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Bridging systems and selves: a qualitative exploration of peer navigation as a developmentally tailored engagement strategy for adolescent HIV services

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Abstract

Background Adolescent peer navigation is a promising strategy to improve engagement and health outcomes among adolescents living with HIV (ALHIV), yet youth-focused models remain underdeveloped and poorly documented, particularly in low- and middle-income countries. The Moi Teaching and Referral Hospital (MTRH) Rafiki Centre in Eldoret, Kenya—one of Africa's largest adolescent health centers—employs young adults living with HIV as peer navigators to support clients aged 14–24. Peer navigators meet defined eligibility criteria, including secondary school completion, ART adherence, and viral suppression, and are employed until age 25. Their compensation is supported primarily by USAID/PEPFAR-funded annual stipends, placing them outside formal health workforce structures and limiting access to employment benefits. This study addresses a critical evidence gap by providing an in-depth analysis of the structure, functioning, and perceived impact of this adolescent peer navigator model.

Methods In June 2024, we conducted semi-structured qualitative interviews with 23 participants: eight current peer navigators, six former navigators, and nine health care workers who supervise or collaborate with peers. Interviews explored peer roles, training, supervision, program strengths and challenges, and perceived effects on adolescent outcomes. Audio-recorded interviews were transcribed and analyzed using reflexive thematic analysis, combining deductive codes based on interview domains with inductively generated themes.

Results Participants described peer navigators as central to adolescent engagement, trust-building, and improved clinical and psychosocial outcomes. Shared lived experience allowed peers to normalize HIV, promote adherence, reduce stigma, facilitate disclosure, and strengthen adolescents' self-acceptance and coping. Peer navigation functioned as a bidirectional bridging mechanism: peers guided adolescents through clinical and social systems while conveying youth realities back to providers, enhancing responsiveness and equity. Peers, however, reported significant emotional burden, safety concerns during community visits, and challenges maintaining boundaries with clients. Structural vulnerabilities were prominent; reliance on donor-funded stipends without formal recognition,

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living wages, or benefits created job insecurity, undermined professional legitimacy, and threatened program sustainability.

Conclusions The Rafiki Centre's program demonstrates how adolescent peer navigation can advance youth-friendly HIV care by integrating lived experience into health systems in ways that improve adherence, reduce stigma, and enhance psychosocial well-being. Yet the same features that make peer navigation effective also create vulnerabilities that require institutional support. Strategic frameworks and institutional structures that allow timely and honorable entry and exit of peer roles, support in transitioning to other opportunities, and protections for physical, emotional and financial safety are essential for sustaining and scaling this developmentally attuned, equity-promoting model of adolescent HIV care.

Keywords Peer navigation, Adolescents, HIV, Youth-friendly services, Kenya

Introduction

Peer navigation has emerged as a promising strategy to improve health outcomes among adolescents living with HIV by leveraging the unique power of shared lived experience. While adult peer navigator models—where clinic patients help each other navigate the complexities of the health care system—are well established, similar adolescent-focused approaches remain underdeveloped, particularly in low- and middle-income countries (LMICs), where young people face distinct developmental and structural barriers to care [1, 2]. Health systems are largely designed for adults and often fail to accommodate adolescents' relational, emotional, and social needs, leaving critical gaps in engagement, retention, and overall health outcomes [3].

Adolescent peer navigation programs are grounded in developmental theory, which recognizes adolescence as a pivotal period of identity exploration, increasing autonomy, and heightened reliance on peer relationships [4]. For adolescents living with HIV, these developmental transitions intersect with stigma, disclosure challenges, and complex emotional experiences, further complicating engagement with care [5–8]. Adolescent peer navigators are young people living with HIV who are the same age or slightly older than the clinic patients they assist and who share similar lived experiences; they are therefore uniquely positioned to bridge these gaps. Acting more like older siblings or friends rather than authority figures, they empower adolescents to take ownership of their health, navigate healthcare systems independently, and cultivate self-acceptance. By providing representation, validation, and lived examples of successful HIV treatment, peer navigators enhance both clinical outcomes, including ART adherence and viral suppression, and psychosocial outcomes, such as self-confidence, social connectedness, and resilience [9].

The World Health Organization underscores that adolescent and youth-friendly health services must be accessible, acceptable, equitable, appropriate, and effective [10, 11]. Peer navigation contributes directly to these objectives by creating safe, non-judgmental spaces, reducing stigma, improving treatment literacy, and fostering trust between adolescents and health systems. Despite the demonstrated benefits of adult-focused peer programs on retention and viral suppression, far less is known about how peer navigation functions for adolescents or how models can be optimized for the specific developmental and social contexts of youth. Detailed description of adolescent peer navigator programs—including peer eligibility, training, supervision, and support structures—is limited, leaving a critical evidence gap for implementation, policy, and scale-up of youth-centered HIV care models and replication in other disease areas.

This study addresses that gap by providing a detailed qualitative description and analysis of the Rafiki Centre's Adolescent Peer Navigator Program in western Kenya. Drawing on interviews with peer navigators ("peers") and health care workers, we examine peer eligibility, roles and responsibilities, training, supervision, and perceived impacts on adolescent health outcomes and well-being, while also highlighting structural and personal challenges facing peers.

Methods

Study design, participants, sampling and recruitment

In June 2024, we conducted a qualitative evaluation of the Adolescent Peer Navigator Program at the MTRH Rafiki Centre for Excellence in Adolescent Health. This work was intended to be pragmatic, in order to characterize the adolescent peer navigator program, comprehensively describe the model and identify both challenges and successes of the program. Using semi-structured interviews, we engaged three stakeholder groups: (1) current peer navigators employed at the Rafiki Centre; (2) former peer navigators; and (3) health care workers who supervise or work alongside peer navigators. Current peer navigators and health care workers were recruited through the research team's existing collaboration with the Rafiki Centre. Study staff approached eligible peer navigators and supervising health care workers in person to invite participation. With assistance from the current peer

navigator team, researchers also identified and contacted previously employed peer navigators.

Study setting

This study was conducted within the AMPATH research network, an academic collaboration between Moi University School of Medicine, Moi Teaching and Referral Hospital in Eldoret, Kenya, and a consortium of North American universities led by Indiana University [12–14]. AMPATH provides care for more than 7,000 children and youth living with HIV and includes the Rafiki Centre of Excellence in Adolescent Health, one of the largest adolescent health centers in Africa. Uasin Gishu county, where this work takes place, has an HIV prevalence rate of 4.3%, with young people ages 15–24 accounting for 39% of new infections [15, 16]. Care disengagement among this group remains high, re-enforcing the need for peer engagement strategies.

Ethical considerations

Ethical approval was obtained from the Icahn School of Medicine at Mount Sinai Institutional Review Board in New York, NY, USA (study #23-01431), the Moi University/Moi Teaching and Referral Hospital's Institutional Research and Ethics Committee in Eldoret, Kenya (#0004678) and the Kenyan National Commission for Science, Technology and Innovation (NACOSTI P254173725). All participants were over the age of 18 years with English proficiency and provided informed consent for themselves. All participants received 1,000 Kenyan Shillings (~$8 USD) for their time, an amount determined by the local regulatory body.

Research team and reflexivity

The study team included Kenyan investigators with affiliation with the Rafiki Centre and extensive history working with peer navigators and international investigators without Rafiki Centre affiliation. The study was led by a female international principal investigator (AC) with expertise in conducting research with adolescents living with HIV in Kenya and a female Kenyan site investigator (EA) with clinical expertise in caring for children and adolescents living with HIV. EA is also the director of the Rafiki Centre and therefore had extensive experience working with peer navigators. The remaining team consisted of a Kenyan program manager (JA), two international research assistants (AB, SS) and three additional international co-investigators (RV, LE, MO) who have extensive expertise in research with vulnerable adolescent populations in the study setting. We intentionally used a combined insider-outsider approach to conducting interviews and analysis to mitigate confirmation bias from team members affiliated with the program. Interviews and analysis were conducted by international team members (outsiders), with findings reviewed and confirmed with Kenyan team members (insiders).

Data generation and analysis

The study team developed three stakeholder-specific interview guides (Appendix 1). The interview guides aimed to characterize the adolescent peer navigator program in order to comprehensively describe the model. Interviews examined two primary domains: (1) the structure of the peer navigator model—including role expectations, responsibilities, training, and integration within the clinical team—and (2) participants' experiences with the program, such as challenges encountered when working with adolescents and the ways peer navigators' lived experience shaped their performance. Former peer navigators were additionally asked about their transition out of the role, while health care workers reflected on these domains from a supervisory perspective.

International investigators conducted each interview in English in private rooms in the clinical setting. All study participants were fluent in English. Interviews were audio-recorded and transcribed for analysis. To foster open dialogue, especially around the vulnerabilities of the peer navigator role, no field notes were collected during interviews, and no external observers were present. Data were analyzed following Intentional Peer Support principles, which emphasizes the use of similar experiences to build trust and create new perspectives among clients [17]. This approach moves away from 'fixing' client issues and toward navigating challenges together. We conducted a mixed deductive and inductive conventional content analysis [17]. Investigators AC, AB and SS led the content analysis based on an initial framework of codes and themes derived from the interview questions; additional themes and codes arose from the data. The description of the peer navigator role arose from the deductive analysis, while findings around program impact and role challenges arose inductively. The researchers independently extracted and analyzed data using the qualitative software program ATLAS.ti 24 and generated initial themes independently before comparing results and reaching a consensus. In a series of interpretive meetings, both international (LE, RV, MO) and Kenyan investigators (EA, JA) discussed analytic notes and further defined and refined themes.

Results

We enrolled 23 participants: eight current peers (median age 25 years; 5 female, 3 male), with a median employment length of 18 months (IQR: 1–6 years); six former peers (median age 31 years; 2 female, 4 male) with a median employment length of 5.5 years (IQR: 2–9 years), and nine female health care workers with a median employment length of 4 years (IQR:3–7 years).

This analysis led to the description of the adolescent peer navigator model described above, and the following additional themes: program impact, peer navigation as a bi-directional role, peer navigator experiences and challenges, and structural employment challenges.

Program context: the adolescent peer navigator model

This peer navigator model description was derived from the semi-structured interviews with current and former peer navigators and healthcare workers and summarized in narrative form. Established in November 2016, the Moi Teaching and Referral Hospital (MTRH) Rafiki Centre is a combined adolescent medicine and research clinic that provides a "one-stop shop" for free reproductive health, mental health, nutrition, chronic disease management, HIV prevention and treatment services and life skills for adolescents living with HIV in Eldoret, Kenya. It provides adolescent-friendly services to nearly 1,400 adolescents in Eldoret, Kenya, with viral suppression rates around 95%. The clinic also serves as a training location for future pediatricians, nurses, social workers, and counselors on adolescent-friendly care, and it is the training center for the Academic Model Providing Access to Healthcare (AMPATH's) other 500 + care sites across western Kenya that serve more than 15,000 children and adolescents living with HIV.

The Rafiki Centre's Adolescent Peer Navigator Program is designed to support adolescents living with HIV by leveraging the unique expertise of peers with lived experience. Peer navigators are young adults (≥ 18 years) living with HIV who are aware of their status and willing to share their experiences with clients. Most peers are former Rafiki Centre patients, though some are recruited through formal job postings. Eligibility criteria include completion of secondary school, consistent antiretroviral therapy (ART) adherence, documented viral suppression, and regular clinic attendance. Peers are employed until age 25, allowing for up to seven years of service. Peer navigators support adolescents aged 14–24 who are aware of their HIV status and engaged in care at the Rafiki Centre. Clients are assigned to peers by age cohort rather than gender, with each peer responsible for a defined group. Peers with additional training provide targeted support for adolescents with complex needs, including those disengaged from care, pregnant or parenting, or experiencing homelessness or street involvement. Clinic volumes fluctuate seasonally due to boarding school schedules, with peers typically seeing 5–20 clients per day during school terms and up to 60 per day during school holidays.

Peer navigators serve as frontline staff, delivering a combination of administrative, clinical, and psychosocial support. Within the clinic, they manage client intake, scheduling, referrals, and documentation. They also conduct home visits for adolescents lost to follow-up or facing barriers to care, providing individualized counseling, assessing needs, and supporting re-engagement. Peers deliver sexual and reproductive health and mental health education in schools and coordinate care continuity for traveling clients through an informal network of peers across AMPATH sites. Across settings, including phone-based interactions—navigators provide psychosocial support and health education covering HIV, sexual and reproductive health, mental health, and general wellness. They facilitate peer support groups, assist with ART adherence and disclosure challenges, and organize community-building activities such as "fun days" and income-generating skills training (e.g., tailoring, beadwork, farming, and hairdressing). Relevant interactions are documented in the electronic medical record. Working hours are structured around adolescents' schedules (08:00–18:00, Monday–Saturday), with additional phone-based support as needed. Peer navigators report to the clinician and nurse in charge and collaborate with a multidisciplinary team, including clinicians, nurses, psychologists, and counselors, for mentorship and guidance.

Peer navigators receive an initial training at the time of hiring, with senior peers occasionally participating in subsequent cohort trainings as refreshers. The curriculum equips peers with the knowledge and skills necessary to support adolescents across clinical, behavioral, and psychosocial domains. Core modules cover role responsibilities, communication, and group facilitation. HIV-specific content addresses ART adherence, disclosure, pre- and post-exposure prophylaxis (PrEP/PEP), and Operation Triple Zero foundations, alongside strategies for promoting self-acceptance and healthy relationships. Additional modules address sexual and reproductive health, mental health, substance use, ethics in working with vulnerable adolescents, conflict resolution, and personal development. A general wellness component includes nutrition, anatomy, exercise, self-esteem, and body image. Together, these modules prepare peers to deliver youth-centered, developmentally appropriate care.

Despite their critical contributions, peer navigators face challenges in integrating into the formal health system. Some peer navigators retain the role while enrolled in tertiary education, requiring complex balancing of multiple demands. Many have and will not complete post-secondary education, placing them outside standard hiring frameworks and sometimes undermining professional legitimacy. Program funding relies primarily on time-limited donor support (e.g., USAID, PEPFAR), with peer navigators compensated through annually renewed stipends rather than formal salaries. This structure limits compensation and access to employment benefits, including health insurance and paid leave, contributing to feelings of undervaluation among peer navigators.

Program impact

Participants highlighted the transformative role of peer navigators for adolescents. Peers fostered inclusive, non-judgmental spaces, and helped the clinic to run smoothly by mitigating adolescent patient challenges and providing health education and guidance. Two healthcare workers said:

> *Their value is high with Rafiki. Without them, the adolescents are very difficult to handle… they can intercede and ensure the clinic runs smoothly without many challenges. (Female, Healthcare worker 4)*

> *We found it very important that when [health education or recommendations] comes from us [health care workers] it is different and it is taken better when it comes from the peers… When the client discovers this person takes medication just like me, it sinks to them. (Female, Healthcare worker 7)*

Peer navigators were credited with being able to uniquely connect with adolescent patients, establishing trust that leads to improved psychosocial outcomes, including self-confidence, self-acceptance, and resilience as well as opportunities to provide support. Peer navigator and health care worker participants said:

> *It's good [for clients] to have someone who they can trust. He can call you anytime just to consult how they are doing. Before someone calls, they have that trust in you. And they're sure you can help me. So that is, it's a good feeling. (Male peer navigator, 4)*

> *I think it [trust] is very crucial. I always say this -- in any relationship there must be trust and for trust to be maintained, everyone must respect each other. (Male, Peer navigator 1)*
> *The peers are of the same age… If a client is able to give their personal issues to the peer, then we can support them all. They are so valuable bringing the adolescents just to understand themselves… to have that picture of having that self-confidence, self-love and to build themselves and prepare for a future. (Female, Healthcare worker 3)*

Peers also helped normalize HIV disclosure, reduce stigma, and address challenges unique to adolescence.

> *That is our core objective that adolescents living with HIV are actually comfortable adhering [to ART]; they are able to and know how to disclose [their HIV status] to their sexual partners; they don't face stigma in school; and they learn how to navigate school life if they don't want to disclose [their HIV status], including some of the tactics that they can use. (Female, Former peer navigator, 3)*

Bi-directional bridging role

Study participants consistently situated peer navigators in a bi-directional bridging role within the health system, supporting adolescents through their challenges while conveying these lived realities back to the healthcare worker team. One male peer navigator provided a hypothetical example based in previous experience in which a client discloses significant harm only to him; his role as a peer navigator subsequently allowes him to report this information back to the health system to get the client the care needed:

> *So, if a client tells me something like for example, 'my dad raped me' and that is a very bad picture, what I will do is go over to the next professional because I am not well conversant with that. I will go to the next professional and tell them this client has been going through something, and it has disturbed her. I am asking for you to offer this and this service and then go back to the client, talk to the client and tell them. (Male, Peer navigator 1)*

Outside of emergency cases requiring immediate attention, healthcare workers described a formal structure for peer navigators to report client needs back to the clinical team:

> *On Tuesdays we have a meeting for all the staff plus the peers. Normally that is when we discuss our clients but during the meeting that is when the peer can say, 'I talked to a certain client, maybe this is what they are going through, and this is what I feel should be done. (Female, Healthcare Worker 9)*

This bi-directional role, in which adolescent peer navigators can seamlessly and quickly connect clients to care, was credited with improved clinical outcomes, like strong clinic HIV suppression rates:

> *If you look at our suppression rates, we have crossed over with around 97% suppression and that's happening because the peer navigator will tell you [that this client] has a problem, we need to provide additional support to this person. (Female, Healthcare worker 4)*

Peer experiences and challenges

Peers described a complex and emotionally demanding role. Navigating relationships with clients required maintaining professional boundaries, particularly around

romantic or sexual advances. Safety concerns were significant, especially during home visits.

I had to go with [male peer navigator] if we were to go somewhere… Sometimes they will fear him. So, I don't have to go alone… they can even rape you. (Female, Former Peer Navigator 2)

You make sure you maintain that friendship; you don't go beyond friendship. Because if you do and it doesn't work, you may find someone who is rude… that person will refuse medication. (Female, Peer Navigator 1)

Disclosure Disclosure of HIV status was sensitive; peers used selective disclosure to support adolescents while protecting their own privacy. Emotional burden on the peer navigators was substantial, given the overlap between peers' and clients' life stages and challenges.

I said there is no consequence because we are sharing everything… Whatever I am going through, the other person is also going through. (Female, Peer Navigator 4)

Remember these peers are of the same age as the people they are working with, the clients. So, they have their own burden… sometimes they are also burdened with their own problems—challenges of disclosure, relationships, and they don't know how to handle it. (Female, Healthcare worker 2)

Employment and structural challenges

Peers reported challenges related to employment logistics, including limited recognition, insufficient compensation, lack of formal benefits such as health insurance and paid time off, and high workloads. Both peers and health care workers emphasized the need for greater professional acknowledgment and support.

I would like to be recognized like a profession because we spend most of the time here. We are the ones who actually interact more with the clientele. (Male, Peer Navigator 6)

For me, I think they need to have some days off because the work they are doing is a lot. For the salary, they are the face of the adolescent clinic, they need good money… and they are being given stipends. I propose for better. (Female, Healthcare worker 1)

Supervision and support

Health care workers described supervision as multifaceted, encompassing clinical guidance, emotional support, personal growth, and promotion of self-acceptance. Supervisors provided case-specific guidance to strengthen peers' clinical decision-making and problem-solving.

If it is within my capacity, if it is something to do with a certain condition or if it is a problem with the client then I am able to educate this particular peer on how to handle such an issue… So, I am able to empower them with the knowledge I know. (Female, Healthcare worker 5)

Supervision also addressed emotional well-being, with structured opportunities for debriefing, counseling and mentoring helping peers cope with the emotional demands of their work.

They are too emotional at times because of the overwhelming work, but they normally come among themselves and talk about it and when it is so heavy they go to our in-charge. They will be called, and they air their views, and it will be heard and helped out; we discuss on how to reduce it or how to do it in a better way. (Female, Healthcare worker,6)

My role is also to support them, ensure that beyond here they are also growing themselves… I would also want to build them personally to ensure that they are becoming people in the society that can work, because sometimes with stigma and all that you don't want to make them feel like because they are HIV positive that is what they should just be doing; they can do any other thing that anybody else is doing out there. (Female, Healthcare worker 8)

I do a lot of psych education, helping them to have self-awareness, making them to be assertive and just working with their mental to have that wellness and to come to full acceptance. (Female, Healthcare worker 2)

Discussion

This study contributes a needed description of a peer navigator model designed specifically for adolescents living with HIV, addressing a notable gap in the literature where such models remain undocumented. Our data describe how peer navigation functions not only as an engagement strategy but also as a bi-directional bridging role, communicating needs between the adolescent and the health system.At the Rafiki Centre, adolescent peer navigators serve as the first and last point of contact for clients, supporting registration, counseling, health

education, system navigation, and broader psychosocial wellbeing. Health care workers consistently credited peers with transforming clinical outcomes—most notably improving viral suppression rates to over 90%—while also advancing adolescents' self-acceptance, confidence, and willingness to disclose their HIV status [15]. In all these ways, peer navigators not only support adolescents' engagement in care but also address broader developmental realities, providing holistic, youth-centered support that fosters self-acceptance, resilience, and long-term well-being.

A central contribution of this study is the articulation of peer navigation as a **bidirectional bridging role**: peer navigators guide adolescents through complex health and social systems, while simultaneously conveying the lived realities of young people back to providers and systems. This dual function aligns with the growing emphasis on relational implementation strategies in translational science, emphasizing the importance of closing feedback loops between youth and health systems [18, 19]. By embedding peers into care pathways, outreach structures, and feedback processes, programs like Rafiki's enhance cultural alignment, responsiveness, and equity, particularly for youth who might otherwise disengage due to stigma, discrimination, or mistrust. Peer navigation therefore represents not only an effective approach to HIV care but also a scalable, equity-focused strategy for adolescent engagement in health systems.

This study also highlights critical challenges inherent in peer navigation. Identity proximity—being the same age as clients—facilitates trust and relatability but introduces vulnerabilities. Female peers described managing romantic or sexual advances from male clients, safety risks during community visits, and male and female peers reported the emotional burden of supporting adolescents while navigating their own challenges with disclosure, stigma, and relationships. Health care workers corroborated the emotional weight of the role; additional mental health supports are needed to mitigate the psychological and mental health burden experienced by peers. Rafiki's approach—including comprehensive training, flexible supervision, debriefing sessions, and peer support spaces—illustrates an important model for mitigating these risks and when paired with more robust mental health supports, should be considered essential for replication or scale-up.

Importantly, the present evaluation identified that the precarity of peer navigator employment represents a significant challenge for peers and their clients. Many peers, lacking advanced education, fall outside formal hiring structures, relying instead on short-term donor funding and annually renewed stipends to receive pay for their roles. This arrangement limits compensation, job security, and access to benefits such as health insurance and paid leave, despite peers' central role in adolescent care. Both peers and health care workers emphasized the misalignment between responsibilities and recognition, highlighting how informal payment structures and low pay undervalue contributions and threaten program sustainability. These challenges point to a broader picture of limited employment opportunities for youth in Kenya, who have an unemployment rate of 67% [20–22]. Limited educational opportunities lead over one million young people to enter the labor market annually without skills applicable to the formal sector, pushing most into precarious informal work. Together, these dynamics underscore the urgent need for more stable, formalized employment pathways that recognize and sustain the essential contributions of peer navigators within Kenya's constrained youth labor market.

Programmatically, these findings resonate with broader concerns about reliance on "soft money" to sustain community-based HIV programs [23]. To secure the long-term viability of peer navigation, strategic frameworks and institutional structures that clarify and reiterate the role of the adolescent peer navigator are critically needed. Institutions must implement structures that allow for timely and honorable entry and exit from the peer navigator role and impose restrictions on both hours worked and excess task shifting from health care workers. Additionally, institutional structures may provide additional protections for peer navigation physical, emotional and financial safety, support in transitioning to other opportunities at the time of role exit, and lastly, appropriate and equitable pay. Institutions must recognize peer navigators as essential members of the HIV response, moving beyond temporary stipends to provide fair wages, insurance, rest, and labor protections. Institutionalizing the role would not only improve retention and wellbeing among peers—many of whom are living with HIV themselves—but also ensure that the demonstrated clinical and psychosocial gains of peer navigation are sustained. Furthermore, as peer navigator structures exist for adult populations as well, investments in capacity building for the transition of adolescent peer navigators into adult care settings not only provides employment stability for peers, but also for continuity of care supports for patients. Critically, such commitments reframe peer work from a stopgap intervention to a professionalized, developmentally appropriate workforce strategy that strengthens health systems and improves health outcomes.

Future research should examine the mechanisms with which adolescent peer navigation impacts client clinical outcomes, like ART adherence, viral suppression and mental health. Implementation-effectiveness trials, mixed-method evaluations, and youth-reported outcomes are particularly needed to assess impact across

diverse contexts. Comparative studies should also explore how peer models differ from traditional provider-led engagement strategies, and how factors such as identity-matching, training intensity, and relational continuity shape effectiveness. Peer navigation holds significant promise, not only as a tool for access, but as a catalyst for systems transformation.

This study has limitations. First, assessments in this study focused on a single peer navigation program for adolescents living with HIV in Eldoret Kenya; our findings therefore may not be generalizable to other communities in Kenya or a global context, or to peer navigation programs supporting other patient populations. Second, the data were collected qualitatively without quantitative data to augment the findings. Nonetheless, qualitative inquiry provides rich context and understanding for the adolescent peer navigator model itself, and these in-depth data were critical to our objective. Finally, this study did not include the perspectives of peer navigators' clients, which may have provided additional insight into the role and its' impact on clinical care.

This study has several notable strengths. First, the qualitative design allowed for in-depth exploration of peer navigator experiences, capturing nuanced perspectives that would be difficult to elicit through quantitative methods alone. By centering the voices of peers alongside those of health care workers, the study provides a more comprehensive understanding of the structural and relational dynamics shaping peer-delivered adolescent services. Importantly, we were able to enroll all peer navigators and their supervisors employed at the study site, as well as individuals previously employed as peer navigators. Second, the inclusion of multiple stakeholder perspectives strengthened the credibility of the findings through triangulation, enabling convergence and contrast across participant groups. The use of systematic coding procedures and iterative team-based analysis further enhanced analytic rigor and reflexivity, reducing the influence of individual researcher bias. Third, the study was conducted in a real-world service delivery setting, increasing the relevance and applicability of findings to ongoing programs and policy discussions. The focus on employment precarity among peer navigators addresses an underexplored but critical dimension of adolescent health interventions in low-resource settings.,. Finally, the study's contextual grounding within Kenya's broader youth labor market allows findings to be interpreted within structural economic realities, enhancing their transferability to similar settings where informal employment and donor-dependent health programs are common.

Conclusion

This study provides a description of an adolescent peer navigator model for adolescents living with HIV in Kenya, which can be adapted for use with other clinical populations and in other settings. Adolescent peer navigation integrates lived experience into health systems in ways that facilitate trust, improve adherence, reduce stigma, and enhance youth well-being. Yet, the very features that make peer navigation effective—its reliance on youth identity and relational proximity—also create challenges that require structural investment and protection. For programs like the Rafiki Centre's to be sustained and scaled, health systems must move toward institutional structures that appropriately define the scope of the role, provide support, and ensure that their expertise, labor, and lived experience are valued as integral to the HIV response.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-026-14659-z.

Supplementary Material 1

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Author contributions

AC conceived the study and led the development of the research design. LE, RV, MO, and EA provided content and setting expertise in the design, implementation and analysis of the study. AC and JA coordinated study implementation and oversaw data collection. AC, AB and SS conducted the qualitative analysis, with all authors contributing to interpretation of the findings through iterative team discussions. JA provided project administration and logistical coordination. AC drafted the initial manuscript. All authors contributed to critical revisions of the manuscript, approved the final version, and accept responsibility for the integrity of the work.

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Data availability

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the Icahn School of Medicine at Mount Sinai Institutional Review Board in New York, NY, USA (study #23-01431), the Moi University/Moi Teaching and Referral Hospital's Institutional Research and Ethics Committee in Eldoret, Kenya (#0004678) and the Kenyan National

Commission for Science, Technology and Innovation (NACOSTI P254173725). The research was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. All participants were over the age of 18 years with English proficiency and provided informed consent for themselves.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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