

The power of peers and community in the continuum of HIV care



Diagnosing the estimated 38 million people living with HIV globally and ensuring they are linked to, and remain fully adherent to, their lifelong antiretroviral therapy (ART) is an unprecedented global public health intervention. ART adherence ensures not only the wellbeing of people with HIV but also the reduction in horizontal and vertical transmission that viral suppression can bring. That low-income and middle-income countries, especially in sub-Saharan Africa, with sometimes fragile and inadequate health systems account for the majority of people with HIV gives context to the extent of this challenge.

From the earliest days of combination treatment for HIV, the role of communities in the HIV response, including in the provision of HIV care, has been critical.^{1,2} Ongoing care for people with HIV and the provision of a client-centered, differentiated service delivery involves cadres and community structures beyond traditional health facilities, especially in sub-Saharan Africa. However, where treatment education, funding, and support for community health workers and peer cadres in providing HIV care was once considered core HIV programming, funding cuts and calls for the so-called de-siloing of programming have resulted in the collapse of these community responses.

In *The Lancet Global Health*, Webster Mavhu and colleagues³ describe how a multi-component, community-based, peer-led intervention (Zvandiri) among adolescents (aged 13–19 years) with HIV in Zimbabwe resulted in a 42% improvement in viral load outcomes compared with adolescents who continued with standard public sector care, after 24 months of follow-up. This study and its results are important for several reasons.

Although differentiated ART delivery programmes are designed to enable long-term ART adherence, robust evaluation of community-based and peer-led treatment support programmes has rarely been done. All too often, such interventions are described but not evaluated, piloted, or taken to scale. By contrast, Zvandiri has now been evaluated, adapted, and implemented in seven African countries (Eswatini, Mozambique, Nigeria, Rwanda, Tanzania, Uganda, and Zimbabwe).

The Ministry of Health and Child Care in Zimbabwe should be congratulated for their endorsement of the Zvandiri model in national policy and for scaling-up the intervention nationally.⁴ The Zvandiri evaluation will help to justify further scale-up, which will hopefully continue to ensure that support is maintained in Zimbabwe and beyond.

Zvandiri is responsive to the needs of adolescents with HIV, who are predominantly from sub-Saharan Africa and face a lifetime of treatment ahead. Adolescents with HIV often struggle to manage long-term treatment regimens and develop treatment autonomy, as they explore personal and sexual identities and transition into adulthood.⁵ Global data suggests that, although we have seen the positive effects of universal ART on mortality and morbidity in children and adults, this has not been the case with adolescents. Zvandiri recognises that adolescents with HIV are heterogeneous and have needs that change over time. The programme provides wraparound services that intensify during periods of increased need. That this project was implemented in Zimbabwe should provide reassurance of its feasibility under difficult socioeconomic conditions.

It is critical in the wake of this evidence of the effects of a differentiated service delivery model that at least five lessons are taken to heart. First, the importance of community investment. Sustained, sufficient financial support of programmes that goes beyond fragile donor funding to become part of the HIV response is needed. Quality HIV programming requires funding for community involvement, including treatment literacy, community-based provision of services, and community-led monitoring.

Second, the need for investment in peer cadres.⁶ Peers are critical in providing HIV services, including community-based services and the provision of psychosocial support. There is evidence to support peer-led services for adolescents and key populations, but peer navigators, community health workers, and other cadres are also essential to reduce stigma and improve outcomes.⁶ Zvandiri's community adolescent treatment supporters receive compensation and continuous quality training and mentorship. The

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pioneers of Zvandiri are also developing a career pathway model for these treatment supporters as they graduate into the job market.

Third, the value of investing in group models of HIV service delivery. As with community cadres, HIV support groups date back to the beginning of the epidemic. Today, however, group models of service provision are seldom encouraged or supported within facilities with high client volumes, with a singular focus on longer ART refills as a new one-size-fits-all solution. Zvandiri showcases the value of support groups where peers can share and discuss. Group models are additionally relevant for adults living with HIV, and models such as Adherence Clubs⁷ and community ART refill groups should be supported alongside longer ART refills.⁸

Fourth, an acknowledgement of and response to the changing needs of people with HIV. Zvandiri includes differentiation between a general and intensified package during periods of increased risk of treatment failure. It would be helpful to know the optimal ratio of clients to each community adolescent treatment supporter and the maximum number of clients a treatment supporter can reasonably manage. History has taught us that, as programmes are incorporated into public health management systems, these ratios become important to ensure ongoing fidelity and quality of the programme in the face of budgetary pressures and constraints.

Finally, we as a research community must continue to innovate. Zvandiri includes monthly support groups in communities and ART refills from facilities every 3 months. Could adolescents in the Zvandiri model receive their ART refills at every third support group meeting?⁹ Continual innovation in simplifying delivery that supports clients and the health system is essential to ensuring quality and efficient HIV programming.

Mavhu and colleagues argue that the Zvandiri intervention is greater than the sum of its parts, where, for example, they cannot quantify the effects of

sustained viral suppression among those adolescents who were clinically stable and in the intervention. Going forward, as researchers, we must acknowledge that because differentiated service delivery is client-centred, operational research might be best placed to evaluate the impact and investment in communities should be prioritised.¹⁰

We declare no competing interests.

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