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Lifelong ART for 20 million people in sub-Saharan Africa: communities will be key for success

At the end of 2012, 9·7 million people accessed antiretroviral therapy (ART) in resource-limited settings.[1] Scale-up of ART in the past decade is estimated to have averted more than 4 million deaths. Nevertheless, an additional 16 million people are eligible for treatment under the new WHO guidelines[1] but are yet to receive it, most of whom are in sub-Saharan Africa; all HIV positive individuals will eventually need ART.[2] Inevitably these guidelines will affect societies in high-prevalence settings, where up to a third of the adult population will have to change their lifestyle to adhere to lifelong care and treatment.

Increasing evidence shows the potential for community participation to reinforce the continuum along the care pathway. First, uptake of HIV testing can increase rapidly through application of home-based and community-based HIV testing strategies.[3] Moreover, new technologies such as self-testing with rapid oral tests offer great potential for self-management and community participation.[4] Second, new simple technologies such as point-of-care CD4 cell tests favour community participation, and result in a reduction of the time to eligibility assessment.[5] Another strategy that has been proposed, but not yet fully evaluated, is for community health workers (CHWs) or trained expert patients to initiate ART for clinically stable and eligible patients within their community.[6] Such a demedicalised approach would not have been possible to contemplate only a few years ago when most patients presented late, with multiple comorbidities, and when ART needed careful supervision. Although late presentation is a challenge, overall, people are seeking care when less sick, treatment guidelines are encouraging earlier initiation of ART, and the standard first-line ART is far less toxic and easier to administer than past drugs.[2] Furthermore, simple screening instruments to rule out tuberculosis with simple questionnaires have been validated.[7] Finally, several studies have shown that delivery of ART within the community is associated with sustained retention and adherence.[8] CHWs can assure ART supply within their communities, including through home-based delivery.[9] Other approaches to community ART include monthly refills at community pharmacies or rotation of community support group members who pick up ART for the whole group at health facilities. In Mozambique, this rotation approach resulted in more than 90% retention at 4 years, which shows that retention is greatly enhanced when people living with HIV/AIDS have an active role in the daily management of their disorder.[9,10] These community-based interventions have been piloted in isolation, in different settings, but can be brought together into an overarching comprehensive HIV care model that recognises the contribution of these community-based interventions as a central part of the overall response.

For this to work, first, community-driven programmes need to be designed in collaboration with the expected beneficiaries because the sustainability of the community programme depends on the development of leadership and bonding trust relationships. Second, a community-driven chronic care model can work only if a functional referral system is in place for people who fall ill. Finally, community models come at a cost, in particular the need to ensure remuneration for lay workers; however, these costs are small compared with the costs associated with clinic-based care.[9]

Nevertheless, we believe that a comprehensive community-driven HIV care model which assures a continuum for uptake, linkage, and retention could be the way to go to address the enormous challenges of weak health systems and uncovered patient's needs in the most affected countries.

We declare that we have no competing interests.

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