O13 - Keeping the Patient in the Centre of Quality Care: What Matters?

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Confidentiality matters: innovative HIV testing

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The global scale-up of HIV testing services (HTS) has been tremendous; however, many of these tests never reach those with undiagnosed HIV and at high ongoing risk, for example, key populations, men and adolescents. Approximately 40% of people with HIV remain undiagnosed, and thus unable to receive life-saving treatment or effective prevention to stop onward transmission. To achieve the United Nation's 90–90–90 goals, greater efforts and innovations are needed, starting with the first 90 goal, which calls for the diagnosis of 90% of all people with HIV by 2020. Globally, 35% of new HIV infections are among key populations and their partners. Yet, HTS coverage and uptake among key populations remains poor and irregular worldwide. Men also remain unreached and untested, and evidence shows men present late in disease stage and have higher HIV-related mortality compared with women. Young people in high incidence settings, particularly sub-Saharan Africa, also remain untested and unlinked to prevention and treatment. It is well documented that among these populations, unfriendly services, fear of stigma and discrimination, and lack of privacy and confidentiality are barriers to HTS uptake. In many environments, this is further exacerbated by restrictive policies, such as age of consent laws and policies which criminalise key populations for their behaviour; deterring HTS uptake among those with greatest need. HTS approaches must evolve and utilize innovative methods that are effective, acceptable and meet the patient's need for confidentiality, such as HIV self-testing, anonymous and assisted HIV partner notification, and community- and facility-based models which take place in discreet locations, offer night-time hours, use trusted peers and lay providers, and are designed to be friendly and attractive to key populations, men and adolescents. Placing people at the highest risk of HIV at the centre of HIV testing programmes is essential, and this is the only way to reach and go beyond the first 90 goal.

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Convenience matters: catalogue STI testing and PrEP

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Mathematical modelling suggests that reducing HIV incidence among men who have sex with men (MSM) will require achieving high coverage of multiple HIV prevention interventions [e.g. HIV testing, sexually transmitted infections (STI) testing, condom promotion and pre-exposure prophylaxis (PrEP)]. For reasons of convenience and to minimise the burden on healthcare providers, we have developed

systems to offer self-service options for HIV self-testing with telemedicine counselling, if requested; home specimen collection with mail-in processing of tests for HIV, urethral and rectal STIs; and at-home self-monitoring of behaviours and laboratory screens for MSM on PrEP. Acceptability has been high among MSM and their healthcare providers for these programmes. However, some challenges remain in the evaluation of programmes and in bringing programmes to a broader scale in the United States. Mail-out kits for STI testing and for PrEP monitoring offer important options to reach the highest risk MSM with a higher frequency of STI testing, and to lower the burden of follow-up PrEP care.

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Context matters: one-stop medical care from Eastern Europe to downtown London

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Despite great advances in HIV medicine, people living with HIV (PLHIV) in many European settings are not attaining optimal health outcomes. This situation raises important questions about how well national and local health systems are meeting the full spectrum of PLHIV health needs. The public health community's increasing interest in health system performance in recent years presents important opportunities for researchers, policy-makers, community stakeholders and others to explore how PLHIV healthcare can be advanced in tandem with efforts to improve overall health system functioning. A key issue in this realm is the goal of making health systems more people-centred. As health system experts continue to explore what constitutes a ''people-centred health system'' in theory and in practice, the HIV field stands poised to make unique contributions to this emerging body of knowledge, which is greatly needed by policy-makers who seek to make health systems more cost-efficient and more equitable. Providing integrated ''one-stop'' medical care is one important aspect of people-centred health systems, but how can critical practices stemming from integrated care be transferred to HIV care and applied effectively in markedly different settings within and across countries? This presentation draws on the paradigm of people-centred health systems to provide strategic thinking into how to utilize local and national healthcare contexts to drive forward this next step in HIV care, which includes how to improve the quality of life of PLHIV.

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Choice matters: differentiated models of care

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Differentiated care is a patient-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV, while reducing unnecessary burdens on the health system. By providing differentiated care, the health system can refocus resources to those most in need. Antiretroviral therapy (ART) delivery may be differentiated according to the medical needs of the patient, subpopulation and contextual factors. Using the ''building blocks'' of differentiated care, a model may be built to determine where, how often and to whom ART is provided to. Differentiated ART delivery for stable patients has demonstrated positive outcomes for both health systems and patients. In South Africa, HIV Adherence Clubs, where groups of 20 to 30 patients meet at either a facility or community location to receive their ART, have demonstrated higher rates of both retention (97% vs. 85%), virological uptake and suppression than those in conventional care. Community ART groups in Tete, Mozambique, where self-formed groups of patients on ART collect medication for each other, demonstrated retention within the model of 98%, 96%, 93% and 91% at 12, 24, 36 and 48 months, respectively. Such group models of ART delivery have also demonstrated an impact on reducing clinical visits, along with enhancing peer and community support. Moving forward, differentiated ART delivery must be adapted beyond stable patients and the principles applied across the HIV cascade. By adopting such patient-centred approaches, differentiated care will be a part of the solution to reach the United Nation's 90–90–90 target in the era of start all.**O**