be filled and accomplished some of them preferred rather to continue with traditional care and treatment.

KII participants responded that there is less commitment among the providers and health extension nurses in the facility to cascade the service for the reason inadequate orientation given about the program, secondly staff turnover or rotation and providers understand and comparison of option less monitoring so that some CAG and PCAD group been dissolved and regrouped due to less follow up from the provider and all team.

4.4.2 Fear of Stigma and discrimination

Participants responded that they have fear of stigma even if they disclosed with their families and some people they know they fear someone may know their HIV status at their workplace, or neighborhood. Fear of stigma the group member because they share their status from their place. One of the respond stated that

> '*I work at tea coffee shop if someone knows from other than my group member I fear that i may loss my customers may never work there. As 45 years participant responded. the other one client 002 said I liked taking the drug refill with my group but don't want be recognized at community so preferred to take my drug out of my community''.*

4.4.3. Confidentiality

The help of health professionals with Community ART refilling group chose their group members most of them know each other from their life experience , However, they doubted their status and their secrecy would be out of their group so they has always the issue of privacy raised frequently among the group. Some of the participants mentioned they fear that Confidentiality might be breached while they get refilled their drug at the community distribution site. The other point which was raised during FGD preferred to take their drug out community they are taking at facility fearing needing their privacy. "*We were eight when we start drug refilling among the group now we are five three of them left the group because fearing of their status might be shard to other people. Participant 10 from CAG member and the other respondent said while I meet my group during drug refilling time I feel so unease some body may know my status".*

4.4.4. Expectations of Economical Support.

Every client who is involved in CAG or PCAD has been provided with sanitary materials such as soap, gloves and masks while they come meet the group especially during COVID pandemic from Mahabre Hiwot Social Service development organization, however there has been some kind of expectation raised beyond among the client to be enrolled in the group ''*KII clients responded they have been asked if they provide them with money or other materials to be involved in the group. on the other hand FGD respondents said I prefer the program to be strengthened and continued, I expect that the government bodies support us like income generating activities because most of our group members are at risk of financial problem. I wish they support us."*

4.4.5 Luck of trust on quality of the service

Participant on key informant said that some clients raised the issue of trust by clients on Community based ART services because client fear that they will be out of from the facility they May not return back to the facility . Participant 09 said that "*I thought we would not return back to health facility for the service now I realized that i take the drug every three month once in the community and six month at facility".*

4.4.6. Shortage of health extension workers

There are limited numbers of health extension workers compared to the area and made the program to run so early in the hospital there is no health extension worker but with their initiative the group is running the service using nurses from Mahabre Hiwot implementing partner working supporting the hospital.

4.5. Prospects of Community Based ART (CAG/PCAD)

Community based antiretroviral treatment cascaded in collaboration with international partners has made significant effort to expand the access to ART across the country. As Key informants stated that there are enabling environment for the program to sustain all Activities have been monitored with health bureau and HIV office in the Subcity work together and conduct joint supervision and every activity are monitored and evaluated. on one hand, the system such as Task shifting as one of as an activity has been shifted from doctors to nurses at community level so that community volunteers and HIV experts run the activities because health professionals are engaged in other life threatening issues.

> *KII one of the nurse said that I have been in maternity leave for more than three months for that I didn't worry about my patients which I follow might default, or lost*

from the treatment because during my absence as most my clients were linked in community based ART are refilling their drug at community level it really lessens the burden.''

The other Respondents from HAPCO said that *community based ART is a government concern in order the relive the burden of health institutions has been taken as one major task for health extension worker which is also found in HIV prevention and care treatment package. it has been monitored and evaluated jointly by our experts jointly from health bureau and HAPCO and concerned NGOs.*

Respondents from FGD community volunteers and health extension works at community level

All respondents said that clients who are engaged in community based ART do not miss their appointment because of the system if they miss they can be traced easily. Because we communicate them at least once in a week the designed program helped them to so they can be traced. the group leader know their situation before their appointment time because they communicate key informant said that:

KII 6 community ART has there is no almost lost to follow client who are engage in CAG or PCAD because they only traced contacted at early time. the group cohesion among them helped no one to be lost from the treatment, relations to each other they gather not only to they discuss about their health matters, they talk about their social problems and they help with each other, Responds on with FGD interviews they just responded on the prospect they said everyone in our group know that they are taking the drug for themselves they are very awarded, as I am the group leader they call me. Everyone is responsible the program will sustain as far as the support and follow is provided.

Majority of key informants responded that, the clients/patients who are stable are giving them gratitude because most of them stable patients come here only to collect their drug so they are thanking us for being involved in the program so that they can collect their drug without coming to the health facility, and in addition they discuss about their drug the side effect by themselves share experience with each other. on the other hand, being involved in community based ART group allowed them to act further three CAG group have started saving while they meet they save 50 birr each and the money they save and spend it for coffee and tea while they conduct meeting to take their drug, the other group take loan inform who needed it and it revolves.

CHAPTER FIVE

Discussion, Conclusion and Social work Implications

5.1Discussion

The Purposes of the study is to assess challenge and prospects of community based antiretroviral treatment in the case of Akaki kality Subcity on the service provision in selected health facilities, with the qualitative research method the finding discussed in the previous chapter. In this chapter the researcher tried to compare the finding with other studies conducted in Africa and other countries.

Community based antiretroviral treatment service provided in their facilities with two model options that urban health extension worker assisted Community based group (CAG) and the other one is peer lead (PCAD) where they distribute ART for stable patients who gave consent. Its self-forming group where they can access their drug refill closer to their community with their preference. Similar experience exhibited by Médecins SanFrontières applied in eight African countries that ART delivery is provided by a lay cadre or patients, either in-group or individually, at a health facility or in the community; thus, it is no longer linked by space or time to the clinical consultation. These distribution points are managed by people living with HIV who are trained to provide ART refills, adherence support and follow-up of basic support and follow-up health assessments conducted (UNAIDS 2015)

The finding of the study showed that in Community base ART activities conducted such as adherence counseling or peer support and experience sharing, health assessment, also involve them in different socio-economical activities like saving and credit. Link them to health institutions to different services during drug refilling time. Similar results from literature the experience African counties Mozambique tete,CAG model do the same that peer clients then

organize delivery of the antiretroviral medicines to other group members in the community and also provide adherence support and monitor treatment outcomes if there is any problem be referred to the clinic.(UNAIDS 2015)

The research finding reported that CAG or in peer lead group participants did benefited from both provider and client perspective because it reduced frequent visits to the clinic and work load, saved cost and time and feeling comfort while they take ART, the same is true when compare to study of Vandendyck *et al*. (2015) as their study evaluated on stable community ART groups(CAG) in Lesotho stated that they as a member benefited reduced their time, effort and money spent for transportation during the refill and in addition they developed peer support which enhanced adherence to their drug, socioeconomic support and empowered members to deal with stigma resulted feeling of relief and comfort while doing group session and being with their members. the health workers confirmed that they have observed there is increase openness about HIV in their community and community leaders added that CAG members promoted health seeking behaviour and the clinicians reported there is workload reduction.

The finding of the research mentioned as a challenge is fear of social stigma and discrimination which was suggested from participants of CAG and peer lead members as a challenge to get ART refill in the community. Similarly (Yihalem, et.al 2021) has studied that on patients' preference for ART service provision and has found that perceived stigma is one of the challenge for clients who are taking ART and also other study influenced by the visibility of HIV associated activities on stigma (Tom, *et al*., 2013). As per their study, that some of the patient refused to participate in the community based ART programs because of stigma, however the involvement of CHWs has reduced and as part of peer group has been found to lessen the perception of social stigma.

Participants mentioned confidentiality for the client, confidentiality has to be maintained all the time in a group session, there is shared confidentiality where the provider and group member knew their HIV status of the members. Maintaining confidentially as one challenge thinking the group confidentiality might be breached due to these some PLHIV in the group chose rather to continue with conventional care in the clinic. Similarly with study in Mozambique, Malawi and Zambia CAG group some ambiguity has created on the expression of the identity of people in groups. ART patients in groups on the one hand seem to be proud to be a ‘‘member’’ while on the other hand groups carefully regulate their identity and control who has knowledge of their HIV-infected status. The initiated group member do not allowed to share what they have discussed during the session to outsiders and who not keep the secrecy will be punished. (Rasschaert. F etal, 2014) Maintaining confidentiality of members' HIV status at the group level is very crucial, to protect them against stigma and discrimination.

The other challenge is luck of trust on the quality of care, some participants questioned on the quality of the service in terms of provider's skill and so on which is provided in the community as compared to facility services on other study decentralization task shifting and community engagement may come at the cost of lower quality of care. Studies suggest that Task shifting to CHWs and PLWHA is restricted by the level of knowledge and skills required to exert defined medical tasks. Though, the results of community-based models that bring care to populations that would not otherwise have had access should not be matched with results from conventional care. (Tom, *et al*., 2013).

One of the challenge that the participants reported were Shortage urban heath extension worker to the demand which was encountered providing Community based Antiretroviral treatment there was none Urban health extension nurse assigned in the hospital has tried to substitute that

Staff nurse by MSD to reach their goal. The government has assigned urban health extension workers in all health centers but there is shortage who is supposed to deal with 16 package of community. the other finding stated that as challenge is luck of trust on service health extension workers are not assigned at hospital so due to this their place covered by Mahaberehiwot for Social development organization(MSD).

Ethiopian government in collaboration with international partners has made significant effort to expand the access to ART across the country. Therefore, Community based ART is implemented and scaled up all over the country. Regarding sustainability all activities are monitored jointly with health bureau and HAPCO in the Subcity they work together and fill the gap. All activities monitored and evaluated. on one hand, the system such as decentralization and task shifting as one of as an activity which has been shifted from doctors to nurses to community level so that lay cadres and HIV experts run the activities. in order to achieve the goal 95-95-95, for the treatment coverage has to be increased in order to end AIDS by 2030. it's time to deliver differently based on the need of the client (IAS 2015) in support of this as Decentralization and task shifting of HIV care and treatment services have contributed to this achievement. (WHO, 2020).

5.2 Conclusion and Recommendations

5.2.1 Conclusions

The study has assessed the prospects and challenges of community based antiretroviral treatment modalities in Akakikaliti Subcity governmental selected health centers and one hospital. Community based ART CAG/PCAD has showed an increased access to treatment for those stable and are far from the clinic and busy at work. clients who are involved in CAG/PCAD groups has benefited from the program as it is cost effective and relived the workload of the provider and saved their time, decreased frequent visits to the clinic, felt comfort, moreover the group member has been empowered and has been involved in different saving and credited schemes and also other social support however, stigma has been decreased somehow some participants mentioned about fear of stigma and discrimination as a challenge on the contrary. More over the service has brought a good opportunity providing flexible services for stable patients so that they could get ART drug out of facility with their place of preference as the result it helped to increase ART uptake, retention in care, improved access to care and treatment.

Recommendations

Based on the findings the researcher recommended the following points for improvement of community based ART services provided in Akakikaity sub city health facilities

- Strengthening the health system from facility to community level by using available community resource to strengthen the program.
- Community stakeholder has to be consulted and involved in planning and decision making process. it doesn't has to be a onetime meeting or orientation, Stakeholders has to be involved in every planning, implementing and evaluation process so has to get the

ownership the program for the sustainable implementations of community based Antiretroviral models.

- Increase awareness and education regarding HIV and ART on the importance of adherence and reduce stigma associated with taking the drug in the community set up.
- Provide timely training, mentorship support for community health extension workers, ART nurse on the updates ARV drugs, on community based antiretroviral treatment models so that can effectively support PLHIVs in their adherence and well-being.
- Capacitate with training or other supports for peer support groups has a potential impacts on community based ART who are working in the facility to community level, such as adherence supporters, case managers, community volunteers or community resource persons, peer leaders in order to motivate them.
- Have regular and strong supportive supervision and follow up facility to community level.
- Community based antiretroviral treatment needs integration with other health services such as with other maternal health and TB (tuberculosis) care, maternal health and reproductive health services in order to reduce stigma and improve the overall health outcomes.
- Community based antiretroviral treatment service has to have strong monitoring and evaluation system for sustainable program.
- Consider cost-effective approaches mobilize resources from community and solicit funding from international donors to increase in health gains with a high proportion of people reaching viral suppression.
- Community-based initiation and delivery of ART is an effective strategy and should be scaled up to rural areas to address the gap in viral suppression overall and retention in care.

5.3 Social work Implications

Community based ART aimed as a strategy for resource limited countries meant to reduce both the burden of health professionals and patients. the finding presented with challenges such as stigma, less acceptance of the program, quality of care and issues of confidentiality, in order to make the service comprehensive closer to people and also to fill the gap Social work plays a critical role in implementing and sustainability of community based antiretroviral treatment programs. The implications of social work in this area include the following:

Implication for practice

Social worker can provide comprehensive support that address not just for medical needs of individuals on ART, but also for their social, emotional, and psychological needs, this holistic approach can improve treatment adherence and health outcomes.

Social worker can also involve in supporting communities and individuals in accessing antiretroviral treatment and could involve in group support and also in individual help people living with HIV cope with emotional and social challenge they face. Social workers assist the individual to get for financial support. Involve in awareness creation activities communities on reducing stigma and advocating for policies to combat discrimination, highlighting the need for community-based ART in resource-limited countries and health-decongested areas.

Implications to policy and program

Social worker can engage in policy advocacy to influence decision makers about resources, and support for community based ART programs. They can involve in advocacy and empower people living with HIV to advocate to their right both at community and policy level. over all social work is essential in creating, supporting and inclusive environment for PLHIV so they can get their ART treatment accessible and promoting community based responses to epidemic by

addressing social determinants of health, reducing stigma, providing comprehensive support, and ensures that everyone accesses to the care and service they need.

Implication to research

The finding of the resarch could serve as an input and a guide for further research. Since research is limited on community based ART in the country. future researches should focus on needs investigating different service delivery model and assess the effectiveness and the other one is research on scalability to other rural areas, research on integrations of other services like TB and also exploring the long term outcome of community based ART regarding ART retention in care, adherence.

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Appendix I Participant consent form

Dear participant

My name is Arest Mamo. I am a student in the postgraduate program of Addis Ababa University, graduate School Of Social Work. This questionnaire has been designed to ask for information for purely academic purpose. It is intended to assist the researcher, in partial fulfillment of the award of a Master Degree, titled ‘‘Assessing the Prospects and Challenges of Community Based ART Services in the Case of Akaki-Kaliti Health Facilities in Addis Ababa’’. Since the data collected is for academic purposes only, the information you provide is remain confidential

The interview will take approximately 40 to 50 minutes of your time, voice recorder and notes will be taken as well, you can withdraw the interview if you do not feel comfortable during the process and you have the right to decline to answer any questions or end the interview. If you have any concern you can contact me through cell phone +251-911458104 or email address arstm2006@gmail.com.

I would appreciate the genuine response you give to the questions. All information given will be strictly confidential.

I certify that I have been informed and understood about the purpose of the study and decided to provide my willingness to participate in the interview.

Name of participant_____Signiture_____Date_____

Name of the researcher__ Arest Mamo Signature_____ Date_____

በተሳታፊዎች የሚሞላ የስምምነት ሰነድ

የተሳፊዎች የቃለመጠይቅ መመሪያ

እኔ አርዕስት ማሞ የአዲስ አበባ ዩኒቨርስቲ የሶሻልዎርክ ትምህርት ክፍል ሁለተኛ ዲግሪ ተማሪ ስሆን፤ ለዲግሪ ማሟያ በኣቃቂ ቃሊቲ ክፍለ ከተማ ባሉ ጤና ተቋማት ማኅበረሰብ ተኮር ጸረ-ኤችአይቪ የአገልግሎት ተግዳሮት እና ተስፋ ሰጪ ሁኔታዎች ላይ ጥናት ለማካሄድ ታቅዷል።ለዚህም በአቃቂ ቃሊቲ ክፍለከተማ ኢችአይቪ መከለከልና መቆጣጠር ጽ/ቤት እና በጤናተቋም ጸረኤች ላይ የሚሰሩ ባለሞያዎች እነዲሁም ማህበረሰብ ተኮር የጸረ ኤችኤይቪ ተጠቃሚዎችን ቃለመጠይቅ ማድረግ ነው። የጥናቱ አላማ በአቃቂ ቃሊቲ የማህበረሰብ ተኮር ጸረኤችአይቪ ሞዴሎች ተግባራዊነታቸውና የሚገጥማቸው ተግዳሮቶችን የዳሰሳ ጥናት ማካሄድ ነው። ተሳታፊዎች የሚሰጡት መንኛውም መረጃ ሚስጥራዊነቱ የተጠበቀ ነው። በጥናቱም ላይ የተሳታፊው ማንነት አይጠቀስም።

በቃለመጠይቁ ከ 30-50 ደቂቃ ይወስዳል።ቃለመጠይቅ ለማድረግ ይረዳን ዘንድ መቅረጸ ድምፅ እና መስታወሻ እንጠቀማለን በጥናቱ ለመሳተፍ ምኞት ካለተሰማዎት አቁዋርጦ መሄድ መብተዎ የተጠበቀ ነው። በቃለመጠይቅ በመሳተፈዎ እባክዎትን ስምዎንና ፊርማዎን በማኖር ፍቃደኝነትዎን ይግለጹ፡በቅንነት የተመሰረተ የሚሰጡት መረጃ እያመሰገንኩ በጥናቱ ገቦሪያ ማንኛውም ጥያቄ ካለዎት በ ስልክ ቁጥር 251-911458104 ወይም በኢሜይል arstm2006@gmail.com.

በስምምነት ስንዱን ሃሳብ አንብቤ / ተነቦልኝ/ በጥናቱ ለመሳተፍ ተስማምቻለሁ።

የአጥኚው ስም……አርእስት ማሞ… **የተሳታፊው ስም……..**

ቀን…….. **ቀን……..**

ፊርማ…….. **ፊርማ……..**

Appendix II – In-depth Interview guide

My Name is Arest Mamo; I am graduate student of Addis Ababa University School of Social Work. I am conducting a research in titled "Assessing on Prospect and challenges of Community Based ART (CAG, PCAD) in Addis Ababa at Akakikaliti Subcity in Partial fulfillment of Masters of Social Work. The information you will provide is very vital and will be an input in the study. I appreciate your willingness to be involved in the research if you have questions and comments you are free to share for the interviewer.

A. Background Information of participants who are involved in Community ART(CAG/PCAD)

1. Sex_____
2. Age_____
3. Marital status_____
4. Religion_____
5. Educational level_____
6. Sources of income _____
7. Date/ year of ART started…….

B. Questions related to Community based ART

8. When did you know your HIV Status? for how many years have you on antiretroviral treatment?
9. What kinds of services do you get at community based ART? probe
10. How did you get involved in Community based ART (CAG /PCAD)?

11. How frequently did you go to health facility before entering to Community based ART? And how about now being in Community Based in ART?
12. How many times in a year do you contact your group member in Community ART to collect your drug?

C. Challenges and prospects of Community based ART

13. How do you feel being in group and taking ART with your friends?
14. How many times do you take ART while you are in group in the community?
15. What people say about Community ART and their acceptance about the model?
16. Do you get all services that are provided at health facility while you are in CAG/PCAD group?
17. What benefit did you get involving in community based ART as compared to Facility Based ART service?
18. What challenges did you face in involving in community based ART services?
19. What expenses do you expend while in Community based ART? Have you ever come across to any exclusion, discrimination stigma of being in Community based ART group
20. How are the support of urban health extension workers and leaders support?
21. What is the prospect of Community based ART?
22. Do you have some to add regarding the Services?

Thank You!

Appendix III - Interview guide for Key Informants

My Name is Arest Mamo; I am graduate student of Addis Ababa University School of Social Work. I am conducting a research in titled "The challenges and prospects of Community based Antiretroviral treatment (CAG, PCAD) in Addis Ababa at Akakikaliti Subcity in Partial fulfillment of Masters of Social Work. The information you will provide is very vital and will be an input in the study. I appreciate for your willingness and your response is very confidential. If you have questions and comments you are free to share for the interviewer.

A. Background Information of participants who are at Community ART (CAG/PCAD)

1. Sex_____
2. Educational background_____
3. Occupation _____
4. Position_____

1. How do you describe CBART services in your facility / Subcity? When did you start and how many CAG/PECAD groups are getting the services?
2. How do you describe CBART in contributing to 95-95-95 HIV AIDS achievement and the roles of health professionals, communities and clients?
3. What are the benefits of Community based ART in your facility?
4. What are the major challenges in providing Community based ART? With health extension workers and peers in providing the service as like in health institution ART nurse? Have you faced challenge in your in providing the service?
5. What will be the prospects CBART in providing in all health facilities.

Appendix IV – Focus group Interview guide

My name is Arest Mamo. I am a student in the postgraduate program of Addis Ababa University, College of Social Sciences, and School of Social Work. I am conducting a study in titled "The Challenges and prospects of Community based antiretroviral treatment" I have few questions for discussion regarding CBART. Thank you in advance to involve in FGD, Your response in our discussion will be very confidential. Can I proceed?

1. How do you describe about the service of CBART and models in your area?

2. What are the befit of involving in CBART? for the facility, health professionals and for the client?

3. What contribution have you observed beyond involving in CBART?

4. What are the challenges do you encounter in getting community based ART?

5. What will be the future of CBART in getting the service? Do you have any suggestions?

Thank you for your cooperation to involve in FGD

Appendix V – Observation checklist

1 Up on the consent physical appearance of the client during FGD our meeting.

2 interaction among CAG/ PECAD group members

3 interaction among health professionals and clients