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Educational and Empowerment Processes in Community-Based Peer Facilitation for Supporting Antiretroviral Therapy Adherence among People Living with HIV

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Abstrak

Fasilitasi sebaya berbasis komunitas berperan dalam mendukung keterlibatan terapi antiretroviral (ART) pada orang dengan HIV (ODHIV), tetapi mekanisme pendidikan dan pemberdayaan yang mendasarinya masih belum banyak dipahami. Penelitian ini mengkaji proses fasilitasi sebaya pada Saburai Support Group (SSG), Indonesia. Penelitian menggunakan studi kasus intrinsik kualitatif dengan delapan informan yang dipilih secara purposif, terdiri atas dua fasilitator sebaya, dua ODHIV, dua pengelola organisasi, dan dua tenaga kesehatan. Data dikumpulkan melalui wawancara semi-terstruktur, observasi partisipatif, catatan lapangan, dan analisis dokumen, kemudian dianalisis menggunakan kerangka interaktif Miles, Huberman, dan Saldaña. Hasil penelitian mengidentifikasi lima proses yang saling terkait, yaitu membangun kepercayaan, asesmen kebutuhan dan dukungan edukatif, dukungan psikososial, kolaborasi dan advokasi, serta pemantauan dan penguatan kemandirian. Fasilitator sebaya tidak hanya berperan sebagai pendukung pengobatan, tetapi juga sebagai pendidik, fasilitator pembelajaran, mediator pengetahuan, advokat, penghubung, dan agen pemberdayaan masyarakat. Temuan tersebut menghasilkan Model Fasilitasi Sebaya Berbasis Komunitas yang diturunkan secara empiris melalui alur kepercayaan–kapasitas–koneksi–kemandirian. Studi ini menempatkan fasilitasi sebaya sebagai bentuk pembelajaran berbasis komunitas dan pendidikan nonformal yang mengintegrasikan pendidikan kesehatan, dukungan psikososial, dan pemberdayaan untuk mendukung keterlibatan pengobatan serta pengelolaan diri. Penelitian lebih lanjut diperlukan untuk mengkaji transferabilitas model pada konteks yang berbeda.

Kata Kunci: *Dukungan Sebaya; Fasilitator Sebaya; Kepatuhan Terapi Antiretroviral; Dukungan Psikososial; Pemberdayaan Masyarakat.*

Abstract

Community-based peer facilitation can support antiretroviral therapy (ART) engagement among people living with HIV (PLHIV), yet its educational and empowerment mechanisms remain insufficiently understood. This study examined peer facilitation within the Saburai

Support Group (SSG), Indonesia. Using a qualitative intrinsic case study, eight participants were purposively selected, comprising two peer facilitators, two PLHIV, two organization managers, and two healthcare workers. Data were collected through semi-structured interviews, participant observation, field notes, and document analysis and analyzed using the interactive framework of Miles, Huberman, and Saldaña. The findings identified five interconnected processes: trust building, needs assessment and educational support, psychosocial support, collaboration and advocacy, and monitoring and strengthening independence. Peer facilitators functioned not only as treatment supporters but also as educators, learning facilitators, knowledge mediators, advocates, connectors, and community empowerment agents. These findings informed an empirically derived Community-Based Peer Facilitation Model organized around a trust–capacity–connection–independence pathway. The study highlights peer facilitation as a form of community-based and nonformal learning integrating health education, psychosocial support, and empowerment to support treatment engagement and self-management. Further research is required to examine the model's transferability across different contexts.

Keywords: *Community-based Support; Peer Facilitator; Psychosocial Support; Antiretroviral Therapy Adherence; Community Empowerment.*

INTRODUCTION

Human Immunodeficiency Virus (HIV) infection remains a complex global public health challenge because its management involves not only clinical considerations but also social, psychological, cultural, and economic factors. Although advances in antiretroviral therapy (ART) have reduced mortality and improved life expectancy among people living with HIV (PLHIV), long-term treatment engagement continues to be affected by stigma, discrimination, limited social support, depression, and treatment non-adherence (World Health Organization [WHO], 2022; Joint United Nations Programme on HIV/AIDS [UNAIDS], 2024). These barriers may contribute to treatment discontinuation, loss to follow-up, and difficulties in achieving viral suppression. UNAIDS (2024), through the 95–95–95 targets, emphasizes that progress in HIV control depends not only on access to healthcare but also on sustained engagement in care. This has increased attention to community-based approaches that complement facility-based services by strengthening social support, participation, and individual capacity. Within this context, community facilitators have an important role not merely in conveying health information but also in creating opportunities for participatory learning, strengthening social networks, facilitating access to resources, and supporting individuals in making informed decisions about their health. From a community empowerment perspective, such facilitation can be understood as a capacity-building process through which individuals develop greater awareness, agency, and ability to manage their lives (Freire, 1970; Ife, 2016).

In HIV care, this educational and empowerment dimension is particularly important because many challenges experienced by PLHIV cannot be addressed through medical intervention alone. In addition to accessing ART, individuals may need opportunities to understand treatment information, discuss misconceptions and concerns, develop coping strategies, navigate healthcare services, and strengthen their capacity for treatment self-management. Peer facilitators can contribute to these processes through education, counselling, motivation, mediation, advocacy, and linkage between PLHIV and healthcare services (WHO, 2022). Their shared experiences may also create a relational environment in

which knowledge and practical experience can be exchanged through dialogue rather than through one-way information delivery. Previous studies have shown that peer support is associated with treatment engagement, quality of life, and participation in healthcare services among PLHIV (Chambers et al., 2021). These findings establish the importance of peer support in HIV care; however, they provide less explanation of how peer facilitation operates as a learning, capacity-building, and empowerment process through which treatment engagement can be supported.

In Indonesia, community participation has become an important component of HIV/AIDS response, with civil society organizations contributing to case outreach, ART support, tracing individuals who are lost to follow-up, health education, psychosocial assistance, and stigma reduction. Nevertheless, community-based programmes operate under varying facilitator capacities, organizational resources, and local service arrangements. The Saburai Support Group (SSG) in Bandar Lampung provides a relevant setting for examining these processes because peer facilitators are involved across multiple forms of support, including outreach, needs assessment, HIV and ART education, psychosocial counselling, mediation with healthcare facilities, advocacy, and treatment monitoring. These activities suggest that peer facilitation involves more than treatment assistance: facilitators may also function as community educators, learning facilitators, knowledge brokers, and empowerment agents who help PLHIV interpret health information, identify their needs, access relevant resources, and progressively strengthen their capacity for self-management.

Although previous research has established the contribution of peer support to HIV care, less is understood about the mechanisms through which peer facilitators integrate educational, psychosocial, relational, and advocacy processes within community-based practice, particularly in the context of Indonesian community organizations. Existing studies have predominantly emphasized outcomes such as ART adherence, retention in care, and quality of life, whereas the processes through which facilitators identify learning needs, mediate knowledge, build capacity, mobilize social support, connect individuals with services, and foster greater independence remain insufficiently understood. This gap is important because sustained treatment engagement may depend not only on receiving support but also on whether PLHIV develop the knowledge, confidence, social connections, and capacity required to manage their treatment more independently. Examining these mechanisms therefore provides an opportunity to understand peer facilitation as both a support practice and a community-based educational and empowerment process.

Accordingly, this study examines the mechanisms of community-based peer facilitation within the Saburai Support Group, with particular attention to the educational, psychosocial, relational, and empowerment processes through which facilitators support ART adherence among PLHIV. Specifically, the study aims to analyse how peer facilitators build supportive relationships, identify needs and facilitate learning, provide psychosocial support, mediate access to services and community resources, and strengthen treatment self-management. Based on these empirically derived processes, the study proposes a conceptual model of community-based peer facilitation that describes the interconnected pathways through which trust, capacity development, social connection, and increasing independence may contribute to sustained engagement with ART.

METHOD

This study employed a qualitative approach using an intrinsic case study design to develop an in-depth understanding of community-based peer facilitation for people living with HIV

(PLHIV) within its real-life context. The case study design was considered appropriate because the study focused on how peer facilitators provided support, facilitated learning and capacity development, and interacted with PLHIV and healthcare services within a specific community setting (Yin, 2018). The study was informed by a constructivist paradigm, which understands social reality as constructed through participants' experiences, interactions, and interpretations (Lincoln & Guba, 1985). Accordingly, the study focused not on quantitatively measuring the effectiveness of peer facilitation or changes in antiretroviral therapy (ART) adherence, but on understanding participants' experiences and the mechanisms through which community-based peer facilitation supported treatment engagement, psychosocial well-being, and the development of self-management capacity.

The study was conducted at the Saburai Support Group (SSG) in Bandar Lampung City, Lampung Province, Indonesia. The research site was purposively selected because SSG is a community-based organization that has provided sustained support for PLHIV since 2004 using a peer-facilitator approach. Its activities include outreach to key populations, ART-related support, HIV and ART education, psychosocial counselling, follow-up of individuals who have been lost to care, advocacy for the rights of PLHIV, and collaboration with healthcare facilities. These characteristics provided an information-rich setting for examining peer facilitation not only as a form of treatment support but also as a community-based educational, psychosocial, and empowerment process. Participants were selected through purposive sampling based on their knowledge, experience, and direct involvement in community-based HIV support (Patton, 2015). The study involved eight participants, comprising two peer facilitators, two PLHIV receiving support from SSG, two SSG organization managers, and two healthcare workers collaborating with SSG. Peer facilitators were included based on their active involvement in outreach, HIV and ART education, psychosocial support, treatment assistance, and advocacy. PLHIV participants were selected based on their direct experience of receiving peer-facilitation support from SSG. Organization managers were included because of their involvement in managing and coordinating community-based support activities, while healthcare workers were selected based on their experience of collaborating with SSG in providing HIV-related services. The inclusion of these four participant groups enabled the study to examine peer facilitation from multiple perspectives and to compare experiences across facilitators, service recipients, organizational actors, and healthcare providers.

Participant recruitment and data collection continued until thematic saturation was considered sufficient. Saturation was assessed iteratively during data collection and preliminary analysis by comparing information obtained from successive interviews across the four participant groups. Saturation was considered sufficient when additional interviews no longer generated substantively new codes, categories, or explanations concerning the mechanisms of peer facilitation and when recurring patterns related to trust building, educational support, psychosocial support, collaboration and advocacy, and treatment self-management were consistently identified across the data (Guest et al., 2020). This iterative assessment indicated that the collected data provided sufficient information to address the research objectives while recognizing the context-specific nature of the case.

The study drew on both primary and secondary data. Primary data were generated through semi-structured in-depth interviews, limited participant observation, and field notes. The interview guide was informed by the concepts of community empowerment, peer facilitation, and social support. Interview questions explored participants' experiences of the support process, strategies for building trusting relationships, identification of individual

needs, HIV and ART education, psychosocial support, coordination with healthcare services, advocacy, treatment monitoring, and the development of self-management capacity. Particular attention was given to how facilitators helped PLHIV understand treatment-related information, reflect on their experiences, make informed decisions, and progressively develop greater capacity to manage their treatment. Observations focused on interactions between peer facilitators and PLHIV and, where relevant, their interactions with organizational and healthcare stakeholders. Secondary data were obtained from organizational documents, activity reports, support-related standard operating procedures, HIV/AIDS programme reports, and relevant policy documents. The use of multiple data sources enabled a contextualized understanding of peer-facilitation practices within SSG.

Trustworthiness was strengthened through source triangulation, methodological triangulation, and member checking. Source triangulation involved comparing accounts from peer facilitators, PLHIV, organization managers, and healthcare workers. Methodological triangulation was conducted by comparing interview findings with observations, field notes, and relevant documents. Member checking was conducted with selected key participants to examine whether the researchers' interpretations adequately reflected their experiences and intended meanings (Denzin, 1978; Lincoln & Guba, 1985). Throughout this process, attention was given to both convergence and variation across participant perspectives to avoid relying on a single account of the peer-facilitation process.

Data analysis was primarily guided by the interactive qualitative analysis framework of Miles et al. (2014), comprising data condensation, data display, and conclusion drawing/verification. Analysis was conducted iteratively alongside data collection. Interview recordings were transcribed and read repeatedly to achieve familiarity with the data. During data condensation, meaningful segments of the transcripts were assigned initial codes representing participants' experiences, facilitator practices, interactions, and perceived mechanisms of support. Related codes were compared and grouped into broader categories. These categories were subsequently examined across participant groups and data sources to identify recurring patterns, similarities, differences, and relationships. Data displays, including thematic matrices and analytical narratives, were used to organize the categories and facilitate comparison across participant perspectives. Emerging interpretations were continuously verified against interview transcripts, observational records, field notes, and documentary evidence.

Within this analytical process, principles of thematic analysis informed the transition from categories to higher-order themes (Braun & Clarke, 2021). Thematic analysis was used to support the interpretation and refinement of patterns emerging from the coding and categorization process rather than as a separate second analytical method. The analytical progression therefore followed the sequence raw data → initial codes → categories → themes → relationships among themes → conceptual model. Through iterative comparison and interpretation, five interconnected themes were developed: trust building; needs assessment and educational support; psychosocial support; collaboration and advocacy; and monitoring and strengthening independence. Particular attention was given to identifying how educational processes, including information exchange, dialogue, learning from lived experience, knowledge development, and support for decision-making, interacted with psychosocial and relational forms of support.

The relationships among the five themes were subsequently synthesized into a proposed conceptual model of community-based peer facilitation. The model represents peer facilitation as a dynamic and interconnected process in which trust facilitates meaningful

needs assessment and learning; educational and psychosocial support contributes to capacity development; collaboration and advocacy strengthen connections with relevant resources and services; and continued monitoring supports increasing independence and treatment self-management. The model was treated as an empirically derived conceptual representation of the mechanisms identified within this particular case, rather than as a validated model or evidence of the effectiveness of peer facilitation in improving ART adherence. This distinction reflects the qualitative and case-specific nature of the study.

The study was conducted in accordance with established principles of research ethics. Prior to data collection, formal permission to conduct the study was obtained from the Saburai Support Group (SSG), Bandar Lampung, through Research Approval Letter No. 417/009/SSG-LPG/II/2025, dated 22 February 2025. This institutional permission authorized the researcher to conduct the study within SSG and to undertake data collection related to its community-based support activities. Before data collection, all participants were provided with clear information regarding the study objectives, data collection procedures, voluntary participation, confidentiality protections, and their right to withdraw from the study at any time without consequences. Informed consent was obtained from all participants prior to participation. Given the sensitive nature of HIV-related experiences and the involvement of PLHIV, particular attention was paid to protecting participants' privacy, dignity, and confidentiality throughout data collection, analysis, and reporting. Personally identifiable information was removed from transcripts and research records. Participants were represented using anonymous codes: PF1–PF2 for peer facilitators, PLHIV1–PLHIV2 for PLHIV participants, OM1–OM2 for organization managers, and HCW1–HCW2 for healthcare workers. Information that could indirectly reveal participants' identities was excluded from the reporting of findings, and research data were used solely for research purposes.

RESULTS

Analysis of the interview, observation, field-note, and documentary data generated five interconnected themes that explain how community-based peer facilitation was practiced within the Saburai Support Group (SSG): (1) trust building, (2) needs assessment and educational support, (3) psychosocial support, (4) collaboration and advocacy, and (5) monitoring and strengthening independence. These themes were developed through iterative coding and categorization across the accounts of peer facilitators, PLHIV, organization managers, and healthcare workers. Codes referring to empathy, confidentiality, and openness were grouped into trust building; codes concerning identification of individual needs, HIV and ART information, and dialogue were grouped into needs assessment and educational support; codes related to emotional support, motivation, coping, and self-acceptance formed psychosocial support; codes concerning referral, mediation, networking, and service coordination formed collaboration and advocacy; and codes related to follow-up, treatment self-management, and increasing autonomy formed monitoring and strengthening independence. Cross-theme analysis subsequently indicated a broader conceptual pathway involving trust, capacity, connection, and independence.

Trust Building

Trust emerged as the relational foundation of peer facilitation. Across participant accounts, openness was associated with facilitators' ability to listen empathetically, maintain confidentiality, avoid judgment, and sustain communication over time. Rather than beginning the relationship with directive instructions about treatment, facilitators first sought to create

a safe interpersonal environment in which PLHIV could discuss their experiences, concerns, and treatment-related difficulties.

> *"I usually start by listening and letting them share at their own pace. I reassure them that their stories will be kept confidential, and I try not to judge them. Because I have gone through similar experiences, I can understand some of their concerns and build trust gradually." (PF1).*

The PLHIV accounts provided a complementary perspective. Feeling accepted and having confidence that HIV status and personal experiences would remain confidential enabled participants to discuss concerns that they might otherwise have withheld.

> *"I felt comfortable talking to the facilitator because they listened without judging me. I trusted that what I shared would remain private, so I could talk about the problems I was facing, including difficulties with my treatment." (PLHIV1).*

The convergence between facilitator and PLHIV accounts indicates that trust functioned as more than a positive interpersonal relationship. It created the conditions necessary for facilitators to understand individual circumstances and for PLHIV to participate actively in subsequent support processes. Regular communication and appropriate sharing of lived experience further strengthened this relationship. Trust therefore served as an enabling mechanism for needs assessment, educational dialogue, psychosocial support, and treatment-related assistance.

Table 1. Empirical Indicators of Trust Building

Empirical evidence	Facilitator practice	Interpretation
PLHIV became more open when they felt accepted	Empathetic listening and non-judgmental communication	Creates relational safety
Concerns regarding disclosure of HIV status	Maintaining confidentiality	Strengthens perceived security
Support relationships developed over time	Regular communication and follow-up	Sustains interpersonal trust
Shared experiences facilitated communication	Appropriate sharing of lived experience	Strengthens peer connection

Needs Assessment and Educational Support

The second theme concerned the integration of individual needs assessment with educational support. Facilitators described the need to understand PLHIV's circumstances before determining what type of assistance was appropriate. Assessment included treatment-related concerns as well as psychological, social, family, and, where relevant, economic circumstances. This process was conducted primarily through dialogue rather than through a standardized one-way assessment.

> *"Before giving advice, I ask what has been most difficult for them lately. Their concerns are not always only about medication; sometimes they are worried about telling their family, side effects, or getting to the clinic. Once I understand the situation, I can discuss what information or support might be useful." (PF2).*

Educational support was embedded within this assessment process. Facilitators discussed HIV, ART, treatment continuity, possible treatment-related difficulties, and access to healthcare services according to the needs identified. Education was not limited to transmitting medical information. Facilitators translated information into accessible language, responded to misconceptions and questions, related information to participants' everyday experiences, and encouraged PLHIV to make informed treatment-related decisions.

> *"I used to feel confused about the information I received and was not sure what questions to ask at the clinic. The facilitator explained things in a way I could understand and helped me think of what to discuss with the health worker. Now I feel more prepared to make decisions about my care." (PLHIV2).*

These findings show that peer facilitators performed an educational role alongside their support role. They functioned as community educators, learning facilitators, and knowledge brokers by helping PLHIV interpret health information and connect it to everyday treatment practices. Educational support therefore contributed to capacity development by strengthening knowledge, awareness, confidence, and informed decision-making.

The findings also indicate that assessment and education were reciprocal rather than strictly sequential. As PLHIV became more comfortable discussing their experiences, new needs could emerge, requiring facilitators to revisit earlier explanations or provide different forms of learning support. This dynamic interaction illustrates why education within peer facilitation was better understood as an ongoing learning process than as a single information-delivery activity.

Psychosocial Support

Psychosocial support emerged as the third theme. Participant accounts indicated that ART-related challenges were intertwined with anxiety, self-acceptance, stigma, family relationships, and fluctuations in motivation. Facilitators therefore combined treatment-related information with emotional support, counselling, encouragement, and assistance in coping with social and psychological difficulties.

> *"There were times when I felt tired and worried about taking ART. The facilitator encouraged me to talk about what I was feeling and reminded me that I did not have to face everything alone. That support helped me feel more accepted and motivated to continue managing my treatment." (PLHIV1).*

Facilitators described psychosocial support as an ongoing relational process. Continued communication allowed them to recognize changes in participants' emotional conditions and to respond when PLHIV experienced treatment fatigue, stigma, family difficulties, or other circumstances that could disrupt engagement with care.

> *"When someone is struggling, I try to stay in contact and listen to what is happening. I encourage them without pressuring them, and when needed, we talk through their concerns together. Sometimes knowing that someone is available to listen can help them feel less alone." (PF1).*

Educational and psychosocial processes frequently overlapped. Better understanding of ART could reduce uncertainty, while emotional security made it easier for PLHIV to discuss treatment concerns and engage with information. Participants' experiences therefore suggested that psychosocial support contributed to confidence, coping capacity, self-acceptance, and motivation associated with sustained treatment engagement.

These findings should not be interpreted as quantitative evidence that peer facilitation improved ART adherence. Rather, participants described educational, emotional, and motivational mechanisms that supported their engagement with ART and treatment-related self-management.

Table 2. Forms and Functions of Psychosocial Support

Empirical evidence	Facilitator practice	Reported contribution
Anxiety and emotional distress	Empathetic listening and emotional support	Greater emotional security
Difficulties in accepting HIV status	Counselling and non-judgmental interaction	Strengthened self-acceptance
Fluctuating treatment motivation	Encouragement and motivational reinforcement	Support for continued treatment engagement
Experiences of stigma	Dialogue and coping support	Strengthened capacity to manage social challenges
Difficulties accessing services	Service navigation and accompaniment	Reduced perceived barriers to care

Collaboration and Advocacy

The fourth theme demonstrated that community-based peer facilitation extended beyond interpersonal support. Participants described needs that required coordination with healthcare facilities, government services, community organizations, peer networks, and families. Facilitators consequently functioned as bridging actors connecting PLHIV with resources that could not be provided by SSG alone. Healthcare workers described facilitators as important community-level partners because they could maintain communication with PLHIV and help bridge interactions between community members and formal health services.

> *"Peer facilitators help us stay connected with PLHIV in the community. When someone has difficulty accessing services or needs follow-up, they can help communicate the concern to the health facility and support the person in finding the appropriate service." (HCW1).*

Organization managers similarly emphasized that facilitators were involved not only in accompanying individuals but also in coordinating referrals, communicating with service providers, and responding to administrative or social barriers.

> *"Their role is not limited to accompanying someone. They also coordinate with service providers, help arrange referrals, and follow up when administrative or social barriers make it difficult for a person to access support." (OM1).*

Collaboration included relationships with community health centers, hospitals, the Health Office, peer-support networks, community organizations, and, where appropriate, family

members. Depending on the circumstances, facilitators assisted with referrals, ART-related service navigation, communication with health professionals, psychosocial services, and advocacy when PLHIV encountered barriers to accessing services. These findings position facilitators as connectors and community-based knowledge brokers who translate individual needs into appropriate service pathways. Collaboration and advocacy therefore contributed to the connection component of peer facilitation by linking PLHIV with institutional, social, and community resources.

Table 3. Collaboration and Advocacy in Community-Based Peer Facilitation

Collaboration partner	Facilitator practice	Contribution to the support process
Community health centers and hospitals	Referral, communication, and service navigation	Connection with healthcare services
Health Office	Programme and service coordination	Linkage between community and formal HIV services
Peer-support networks	Experience sharing and psychosocial support	Expansion of peer and social support
Family members	Facilitation of supportive relationships, where appropriate	Strengthening of immediate social support
Community organizations	Education, networking, and advocacy	Expansion of community resources and support

Monitoring and Strengthening Independence

The fifth theme concerned continued monitoring and the gradual strengthening of PLHIV's capacity for treatment self-management. Facilitators maintained communication after initial education, counselling, or referral had been provided. Follow-up enabled them to identify emerging treatment-related difficulties, remind participants about relevant services when necessary, and provide additional support when circumstances changed.

> *"I follow up through regular messages or conversations, depending on what the person needs. I ask how things are going and whether they are experiencing any difficulties with treatment or accessing services. If a concern comes up, we discuss what support may be helpful." (PF1).*
> *"At first, I needed more help understanding where to go and whom to contact. Over time, I became more confident asking questions and managing these things myself. I still know I can contact the facilitator if a problem comes up." (PLHIV1).*

Independence in this context did not mean that PLHIV no longer required community or social support. Instead, it referred to an increased capacity to understand treatment-related needs, make informed decisions, navigate services, maintain communication with healthcare providers, and seek assistance appropriately when difficulties arose. Thus, monitoring and strengthening independence represented a gradual transition from facilitator-supported engagement toward greater treatment self-management while maintaining access to supportive networks.

Model Synthesis

The five themes were derived from recurring empirical patterns identified across participant groups and data sources. Their development involved moving from initial codes to

broader categories and subsequently examining the relationships among those categories. This process generated a set of interconnected mechanisms rather than five isolated activities.

Table 4. Empirical Derivation of the Proposed Community-Based Peer Facilitation Model

Representative Empirical Findings	Theme	Facilitator Function	Model Component
Empathy, confidentiality, active listening, openness, sustained interaction	Trust Building	Relational partner	Trust
Identification of individual needs, ART education, dialogue, clarification of information	Needs Assessment and Educational Support	Educator, learning facilitator, knowledge broker	Capacity
Emotional support, motivation, coping support, self-acceptance	Psychosocial Support	Counsellor and motivator	Capacity
Referral, mediation, advocacy, networking, service coordination	Collaboration and Advocacy	Mediator, advocate, connector	Connection
Follow-up, treatment self-management, informed decision-making, increasing autonomy	Monitoring and Strengthening Independence	Supporter of self-management	Independence

The synthesis indicates a broader conceptual pathway of trust–capacity–connection–independence. Trust created the relational conditions necessary for PLHIV to communicate their needs. Needs assessment, educational support, and psychosocial support contributed to the development of knowledge, confidence, coping ability, and treatment-related capacity. Collaboration and advocacy connected PLHIV with healthcare, social, and community resources. Continued monitoring then supported the gradual development of greater independence and treatment self-management. Based on these empirically derived relationships, this study proposes a conceptual Community-Based Peer Facilitation Model for Supporting ART Adherence. The model does not represent a validated intervention or demonstrate causal effectiveness. Rather, it provides an empirically derived representation of how peer-facilitation mechanisms were experienced and practiced within the SSG case.

Importantly, the model is dynamic rather than strictly linear. Trust may need to be strengthened again when new difficulties arise; new circumstances may require renewed needs assessment and educational support; psychosocial difficulties may emerge during later stages of treatment; and changes in healthcare access may reactivate collaboration and advocacy. Monitoring also provides feedback to earlier components by allowing facilitators and PLHIV to identify changing needs. The five themes therefore operate as mutually reinforcing processes within an ongoing community-based support system.

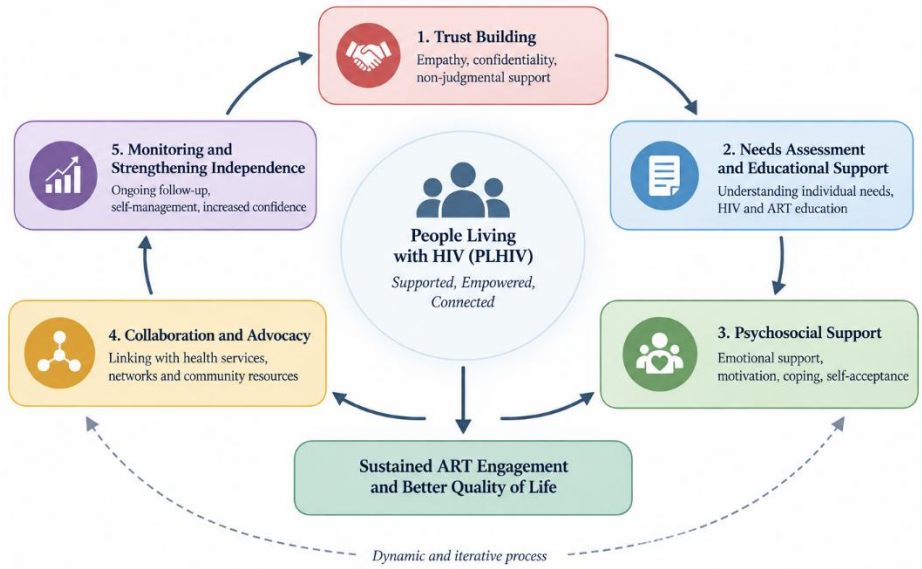


Figure 1. Proposed Community-Based Peer Facilitation Model for Supporting ART Adherence

DISCUSSION

From The findings suggest that community-based peer facilitation within the Saburai Support Group (SSG) is better understood as a multidimensional process than as a narrowly defined form of treatment assistance. Across the five themes, peer facilitation connected relational trust, educational support, psychosocial assistance, service navigation, advocacy, and the gradual development of treatment self-management. The proposed pathway of trust–capacity–connection–independence provides an interpretive synthesis of these processes. Rather than indicating a causal sequence leading to improved ART adherence, the pathway describes how different forms of facilitation may interact to support sustained treatment engagement. Three theoretical perspectives are particularly useful for explaining these findings: community empowerment, Social Support Theory, and Self-Determination Theory. Together, they illuminate how peer facilitation operates through relational, educational, motivational, and community-level mechanisms.

Peer Facilitation as a Trust-Based Empowerment Process

A central finding of this study is that trust functioned as an enabling condition for subsequent forms of peer facilitation. Previous research has similarly identified trust and shared lived experience as important features of peer support for PLHIV. Berg et al. (2021), for example, reported that peer-support interventions can facilitate engagement with HIV-related care, while broader peer-support literature emphasizes the value of experiential similarity in creating relationships that differ from conventional professional–client interactions. The present findings are consistent with this literature but add an important qualification: shared experience alone was not sufficient to establish a supportive relationship. Trust was actively developed through confidentiality, empathetic listening, non-judgmental interaction, consistency, and sustained communication.

Community empowerment provides a useful theoretical explanation for this finding. From Freire's (1970) perspective, empowerment begins when individuals are positioned as subjects who can participate in dialogue and critically engage with their own circumstances rather than as passive recipients of expert instruction. In the present study, trust created the relational conditions necessary for such participation. PLHIV could communicate concerns, articulate

needs, question information, and participate in decisions concerning their treatment when the facilitation relationship was experienced as safe and non-judgmental. Trust therefore had an educational function as well as an interpersonal one: it enabled dialogue and made participants' experiences legitimate sources of knowledge within the learning process. This interpretation also corresponds with Ife's (2016) conceptualization of community empowerment, in which meaningful participation, access to resources, and increased capacity to influence decisions are central. The findings suggest that empowerment did not begin with the transfer of knowledge or provision of services. It began with a relational environment that allowed PLHIV to articulate their own circumstances. This extends previous understandings of peer support by positioning trust not merely as a desirable characteristic of supportive relationships but as a pedagogical and empowerment condition through which subsequent learning, psychosocial support, and self-management become possible.

For community and nonformal education, this finding has practical implications for facilitator preparation. Training should not assume that subject-matter knowledge about HIV and ART is sufficient. Facilitators also require competencies in empathetic communication, active listening, confidentiality, non-judgmental interaction, and dialogical facilitation. These relational competencies establish the conditions under which community-based learning and empowerment can occur.

From Information Provision to Educational Facilitation and Capacity Development

The educational dimension represents one of the most important contributions of the findings. Peer facilitators did not simply provide information about HIV and ART. They identified individual needs, clarified information, responded to misconceptions and concerns, connected formal health knowledge with everyday experiences, and supported PLHIV in interpreting information for treatment-related decision-making. This suggests a distinction between information delivery and educational facilitation. Previous studies of HIV peer support have frequently emphasized informational support as one component of broader support interventions. Within Social Support Theory, informational support refers to advice, guidance, and information that assist individuals in responding to particular problems (House, 1981). The present findings confirm the importance of informational support but extend this interpretation by showing that information became meaningful through a relational and dialogical process. Facilitators did not simply transmit predetermined messages; they mediated knowledge according to individual circumstances and supported participants in relating that knowledge to lived treatment experiences.

This process can also be interpreted through community empowerment. Freire's (1970) dialogical perspective distinguishes education based on one-way transmission from learning that emerges through dialogue and reflection on lived realities. Although the peer-facilitation activities in this study were not formal educational programmes, the processes identified in the data share important characteristics with community-based and nonformal learning: they were contextual, needs-responsive, experiential, dialogical, and embedded in everyday life. Learning occurred within ongoing relationships and was connected directly to problems experienced by PLHIV. This interpretation expands the role of peer facilitators beyond that of treatment supporters. The findings indicate that they can also function as educators, learning facilitators, and knowledge mediators. As educators, they provide and clarify health-related knowledge; as learning facilitators, they create opportunities for dialogue and reflection; and as knowledge mediators, they connect formal medical information with the language, experiences, and circumstances of community members. Their lived and community

experience becomes particularly important because it enables them to translate institutional knowledge into forms that are more accessible and practically meaningful.

The theoretical contribution is therefore a shift from understanding peer education primarily as information transfer toward understanding peer facilitation as a capacity-development process. Within the proposed model, *capacity* does not refer only to increased knowledge. It encompasses the developing ability to understand information, identify needs, ask questions, consider alternatives, make informed decisions, and respond to treatment-related challenges. For nonformal and community education, this finding suggests that peer-facilitator development should incorporate principles of adult and community learning. Training could include needs assessment, dialogical communication, facilitation techniques, experiential learning, health literacy, reflective questioning, and strategies for translating technical health information into accessible community knowledge. Such competencies would strengthen the facilitator's educational role without transforming peer facilitation into a formal teacher-centered process.

Psychosocial Support as an Integrated Mechanism of Capacity and Motivation

The findings further indicate that educational support cannot be separated easily from the psychosocial circumstances of PLHIV. Knowledge about ART may be available, but the capacity to act on that knowledge can be affected by stigma, anxiety, difficulties in self-acceptance, social relationships, and fluctuations in motivation. This helps explain why the peer-facilitation process combined education with emotional support, encouragement, counselling, practical assistance, and continued interaction. Social Support Theory provides a more precise interpretation of this finding. House (1981) distinguishes four forms of social support: emotional, informational, instrumental, and appraisal support. These forms were interconnected within the facilitator practices identified in this study. Emotional support was reflected in empathy and acceptance; informational support in HIV and ART education; instrumental support in service navigation and assistance with practical barriers; and appraisal support in encouragement and recognition of participants' capacity to manage treatment-related challenges.

The findings therefore support the relevance of Social Support Theory while also illustrating that these categories do not necessarily operate independently in community practice. Educational information may have limited practical value when an individual is experiencing severe anxiety or stigma. Emotional support can create sufficient psychological security for an individual to discuss misunderstandings about treatment. Instrumental assistance may enable knowledge and motivation to be translated into actual access to healthcare. Appraisal support can reinforce confidence after an individual has successfully managed a treatment-related challenge. The contribution of peer facilitation consequently lies partly in the integration of these different forms of support within an ongoing relationship.

Self-Determination Theory further helps explain why such integrated support may be relevant to treatment engagement. Deci & Ryan (2000) argue that motivation is supported through the psychological needs for relatedness, competence, and autonomy. The findings correspond to these dimensions in several ways. Trust and acceptance contribute to relatedness; education, experience, and problem-solving can strengthen competence; and participation in treatment-related decision-making can support autonomy.

This theoretical interpretation shifts the meaning of adherence support away from simple compliance with external instructions. Peer facilitators may support conditions under which PLHIV progressively understand the rationale for treatment, develop confidence in managing

treatment, and assume greater ownership of health-related decisions. Thus, the findings do not demonstrate that peer facilitation *causes* improved ART adherence. Rather, they identify relational and motivational mechanisms through which peer facilitation may support sustained ART engagement and treatment self-management. This distinction has practical implications for facilitator training. Programmes focused exclusively on medication reminders or HIV knowledge may overlook the psychological and motivational conditions underlying treatment engagement. Facilitator capacity building should therefore integrate health education with basic psychosocial support, motivational communication, stigma-sensitive interaction, identification of emotional distress, and appropriate referral when participants require professional services beyond the facilitator's role.

Facilitators as Knowledge Mediators, Connectors, and Community Empowerment Agents

Another important finding is that peer facilitation extended beyond the facilitator–PLHIV relationship. Facilitators connected individuals with healthcare facilities, community organizations, government services, peer networks, and family resources. This indicates that the capacity of PLHIV to manage treatment cannot be understood solely as an individual characteristic; it is also shaped by access to supportive social and institutional environments.

Previous peer-support research has documented the role of peers in service navigation and linking individuals with HIV care. The present study is consistent with this literature but broadens the interpretation of navigation. Facilitators were not merely directing PLHIV toward existing services. They mediated communication, interpreted service procedures, identified appropriate resources, facilitated referrals, and advocated when participants encountered barriers. In this sense, they operated at the boundary between community knowledge and institutional systems. Community empowerment theory is particularly relevant here because empowerment involves both individual capacity and access to structures and resources that make meaningful action possible (Ife, 2016). Increased knowledge or motivation may have limited impact if an individual cannot navigate healthcare institutions or faces administrative and social barriers. Facilitators therefore contributed to empowerment by helping connect personal capacity with external resources.

This finding expands the conceptual role of peer facilitators into that of community empowerment agents. Their functions can be understood across several interconnected dimensions: as educators they facilitate understanding; as knowledge mediators they translate between formal health information and lived community experience; as psychosocial supporters they strengthen emotional and motivational resources; as connectors they link individuals with services; and as advocates they assist in negotiating barriers within broader systems. The distinction is important for nonformal education because it demonstrates that community learning is not confined to the acquisition of knowledge. Learning can also involve developing the ability to navigate institutions, access resources, communicate with service providers, and participate more confidently in decisions. Peer facilitation therefore connects learning with social action, which is central to empowerment-oriented community education.

Practically, community organizations should recognize these multiple roles when designing facilitator development programmes. Training should include not only HIV knowledge and interpersonal communication but also service mapping, referral procedures, case coordination, advocacy, network building, and interprofessional communication. Health services, in turn, need mechanisms that recognize peer facilitators as community partners and provide clear channels for communication and referral.

From Continued Support to Supported Independenc

The fifth theme adds another dimension to the interpretation of peer facilitation: the purpose of ongoing support was not necessarily to maintain permanent dependence on facilitators. Monitoring and follow-up could progressively support PLHIV in developing greater confidence and capacity to manage treatment, navigate services, and seek assistance appropriately when needed. This finding can be interpreted through the intersection of community empowerment and Self-Determination Theory. From an empowerment perspective, increasing independence reflects greater capacity to exercise control over decisions and resources affecting one's life (Ife, 2016). From the perspective of Self-Determination Theory, the development of competence and autonomy becomes particularly relevant (Deci & Ryan, 2000). Support is potentially empowering when it strengthens an individual's ability to act rather than continually substituting for that ability.

The findings therefore suggest a distinction between dependency-producing support and capacity-building support. Facilitators may initially provide relatively intensive assistance, particularly when PLHIV encounter unfamiliar treatment procedures, emotional distress, or barriers to healthcare. As knowledge, confidence, and service-navigation capacity develop, the facilitator's role can shift toward reinforcement, monitoring, and assistance when new difficulties emerge. However, independence should not be interpreted as complete separation from community support. The findings are better captured by the concept of supported autonomy: individuals develop greater capacity for self-management while retaining access to relational, community, and healthcare resources. This interpretation is consistent with the dynamic nature of the proposed model. A person who has developed considerable independence may still require renewed educational, psychosocial, or advocacy support when circumstances change.

For community education, this suggests that successful facilitation should not be evaluated solely by the amount of assistance delivered. An equally important consideration is whether the process progressively strengthens participants' capacity to identify problems, make decisions, access resources, and manage their own needs. Facilitator training should therefore include strategies for gradually shifting from direct assistance toward supported self-management.

Theoretical Contribution of the Proposed Community-Based Peer Facilitation Model

Taken together, the findings provide an empirically derived basis for the proposed Community-Based Peer Facilitation Model, represented through the pathway trust–capacity–connection–independence. The contribution of this model does not lie in claiming a new or validated intervention for improving ART adherence. Rather, its contribution lies in integrating several mechanisms that are often considered separately in discussions of peer support.

Trust represents the relational condition that enables participation and dialogue. Capacity develops through educational and psychosocial processes that strengthen knowledge, confidence, coping, and decision-making. Connection reflects access to social, community, and institutional resources through collaboration and advocacy. Independence represents the gradual development of treatment-related self-management while maintaining access to supportive networks. The three theoretical perspectives explain different but complementary dimensions of this pathway. Community empowerment explains movement from participation and dialogue toward increased capacity, access to resources, and agency. Social Support Theory explains how emotional, informational, instrumental, and appraisal resources

operate within facilitator relationships. Self-Determination Theory helps explain how these supportive conditions relate to relatedness, competence, and autonomy. Their integration provides a more comprehensive interpretation than any single framework alone.

The findings both confirm and extend previous research. They are consistent with studies demonstrating the relevance of peer relationships and social support to HIV care, including Berg et al. (2021). However, they extend this literature by showing how peer support can be understood as an educational and empowerment process, particularly through the roles of facilitators as educators, learning facilitators, knowledge mediators, connectors, and empowerment agents. The study therefore shifts analytical attention from asking only *whether peer support contributes to treatment engagement* toward examining *how learning, relational support, resource connection, and developing autonomy interact within community-based facilitation*. At the same time, the findings should not be interpreted as establishing a universal sequence. The proposed model is dynamic and context-dependent. Trust may need to be rebuilt, needs reassessed, information revisited, or advocacy reactivated as circumstances change. Consequently, the model is best understood as a conceptual and empirically derived framework from the SSG case whose transferability to other settings requires consideration of contextual similarities and further empirical investigation.

Educational and Practical Implications

The findings have several implications for community-based and nonformal education. First, peer-facilitator training should move beyond content mastery. Knowledge of HIV and ART remains important, but facilitators also require competencies in needs assessment, dialogical communication, adult and community learning, health literacy, reflective facilitation, psychosocial support, service navigation, advocacy, and collaborative networking. This broader competency profile reflects the finding that facilitators operate simultaneously as educators, supporters, mediators, and community empowerment agents. Second, peer facilitation can be developed as a form of community learning rather than merely a mechanism for delivering health messages. Learning activities should begin from participants' experiences and needs, use accessible language, create opportunities for questions and reflection, and connect knowledge with practical decisions. Such an approach is particularly relevant to nonformal education because learning occurs flexibly within everyday community contexts rather than through standardized classroom-based instruction.

Third, health education should be integrated with psychosocial support. Providing accurate information alone may be insufficient when stigma, anxiety, low self-confidence, or social barriers influence an individual's capacity to act on that information. Community-based health education can therefore be strengthened by combining knowledge development with emotional support, motivational communication, coping strategies, and opportunities for supported decision-making. Fourth, facilitator capacity development should be continuous rather than limited to initial training. Facilitators encounter changing treatment information, complex psychosocial circumstances, ethical issues, service barriers, and situations that may exceed their competencies. Community organizations should therefore provide ongoing learning opportunities, reflective supervision, case discussion, updated health information, and clear mechanisms for professional referral when required.

Finally, effective peer facilitation requires institutional collaboration between community organizations and healthcare services. Community organizations possess relational and contextual knowledge that can facilitate engagement with PLHIV, while healthcare institutions provide clinical expertise and formal treatment services. Clear referral pathways,

communication mechanisms, role boundaries, and opportunities for joint capacity building can help connect these complementary resources. The proposed model therefore suggests that strengthening ART-related support requires investment not only in individual facilitators but also in the learning and collaboration ecosystem surrounding community-based facilitation.

CONCLUSION

This study provides an in-depth understanding of community-based peer facilitation in supporting ART engagement among people living with HIV (PLHIV) within the Saburai Support Group (SSG). Five interconnected processes were identified: trust building, needs assessment and educational support, psychosocial support, collaboration and advocacy, and monitoring and strengthening independence. Peer facilitators therefore function not only as treatment supporters but also as educators, learning facilitators, knowledge mediators, counsellors, advocates, connectors, and community empowerment agents. Based on these findings, the study proposes an empirically derived Community-Based Peer Facilitation Model organized around the trust–capacity–connection–independence pathway. The model highlights how relational, educational, psychosocial, and community-based processes may interact to support treatment engagement and self-management. The findings also suggest the importance of strengthening facilitator competencies in community learning, psychosocial support, communication, advocacy, and collaborative networking.

However, the study is limited by its single-case design, purposive sampling, and small qualitative sample of eight participants, which restricts broad generalization. The study also relied primarily on participants' qualitative accounts and did not quantitatively measure ART adherence or clinical outcomes, while the proposed model has not yet been externally validated. Therefore, the findings should be considered in terms of transferability rather than generalizability, and further research across diverse community and healthcare settings is needed to examine and refine the proposed model. Formal permission to conduct the study was obtained from the Saburai Support Group (SSG), Bandar Lampung, through Research Approval Letter No. 417/009/SSG-LPG/II/2025, dated 22 February 2025. All participants received information about the study procedures, voluntary participation, confidentiality, and their right to withdraw before providing informed consent. Participant identities were protected using anonymous codes, and potentially identifying information was excluded from the research records and reporting.

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