



Integrated Person-Centered Health Services

Translating Learnings from the HIV Response to Pave the Way to Universal Health Coverage



FRIENDS
OF THE GLOBAL FIGHT | AGAINST AIDS,
TUBERCULOSIS
AND MALARIA



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Cover photo: Karima, pictured with her son, is one of many people living on the Niger/Nigerian border who must travel long distances to access health care services. The Global Fund/David O'Dwyer.

Executive Summary

Emerging from COVID-19 public health restrictions, countries are redoubling their efforts to get on track to achieve Universal Health Coverage (UHC) by 2030. Following the severe health service disruptions associated with COVID-19, it is critical that stakeholders focus not only on access to care but also on the quality of care people receive. Fulfilling the fundamental right to health demands that every person receives care that is respectful and responsive to their needs and circumstances.

The HIV response has pioneered integrated people-centered health services—an approach to health services that puts “people and communities, not diseases, at the center of health systems” and empowers “people to take charge of their own health rather than being passive recipients of care.”¹ Early in the HIV response, from Uganda to Thailand and New York City, people living with HIV, communities and health care workers established multi-disciplinary home-based care services, case management and peer navigation models, and self-care and treatment literacy support groups that not only focused on HIV but also on other healthcare needs, including sexual and reproductive health, sexually transmitted infections, co-infections like tuberculosis and hepatitis C, and mental health. This focus on holistic approaches has endured, as the U.S. Agency for International Development in 2023 emphasized the importance of integrating HIV services with primary health care (PHC).²

An integrated person-centered care (IPCC) approach is essential for several reasons. Complex, intersecting inequalities influence HIV risk and negatively affect service access, meaning that standardized, one-size-fits-all approaches inevitably leave many people living with HIV behind. At all stages of life, but especially as people living with HIV age, people living with or vulnerable to HIV have an array of health issues that affect their well-being as well as the outcomes of HIV services. As countries prioritize PHC as the foundation for achieving Universal Health Coverage, the engagement of the HIV field is needed to ensure that integrated approaches meet the comprehensive needs of people living with or vulnerable to HIV.

HIV-related innovations designed to tailor services for people’s needs and preferences include differentiated service delivery, a people-centered approach that adapts service delivery for clients’ convenience and different medical needs. These innovations proved pivotal to preserving access to essential HIV services during COVID-19. Differentiated service delivery strategies include the provision of multi-month prescriptions and dispensing for clients established on treatment; distribution or pick-up of antiretroviral medicines at homes, community outlets, and pharmacies; strategic use of multiple cadres of health workers for a multidisciplinary approach; utilizing trained community health workers to monitor clients’



Photo: A doctor prepares an HIV test using a blood sample at Muhoza Health Center, Rwanda. The Global Fund/Vincent Becker.

health and treatment adherence; telemedicine; decentralizing HIV services to non-facility outlets (e.g., pharmacies; workplaces etc.); and extended service hours. These differentiated approaches can include a blend of public-, private- and community-led models of care in a given geographic area to optimize choice and uptake among those in need of HIV services.

Evidence underscores that IPCC, when adequately financed and done well, not only increases client satisfaction but is also associated with improved health service utilization and health outcomes. IPCC removes deterrents to health service access and encourages people to remain in care. Through multidisciplinary approaches, IPCC also addresses social determinants of health (such as the effects of poverty, homelessness or housing instability, stigma, racism, and social marginalization) that mainstream health systems are often poorly equipped to tackle.

Further expanding HIV-related IPCC, within HIV service platforms and in broader PHC settings in the public and private sector, will strengthen the HIV response and bring the world closer to ending AIDS as a public health threat. In addition, the platforms created and the lessons learned through HIV investments have the potential to serve as a bridge to broader implementation of IPCC in PHC, and build momentum towards UHC. Implementation of the USAID Primary Impact Initiative, which aims to accelerate progress in PHC, including integration of U.S. government assistance for HIV and malaria, offers an opportunity to build PHC systems that benefit from lessons learned in responding to HIV.³

Friends of the Global Fight Against AIDS, Tuberculosis and Malaria, PATH, and JSI examined current implementation, financing, and policies for HIV-related IPCC as part of the broader HIV response from now to 2030, with the aim of identifying key lessons learned and outlining future recommendations to help chart a way forward to broader implementation of IPCC. Several key points emerged:

PEOPLE ARE MUCH MORE THAN THEIR DISEASE STATUS

People living with HIV and those in need of HIV prevention are increasingly demanding access to a wider range of integrated health services to respond to other pressing needs like mental health, non-communicable diseases and sexual and reproductive health. Mental health care is an illuminating example of this shift where COVID-19 exacerbated isolation and stress, and frayed safety nets, deepening existing mental health morbidity and triggering new events of anxiety, depression, and post-traumatic stress disorder among people living with HIV, key populations, and others. The need for effective, pragmatic, and integrated mental health care as part of HIV services is more pronounced than ever and is being advocated for through community-led monitoring and other avenues.

IPCC IS A BRIDGE TO SUSTAINING THE HIV PROGRAM GAINS AS PART OF UHC

Global health investment in HIV has generated marked improvements in health outcomes but often siloed and disconnected from country efforts to strengthen PHC and achieve health for all. As countries

advance on their UHC 2030 commitments, it will be critical to identify ways to embed HIV services in public health insurance schemes. In addition, there are numerous learnings that can be drawn from HIV programming and research that can benefit health systems as a whole, such as multi-month prescriptions and dispensing, and devolving services to communities through decentralized models.

IN BUILDING OFF THE HIV EXPERIENCE TO EXPAND IPCC, WE SHOULD MOVE STEADILY BUT DELIBERATELY

By definition, IPCC differs by population and setting, as all services must be tailored to the needs of those who seek them. We can learn by expanding IPCC, allowing evidence of what works and what doesn't in different settings to guide the transformation of health systems.

WE MUST PREPARE AND SUPPORT THE HEALTH WORKFORCE TO DELIVER IPCC

Health workers need to be trained in IPCC, and the systems they work in and the metrics they use must incentivize and support them to deliver person-centered care.

NEW RESOURCES WILL BE NEEDED TO EXPAND IPCC

As the world is not currently on track to end AIDS as a public health threat, following through on HIV commitments, including dedicating resources to HIV services, is essential. While HIV platforms offer a bridge to broader adoption of IPCC, HIV services on their own cannot deliver IPCC for all people living with, vulnerable to, or affected by HIV without additional resources.

COMMUNITIES ARE KEY

IPCC can't be effectively implemented without the active engagement and leadership of communities through design, delivery, and evaluation. Communities have an essential role in health governance and decision-making, designing IPCC in ways that meet community needs, delivering services in the community, and monitoring service access, quality, appropriateness, and outcomes.

CONTINUALLY WORK TO MEASURE AND IMPROVE QUALITY

New metrics and financing incentives will be needed for IPCC. Client feedback is essential, providing guidance to service providers on how to improve service quality.

PROTECT TAILORED SERVICES FOR KEY POPULATIONS

While all populations can benefit mightily from IPCC, not all service platforms reach all populations equally well. For key populations in many settings in the near term, public-sector PHC settings may not always be prepared to offer the type of respectful and holistic care and support they receive through community-led or private-sector PHC services. Integration of person-centered services for key and marginalized populations are likely to be most effective in population-specific service channels and systems, underscoring a need for strategic financing mechanisms to sustainably maintain these tailored service models that exist outside of public-sector settings.

The Sustainable Development Goals and UHC are premised on reaching those in the most vulnerable conditions first. Although work remains to end AIDS as a public health threat, the HIV response provides a model for how to prioritize person-centered approaches for the most marginalized communities. While doing what needs to be done to follow through on the commitment to end AIDS as a public health threat, broader lessons can be learned from the HIV response to inform person-centered UHC and health for all. This report concludes with an action plan for how key actors can contribute to expanded access to IPCC.

“The full and best definition of UHC is a health system that meets people where they are and where they are most comfortable seeking care.”

— *Global health expert*

“The AIDS movement is a pathfinder in the area of person centered care.”

— *Multilateral agency representative*

Introduction

The world has united around the goal of achieving universal health coverage (UHC) by 2030. As we work to expand access to care, we must also ensure that care that is available is of good quality and responsive to the people who use health services.⁴

The HIV response has pioneered innovative health service delivery strategies that work for diverse people in a range of settings. In addition to bringing health services to tens of millions of marginalized and underserved people worldwide, high coverage of HIV services has resulted in steadily declining AIDS-mortality and marked increases in rates of HIV viral suppression.⁵

Despite these gains, progress towards ending HIV has slowed, with the reduction in the number of new HIV infections in 2021 being the lowest since 2016. Structural barriers and under-funding of responses for key populations continue to hamper access to combination HIV prevention and treatment services. Certain key populations⁶ are at substantially higher risk of acquiring HIV (14-35 times higher than the population as a whole) and an estimated one in four members of key populations are not aware of their HIV status.⁷ At present, the world is far off track to reach the 2030 goal of ending AIDS as a public health threat.

To address these persisting inequities and to bridge HIV programming with broader initiatives to strengthen PHC systems, the HIV response has prioritized integrated, person-centered care (IPCC). IPCC is holistic, coordinated, delivered in a manner that is responsive to each individual’s broader health and wellness needs, and adapted in response to what individuals need and want. As many people living with HIV are not well-served by mainstream services and systems or prefer seeking care elsewhere, HIV programs have developed ways to deliver high-quality services that meet the needs of marginalized people. As HIV vulnerability and outcomes are heavily influenced by social and medical co-morbidities, HIV services have strived (not always successfully) to provide integrated, holistic care and support to optimize health outcomes.

There are growing calls among health champions to build on the lessons learned from the HIV response to expand access to IPCC more broadly.^{8,9,10} Towards this end, this report examines lessons learned about IPCC from experience with HIV. This review has identified both challenges and opportunities in leveraging these lessons to build stronger, more person-centered health systems.

“We need to look at the person as a whole, not as a disease vector, to ensure that we are treating people with dignity.”

— *Private sector informant*



Photo: A community outreach worker does door-to-door delivery of ART medicine to people living with HIV. The Global Fund.

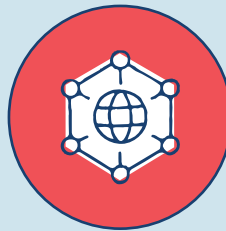
To undertake this analysis, the project team examined the peer-reviewed scientific and grey literature on service integration and person-centered health service delivery approaches. From November 2022 through February 2023, the project team also interviewed more than 30 key informants, including networks of people living with HIV and key populations, program implementers (from both public and private sectors), national government policymakers, researchers, and representatives of international donors and multilateral agencies, and civil society organizations.¹¹

This review identifies several key actions that are required to fully realize the promise of IPCC:



INVEST IN THE HEALTH WORKFORCE

The health care workforce is essential to success, pointing to the importance of training and ongoing support to enable health workers to own and carry forward the additional tasks required for IPCC.



STRENGTHEN AND SUPPORT COMMUNITY RESPONSES

Community systems need sufficient resources to play their critical role in IPCC, serving as a liaison between communities and health facilities and having the capacity to move quickly in the event of a health emergency.



USE MONITORING TO IMPROVE SERVICE QUALITY

Routine client feedback systems must be in place and used to improve the quality, fit and impact of health services.

“In HIV there has been a lot of learning — developing services that can reach key populations, engaging communications, effective health messaging, establishing trust in the system. Those are “value adds” from HIV. We saw in COVID that the largesse in the HIV space was something people utilized — labs, health care workforce, supply chains, information systems and data. From a systems perspective, there are easy things to pinpoint that apply more broadly beyond HIV.”

— *Global programmer*

“We need to appreciate that people change. People are not static. Therefore, we need to change our priorities and our programs over time.”

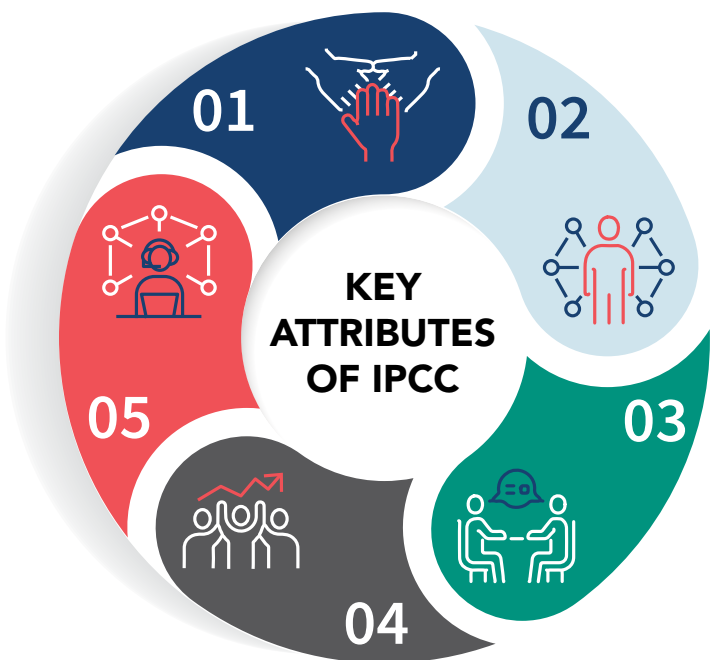
— Health care client

IPCC: What is it? Why is it important?

Integrated person-centered care recognizes that different people have different health issues, including diverse life circumstances that can affect their health. IPCC also acknowledges that the health services people need will differ markedly across their lifespan.

Although the HIV response focused in the first instance on creating services specifically to address HIV, it is obvious that diseases don’t present themselves at a health clinic; rather, people do. HIV services have adapted, evolving over time as the epidemiology of the epidemic changed and as people living with HIV have aged.^{12,13} Only by tailoring health services to the needs and circumstances of individual people, families and communities is it possible to motivate people to seek care, keep people engaged in care, and ensure the best possible health outcomes.

IPCC has several key attributes¹⁴:



1. Services must be comprehensive, holistic, and coordinated.^{15,16}
2. Services must prioritize individual¹⁷ convenience, making it as easy as possible for individuals to access the services they need and reducing disincentives to avoid needed health care.
3. Services must respect each individual’s values and differences.¹⁸
4. Services should empower clients and their households and communities to participate actively in their own care.^{19,20,21}
5. Service systems and sites should actively solicit clients’ feedback and adapt service approaches in response.^{22,23}

We define IPCC to be “integrated care that is designed and delivered in a manner that is responsive to the broader health and wellness needs of individuals throughout their life course and tailored to reflect their preferences.”

“The Holy Grail in our approach to health care is to treat people as people, not on the basis of their illness or condition.”

— *Global health expert*

Photo: This child tested negative for HIV following her mother's enrollment in a program for the prevention of mother-to-child-transmission. The Global Fund/ Karin Schermbrucker.



“What people most want is to be treated with respect, privacy and confidentiality. People want support. They want a place where their needs can be met without judgment.”

— *Multilateral agency representative*

IPCC seeks to maximize individual and public health by addressing the physical, mental, social, and economic needs of each person. Implementing IPCC requires a restructuring of health service delivery,²⁴ mapping the needs and preferences of each individual, ongoing coordination of health staff to provide holistic support, structuring how clinics and health programs provide services in an integrated manner, and prioritizing direct client support and self-efficacy.²⁵ As countries expand PHC to advance towards UHC, national health plans and insurance schemes should be adapted in a manner that encourages and effectively covers IPCC. In particular, service integration should be regarded as a key element of building health system resilience.²⁶

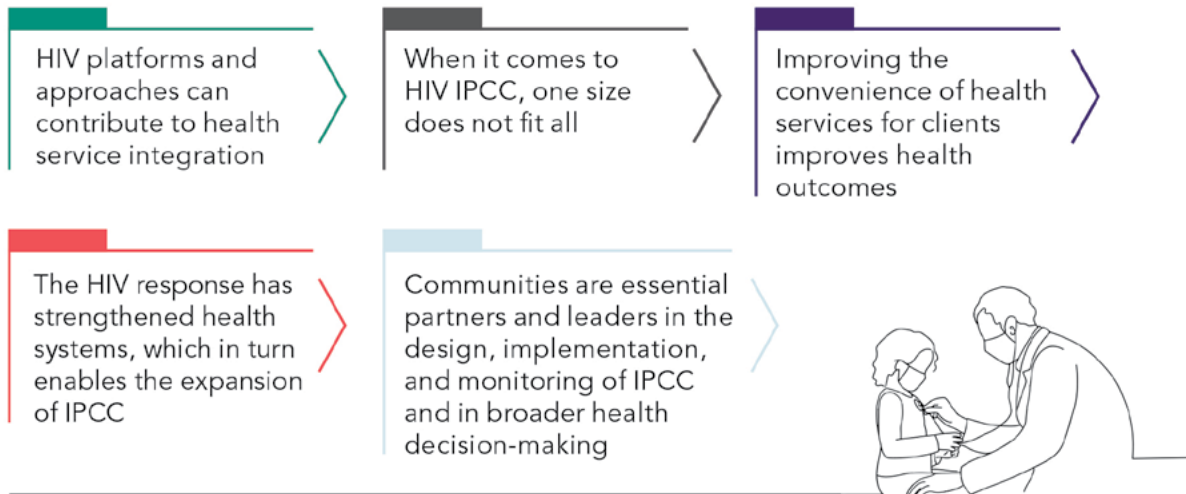
While the HIV response is a leader in implementing service approaches that reflect these characteristics, the reality is that IPCC remains inadequately mainstreamed in most HIV service settings.²⁷ As progress in reducing new HIV transmission and AIDS-related deaths has slowed in recent years,²⁸ further efforts to scale up IPCC in HIV services are an urgent priority.

“PHC has been family medicine. Back in time, the family practitioner did all things to all people. The model for PHC should be an integrated model.”

— *Global health expert*

Lessons learned from delivering IPCC through the HIV response

Experience in implementing IPCC in HIV programs points to several important lessons.



HIV platforms and approaches can contribute to health service integration

Integration of HIV and non-HIV-specific health services occurs in two ways – through the addition of HIV testing, prevention and treatment services in non-HIV-specific services, and through integration of non-HIV health services into HIV testing, prevention and treatment programs. Both approaches to service integration are associated with improved health and health system outcomes.²⁹ Sexual and reproductive health services as well as TB screening and treatment services and maternal, antenatal, and postnatal services are commonly delivered alongside HIV services. There are an increasing number of countries offering screening and treatment for viral hepatitis through HIV services including ART, methadone clinics, PrEP, and in antenatal settings.³⁰ Screening for non-communicable diseases (e.g. hypertension, diabetes, cervical cancer) and mental health morbidity is increasingly integrated at scale in HIV services, although

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It's a huge priority for us, Universal healthcare, primary healthcare, and person-centered care is obviously the overarching. WHO really wants to see much less verticalized programs and there are obviously some good examples and there are a lot of challenges because HIV has been well supported and we've got good systems in place. We want to maintain those whilst also bringing up other services that often actually have higher morbidity and mortality but have been neglected and particularly like cardiovascular disease. Mental health is another area that has been very neglected, too.

— Global health expert

substantially greater progress in this regard is essential.³¹ One modeling exercise found that expansion of multi-disease screening (HIV, diabetes and hypertension) to reach 10% of South African adults would diagnose 492,000 new HIV cases, 1.21 million new cases of diabetes, and 6.35 million new hypertension cases over 10 years.³²

When it comes to HIV IPCC, one size does not fit all

Different contexts and epidemic types demand different health service delivery approaches. In rural areas, where the comparatively few public health facilities are often quite distant from where many clients reside,³³ efforts to provide IPCC will inevitably encounter challenges that are different than those encountered in densely populated urban centers served by larger, multidisciplinary health facilities.

Integration of HIV and related services in mainstream primary care systems may not be effective for groups that are often not well-served by public health facilities and may be aversive to seeking care in these facilities, often due to the prior experience of discrimination or mistreatment while seeking care.³⁴ Currently, data is lacking on the effectiveness of service integration in mainstream health facilities for key populations, such as gay men and other men who have sex with men, sex workers, transgender people, and people who use drugs.³⁵ Other groups whose needs are frequently not well addressed by public health facilities include adolescents and migrants. For groups that are not well served by existing primary care services, a more effective approach to IPCC may be to design integrated service packages and service delivery channels that are specifically tailored for them. In a study done in Omsk and Ekaterinburg, Russia, integration of antiretroviral therapy and harm reduction services was found to prevent 48% of HIV infections and one-fifth of fatal overdoses over 10 years.³⁶

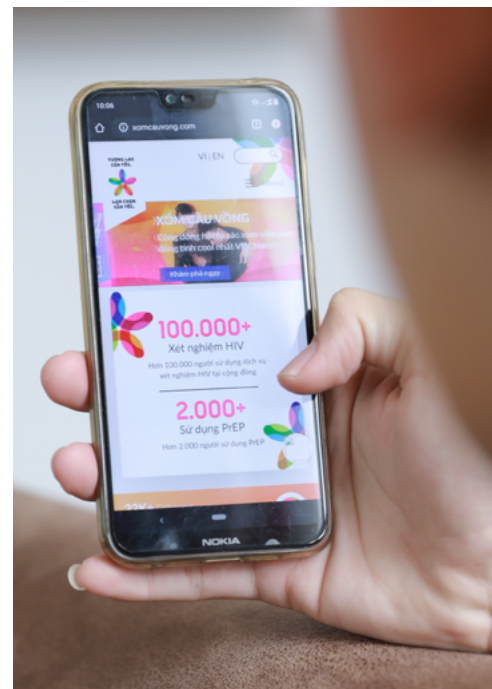


Photo: A client in Vietnam self-assesses their HIV risk using the USAID/PATH Healthy Market's online risk calculator, which helps interested individuals understand their HIV risk and eligibility for HIV pre-exposure prophylaxis. PATH/Phan Tan Phuc.



CASE STUDY: VIETNAM

Accessing integrated PHC services based on client needs through one-stop shops

Key population-led private clinics in Vietnam offer people living with or vulnerable to HIV the ability to access a suite of comprehensive health care services at a single access point through one-stop shops (OSS). Beginning in 2017, these clinics progressively expanded service offerings beyond HIV to include a broader range of sexual and reproductive health services (including screening and treatment for sexually transmitted infections), viral hepatitis, and mental health, to now non-communicable diseases and skin and dental care to address their clients' PHC needs as well as gender-affirming care for transgender people. More than 21,000 unique clients have accessed health care services through five OSS since October 2020. This model has also been beneficial in increasing HIV service uptake, such as PrEP. 27% of clients who were newly enrolled on PrEP between October 2022 and June 2023 first came to OSS seeking care for other health needs. Focusing on transgender women's needs through integrated gender-affirming care and hormone testing at OSS drove PrEP uptake among transgender women from 68 in June 2018 to 638 in September 2021. Learn more about the impact of offering transgender-competent HIV and PHC services through OSS in Vietnam here >> <https://onlinelibrary.wiley.com/doi/10.1002/jia2.25996>.

“By creating a new patient friendly environment you begin to shift people’s expectations and demand for quality services. When we started delivering differentiated HIV care people started asking if they could get that for other health services.”

— *Global health expert*

Improving the convenience of health services for clients improves health outcomes

Making health services as convenient and people-friendly as possible not only increases client satisfaction, but it also improves health outcomes. One approach, sometimes known as “one stop shop,” integrates services in a single service site, increasing the likelihood for care coordination and preventing clients from having to visit multiple service locations. In Kenya, a “one stop shop” model for delivery of pre-exposure HIV prophylaxis (PrEP) increased the rate of PrEP initiation while reducing client wait times.³⁷ Same-site integration of harm reduction and HIV testing, treatment and support services in Kazakhstan significantly improved HIV outcomes for people who inject drugs.³⁸ In Vietnam, integrating gender-affirming care has resulted in a significant increase in PrEP uptake among transgender people.³⁹ Experience with HIV service delivery has highlighted the importance of a multi-disciplinary team approach, which requires the training and active engagement of diverse health worker cadres.^{40,41}

Differentiated service delivery has simplified and decentralized HIV service delivery, reduced burdens on clients, aided in decongesting public health facilities, and, most importantly, generated excellent health outcomes at scale.^{42,43} Differentiated service delivery approaches health care through a person-centered lens (instead of an HIV lens), thus promoting delivery models that enhance convenience, comfort, and choice for clients while ensuring that other health care and wellness needs are addressed. Common approaches to differentiated HIV service delivery include the provision of multi-month dispensing for stable patients, distribution or pick-up of antiretroviral medicines at homes, community outlets, and pharmacies, strategic use of multiple cadres of trained health workers for multi-disciplinary care, reliance on trained community health workers to monitor clients’ health and treatment adherence, decentralizing HIV services to non-facility outlets (e.g., pharmacies; salons etc.) and extended service hours.

The HIV response has also used technological advances to improve outcomes while reducing the burdens on the people who use health services. The



CASE STUDY: NORTHEAST INDIA

Deploying mobile biker teams to decentralize access to integrated HIV services

With support from the US Centers for Disease Control and Prevention, PATH and the Nagaland State AIDS Control Society deployed the Health-on-Bike model to extend the reach of HIV and harm reduction services across 38 remote villages in eastern Nagaland. Teams of two outreach coordinators travel to five community delivery points offering testing and treatment services for HIV, sexually transmitted infections, and tuberculosis; medically assisted therapy; and needle and syringe exchange programs. From August 2021 through May 2023, more than 720 people were tested for HIV, with 48 confirmed HIV positive (6.5% testing positivity) and 92% linked and initiated on HIV treatment. The model also facilitated increased uptake of harm reduction services, with 130 people who inject drugs reached with needle and syringe exchange programs and 70% increase in enrollment in medically assisted therapy.

complexity of early antiretroviral medication regimens has given way to single-pill, fixed-dose combination regimens.⁴⁴ Reliance on centralized laboratory testing of specimens for HIV viral load monitoring is now often supplanted by platforms for point-of-care testing, which is associated with significantly improved viral suppression and rates of retention in care.⁴⁵ In the place of stand-alone HIV counseling and testing centers, a broad array of community-centered testing approaches, including at-home HIV self-testing, has become available.⁴⁶ Telemedicine has helped increase access to HIV self-testing, PrEP and other HIV prevention services while making these services more convenient for the people who use them.

The HIV response has strengthened health systems, which in turn enables the expansion of IPCC

Health systems are weak in many low- and middle-income countries, in large measure due to persistent under-investment in health.^{47,48} Although in 2001 African nations pledged to allocate at least 15% of their budget to health, no country in Southern Africa had allocated even 10% as of 2018.⁴⁹ Donor support for the global HIV response has flatlined.⁵⁰

To a large degree, HIV programming has been able to mitigate some health system weaknesses due to the availability of the unprecedented financing the HIV response has galvanized. Vertical health programs have sometimes received criticism with regard to their effect on broader health systems⁵¹, including attracting staff from other programs and creating parallel systems for health information. However, there is an emerging consensus that HIV investments have also had important positive effects on health systems.⁵² The HIV response has used a substantial portion of its resources to strengthen health systems – hiring and training health care workers, bolstering health facilities, strengthening laboratory and surveillance systems, enabling multi-disease diagnostic platforms, improving health information systems, strengthening health commodity procurement and



Photo: After achieving a suppressed viral load, Doreen Kemunto, a caregiver in Kisii County, shows her life-saving HIV medication provided by USAID/PATH Nuru Ya Mtoto.



CASE STUDY: PHILIPPINES

Leveraging a virtual, community-led platform to improve PrEP uptake

LoveYourself Inc., a community-based organization for young men who have sex with men, established the E-PrEPY service, an all-virtual, community-led, and demedicalized platform offering PrEP services. Under the model, HIV testing and PrEP services are done completely remotely, with PrEP commodities and HIV self-test kits ordered via a QR code and delivered to clients at an address of their choice and trained peers collaborating with physicians to counsel and support clients through telemedicine. Between August 2022 and April 2023, 230 individuals were newly enrolled on PrEP through the E-PrEPY program, with more than 43% of clients completing their first monthly visit and 40% reporting taking PrEP daily. This model highlights that offering demedicalized and virtual PrEP services developed and delivered by peer community members is feasible and effective at improving access to HIV prevention services. Read more about LoveYourself's efforts to drive community-led, demedicalized PrEP services here>> <https://loveyourself.ph/prep-pilipinas-preppys-differentiated-efforts-impact-to-philippines-hiv-response-show-cased-at-ias-2023-in-brisbane/>.

“Differentiated and person-centered care is at our core—we know the market because we are the market.”

— *Implementer/global health programmer*

“When COVID came along and everything was at a standstill, communities came out and said, ‘We need to be there and support each other.’ Communities pooled and shared resources and good, and helped people get services despite transportation restrictions. If we invest in communities, there is a higher chance of sustainability of any health response.”

— *Community network*

supply chain management systems, and catalyzing the decentralization of key health system functions to enable community service delivery. Each year, the Global Fund invests roughly \$1.5 billion, and PEPFAR more than \$1 billion⁵³, in strengthening health systems in low- and middle-income countries. Although the comparative value of vertical versus sectoral investments in strengthening health systems has long been a subject of debate, the benefits of HIV investment for health systems generally became clear during COVID-19⁵⁴, when HIV-financed infrastructure and platforms rapidly pivoted to make considerable contributions to COVID-19 responses while maintaining HIV services.⁵⁵ Beyond the health sector, studies have correlated HIV investments with increases in economic growth and the proportion of girls and boys who are in school.⁵⁶ There is also reason to believe that there are additional benefits to health care systems from HIV-specific investments that have yet to be fully realized, such as the application of strengthened health information systems for a much broader array of health priorities. To fully leverage the potential of HIV investments to yield broad-based benefits, the leading HIV donors, PEPFAR and the Global Fund, have new strategies in place that prioritize the strategic use of resources to strengthen health systems.^{57,58}

Communities are essential partners and leaders in the design, implementation, and monitoring of IPCC and in broader health decision-making

As IPCC demands service provision that is responsive to and tailored for the needs of communities, it is critical that communities are empowered to guide and inform health-related decision-making. One of the distinguishing features of the HIV response is its prioritization of the inclusion of civil society in health governance.^{59,60} Civil society is represented on the governing boards of the Global Fund and UNAIDS and also provides extensive input into the development of country and regional operational plans for PEPFAR. Civil society is represented on Country Coordinating Mechanisms that develop funding proposals and oversee grant implementation for the Global Fund. Communities also participate in the national AIDS councils that guide national HIV responses in many countries.

Community-led responses, a key pillar of the fight against HIV, have helped close health systems gaps and overcome weaknesses in health infrastructure. Communities advocate for needed policy change and deliver essential services, with a unique ability to reach those who are left behind by traditional public sector approaches.^{61,62}

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People must be at the center of our response. People affected by HVI should be in the lead, and we have to help them build their capacity to participate. The moment we recognize people living with HIV as those who should drive the process, policy and implementation will be on the right path. That’s particularly important with an integrated approach. We must have the involvement of people to make the integrated management approach work.

— *Global health expert*

The HIV response has demonstrated the particular value of community-led monitoring, which ensures that performance measurement addresses the needs, perspectives and preferences of the people who use health services. Community-led monitoring helps anticipate and prevent commodity stock-outs, tracks service characteristics that affect client satisfaction and retention in care, and documents instances of stigma, discrimination and human rights abuses in the provision of health services.^{63,64,65}

For community-led responses, relying on the work of uncompensated volunteers is neither fair, sustainable nor calculated to fully leverage the impact of community contributions. The multi-faceted roles of communities in optimizing health and well-being – as citizens, accountability watchdogs, service providers, and advocates – need to be recognized and supported financially.

Photo: As part of the USAID/PATH Integrated HIV/AIDS Project in DRC, doctors review HIV testing registers and client files to ensure all supported clients receive appropriate follow-up services in alignment with national guidelines. PATH/Stella Muyano.



CASE STUDY: GHANA

Using client feedback to improve service quality and continuity in care

As part of an expansive return-to-care campaign under the US Agency for International Development's Strengthening the Care Continuum Project, JSI and partners integrated a client feedback mechanism to understand drivers of treatment interruption among people living with HIV. Drivers and service quality gaps were identified at three levels: 1) individual (treatment side effects; lack of support system); 2) provider (poor health care staff attitude; lack of confidentiality); 3) systems (poor clinic conditions; long distances to facilities; high service cost; inadequate communication/education on available services). To address these gaps, the project instituted a digital health platform to enhance client treatment literacy; scheduled appointments at more convenient times; expanded decentralized care models offered to clients; trained providers on client communication skills; and instituted an appointment reminder and follow-up system. These service adjustments led to a reduction in treatment interruption among people living with HIV from 45% (October–December 2019) to 1% (April–June 2021), with more than 8,000 additional people living with HIV actively supported on treatment. Learn more here >> <https://www.jsi.com/care-continuum-project-in-ghana-shows-increasing-numbers-of-people-on-hiv-treatment/>.

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Community-led monitoring [ensures that] health services are informed by evidence generated by communities themselves, presented by communities themselves, and then policy-makers are brought in by communities to agree together on the direction to take forward.

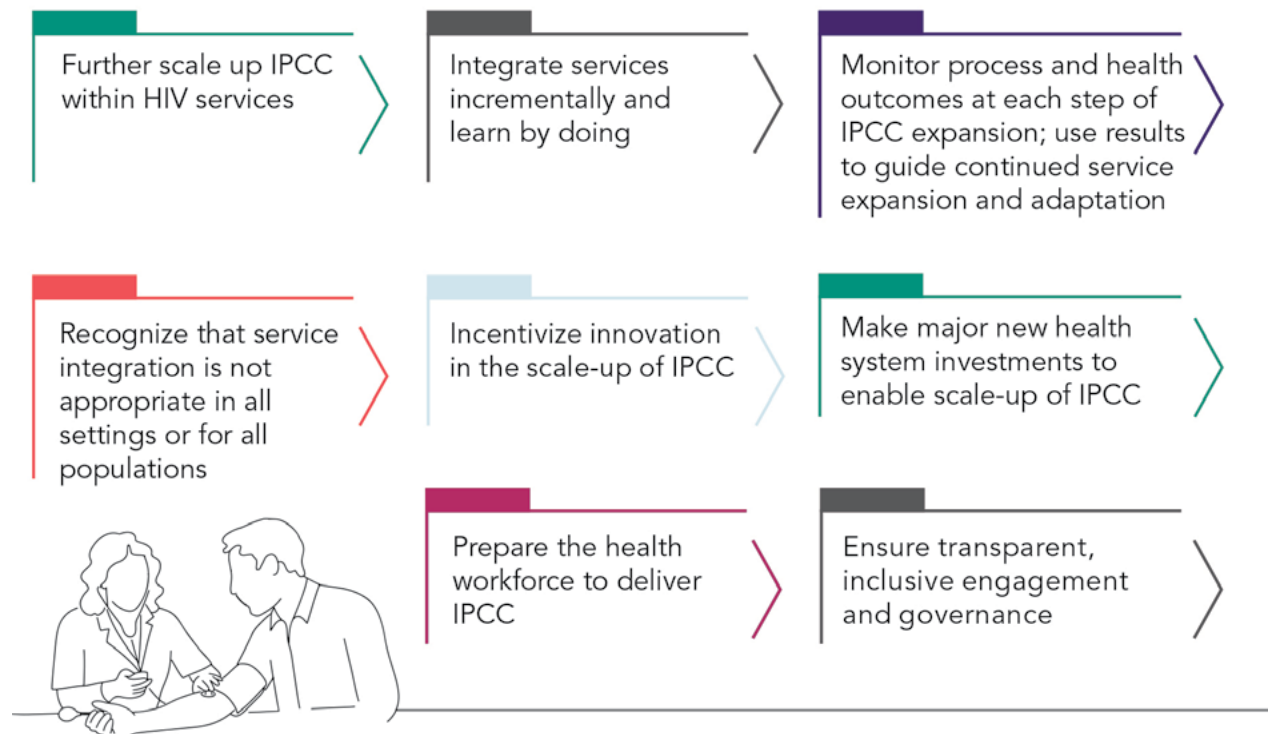
— *Community network*

Building on lessons learned from HIV to increase delivery of IPCC

HIV, now considered a chronic disease for most, has shown the value of person-centered care as a defining feature of health service delivery. In this regard, HIV is not alone, as service integration and person-centered approaches have proven effective in programs for non-HIV-specific health problems.^{66,67}

Having resilient, integrated, person-centered PHC relationships in place also aids in mounting rapid, effective responses to health emergencies. Robust, pre-existing relationships between individuals and their service providers and systems help instill trust in the health system, a key, often-determinative element of effective pandemic responses.⁶⁸ For example, in 2021, hundreds of community communications and mobilization specialists who had already been recruited and trained proved pivotal in swiftly bringing under control a potentially severe outbreak of Ebola in Guinea.⁶⁹

Experience in scaling up IPCC in HIV service settings identifies several key actions.



Further scale up IPCC within HIV services

The fight against HIV is far from over, and the need to intensify and improve efforts to end AIDS as a public health threat is evident from the slowdown in progress in preventing new HIV transmission and AIDS-related deaths. Although HIV programs helped pioneer IPCC, the approach is not yet mainstreamed across HIV services, underscoring the need for further investments and service adaptations to make IPCC standard practice for HIV services in all settings. Further integration of mental health services and screening, prevention and treatment of non-communicable diseases are important avenues to pursue. Particular efforts are needed to incorporate IPCC approaches in HIV prevention services, which often occur outside health systems. As one example of IPCC for HIV prevention, programs should provide screening for gender-based violence and family planning services alongside HIV prevention services for adolescent girls and young women. While HIV programs have made important strides in integrating with sexual and reproductive health services and antenatal services, significant further progress in these areas is needed. In one HIV prevention project in Kenya focusing on reducing HIV risks and vulnerability among adolescent girls and young women, a gender-affirming approach was mainstreamed across all service components and HIV-specific services were complemented by household economic support, food security and nutrition, education and life skills, water and sanitation, and social protection. Similarly, both PrEP and voluntary medical male circumcision services can be better leveraged to link clients to integrated primary care services.

Integrate services incrementally and learn by doing

Just as HIV services adapted over time to integrate a broader range of services, expanding IPCC by building out from HIV infrastructure and approaches should also be undertaken incrementally. IPCC is context-specific and demands a deliberate approach that includes community input, purposeful structuring of service systems, supportive policy and financing, and inculcation of specific skills among health workers. For HIV programs that have not done so, an important first step is to integrate health services that naturally accompany the provision of HIV care, such as screening for sexually transmitted infections, sexual and reproductive health services, TB screening and treatment, viral hepatitis screening, treatment and vaccination, and screening, treatment, and prevention of common HIV-related opportunistic infections. As success in HIV treatment and care depends on addressing social and economic barriers that individuals and communities face, programs should proactively look to build meaningful,

“It’s all about balance. In the HIV response, we need to be more humble and consider what other disease areas can learn from HIV as well as what the HIV response can learn from other disease areas.”

— *Global health expert*

“While HIV programs have made important strides in integrating with sexual and reproductive health services and antenatal services, significant further progress in these areas is needed.”



Photo: Antonite Osoro, a health care provider, explains an HIV self-test kit during a community outreach session promoted by the USAID/PATH Nuru Ya Mtoto-supported project in Homa Bay County. Denise Akun/ PATH Kenya

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What is the prevention package you can integrate into HIV services? Vaccines, prenatal counseling, protection of partners in discordant couples, looking at living with HIV long-term. If you are seeing women of reproductive age, you should offer contraception to everyone. At HIV clinics, we can provide rapid, point-of-care diagnostic tests for HPV and other STIs.

— *Global health expert*

“In every program design, we need to gather evidence. That will help drive how we want to scale up. We also need to recognize what is available in terms of evidence. Where has an integrated approach worked? What are the lessons?”

— National health ministry official

“We need to build metrics around comprehensive services to show they can be successful.”

— Global health expert

Examples of useful metrics include client satisfaction, ongoing tracking of program attributes that affect client satisfaction (e.g., cleanliness, length of wait time, client-friendly hours, provider attitudes, measures to ensure privacy and confidentiality) and service uptake, and tracking of the breadth of health provider training.

integrated options for mental health, harm reduction, economic and employment support, food and nutrition, and other essential services. Careful consideration of how programs are financed and the incentives this financing creates can help encourage programs to implement IPCC.

Taking it slowly in leveraging HIV services to expand the scale-up of IPCC in the broader health systems will help ensure that we reap the benefits of IPCC without losing the unique attributes of HIV services. As person-centered care coordination requires the sharing of information among professionals involved in care delivery, measures to protect the privacy and confidentiality of personal information are essential.

Monitor process and health outcomes at each step of IPCC expansion and use results to guide continued service expansion and adaptation

New metrics and mechanisms for person-reported data are needed to monitor the degree to which health services adhere to IPCC values and principles.⁷⁰ Examples of useful metrics include client satisfaction, ongoing tracking of program attributes that affect client satisfaction (e.g., cleanliness, length of wait time, client-friendly hours, provider attitudes, measures to ensure privacy and confidentiality) and service uptake, and tracking of the breadth of health provider training. Better outcome indicators are also needed, including person-reported outcomes, in order to ensure that health services are delivering what people need. Health facility scorecards can provide a snapshot of how service sites are doing and where improvements are needed. Regular data reviews (such as weekly review of metrics for clinical sites or integration of client satisfaction in health management information systems) should be implemented, with an emphasis on identifying outcomes and patterns that require adaptation in service systems and approaches. The lack of unique patient identifiers in many settings makes it difficult to track services across different services sites, or even within the same facility.

As an important step, funders should critically examine existing indicators and reporting requirements to ensure that they do not inadvertently discourage IPCC. For example, while the HIV response is rightly hailed for its commitment to service and outcome targets, focusing solely on numeric targets might in some cases deter providers from taking the additional time required to provide individually tailored, person-centered care and support. To enable broader implementation of IPCC, outcome indicators need to be complemented with more person-centered indicators.⁷¹

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An important first step is to integrate health services that naturally accompany the provision of HIV care, such as screening for sexually transmitted infections, sexual and reproductive health services, TB screening and treatment, viral hepatitis screening, treatment and vaccination, and screening, treatment, and prevention of common HIV-related opportunistic infections.

Community-led monitoring is an especially valuable means for evaluating health programs and systems from the perspective of the people who use services. Further investments are needed to scale up community-led monitoring and to ensure that meaningful client engagement systems are implemented across service delivery outlets.

As countries work to devise and implement national health insurance schemes and other strategies to expand health care access, monitoring systems for PHC will undoubtedly be broadened and strengthened. Towards the aim of ensuring holistic, person-centered care, it is important to avoid separate, siloed monitoring systems for HIV and PHC.

Recognize that service integration is not appropriate in all settings or for all populations

Most of the discourse on service integration has focused on pathways to integrating services in public sector systems. While this is a critical priority, the reality is that many mainstream public sector systems often do not welcome or effectively address the needs of key and vulnerable populations. Building the capacity of public sector systems to effectively address everyone's holistic health needs is a critical priority, but insisting that these mainstream systems are the sole platform for implementing IPCC means that many populations will be left behind during the time required to prepare health systems to deliver high-quality, non-discriminatory care to key and vulnerable populations.

For marginalized, chronically underserved populations, we will need to preserve dedicated, community-tailored systems.⁷² Within systems or platforms specifically designed to address the needs of key populations, there are opportunities to provide tailored, integrated service packages. For example, ensuring access to a comprehensive suite of sexual health services is essential in sites and systems that serve adolescents, sex workers, or LGBTQ people.⁷³ In Thailand and Vietnam, key population-led and owned clinics offer an array of primary healthcare services and combined serve more than half of PrEP users nation-wide.⁷⁴ Similarly, bundling services for HIV, viral hepatitis, harm reduction and substance use rehabilitation has important health benefits for people who use drugs. Service integration should be prioritized where it makes sense for specific settings and populations but not be pursued as a one-size-fits-all solution in every situation.⁷⁵

Incentivize innovation in the scale-up of IPCC

HIV programming has served as an incubator of innovation. Key HIV-catalyzed innovations include multi-month dispensing, task shifting in health service delivery (including increased use of community health workers), and community-led monitoring. Building on the legacy of the HIV response, innovation in service delivery approaches should be further encouraged, with outcomes monitored and assessed at each stage of IPCC implementation.⁷⁶ Innovative approaches include one-stop shop models that

“Many of the measurements currently being used are focused on hard numbers. We are not measuring the qualitative aspects through the indicators we are using, so we aren’t really understanding the quality of life that people are leading.”

— *Civil society network*

“Focusing solely on numeric targets might in some cases deter providers from taking the additional time required to provide individually tailored, person-centered care and support.”

“Funders need to incentivize country teams to build in more kinds of health care [in HIV services].”

— *Global health programmer*

“How you decide to finance your health services determines what kinds of services you will get.”

— *Multilateral agency representative*

“There are lessons from HIV that can be translated to other areas, like engaging multiple cadres of health care workers in delivering services; more diffuse supply chain mechanisms that support decentralization; strong treatment literacy to support medication adherence—we need to keep those nuggets and diffuse them to other areas of health systems.”

— *Civil society representative*

“We need to show this is not overwhelming and can be accomplished. You can prioritize and work to filling gaps in strategic ways that don’t require huge funding or complexity.”

— *Global health expert*

bundle diverse services in a single entry point, potentially helping reduce the stigma associated in some settings with utilization of HIV-branded services, and multidisciplinary care teams that coordinate health and social interventions.⁷⁷ Drawing from the successful experience of HIV programming during COVID-19, further efforts are needed to scale up and mainstream telehealth, self-care (including self-testing), and differentiated service delivery for non-HIV-specific health services.⁷⁸ Technological innovations, such as self-administered diagnostics or treatments, can also aid in making health services more convenient and person-centered. For service sites or systems that are only now working to implement IPCC, starting steps might include bundling services that naturally belong together (e.g., services for HIV, sexual health, and sexually transmitted infections), coordinating family care, and sequencing diagnostic appointments and drug refills to minimize client travel time and expense.

Funders should also create incentives for providers to implement IPCC, including ensuring that indicators are in place to encourage, monitor and evaluate IPCC approaches. It has been proposed, for example, quality of life be added as a fourth component of the UNAIDS 90-90-90 (now 95-95-95) targets, which has raised the need and call to focus on client-reported outcomes.⁷⁹

Make major new health system investments to enable scale-up of IPCC

While the HIV infrastructure offers multiple avenues to expand and strengthen PHC, it is neither wise nor feasible to expect HIV budgets on their own to simultaneously finish the job of ending AIDS and compensate for the many weaknesses in national health systems. Indeed, there is an urgent need for additional resources specifically dedicated to the fight against HIV, as the world is badly off track for achieving the target of ending AIDS as a public health threat.⁸⁰ Financing for the HIV response has stagnated in recent years at levels at least \$8 billion below the amount needed to achieve the global targets.⁸¹ Scaling up IPCC will require substantial new resources – for planning, system configuration, workforce training, procurement of diagnostics and medicines required for holistic care, and capacitating community-led responses. To enable the scaling-up of IPCC, international assistance for health will need to grow. To support efforts to build off existing HIV infrastructure (as well as infrastructure created by other vertical health programs), consideration should be given

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No one disagrees with the need for integration and taking a PHC approach, but it is important to find a balance between integration and maintaining quality of HIV services so that it continues to meet the needs of people living with or vulnerable to HIV—so indeed person centered. In the interest of people living with HIV, how can we ensure that the pendulum moves towards horizontal programming while making sure HIV treatment and prevention doesn’t drop off as a priority?

— *Civil society representative*

to increasing PEPFAR and Global Fund appropriations in order to allow their funded programs to work more purposefully across health areas beyond HIV. An additional strategy is to make current vertical programs somewhat more flexible to enable providers to integrate HIV and non-HIV service elements.

Major new resources will be needed to leverage lessons learned from HIV to expand IPCC more broadly in primary care settings. Concerted efforts are needed to fully leverage available national health financing mechanisms to accelerate IPCC implementation across the broader health system. For example, Kenya's National Health Insurance Fund, which began by covering in-patient care, is now expanding to cover out-patient care. In a number of countries, national insurance schemes have negotiated deals to cover a more expansive array of services for non-communicable diseases at selected health facilities. Kenya's economic empowerment program is supporting the use of profits from microfinance initiatives to enable the national health insurance to cover treatments for non-communicable diseases.

The additional health funding needed to make IPCC scale-up feasible should specifically work to address key health system components, with the aim of building robust, sustainable systems of PHC. Strong, secure health information systems that are designed to make them easy for health workers are central to integrated, coordinated, holistic care.^{82,83} Investments are needed to build the capacity of national health ministries to implement IPCC and to identify and support IPCC champions within these ministries.

Low- and middle-income countries themselves must make markedly greater investments in their health systems. Substantial debt relief will be needed to increase domestic fiscal space for health investments, and international concessionary financing mechanisms should incentivize countries to invest in health and human services.⁸⁴ In countries where fiscal space is limited, one strategy for increasing domestic health investments is to commit to steady, incremental, year-on-year increases over a period of time to "re-set" the health allocation at a higher level within the national budgetary process.⁸⁵

“We need to work towards “leapfrogging” integration; for example, first you get 5% of providers to provide hypertension services with HIV, then use policy and finance incentives to jump that to 80%.”

— *Global health expert*

“HIV services are built so vertically. You could go in smoking 40 cigarettes a day and the provider won't mention it.”

— *Health researcher*



Photo: A provider with key population-led social enterprise, Alo Care, provides an HIV test during a Blue Sunday event to promote PrEP and other healthcare services among key population communities. Credit: Hoang Tran

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The real challenge in getting to integrated person-centered care is that by the fact that we're talking about care that is person-centered and community-centered, it requires tailored models for different contexts, which will make financing it complex...It's critical to get the financing right, understanding what clients are willing to pay to then understand what contributions can be at all levels.

— *Global health funder*

“At the global, national and provincial levels, we let the frontline down by coming up with these grant policies and expecting people on the frontline to work miracles.”

“We need to use HIV as a model for how a community can actually be part of the health care system.”

— Multilateral agency representative

Prepare the health workforce to deliver IPCC

To mainstream IPCC across the health system, the health workforce requires substantial, sustained investments, training, and support.⁸⁶ Health workers will need to be trained in IPCC, and they will require supportive supervision, management and incentives to enable them to embrace and implement new ways of practicing. Training at the site-level needs to be as intensive and high-quality as at the central health system level. Guidelines, job aides and capacity-building approaches will need to be tailored to the needs and circumstances of each setting. Low- and middle-income countries should redouble their investments in medical education and take steps to improve the pay, working conditions and professional opportunities available to health workers.⁸⁷ Simplified job aides should be developed to enable busy health workers to deliver care consistent with IPCC. Further investments by the U.S. government in the global health workforce are essential.^{88,89}

While working to close gaps in traditional health worker cadres (e.g. physicians, nurses, laboratory professionals, etc.), a massive drive is needed to recruit and train community health workers. Drawn from the communities they serve, community health workers can play a potentially transformative role in implementing IPCC, serving as the strategic link between communities and health systems and helping ensure that health interventions are tailored to the community’s needs.⁸⁹ Community health workers must be compensated, trained, integrated into care teams, equipped with mobile communications technology, provided with supportive supervision, and given opportunities for professional development.

Ensure transparent, inclusive engagement and governance

Communities know best what works for them and what they need for their own health and well-being. In working to embed IPCC principles and approaches across health systems, we should build off the emphasis in the HIV response on empowering communities to guide and inform the design of service delivery systems. In particular, processes are needed to enhance citizen engagement in demanding IPCC, and communities themselves should be educated to understand the tangible benefits of IPCC and UHC.

To ensure that health systems are designed and operated in a manner that meets the needs of people, communities need a seat at the table in health policy decision bodies – at global, regional, national and sub-national areas. Unfortunately, the inclusive governance approaches used to respond to HIV and TB have often not been mainstreamed across the health sector generally.^{90,91} Inclusive, multi-stakeholder national health assemblies offer one model for driving efforts to revise and adapt health systems along IPCC principles.⁹²



Photo: A TB specialist refills a smart pill box with TB drugs in Ukraine. Smart pill boxes ensure person-centered TB care by providing automated, real-time adherence data to healthcare providers that enable them to tailor counseling to people based on their adherence status. Yevhen Astaforov/Freelance photographer.

SCALING UP IPCC: A CALL TO ACTION

Further scaling up IPCC within HIV services and using the HIV experience as a bridge to broader IPCC implementation across health services generally can be used to inform UHC strategies that meet the needs of HIV-impacted communities.

Urgent, sustained action is needed to ensure that all people have access to health services that are holistic, coordinated, and responsive to each individual's broader health and wellness needs. Not only can IPCC enable superior care, it can also accelerate momentum towards UHC by removing deterrents to service access and utilization, especially among populations that have historically been marginalized and left out of mainstream healthcare.

Diverse actors have key roles to play in capturing the potential of IPCC.

International donors should:

- Recognize that the fight against HIV is far from over and that HIV platforms cannot assume additional responsibilities, such as addressing non-HIV-related health issues, without new resources.
- Leverage lessons learned from the HIV response to forge strategic partnerships among key stakeholders (including international donors, host governments, private sector stakeholders, development banks and civil society) to mobilize sustainable financing for the integration of HIV and PHC.
- Invest substantial new resources in strengthening the health workforce, including at the community level, both for HIV and for broader health systems.
- Create incentives for the application of IPCC principles and approaches in donor-funded health programs, and avoid financing or monitoring approaches that might discourage programs from providing integrated, person-centered care.
- Support and use metrics that capture and incentivize IPCC and drive continuous quality improvement.
- Align investments with country priorities and plans with respect to Universal Health Coverage and PHC.
- Collaborate with the World Health Organization (WHO), national governments and implementing partners in developing and implementing appropriate metrics and monitoring approaches to drive step-wise implementation of IPCC across health services and to enable learning by doing.
- Recognize that IPCC may not be feasible in all settings or for all populations in the near term and continue to invest in sustaining tailored private-sector, community, or virtual service platforms for populations that are not well served by mainstream public sector PHC health systems.

WHO should:

- Prioritize actions to implement the WHO Framework on integrated person-centered health services within HIV services.
- Provide technical support (through a range of practical tools) to national governments, health implementers and community partners to implement and effectively monitor IPCC.
- Develop normative guidance and user-friendly roadmaps on leveraging HIV service platforms to broaden access to IPCC within health systems.

Governments (including national, provincial, district and municipal) should:

- Incorporate HIV services within public-sector health services with a focus on PHC, including prioritization of co-location and people-centered design of clinical service settings.
- Pursue additional financing mechanisms to enable and sustain community, key population-led, and other IPCC delivery platforms, including through social contracting and social enterprise development.
- Allocate substantial domestic investments to greater integration of HIV and primary care, including the customization of primary care structures and strengthening and expanding medical education for diverse health worker cadres.
- Align national normative health guidelines and mandates with IPCC principles and approaches, including for often marginalized groups such as key populations.
- Invest in training and other measures to increase the capacity and motivation of the health workforce to deliver IPCC to all population segments, including people living with HIV and key populations.
- Effectively support community-led service delivery responses as essential partners in all aspects of health governance, planning, monitoring and service delivery.
- Mainstream IPCC indicators across national health information and monitoring systems.

Community-led responses should:

- Demand from both donors and governments that communities be included as essential actors in health governance and be recognized as having an important role in service delivery.
- Demand from both donors and governments that communities be provided with sufficient resources to support IPCC expansion through advocacy, service delivery and community-led monitoring.

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