

Person-centred care stakeholder consultation series

Meeting 3 - 25 May 2023

What are the service delivery considerations for providing integrated person-centred care for people living with or affected by HIV throughout their life-course?

Instructions for participants

- Please ask questions to presenters using the JamBoard. Link in chat
- The chat is for any technical issues or general questions
- Slides will be sent to all participants and posted on the IAS website
- The Q and A and breakout group time is your chance to speak up! Please stay on mute during presentations.



PCC stakeholder consultation objectives

1. Provide a platform for exchange on the concept of person-centred care in the HIV response.
2. Develop a joint consensus statement including recommendations for different groups of stakeholders as they work towards realizing the full potential of person-centred care for the HIV response.

PCC stakeholder consultation series

July 2022 –
Setting the
scene



May 2023 –
Service delivery
considerations



July 2023 –
Prioritization
for action



April 2023 –
Evidence focus



June 2023 –
Core elements
and
mechanisms



Recap of meetings 1 and 2

- PCC must acknowledge the contexts of people seeking care, factors related to their identity and their complex clinical needs
- Healthcare provision must be informed by client experiences and needs, be community-led and community-based and supported by trained providers and peer navigators
- Funding, targets, policies and access to technology are key enablers

July 2022 –
Setting the scene



- PCC frameworks exist that address complex interactions between the person seeking care and health systems
- Evidence for PCC within the HIV response is building
- One size does not fit all
- Community is crucial
- The level of integration of services can expand over time
- Investment in health care providers is key
- Long-term success requires a focus on changing needs over the life-course
- Barrier of stigma and discrimination

April 2023 –
Evidence focus



Meeting 3: 25 May 2023

Meeting objective

To reflect on the practical **service delivery considerations** for delivering integrated person-centred care services as well as the role of **client-reported outcomes** and **quality of life measures**.

Discussion questions

1. What actionable feedback can we provide to healthcare workers and health system administrators on clients' needs and preferences?
2. At the policy and financing level, what measures should be considered to promote person-centred care approaches?
3. What type of demand-creation and awareness-raising activities (Including about client rights, existing services and eligibility criteria for different services) should be implemented to support clients in taking informed choices about their health?
4. What can we learn from the development of differentiated service delivery frameworks and their implementation?

Order of Events

1. Welcome and introduction
2. Presentations (45 mins)
 - Ageing with HIV
 - Role of choice in HIV prevention
 - The origin story of DSD
 - Policy barriers to PCC in Zambia
 - Tailored services for LGBTIAQ+ people growing older with HIV in Vietnam
3. Q and A with presenters (10 mins)
4. Breakout group discussions (15 mins)
5. Report back and moderated discussion (13 mins)
6. Closing remarks

Moderators:



Alan Landay,
Rush University
Medical Center,
United States



Davina Canagasabey,
PATH,
United States



International AIDS Society

iasociety.org

Presentations

Jules Levin

**Ageing with HIV advocate
Executive Director, NATAP,
United States**

- My experiences accessing care in US clinics since being diagnosed with HIV and hepatitis
- My journey of ageing with HIV, shifting needs throughout different phases of my life and the importance of having different entry points into the health system
- Getting our voices heard! Advocating for integrated and tailored services for people growing older with HIV
- The highs and lows of being an "expert by experience"

The Choice Manifesto

Translating HIV Prevention Options into Choices – and Impact

Yvette Raphael, APHA; Joyce Nganga, WACI Health; Navita Jain, AVAC

Advocacy for Choice



Language Check

- Options
 - Biomedical methods that are safe and effective
 - Requires R&D of additional options to add to the “method mix”
- Choice
 - The ability for an individual to select from an array of options
 - Requires policy makers, donors, governments & implementers to make the “mix” available, accessible & affordable

Introduction to the Choice Manifesto

The Women's HIV Prevention Choice Manifesto has been drawn by African women in their diversity, feminists, and HIV prevention advocates across southern and eastern Africa who are united in calling for continued political and financial support for HIV prevention choice which includes the introduction and roll-out of safe and effective options, including long-acting HIV prevention tools.

The Choice Manifesto Guiding Principles

- A future free of HIV for our daughters and women in Africa
- An HIV prevention agenda that includes CHOICE and multiple options for women and girls to prevent HIV as they navigate through the different stages and circumstances of their lives
- An HIV prevention agenda that will focus, invest and prioritize the most affected population which is adolescent girls and young women in Africa and of African descent across the world
- An HIV prevention agenda that puts African women and girls at the center and forefront not only for research but also for access to products that are developed beyond clinical trials.
- An HIV prevention choice agenda that is conceptualized by the community, and responds to community needs.
- An HIV prevention agenda that follows the science and uses epidemiological evidence to make options available to women and girls who are vulnerable to HIV infections.

Call to Action

1. Prioritize key and marginalized populations and scale interventions targeting them while addressing stigma and discrimination, and criminalization
2. Ensure massive scale-up and increased access to the available HIV prevention tools and methods
3. Work tirelessly to ensure women have control over their health, and bodies and access to a range of safe and effective options, including long-acting HIV prevention tools such as the monthly dapivirine vaginal ring, to choose from so that they can choose what works best for them at different times of their lives.
4. Prioritize systematic and non-systematic long-action biomedical HIV prevention options.
5. Ensure that the HIV prevention pipeline is informed by communities in alignment with the [Good Participatory Practice Guidelines](#). It is imperative that communities inform the ongoing and future pipeline, and must be an integral part of research from the onset, design, and formulation, as well as the implementation of research to guide the progress of new interventions.

Call to Action (continued)

6. Adopt a Human Rights approach to choice.
7. Finance the Choice Agenda.
8. Integrate HIV prevention into already existing information and service packages such as family planning, cervical cancer prevention, antenatal care, and postnatal care to ensure easy access and availability of prevention methods for adolescent girls and young women.
9. Support, prioritize and finance interventions to prevent sexually transmitted disease among adolescent girls and young women who are especially vulnerable due to anatomical makeup, and cultural and traditional constraints that hinder negotiation for safer sex and adequate protection against STIs.

Next Steps

- Launch the Choice Manifesto, led by UNAIDS Executive Director Winnie Byanyima, in Uganda with key partners and AWPCAB
- Call for signatures
- Finalize dissemination plan and accompanying activities
- To get involved, e-mail yvette@apha.org.za or joyce@wacihealth.org

Ultimate Goal: Urgent and quick sign-on to the Manifesto by decision-makers, scientists, civil society, global regional donors

Thank You!

Coalition to Accelerate and Support Prevention Research (CASPR)



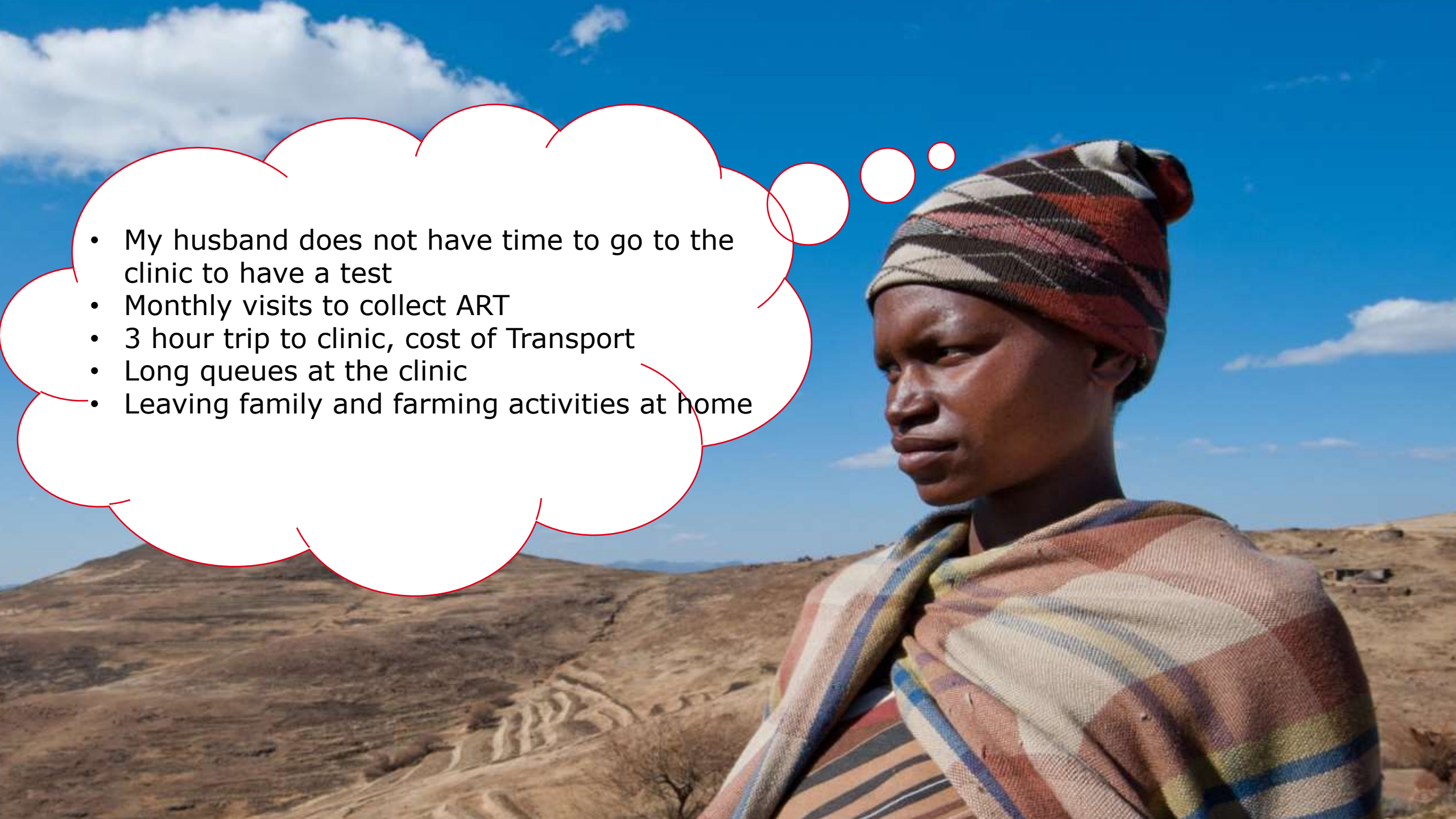
Cooperative Agreement No. AID-OAA-A-16-00031

HIV Vaccine and Biomedical Prevention Research Project—Objective 3



The origin story of differentiated service delivery

Rooting service delivery in
a person centred
approach

- 
- My husband does not have time to go to the clinic to have a test
 - Monthly visits to collect ART
 - 3 hour trip to clinic, cost of Transport
 - Long queues at the clinic
 - Leaving family and farming activities at home



SIMPLIFY THE
WAY I GET ARVs
I AM TIRED OF
WALKING

From 2008... As a response to access challenges and the progressive scale up of ART

Effectiveness of Patient Adherence Groups as a Model of Care for Stable Patients on Antiretroviral Therapy in Khayelitsha, Cape Town, South Africa *Fernandes et al PLoS One 2013*

97% of club patients remained in care compared to 85% of other patients.
Club participation reduced loss to care by 57% (HR 0.43 95% CI 0.21-0.91)

South Africa National Roll Out aiming for 100,000 clubs by next year



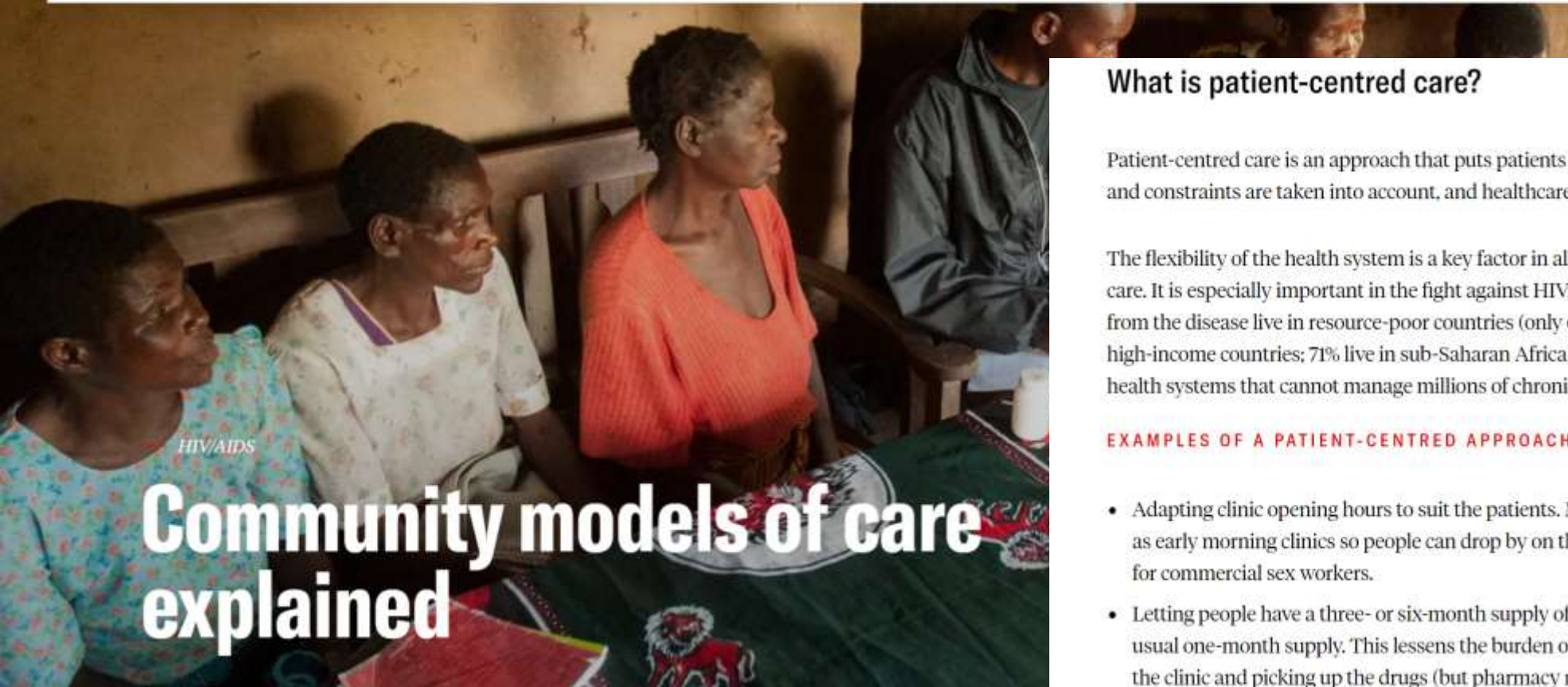
RESEARCH ARTICLE

Community ART Support Groups in Mozambique: The Potential of Patients as Partners in Care

Kebba Jobarteh^{1*}, Ray W. Shiraishi^{2*}, Inacio Malimane¹, Paula Samo Gudo¹, Tom Decroo³, Andrew F. Auld², Vania Macome⁴, Aleny Couto⁴

¹ Division of Global HIV/AIDS, Center for Global Health, Centers for Disease Control and Prevention, Maputo, Mozambique, ² Division of Global HIV/AIDS, Center for Global Health, Centers for Disease Control and Prevention, Atlanta, United States of America, ³ Medical Department, Médecins Sans Frontières, Operational Centre Brussels, Brussels, Belgium, ⁴ Mozambique Ministry of Health, Maputo, Mozambique

And a response to lack of multi-month refills
(Important: often discussed as a barrier to DSD for other chronic diseases)



HIV/AIDS

Community models of care explained

2014

What is patient-centred care?

Patient-centred care is an approach that puts patients first. It means that patients' realities and constraints are taken into account, and healthcare is adapted to those realities.

The flexibility of the health system is a key factor in allowing a patient-centred approach to care. It is especially important in the fight against HIV, as the majority of people suffering from the disease live in resource-poor countries (only 6.5% of HIV-positive people live in high-income countries; 71% live in sub-Saharan Africa). Most of these countries have weak health systems that cannot manage millions of chronic patients.

EXAMPLES OF A PATIENT-CENTRED APPROACH:

- Adapting clinic opening hours to suit the patients. MSF has several adapted models, such as early morning clinics so people can drop by on their way to work, and late night clinics for commercial sex workers.
- Letting people have a three- or six-month supply of their daily ARV drugs instead of the usual one-month supply. This lessens the burden of time and money involved in going to the clinic and picking up the drugs (but pharmacy regulations often prevent this simple measure being implemented).
- Travelling to the people in need: for example MSF in KwaZulu Natal province of South Africa organises door-to-door HIV testing.
- Listening to the challenges faced by patients and working out realistic solutions together. This is done during clinical consultations or counselling sessions.

What are community models of care?



Community driven models of care

Response to challenges of access

Taking the lead of recipients of care



UNAIDS AND MÉDECINS SANS FRONTIÈRES 2015 | REFERENCE

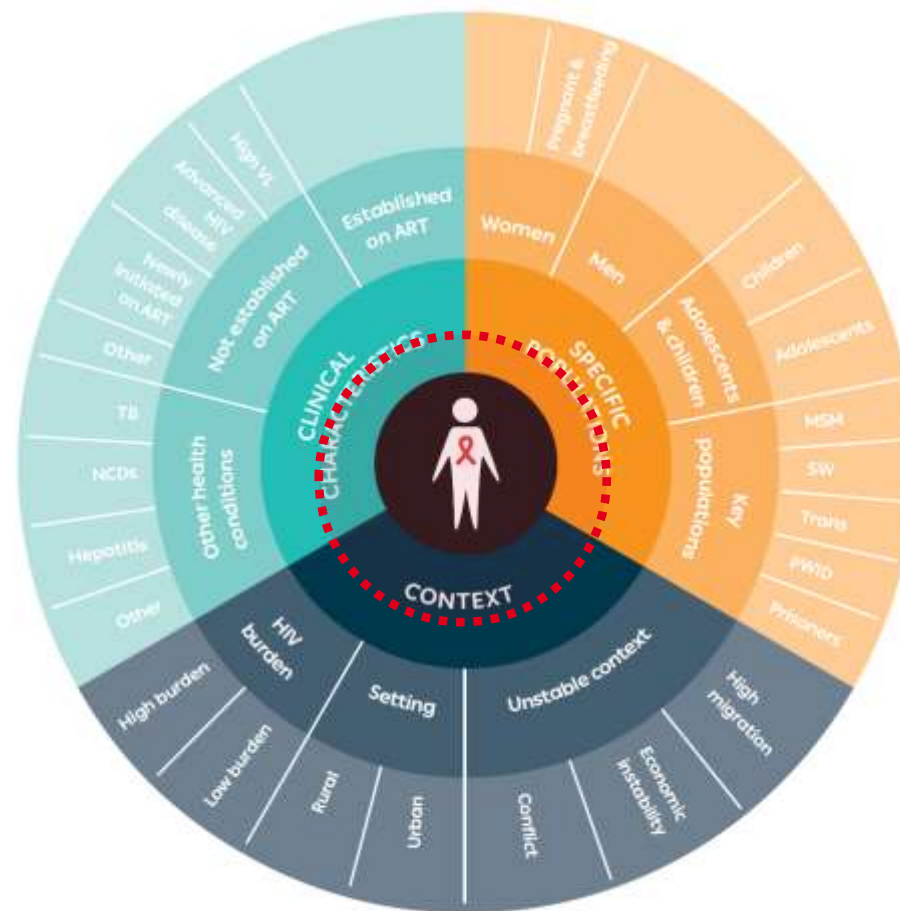
COMMUNITY-BASED ANTIRETROVIRAL THERAPY DELIVERY


EXPERIENCES OF MÉDECINS SANS FRONTIÈRES



The elements and building blocks

Person at the centre



A group of people, including several women and men, are standing outdoors in a rural setting. The woman in the foreground is holding a white sign with red text. The background shows green trees and a dirt path.

NO MORE LONG QUEUES
AT THE HEALTH FACILITY
DUE TO GROUP REFILLS

BUT

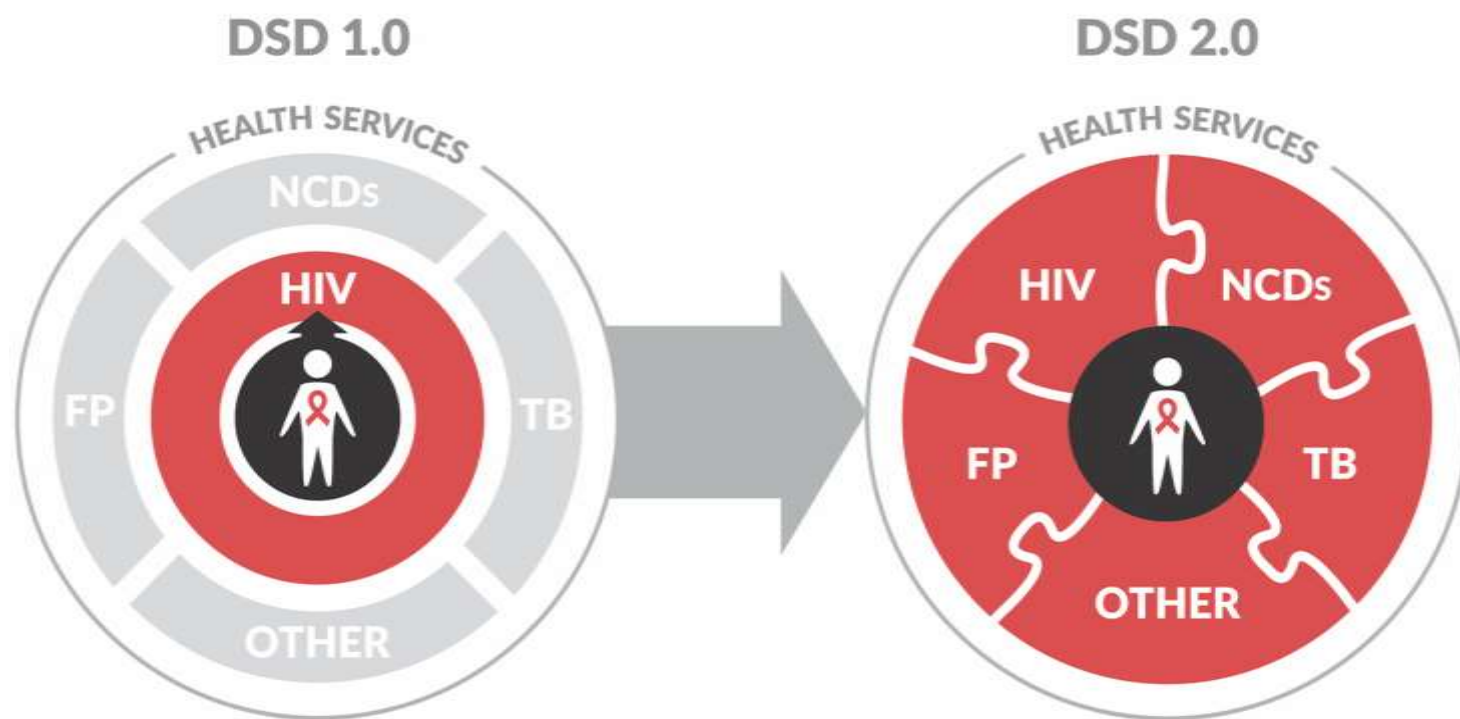


I need my
hypertension
medication

I need my
contraceptives

NO MORE LONG QUEUES
AT THE HEALTH FACILITY
DUE TO GROUP REFILLS

To provide person centred care, differentiated service delivery should not just be for ART or HIV



WHO recommendations for integration

7.9.2 Delivering ART in TB treatment settings and TB treatment in HIV care settings

Recommendation (2013)

In settings with a high burden of HIV and TB, ART should be initiated in TB treatment settings, with linkage to ongoing HIV care and ART (*strong recommendation, very-low-certainty evidence*).

In settings with a high burden of HIV and TB, TB treatment may be provided for people living with HIV in HIV care settings if they have also been diagnosed with TB (*strong recommendation, very-low-certainty evidence*).

Source: Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: summary of key features and recommendations, June 2013 (190)

WHO recommendations for integration

7.9.2 Delivering ART in TB treatment and care settings

Recommendation (2013)

In settings with a high burden of HIV and TB treatment settings, with linkage to care, *(strong recommendation, very-low-certainty evidence)*.

In settings with a high burden of HIV and TB for people living with HIV in HIV care settings with TB *(strong recommendation, very-low-certainty evidence)*.

Source: Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: key features and recommendations, June 2013 (190)

7.9.3 Integrating sexual and reproductive health services, including contraception, within HIV services

Recommendation (2016)

Sexually transmitted infection and family planning services can be integrated within HIV care settings *(conditional recommendation, very-low-certainty evidence)*.

Source: Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach – second edition (3)

Recommendation (2021)

Sexual and reproductive health services, including contraception, may be integrated within HIV services *(conditional recommendation, very-low-certainty evidence)*.

Source: Updated recommendations on service delivery for the treatment and care of people living with HIV (63)

WHO recommendations for integration

7.9.2 Delivering ART in TB treatment and care settings

Recommendation (2013)

In settings with a high burden of HIV and TB treatment settings, with linkage to care, *(conditional recommendation, very-low-certainty evidence)*

In settings with a high burden of HIV and TB for people living with HIV in HIV care settings with TB *(strong recommendation, very-low-certainty evidence)*

Source: Consolidated guidelines on the use of antiretroviral therapy for HIV, key features and recommendations, June 2013 (190)

7.9.3 Integrating sexual and reproductive health services, including contraception, within HIV services

Recommendation (2016)

Sexually transmitted infection and reproductive health services, including contraception, may be integrated within HIV care settings *(conditional recommendation, very-low-certainty evidence)*

Source: Consolidated guidelines on the use of antiretroviral therapy for HIV, key features and recommendations for a public health approach – second edition (3)

Recommendation (2021)

Sexual and reproductive health services, including contraception, may be integrated within HIV services *(conditional recommendation, very-low-certainty evidence)*

Source: Updated recommendations on service delivery for the treatment and care of people living with HIV (63)

7.9.4 Integrating diabetes and hypertension care with HIV care

Recommendation (2021)

Diabetes and hypertension care may be integrated with HIV services *(conditional recommendation, very-low-certainty evidence)*

Source: Updated recommendations on service delivery for the treatment and care of people living with HIV (63)

Frameworks for the integration of TB prevention and family planning into DSD for HIV treatment



[IAS-TPT-supplement-8-Pager-DIGITAL-1-1.pdf](#)
(differentiatedservicedelivery.org)



[DSD -FP Supplement.pdf](#)
(differentiatedservicedelivery.org)

Integration of diabetes and hypertension

Guideline for the pharmacological treatment of hypertension in adults

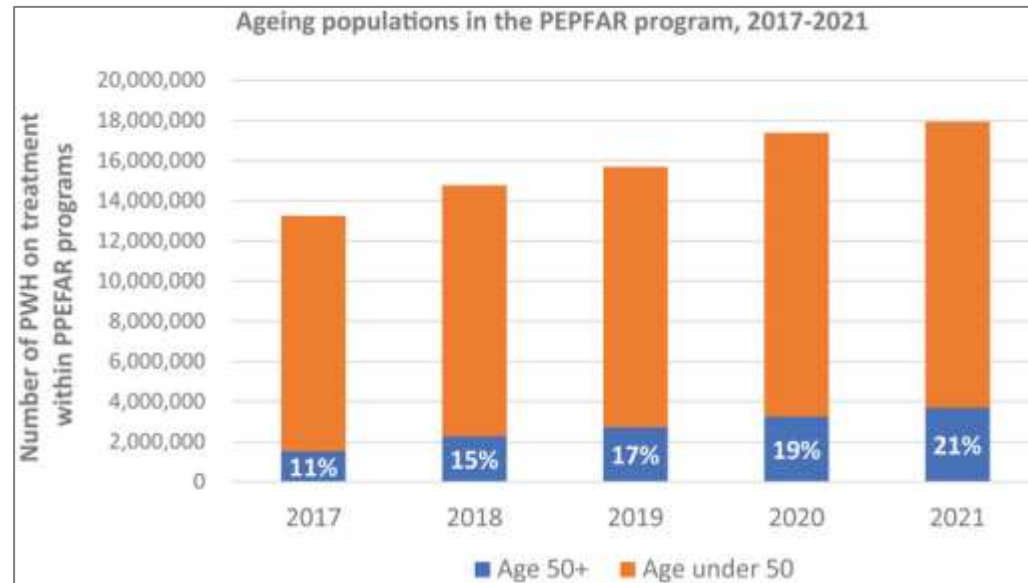
7. RECOMMENDATIONS ON FREQUENCY OF ASSESSMENT

WHO suggests a monthly follow up after initiation or a change in antihypertensive medications until patients reach target.

Conditional recommendation, low-certainty evidence

WHO suggests a follow up every 3–6 months for patients whose blood pressure is under control.

Conditional recommendation, low-certainty evidence



Godfrey, 2022, IAS

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9522630/>

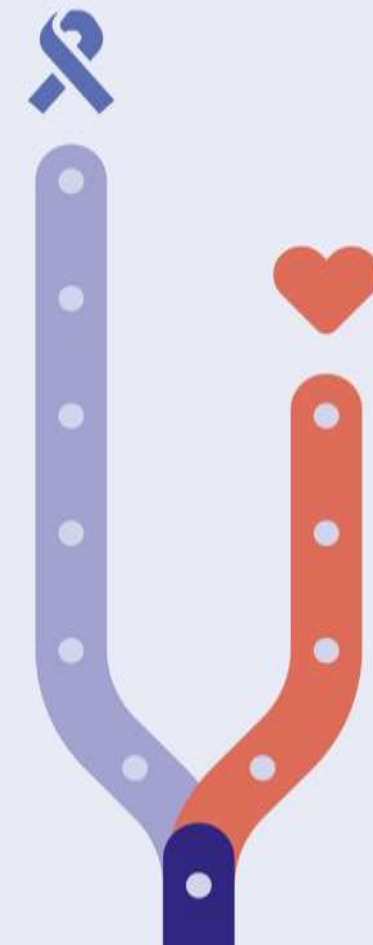
Framework for integration of hypertension (and diabetes) into DSD for HIV treatment

Figure 5: The building blocks of integrated differentiated hypertension and ART care

	Hypertension diagnosis	Hypertension medication initiation	Hypertension medication titration	Medication refill
WHEN	At ART initiation/ re-initiation Entry into DSD for ART Clinical visits for ART	At ART initiation/ re-initiation Entry into DSD for ART Clinical visits for ART	Monthly visits until hypertension is controlled, then every 6 months	Same time as ART refill Refill duration of BP medication and ART (ideally 90 days or longer) should be aligned
WHERE	Room where ART is provided	Room where ART is provided	Room or community location where ART is provided	Room or community location where ART is provided
WHO	HCW who provides ART*	HCW who provides ART*	HCW who provides ART*	HCW, lay person, or peer who provides ART refill
WHAT	Correct measurement of BP	Correct selection of initial BP medication according to protocol	Correct measurement of BP and titration of initial BP medication according to protocol	Hypertension and ART refills**

INTEGRATING HYPERTENSION AND HIV MANAGEMENT

A practical Differentiated Service Delivery toolkit





It's time to deliver differently

A client-centred approach that simplifies and adapts HIV services

Find out more →

www.differentiatedservicedelivery.org



Want to learn more? Register for our free course

ENROLL NOW

Differentiated service
delivery for HIV treatment
Free online course

<https://ias-courses.org/>



»Thank you

Current Status of PCC Service Delivery Implementation and Changes required at Policy Level *Perspectives from Zambia*

PCC Research team: Kombatende Sikombe, PhD MPH, Aaloke Mody, MD, Charles W. Goss, PhD, Ingrid Eshun-Wilson, MD, Sandra Simbeza, MPH, Anjali Sharma, PhD, Laura K Beres, PhD, Jake M. Pry, PhD, Njekwa Mukamba, MPH, Jacob Mutale, Carolyn Bolton Moore, MD, Charles B Holmes, MD MPH, Izukanji Sikazwe, MBChB MPH, Elvin Geng, MD MPH



Georgetown
University



Outline

- Current status of PCC service delivery in Zambia.
- Policy barriers of integration of PCC into service delivery.
- Changes required at policy level.

Status of PCC Service Delivery in Zambia



Good Practice Statement:

"Health systems should invest in people-centred practices and communication, including ongoing training, mentoring, supportive supervision and monitoring of health workers, to improve the relationships between patients and healthcare providers."



GUIDELINES



UPDATED RECOMMENDATIONS ON
**SERVICE DELIVERY FOR
THE TREATMENT AND CARE
OF PEOPLE LIVING WITH HIV**

APRIL 2021

Bottom-Up Approach

 **frontiers** | Frontiers in Health Services

"Provider discretionary power practices to support implementation of patient-centered HIV care in Lusaka, Zambia"

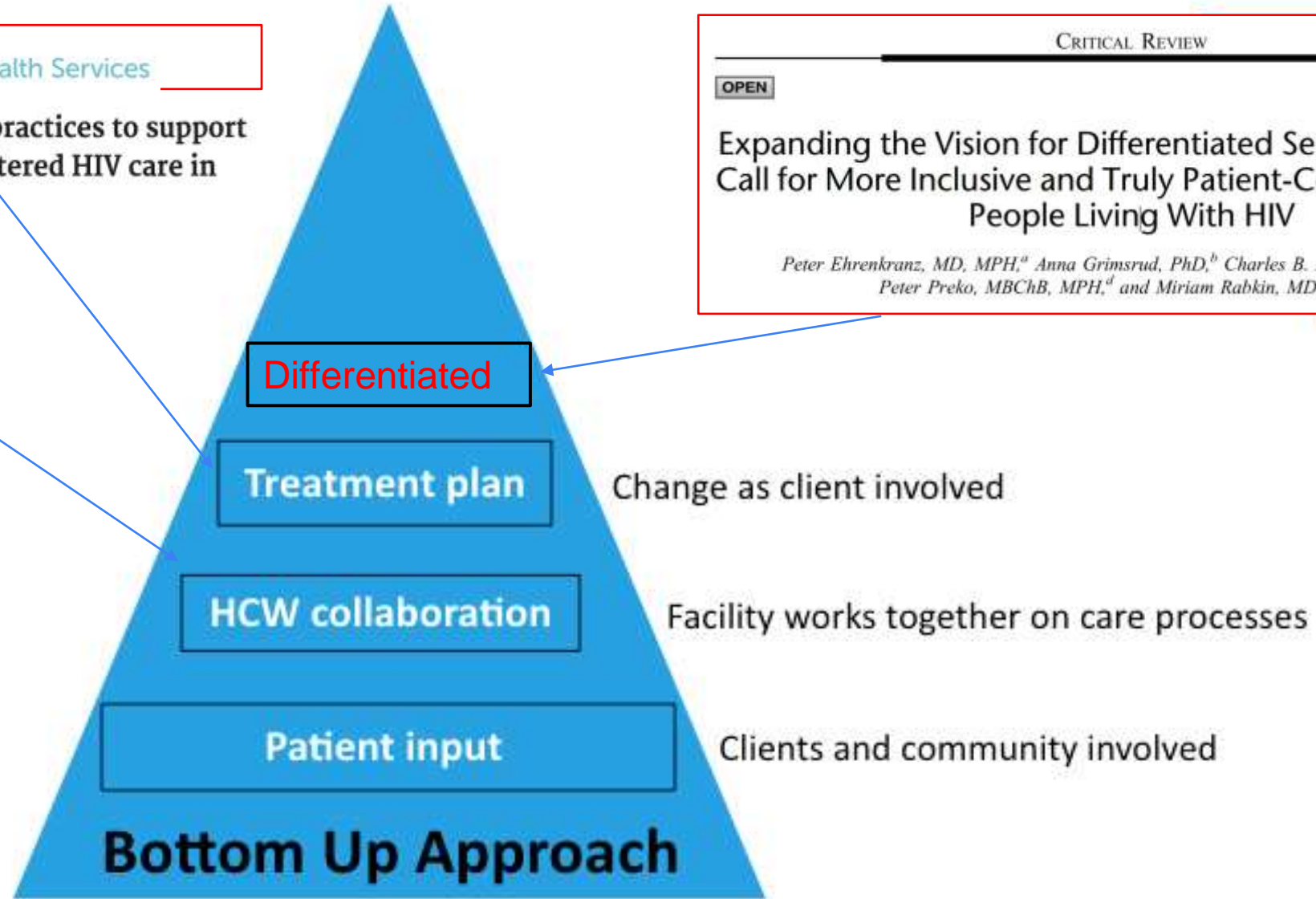
Mwamba et al, 2022

CRITICAL REVIEW

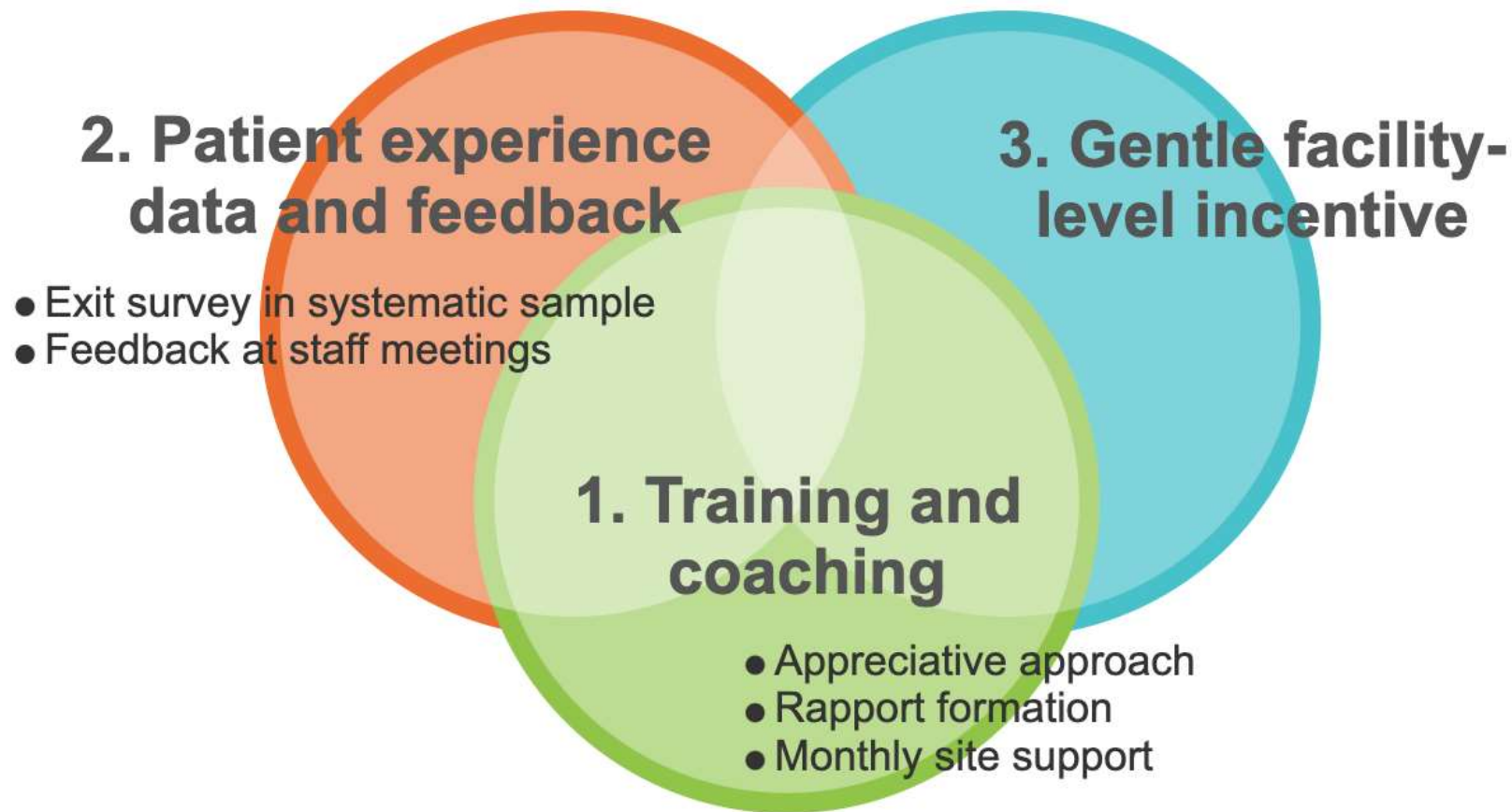
OPEN

Expanding the Vision for Differentiated Service Delivery: A Call for More Inclusive and Truly Patient-Centered Care for People Living With HIV

Peter Ehrenkranz, MD, MPH,^a Anna Grimsrud, PhD,^b Charles B. Holmes, MD, MPH,^c Peter Preko, MChB, MPH,^d and Miriam Rabkin, MD, MPH^d



Human-Centered Design Lessons for Implementation Science: Improving the Implementation of a Patient-Centered Care Intervention





- PEPFAR, BMGF- Non-Governmental Organizations and Implementation partners led
 - *CIDRZ- PCC study in 24 facilities*
 - *Clinton Health Services (CHAI)*
 - *Sweden Embassy of Zambia- Placing People at the Centre(PeaCe) health program*
- ***Growing interest given the need to improve health outcomes, however no firm financial commitments***

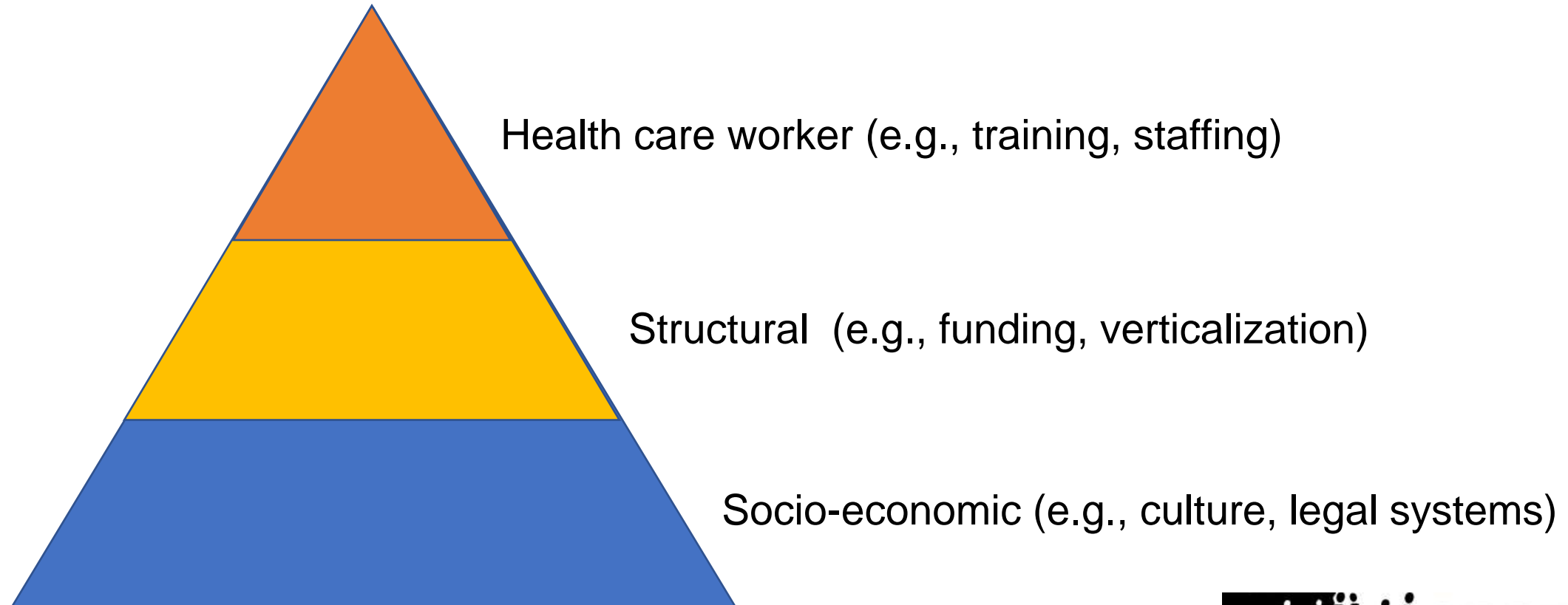


Barriers to the integration of PCC in Service Delivery

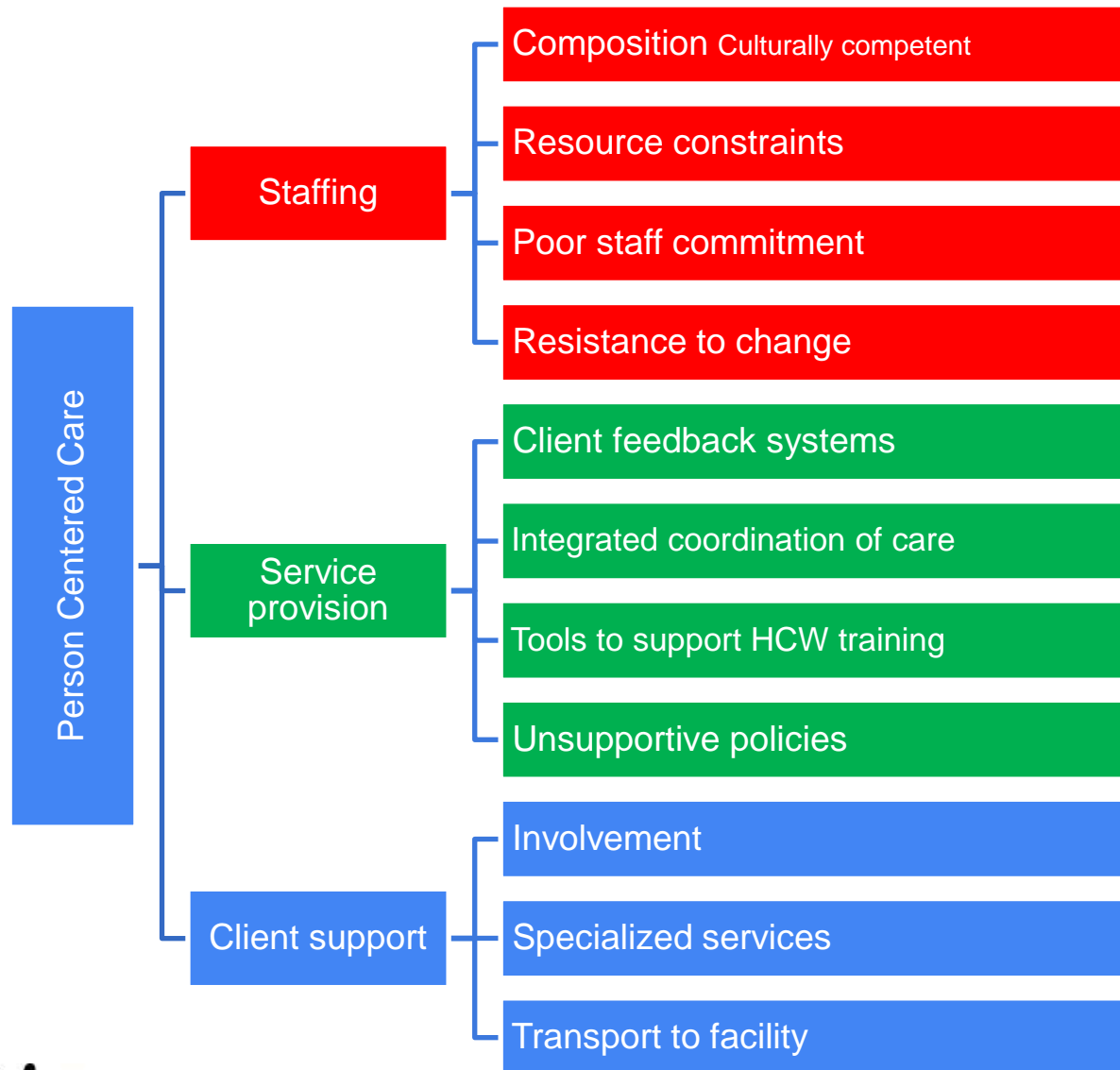
ARTICLE

Patient-Centered Care and People-Centered Health Systems in Sub-Saharan Africa: Why So Little of Something So Badly Needed?

Jeroen De Man MD MPH^a, Roy William Mayega MBChB MPH PhD^b, Nandini Sarkar MA^c,



Barriers of Person Centered Care

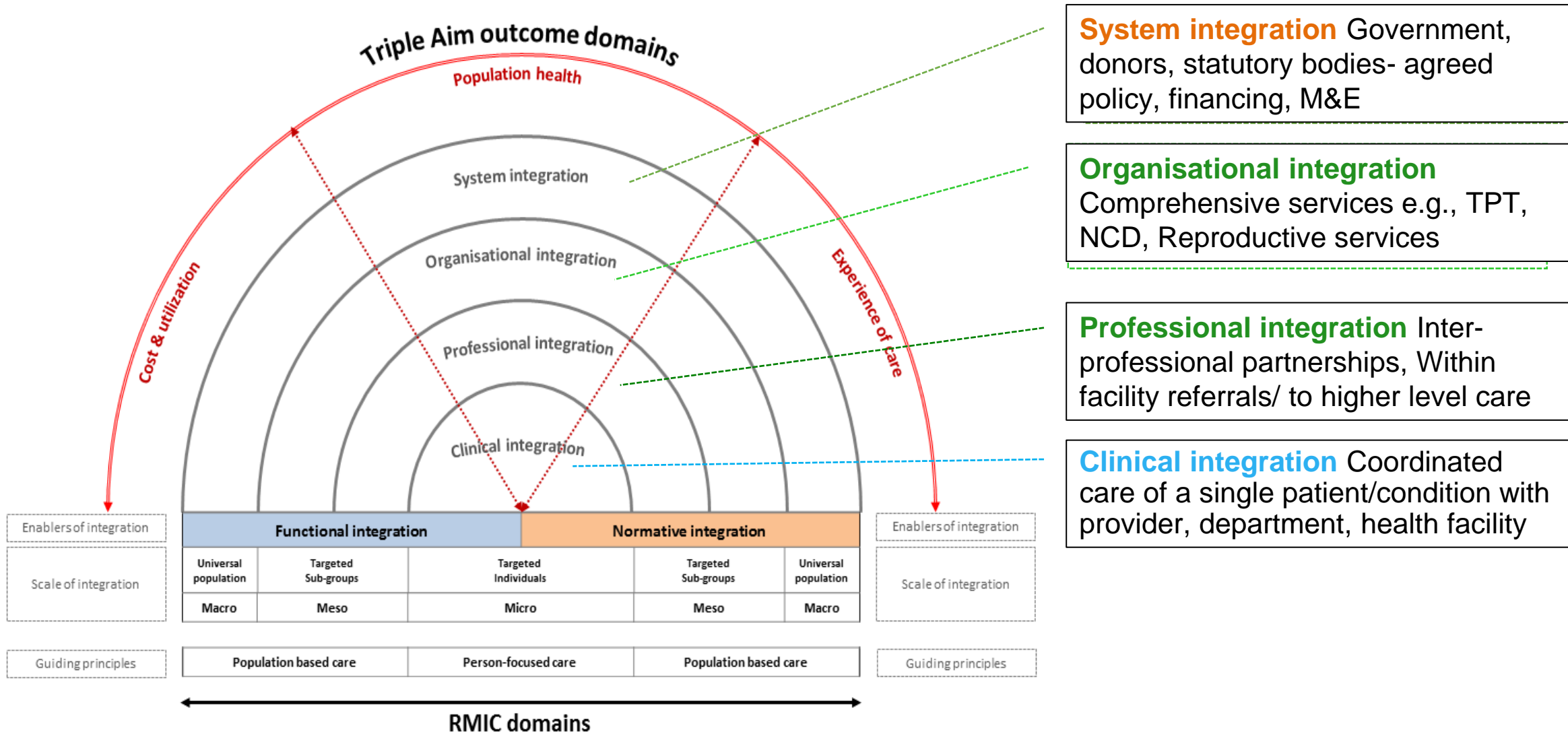


Duffy et al, Trop Med Int Health. 2022;27:479–493

Nkrumah and Abekah-Nkrumah BMC HSR (2019) 19:900

Changes Required at Policy Level

Integration of Person-Centered Care



System integration Government, donors, statutory bodies- agreed policy, financing, M&E

Organisational integration Comprehensive services e.g., TPT, NCD, Reproductive services

Professional integration Inter-professional partnerships, Within facility referrals/ to higher level care

Clinical integration Coordinated care of a single patient/condition with provider, department, health facility

Changes Required at Macro Level

- Leadership buy in and commitment to PCC concept.
- Deliberate policies for funding mechanisms for PCC approaches at all levels.
 - Different components of PCC delivery
 - Measuring client experience
 - Training HCW
 - Mentoring support

Changes Required at Policy Level

- Clear direction from MOH in national strategic documents and guidelines.
- Policies to support education, resources and mentorship.
 - Pre -service training
 - Accreditation in PCC, an incentive
 - Non- punitive mentorship
- Investment for a research agenda that evaluates PCC interventions incorporating all actors of the health system.

Thank You!

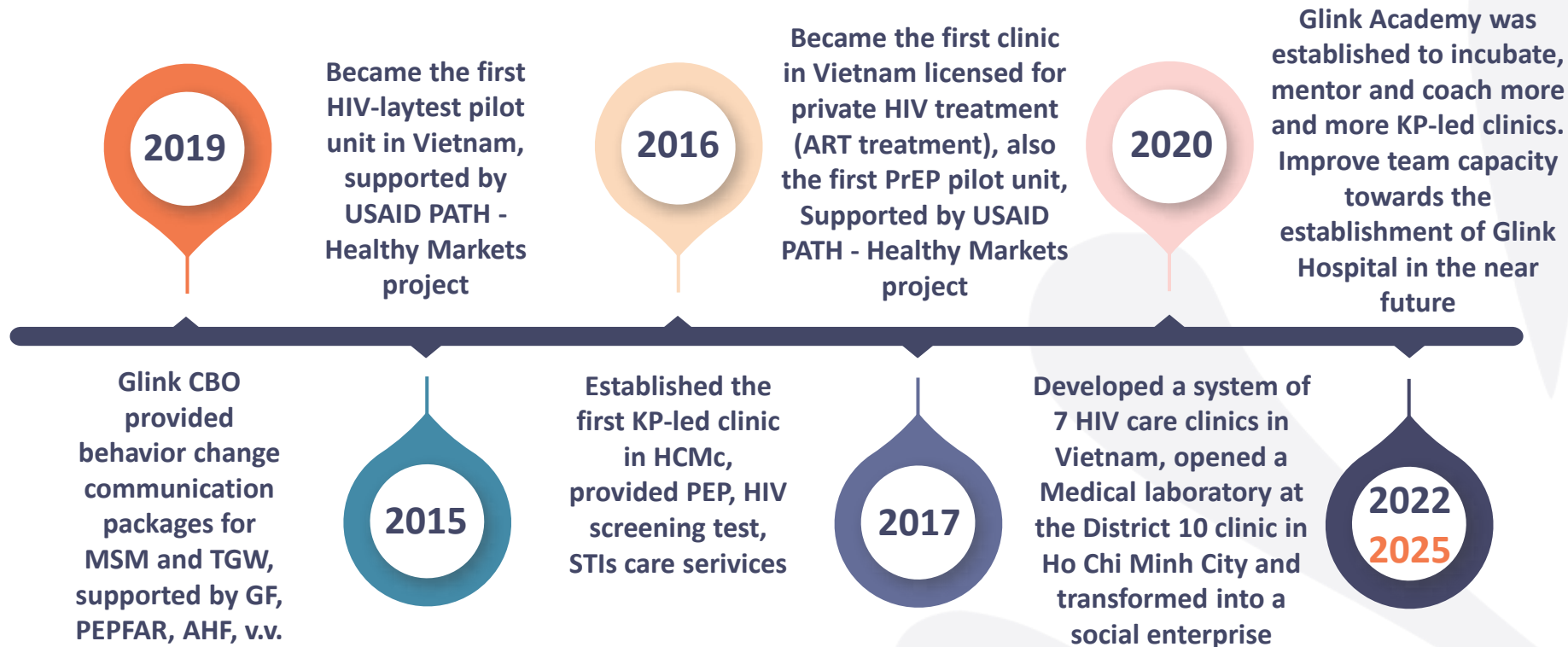


Tailored services for LGBTIAQ+ people with HIV: Preparing for Aging

Mr. An, Nguyen
Deputy Director for Communications
and External Affairs, Glink Vietnam



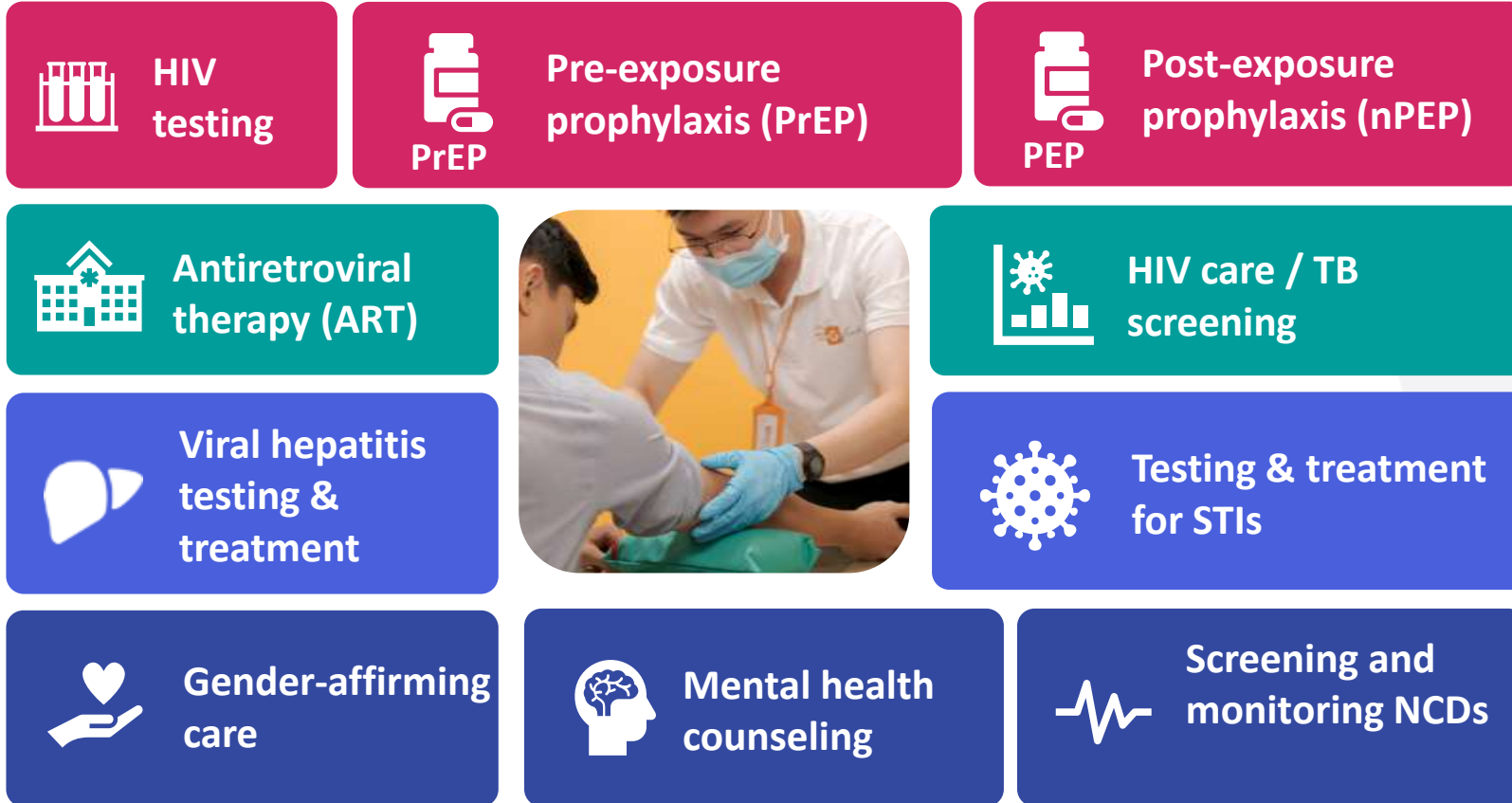
GLINK'S HEALTH SERVICES DEVELOPMENT MILESTONES



OUR VISION:

Glink is an influential organization that provides leadership in supporting the community to access quality healthcare and creates opportunities for LGBTQI+ start-ups in order to elevate their role in community health care delivery.

FROM MEDICAL CARE TO SOCIAL IMPACT



Every year, more than **20,000 new LGBTIQ+ people (mostly young people)** have access to HIV awareness transmission and sexual and gender health care through educational activities implemented by Glink Academy in high schools, colleges, universities, factories and industrial parks.

Glink clinic system currently takes care of more than 21,000 clients with a variety of medical services. (In which, more than 1,200 HIV-positive clients are on ART, and more than 6,300 are on PrEP)

EVEN YOUNG PEOPLE WILL GROW OLD



Problems with long-term use of ARV medication:
Long-lasting side effects, drug-resistant condition, absent-mindedness (leads to forgetting medication), etc.

LGBT-related healthcare needs (even more important for transgender people)

Common diseases in the elderly:
Hypertension, Diabetes, Cardiovascular diseases, Cancers, Functional impairments, etc.

TAILORED SERVICES FOR LGBTIAQ+ PEOPLE WITH HIV: PREPARING FOR AGING



Conduct community needs research in consultation with local and international experts.



Developing the team towards the establishment of general clinics (expected 2023), towards the establishment of a hospital (expected 2025), aim to diversifying services.



Coordinate with local and international organizations and support agencies to test new health models and initiatives suitable for the community.



Learn from practical experience and from experts to build a chain of care services specifically for LGBTIQA+ people with HIV until the end of life.

With the orientation of establishing a Glink nursing home in a more distant future, the chain of health care services for LGBTIQA+ people with HIV from the time of diagnosis until the end of their life will contribute to ensuring that there is no gap in our community.



Any important future responses can only possible when we start preparing today.

Thank you for your participation

Final virtual meeting in this series is on 22 June 2023

What are the core elements and mechanisms for person-centred care within the HIV response and for different stakeholders?

With support from:



Person-
Centred
Care
IAS

What are the service delivery considerations for delivering integrated Person-Centred Care for people living with or affected by HIV throughout their life-course?



Alan Landay,
Rush University Medical Center,
United States



Davina Canagasabey,
PATH,
United States

Meeting 3:
25 May 2023,
15:30-17:00 CEST

Ageing with HIV

**please ask
me - Jules
- any
question.**

**If a PWLH is cured
of Hep C but had
cirrhosis they must
forever every 6
months due an
ultrasound or MRI to
monitor for liver
cancer.**

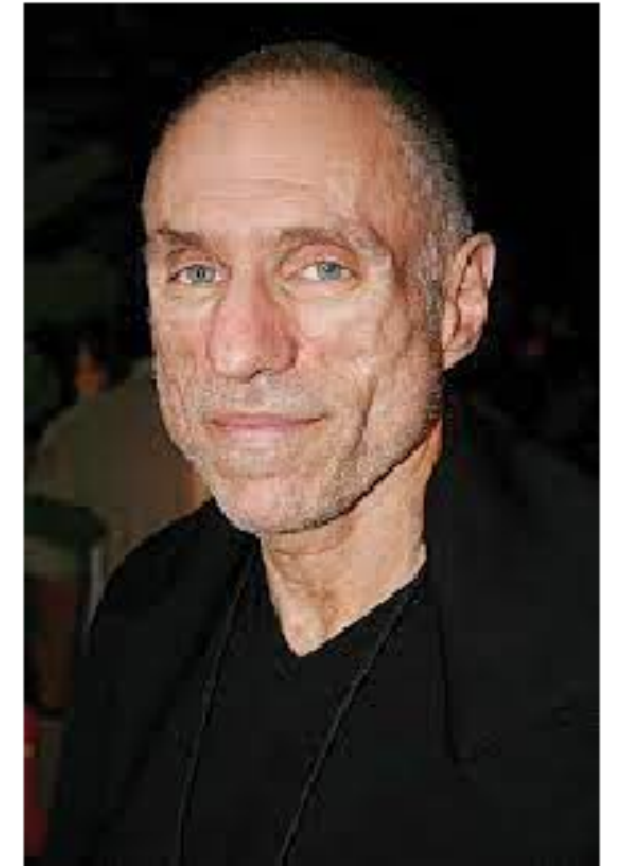
**education of OPLHIV
is key to help them in
self care and be
aware in prevention of
comorbidities, HOW
to educate HIV Health
care professionals to
improve clinical
practice?**

**It's not only
about viral
suppression.**

**great
message**

**PLWH have high
rates of viral and
non-viral hepatitis &
a person must pay
attention to this as
they age - Hp C &
Hep B 7 fatty liver,
and damaged livers.**

**Wholeheartedly agree
w/the critical need for
prioritizing hepatitis
and HIV service
integration--it's been
heartening to see the
recent shifts towards
this, but much more
to be done!**



Jules Levin
National AIDS Treatment
Advocacy Project,
United States

Role of choice in HIV prevention

**Thank you for
highlighting
the difference
between
options and
choice**



Yvette Raphael,
Advocates for the Prevention
of HIV in Africa, South Africa

The origin story of differentiated service delivery

The structural changes to care access are critical to person-centredness. Similarly, MSF has implemented person-centred models in South Africa that emphasize

the patient-provider relationship, which is critical to person-centredness and critically important to patients (See: Exploring Relative Preferences for HIV Service Featur

See: Eshun-Wilson et al Exploring Relative Preferences for HIV Service Features Using Discrete Choice Experiments: a Synthetic Review, Current HIV/AIDS reports. 2020.

And integration, as was said, is critical to successful person-centred HIV care. In fact, it is central to it!

Thank you for clearly explaining the origin of person-centered care, as well as the different integration model..



Helen Bygrave,
Médécins Sans Frontières
and IAS,
United Kingdom

Policy barriers to person-centred care in Zambia

When we talk about HCW education are we including communication skills- i see this as a big gap in many settings - often not included in many curriculums

Implementing PCC in low-middle income countries would really be challenging as this requires more resources at the higher levels of the health systems.

There is success on PCC in many countries in sub-Saharan Africa. Understanding inherent flexibility in the system is possible. Komba&CIDRZ's lessons demonstrate

Among Key populations, there remains a challenge in accessing care because of the laws that hinder access to services. Lots of stigma associated with this

KPs aren't able to access services anywhere so that's a major challenge before we even talk about PCC

Accessing PCC in safe spaces isn't enough. People should be able to access care wherever they want

Sex work has never been legalised in Kenya so how do you integrate PCC in such a situation

Pre service training- Activists need to get involved more in these dynamics as what's happening isn't enough. Schools have in Kenya have introduced KP modules to create aw

There's a lot of advocacy at a micro level and some form of individualized care. Organisations are supporting a lot of advocacy that entails police sensitization. At Governance level, a lot



Kombatende Sikombe,
Centre for Infectious
Disease Research,
Zambia

Tailored services for LGBTIAQ+ people growing older with HIV in Vietnam



An Nguyen,
Glink, Vietnam



Phan Minh Thai,
PATH, Vietnam



Nguyen Thai Ha,
PATH, Vietnam

Really good
discussion on
the different
models.

HIV is a complex disease Focus not only to viral load but also to comorbidities and its prevention (assess on time frailty). The mechanism of AGING and HIV should be known by all.

Routine feedback then support to healthcare workers for data interpretation and use necessary to make it meaningful

We need to **PREVENT** co-morbidities, not just treat them

Discussion question 1:
What actionable feedback can we provide to healthcare workers and health system administrators on clients' needs and preferences?

Policies and financing supportive of HIV service integration with primary care and other care.

Support for healthcare worker education (e.g., preservice training, accreditation)

Inclusion of PCC in guidelines with concrete examples of specific actions to be taken. We have learned that to centre-care on patients we need to centre on providers

PCC frameworks highlight provider teamwork, care coordination and other aspects that are often formally valued but need support for cultural change within facilities

Discussion question 2:

At the policy and financing level, what measures should be considered to promote person-centred care approaches?

Discussion question 3:

What type of demand creation and awareness-raising activities (Including on client rights, existing services and eligibility criteria for different services) need to be implemented to support clients to take informed choices about their health?



Who: the role of primary care (GP) in the coordination of care and having an overview of all of the care seekers needs

Who: Primary care provider referring to specialists (when appropriate)

Does a person living with HIV who is virally suppressed need to see an HIV specialist doctor?

What can HICs learn from LMICs?

In LMICs, HIV care is provided by nurses in a primary care clinic for millions of people with extremely good outcomes in many settings.

It often gets less person-centred when we get further away from primary care

Non-clinical needs (psychosocial and mental health support) need to be considered too.

Discussion question 4:
What can we learn from the development of differentiated service delivery frameworks and their implementation?