

The background of the slide is a photograph of an older man with a white beard and mustache, wearing a blue and white striped shirt. The image is partially obscured by a dark grey rectangular box containing the title text. To the right of the box is a solid red vertical bar.

Person-Centred Care Research Collaborative: Ageing and HIV

20 November 2025

IAS Person-Centred Care (PCC) programme

- Prioritizes integrated, inclusive and responsive healthcare services
- Focuses on changing needs, priorities and preferences of each person living with or affected by HIV
- Empowers clients and is shaped by the many aspects of people's intersectional identities



What is the PCC Research Collaborative?

- **Mission:** To work collectively and efficiently to fill evidence gaps around person-centred care for people living with HIV or vulnerable to HIV acquisition
- **Participants:** Researchers, clients and providers who are championing evidence generation related to client-provider relationships, participatory approaches that value experts by experience as well as specific research and policy gaps related to person-centred care within the HIV response
- **Objective for 2024-2026:** Develop a research agenda for scaling up PCC approaches for people living with HIV or vulnerable to HIV acquisition

Access PCC
programme
resources



Today's objective

Examine the evidence base and identify research gaps with regards to the management of HIV, non-communicable diseases and other health needs to support the quality of life of the growing cohort of older people living and ageing with HIV.

Today's speakers



Reena Rajasuriar,
University of Malaya,
Malaysia



Yvonne Gilleece,
University of Sussex
NHS Foundation Trust,
United Kingdom



Jepchirchir Kiplagat,
Academic Model Providing
Access to Healthcare
(AMPATH), Kenya



Bonaventure Ukoaka,
Excellence Community
Education Welfare
Scheme (ECEWS), Nigeria



Vanessa Fozao Mbi,
Team PATA, Cameroon



Amy Justice,
Yale School of Medicine,
United States



Keri Althoff,
Johns Hopkins University,
United States

Today's panelists



Andrew Tan,
Kuala Lumpur AIDS
Support Services Society
(KLASS), Malaysia



Linda-Gail Bekker,
Desmond Tutu Health
Foundation, South Africa



Genie Siegler,
Weill Cornell Medicine,
United States

Meeting protocols

1. Stay on mute unless you are presenting, or a moderator calls on you
2. Use the chat to ask questions and share your thoughts on the points raised by the presenters
3. If you would like to ask a question or provide a verbal comment during the discussion, raise your hand and wait to be called on





Context-specific screening tools for frailty, osteoporosis, CVD and cognitive impairment: Current evidence and research gaps

Reena Rajasuriar

Centre of Excellence for Research in AIDS (CERiA)

Department of Medicine, Universiti Malaya



DISCLOSURE

No conflicts of interest



A close-up photograph of a person's hand holding a red ribbon, which is a symbol for HIV/AIDS awareness. The hand is positioned on the left side of the frame, with the fingers gently gripping the ribbon. The ribbon is a vibrant red color and is tied in a loop. The background is a soft, out-of-focus light color.

OUTLINE

- Overview of existing screening tools
 - Cardiovascular disease
 - Bone health
 - Frailty
 - Neurocognitive impairment
- Recent research findings
- Areas needing more research

SCREENING FOR CARDIOVASCULAR DISEASE



Tool	Source population	Country	Constraints	Performance studies in PWH
Framingham Heart Study (FHS-CVD)	HIV negative	USA	It is valid for individuals aged 30 to 75. It does not take into account HIV-specific parameters.	Underpredicts CVD risks in women
ACC/AHA Pooled Cohort Equations (PCE)	HIV negative	USA	It is valid for individuals aged 40 to 79. It does not take into account HIV-specific parameters.	Underpredicts CVD risks in black race, women, low/moderate CVD risk.
Data Collection on Adverse Events of Anti-HIV Drugs (D:A:D)	PWH	USA, Europe, Argentina, Australia	Valid only for PLWH aged 18-75 years, with a cumulative NRTI exposure up to about 8-10 years, and PI exposure up to around 5-6 years	Slightly underpredicts CVD risks in low/moderate CVD risk
Systematic Coronary Risk Estimation2 (SCORE2)	HIV negative	European countries	It is valid for individuals aged 40 to 69, without previous CVD or diabetes. It has been validated only for European populations. It does not take into account HIV	As accurate as the PCE and D:A:D in the Swiss HIV Cohort Study.
PREVENT	HIV negative	USA	Validated for adults aged 30 to 79 years old; limited utility to the US (social deprivation index)	Significantly underpredicts CVD risks



SCREENING FOR CARDIOVASCULAR DISEASE

- Comparison of CVD risk assessment tools using REPRIEVE global data

Tool	Overall performance	Geographical differences	Race-specific differences	Sex-specific differences	Key points
PCE	Highest predicted 10-yr risk; most sensitive at identifying high-risk individuals.	Underestimates ASCVD in HICs; overestimates in LMICs.	Underestimates risk in Black/AA men in HICs; closer calibration in White participants	Substantial underprediction in women in HICs (OE $\approx$ 2.4).	Needs recalibration by sex and race in HICs; may overtreat in LMICs.
D:A:D	Similar discrimination to PCE; includes HIV-specific factors.	Same geographic miscalibration as PCE	Patterns mirror PCE	Underprediction in women similar to PCE.	Does not clearly outperform PCE despite HIV-specific inputs.
PREVENT	Lowest predicted risk; reclassifies 38% of PCE-high-risk individuals downward.	Strongly underpredicts in HICs; closer alignment in LMICs.	Down-classifies Black/AA participants the most	Moves many women into “low-risk” categories	Extremely conservative—risks missing large groups who should receive statins.
SCORE2	Intermediate predicted risk. Region-calibrated.	Underpredicts in HICs; borderline acceptable in LMICs.	High down-classification among Black/AA $\geq$ 50 yrs; mixed performance in Asians.	Some down classification in women $\geq$ 50; up-classification in $<$ 50 due to lower cut-off.	Good for European context but produces mixed reclassification patterns globally.

SCREENING FOR CARDIOVASCULAR DISEASE



- Research gaps
 - No single risk tool for primary prevention of CVD performs optimally across the diverse global population of PWH
 - Need tools which account for residual CVD risks associated with HIV and being women → HIV-specific and sex-specific calibration
 - Urgent need to develop CVD risk scores for PWH in LMIC settings – incorporating region-specific epidemiology

SCREENING FOR OSTEOPOROSIS

- Osteoporosis is diagnosed with DXA scans (gold standard) to detect low bone mineral density (BMD) – expensive, limited access in LMICs
- Risk calculators for fragility fracture (clinical risks $\pm$ BMD)

Tool	Source population	Country	Key features	10-year fracture prediction in PWH
FRAX	HIV negative	Global	Calibrated for many countries/regions, integrates traditional risk factors, omits risk of falls, most widely used tool	Underpredicts fractures
Qfracture Score	HIV negative	England, Wales	Traditional risks and non-ART medications, chronic comorbidities cancer, kidney disease, liver disease and epilepsy	Underpredicts fractures, Poorer compared to FRAX
FRESIA	PWH	Spanish (CoRIS)	Traditional risks, chronic comorbidities (CKD, COPD) and HIV-specific factors (baseline/nadir CD4, TDF use), did not consider prior fracture risks in modelling	Better compared to FRAX, improved classification of over 35% with fractures.

SCREENING FOR OSTEOPOROSIS

- Research gaps
 - FRAX underpredicts fracture risks in PWH and studies which incorporate additional parameters to improve the accuracy needed - measures of bone architecture, markers of inflammation.
 - Evolving background risks in PWH – treat all era, switch to bone sparing ARVs, gender-affirming hormone use, WWH initiating TDF during pregnancy and lactation
 - Concentration of validation studies in high-income settings

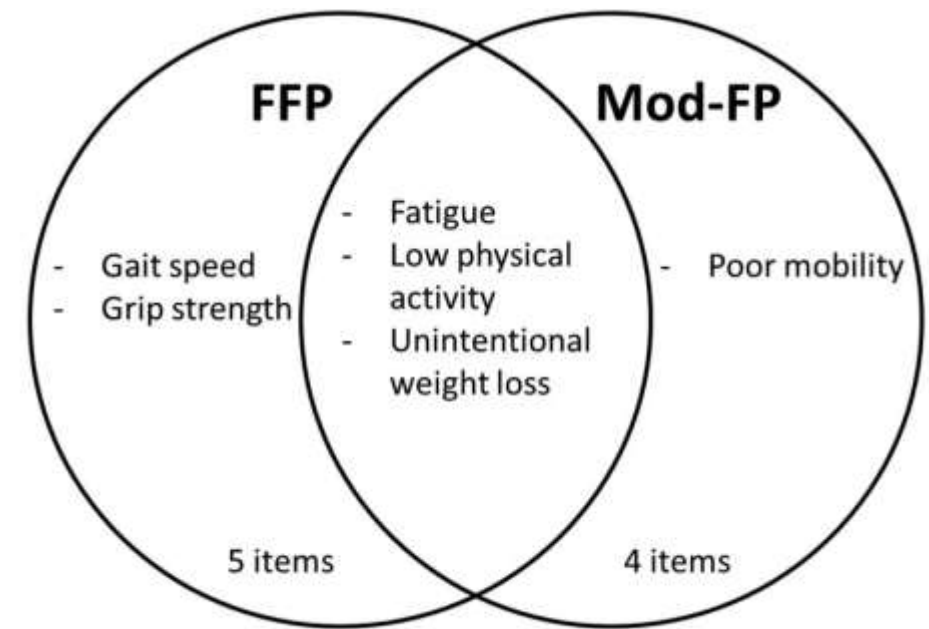
SCREENING FOR FRAILTY

- Many tools to assess frailty – no gold standard
- HIV literature :
 - Diagnosis: Frailty phenotype, Frailty index,
 - Screening: FRAIL Scale, Clinical Frailty Scale
 - Poor consistency across tools
 - Developed in general older population (≥ 65 years); omits HIV-specific factors (immune dysfunction, ARV side-effects)
- Frailty phenotype
 - Dynamometer for grip strength, space to assess gait speed
- Frailty index
 - Low health literacy, limited awareness of medical conditions, poor documentation

SCREENING FOR FRAILTY



- Modified Frailty Phenotype for PWH (CNICS):
 - Self-reported, low burden
 - Frail: AUC ROC=0.93, sensitivity 62%
 - Pre-frail: AUC-ROC=0.86, sensitivity 77%
 - Cohen's kappa = 80%
- Research gaps
 - Lack harmonized assessment for frailty in PWH
 - Feasible across all settings
 - Predict outcomes and amenable to interventions
 - Reasonable sensitivity in PWH ≥ 50 years



Abbreviations: FFP: Fried's Frailty Phenotype; Mod-FP: Modified Fried Phenotype

SCREENING FOR COGNITIVE IMPAIRMENT



Tool	Performance in PWH	Type of tool	Duration	Feasibility for implementation
BRACE	Sensitivity 84% , Specificity 94%	iPad-based, computerized	~12 min	High acceptability; self-administered; minimal training; adaptable to multiple languages; auto-scored; integrates securely with clinical data systems
NeuroScreen	Sensitivity ~ 90% , Specificity ~ 63%	Smartphone-, tablet-based app	~25 min	High acceptability; easy to integrate into EMR; adaptable to multiple languages; automatic scoring; data securely transferred
NCAD	Sensitivity 67% , Specificity 83%	Fully automated computerized headset device	~20 min	Easy for staff to administer; automated scoring & upload; requires ability to use keypad; not yet commercially available
CAMCI	Sensitivity 72% , Specificity 97%	Tablet-based computerized	15–20 min	Easy for low-literacy users; visual + audio instructions; auto-scoring; immediate report generation
CogState	Sensitivity 81% , Specificity 69.9%	Computerized (desktop)	10–15 min	Easy to administer; requires desktop computers (cost implications); secure cloud-based data management

SCREENING FOR COGNITIVE IMPAIRMENT



Tool	Performance in PWH	Type of tool	Duration	Feasibility for implementation
MoCA	Sensitivity 69% , Specificity 58%	Paper or app; interviewer- or app-based	~10 min	Needs cultural/educational adaptation; auto-generated reports via app; simple to administer; limited sensitivity in PLWH
CAT-Rapid	Sensitivity varies (HAND: 64% ; HIV- D: 94%); Specificity 52%	Paper-based, interviewer- administered	~7 min	Quick; useful for detecting HIV dementia; limited ability to detect milder HAND; manual scoring
CSCT	Sensitivity 81% , Specificity 53%	Computerized SDMT-style tool	~2 min	Very fast; easy to administer; auto-scoring; no personal data stored; cannot detect mild HAND reliably
IHDS	Sensitivity 91% , Specificity 17%	Paper-based, interviewer- administered	~2–3 min	Very easy; minimal training; suitable for low education groups; poor specificity; cannot detect mild impairment
MMSE	Sensitivity 46% , Specificity 55%	Paper-based, interviewer- administered	~10 min	Simple; widely known; manual scoring; detects severe impairment; low sensitivity for HAND

SCREENING FOR COGNITIVE IMPAIRMENT



- Research gaps
 - Most tools developed in high-income, English-speaking settings - not suitable for global application without calibration/adaptation
 - Tools used without population-specific normative data – inaccurate interpretation
 - Implementation barriers: quiet space, time to complete, sufficient number of devices
 - Extensive neuropsychological assessments and imaging needed to diagnose NCI – resources not typically available in LMICs.

CHALLENGES BEYOND THE TOOL

- Equitable access, digitally inclusive, cross setting usability (primary and specialist care)
- Unclear guidance on who, when and how frequently to screen – is it different in PWH vs general population?
- Strategies to integrate screening into routine HIV care with minimal burden to the health system and PWH

Research on the prevalence and impact of comorbidities on older women living with HIV, including the effect of menopause, and interventions to improve economic stability and social support among older women

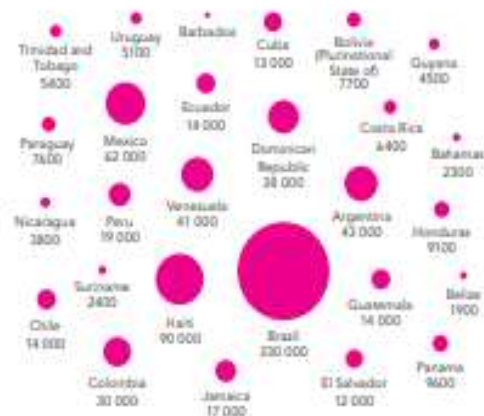
 **IAS** **PCC Research Collaborative**
20th November 2025

Prof Yvonne Gilleece
Honorary Clinical Professor and Consultant in HIV Medicine
Brighton & Sussex Medical School
University Hospitals NHS Foundation Trust Brighton
United Kingdom

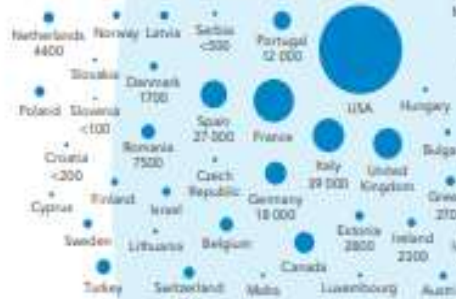
20.2 MILLION GIRLS AND WOMEN LIVING WITH HIV

Girls and women make up more than half of the 37.7 million people living with HIV. Ending AIDS by 2030 requires that we address girls' and women's diverse roles by putting them at the centre of the response.

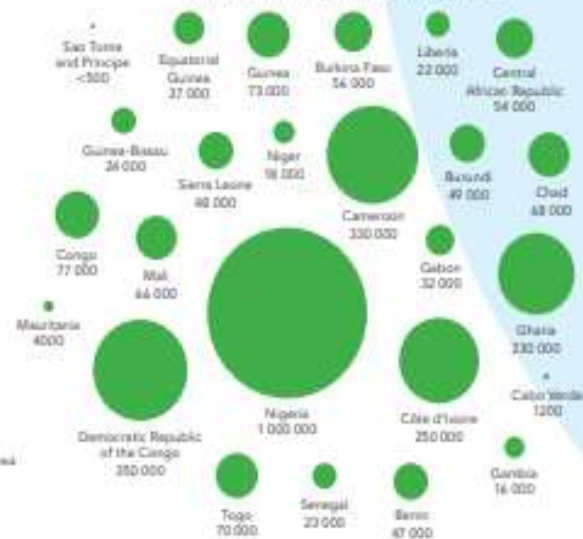
Latin America and the Caribbean



Western and central Europe and North America

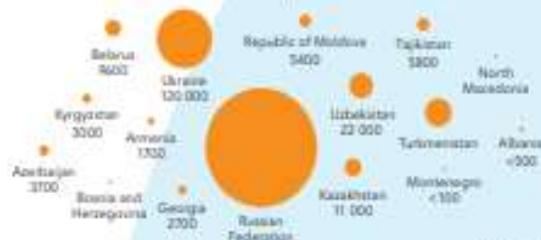


Africa—western and central Africa



No data available for these countries not listed.
Source: UNAIDS 2021 estimates.

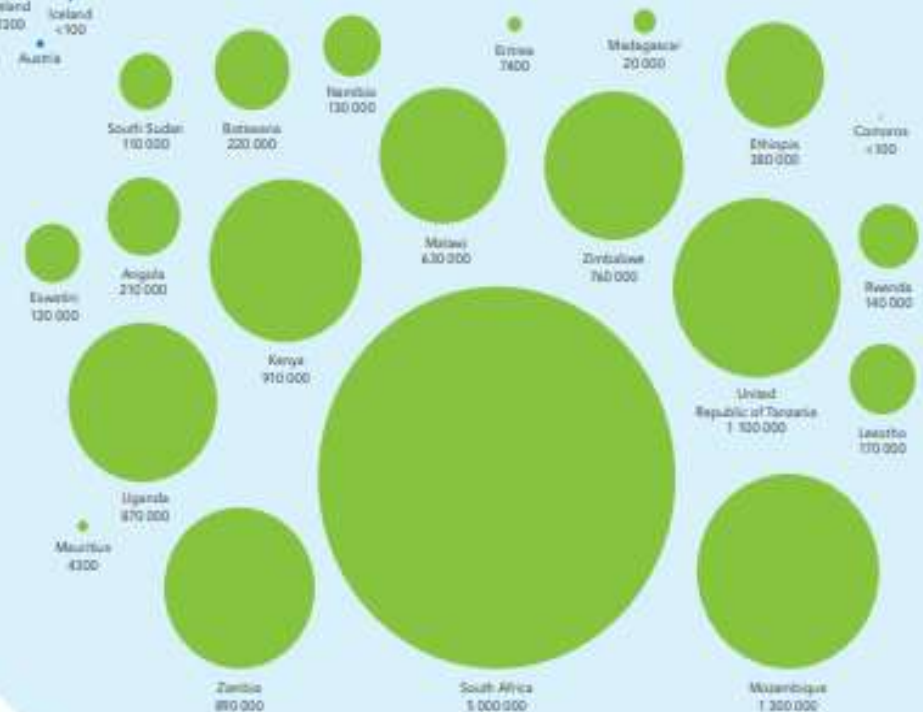
Eastern Europe and central Asia



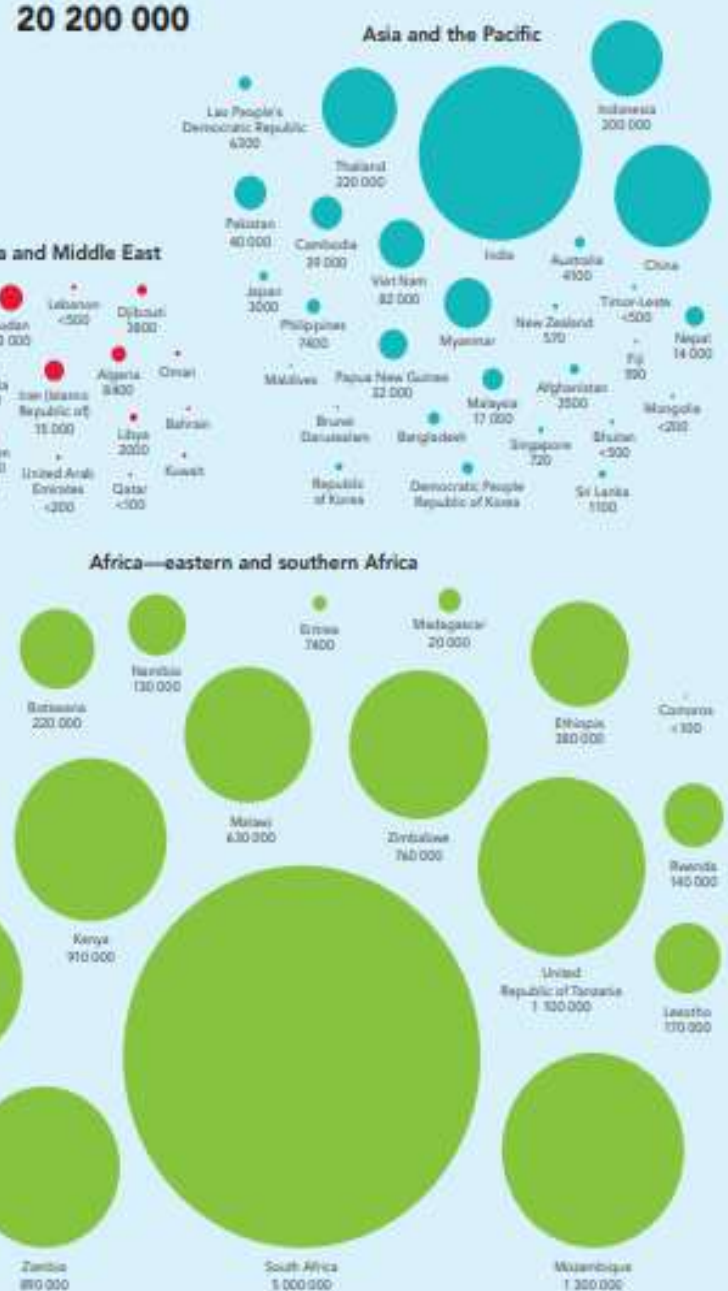
North Africa and Middle East



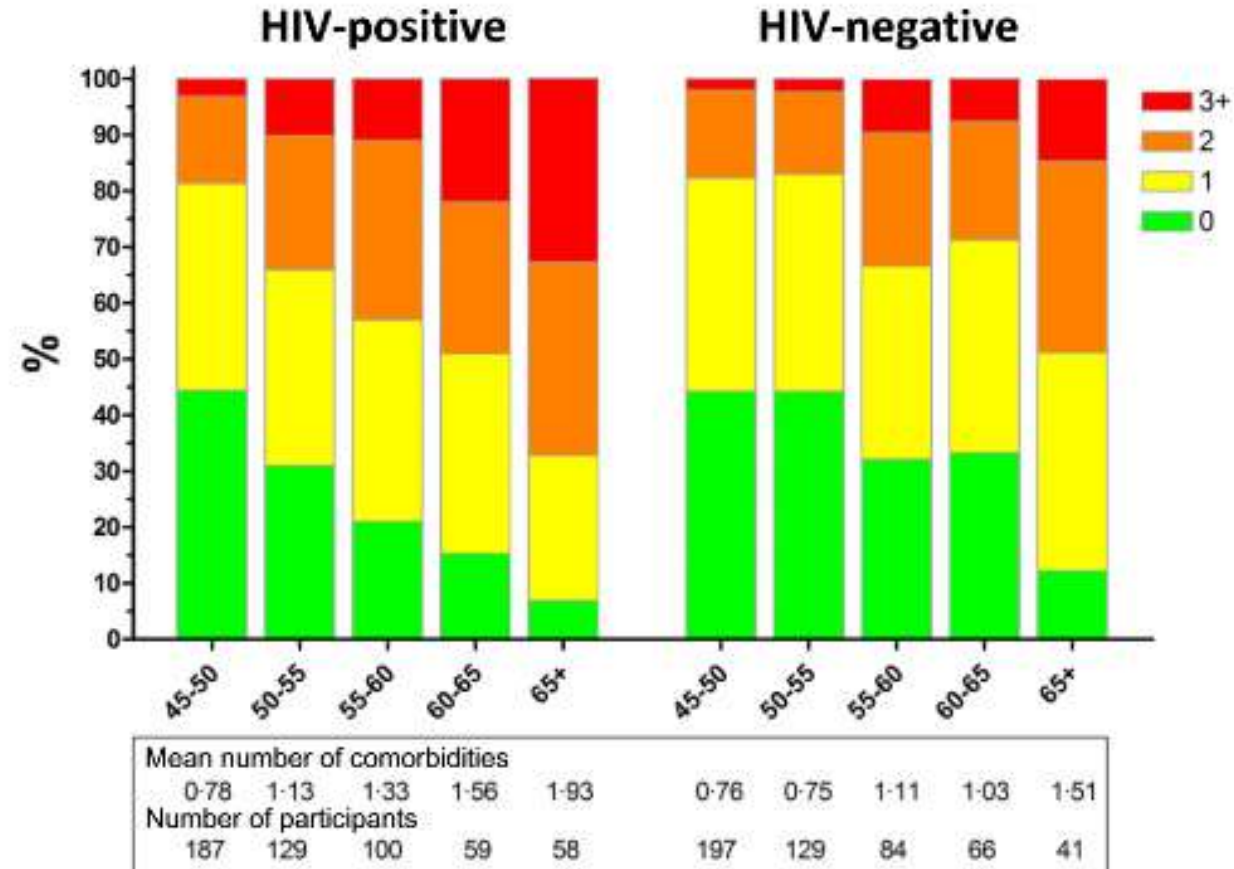
Africa—eastern and southern Africa



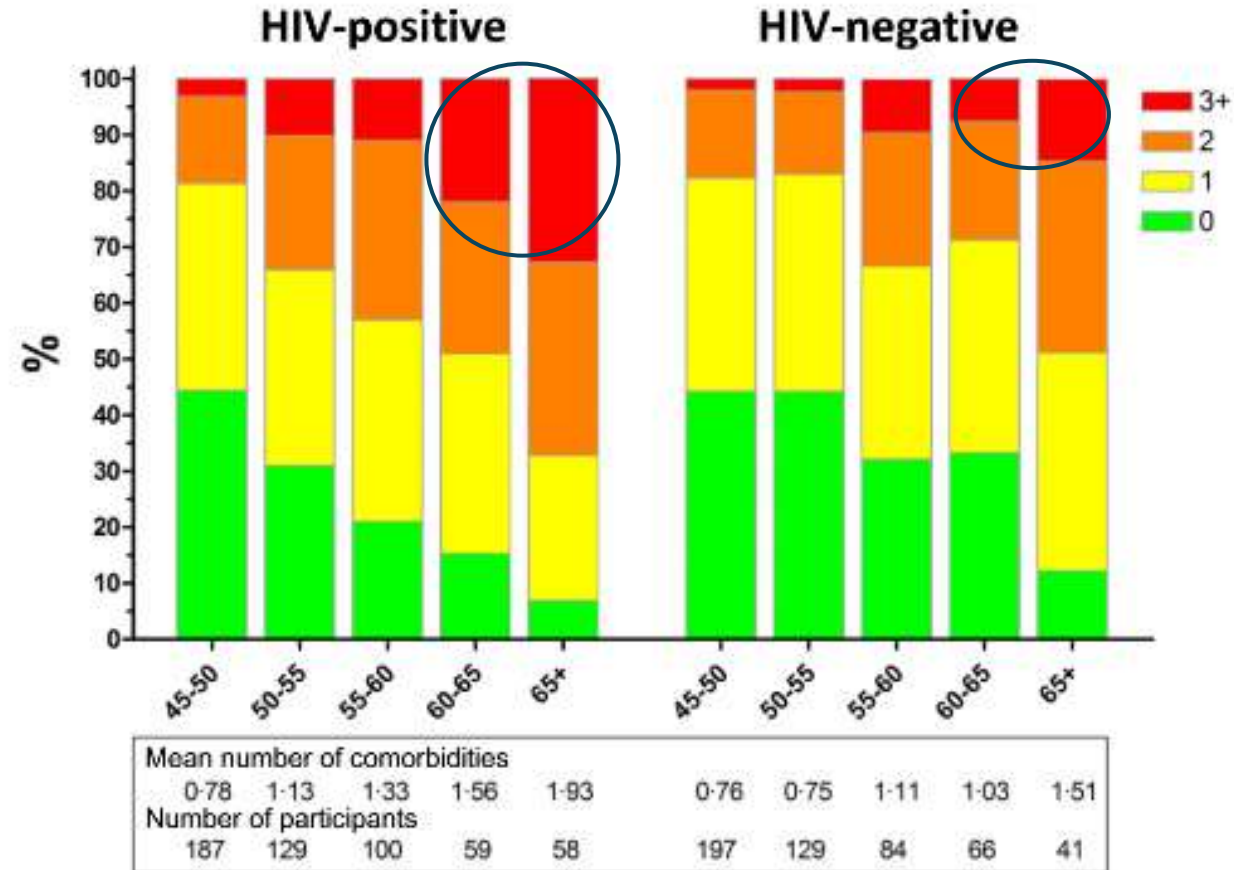
Global



Number of age-associated comorbidities stratified by age



Number of age-associated comorbidities stratified by age

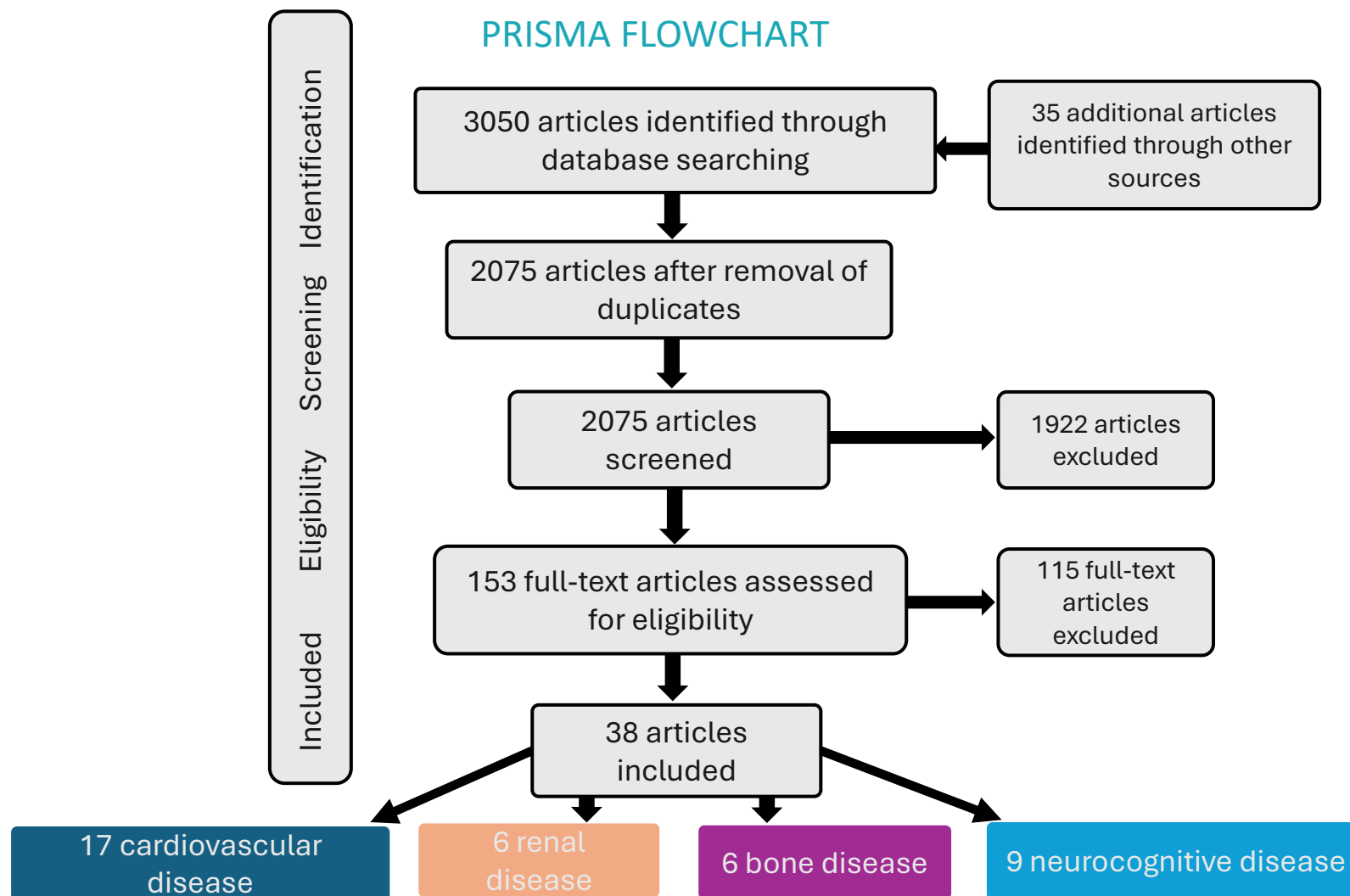


COMORBIDITIES IN WOMEN LIVING WITH HIV: A SYSTEMATIC REVIEW

Sonia Raffe, Caroline Sabin, Yvonne Gilleece



PRISMA FLOWCHART



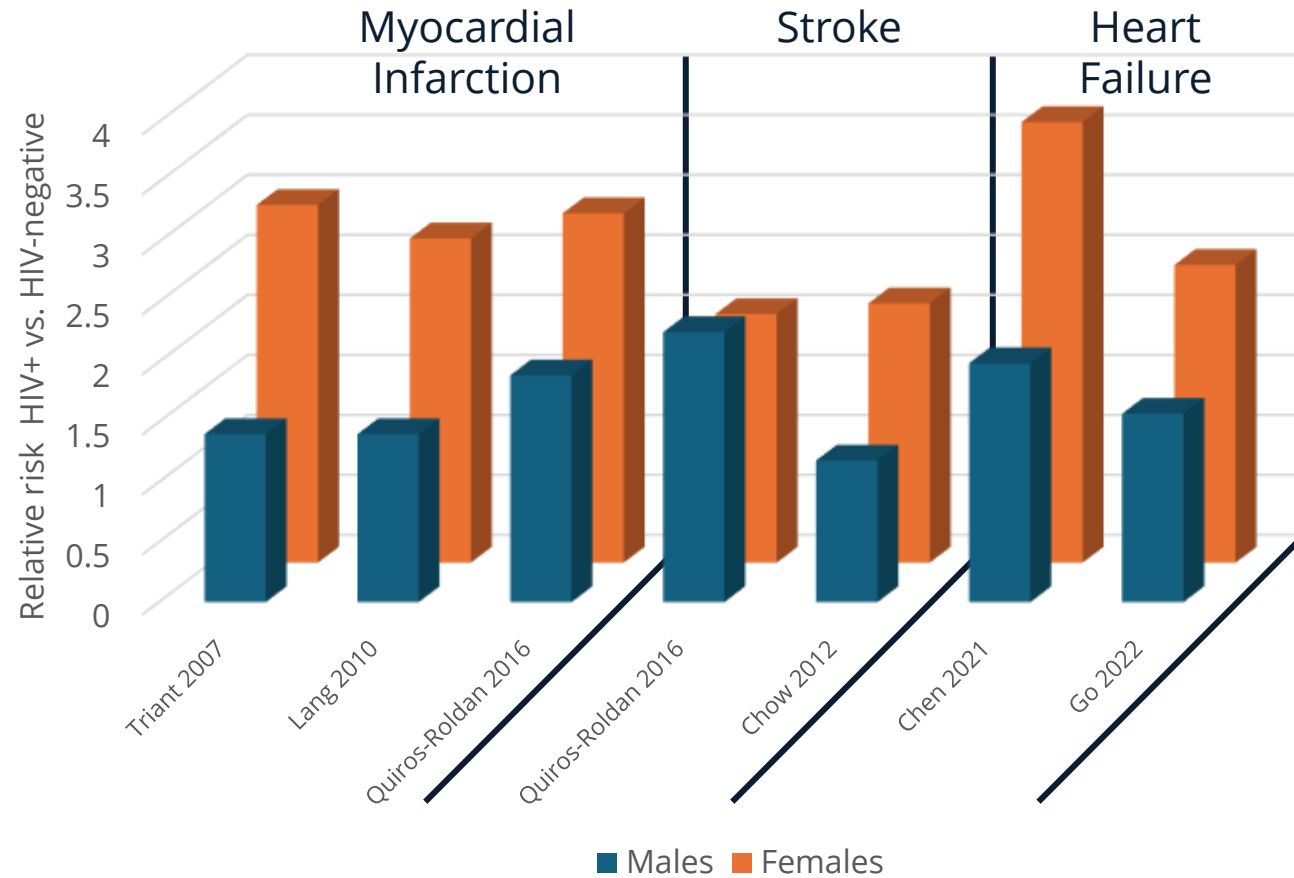
CARDIOVASCULAR DISEASE

- All six studies that looked at the incidence of acute cardiovascular events found WLWH to be at an increased risk

Author, year	Location	Population	Sample size (no/% women)	Mean age	Major findings
Womack, J et al, 2014 ¹	USA	WLWH HIV-neg women	710 (100%) 1477 (100%)	38.8 51	Increased incidence of CV events in WLWH vs HIV-negative women (HR=2.8; 95% CI 2-9.9)
Quiros-Roldan et al, 2016 ²	Italy	PLWH General population	3766 (1081/28.7%) N/A	38 N/A	Greater risk of MI (SIR=2.91) and stroke (SIR=2.07) in WLWH vs general population
Triant, VA et al, 2014 ³	USA	PLWH HIV-neg controls	3109 (1467/33%) 23,327 (12782/34%)	42 42	Higher incidence of major cardiac events in WLWH vs HIV-negative controls (IRR=2.19)
Chow, FC et al, 2012 ⁴	USA	PLWH HIV-neg controls	4308 (1350/31%) 32,423(11204/35%)	42 41	Increased stroke risk in WLWH vs general population (HR 1.21; p<0.001)
Lang, S et al, 2010 ⁵	France	WLWH General population	90,856 person-years (100%) N/A	N/A N/A	Higher MI risk in WLWH vs general population (SMR 2.6, 95% CI=1.8-3.9)
Knudsen, AD et al, 2018 ⁶	Denmark	PLWH HIV-neg controls	08 (135/15%) 11106 (1932/17%)	52 53	Higher prevalence of peripheral artery disease in WLWH vs general population (OR 2.24; 95% CI=1.06-4.73)

- Modifiable cardiovascular risk factors are common and poorly managed in women living with and without HIV¹
- Cardiac CT angiography appearances differ between women living with and without HIV²
- WLWH less likely to have ST-elevation during acute MI or to receive percutaneous coronary intervention than MLWH³

The magnitude of HIV-related risk is higher in women compared to men

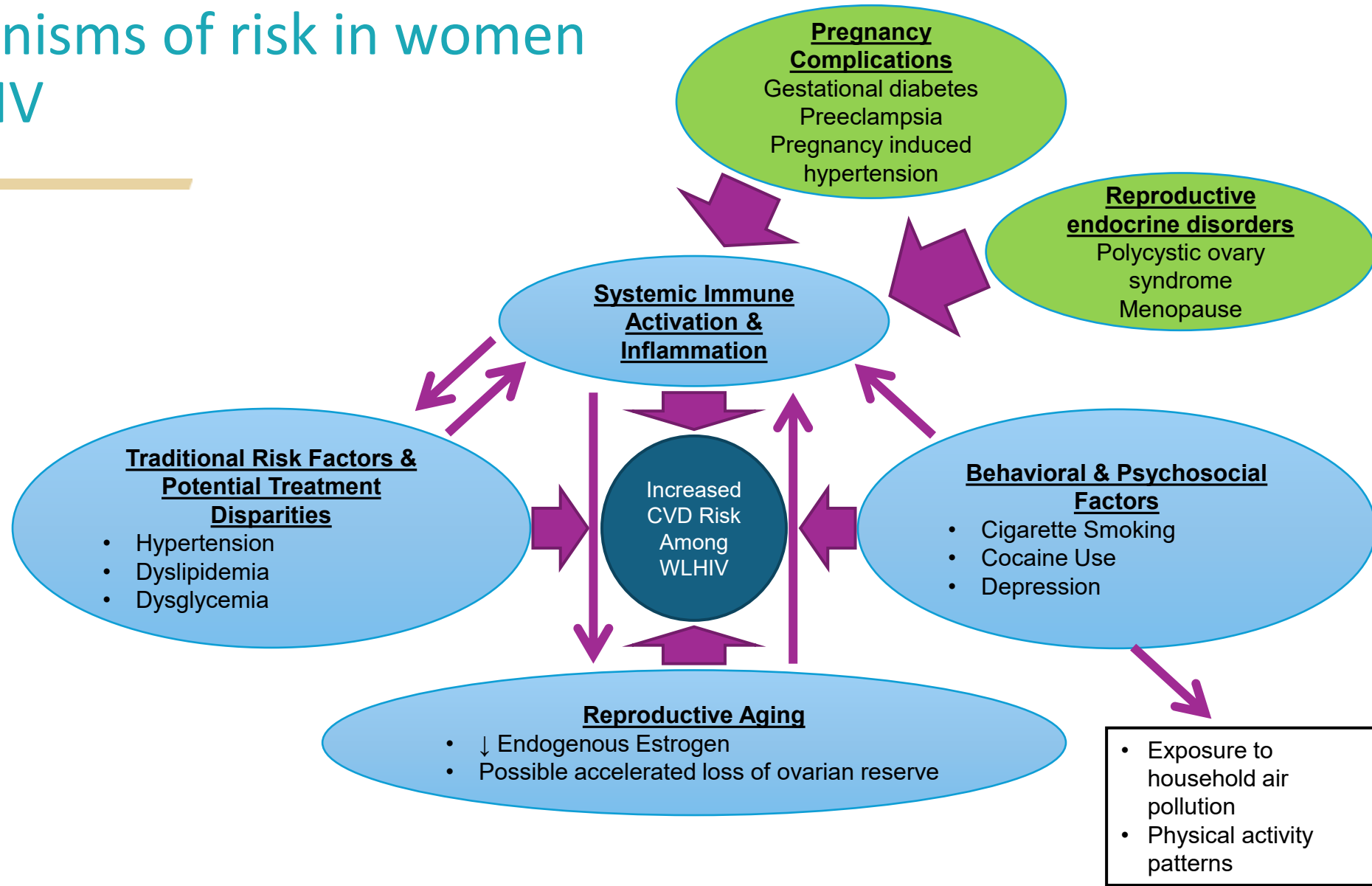


Sex differences for Metabolic Dysfunction Associated Liver Disease (MAFLD)

- Age 52, 25% female
- Steatosis CAP >270 plus BMI >25/T2DM, Fibrosis LSM>8
- Incidence of MAFLD similar between women and men
- Incidence of liver fibrosis was higher in women, 7 vs 5.9 per 100PY, especially if aged >50yo
- Multivariate cox regression model showed
- Predictors of significant liver fibrosis to be
 - MAFLD (aHR 3.3, 95% CI 2.0-5.6)
 - Female sex (aHR 2.2, CI 95% 1.3-3.5)
- CD4 cell count protective (aHR 0.99, 95% CI 0.99-0.99)
- What is the effect of HRT, other drug exposure,
- Viral coinfection?

Baseline characteristics	Female	Male
Prevalence of MAFLD	17.7%	24.3%
Prevalence of liver fibrosis	10.7%	13.4%
Black ethnicity	48%	17%
ALT IU/l	26.4 +/- 20.4	33.4 +/- 22.5
HDL chol, mmol/L	1.46 +/- 0.57	1.11 +/- 0.33
TG, mmol/L	1.69 +/- 0.96	2.47 +/- 2.63

Mechanisms of risk in women with HIV



Meet the Multidisciplinary Team!

Primary Care Dr

Geriatrics Dr

Community HIV nurse

Pharmacist

HIV/ID Dr

HIV/ID Nurse

Dr Specialist interest HIV



Gynaecology
Menopause
Oncologist
Mental health
Interpreter
Peer Mentor

HCP barriers for women to be included in clinical trials

- One crucial shift is classifying pregnant people as "medically complex" rather than "vulnerable," which is a term reserved for prisoners or those with social difficulties^{1,2}
- Instead of thinking it's unethical to do research with pregnant women, researchers should consider that it's unethical not to include them¹

1. Madhusoodanan J. Why Are So Few Drugs Tested for Safety in Pregnancy? Available at <https://undark.org/2020/09/30/drug-testing-safety-pregnancy>. Accessed Feb 2021

2. FDA. Pregnant Women: Scientific and Ethical Considerations for Inclusion in Clinical Trials Guidance for Industry. April 2018. Available at: <https://www.fda.gov/media/112195/download>. Accessed Feb 2021

HCP barriers for women to be included in clinical trials

Thalidomide

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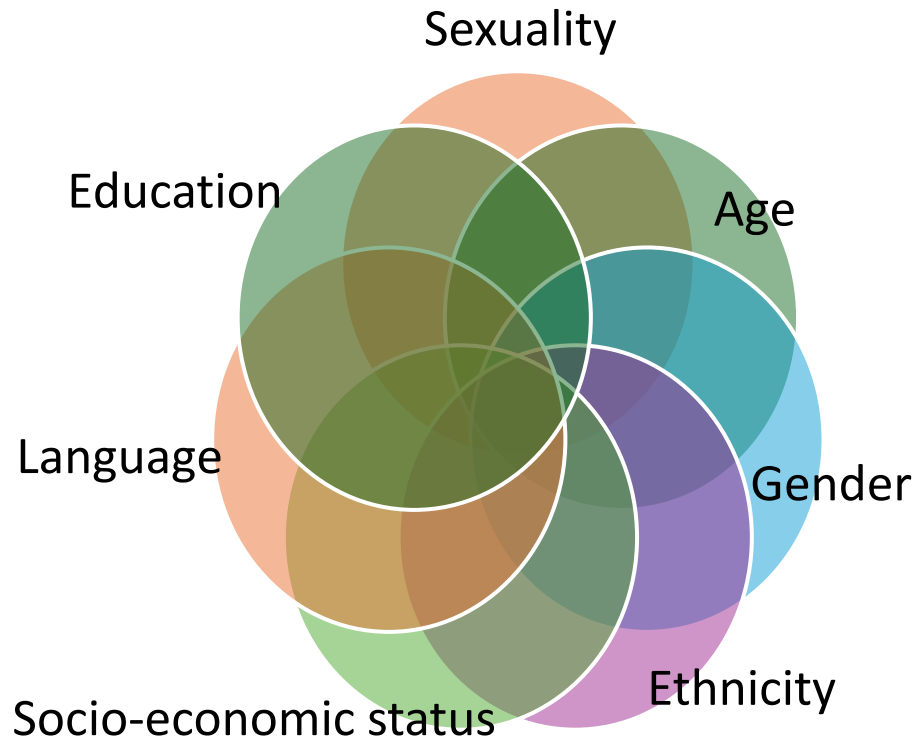
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Barriers for women to participate in clinical trials

Example of inclusion criteria for women in a clinical trial

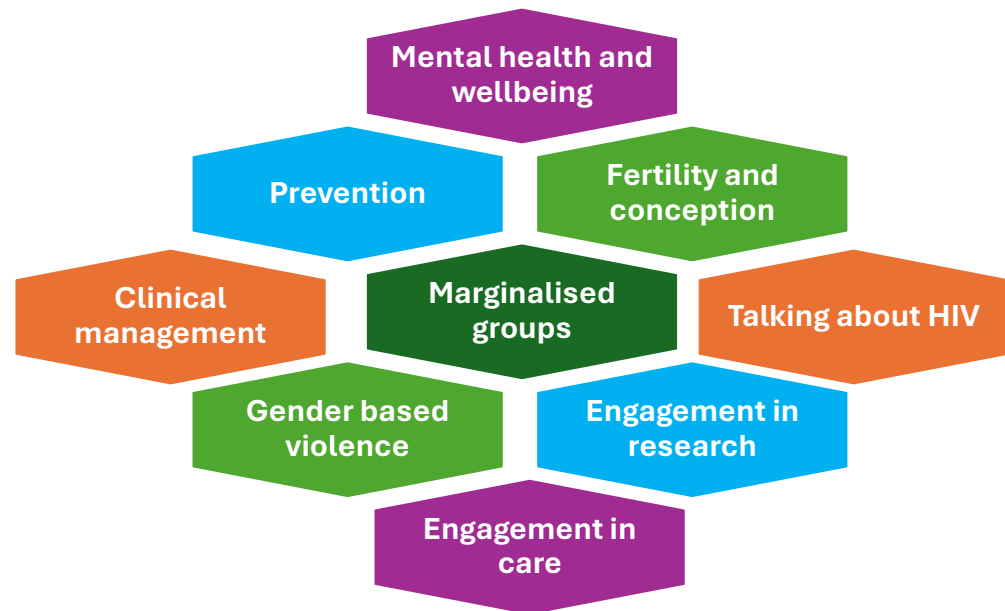
- Women capable of becoming pregnant must use highly effective contraception during the study and for 18 weeks after stopping treatment. Highly effective contraception is defined as either:
 - Total abstinence: When this is in line with the preferred and usual lifestyle of the subject. (Periodic abstinence [e.g. calendar, ovulation, symptothermal, post-ovulation methods] and withdrawal are not acceptable methods of contraception)
 - **Male partner sterilisation (with the appropriate post-vasectomy documentation of the absence of sperm in the ejaculate)**
 - For the female study subjects, the vasectomised male partner should be the sole partner for that patient
 - Use of a combination of any two of the following:
 - Use of oral, injected or implanted hormonal methods of contraception
 - Placement of an intrauterine device (IUD) or intrauterine system (IUS)
 - Barrier methods of contraception: condom or occlusive cap (diaphragm or cervical/vault caps) with spermicidal foam/gel/film/cream/vaginal suppository
- In case of use of oral contraception, women should have been stable on the same pill for a minimum of 3 months before taking study treatment



A Systematic Review of the Inclusion (or Exclusion) of Women in HIV Research: From Clinical Studies of Antiretrovirals and Vaccines to Cure Strategies

Mirjam J. Curno, PhD,† Samuela Rossi, MSc,*‡ Ioannis Hodges-Mameletzis, DPhil,*§
Rowena Johnston, PhD,|| Matt A. Price, PhD,¶# and Shirin Heidari, PhD****

Women
represented
23% of
participants
in 544
studies

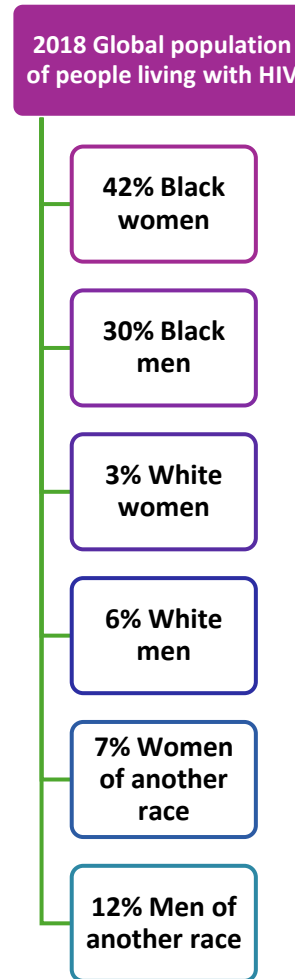


Regulatory randomised controlled trials should aim for at least 50% female and 50% non-white participants to provide sufficient safety data

- Recent study compared the demographic characteristics of people living with HIV globally to those of people who were recruited to the phase III studies leading to the approval of four modern anti-HIV drugs.
- Twenty four phase III studies were included in the analysis
 - ten for dolutegravir (7714 participants)
 - four for bictegravir (2307), eight for TAF (7573)
 - two for doravirine (1407)

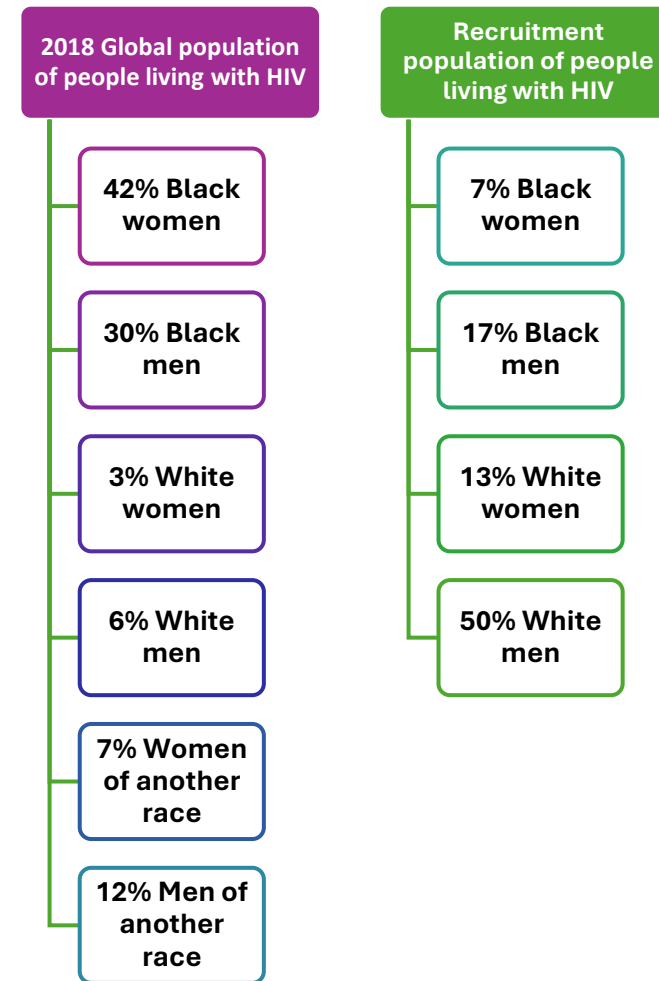
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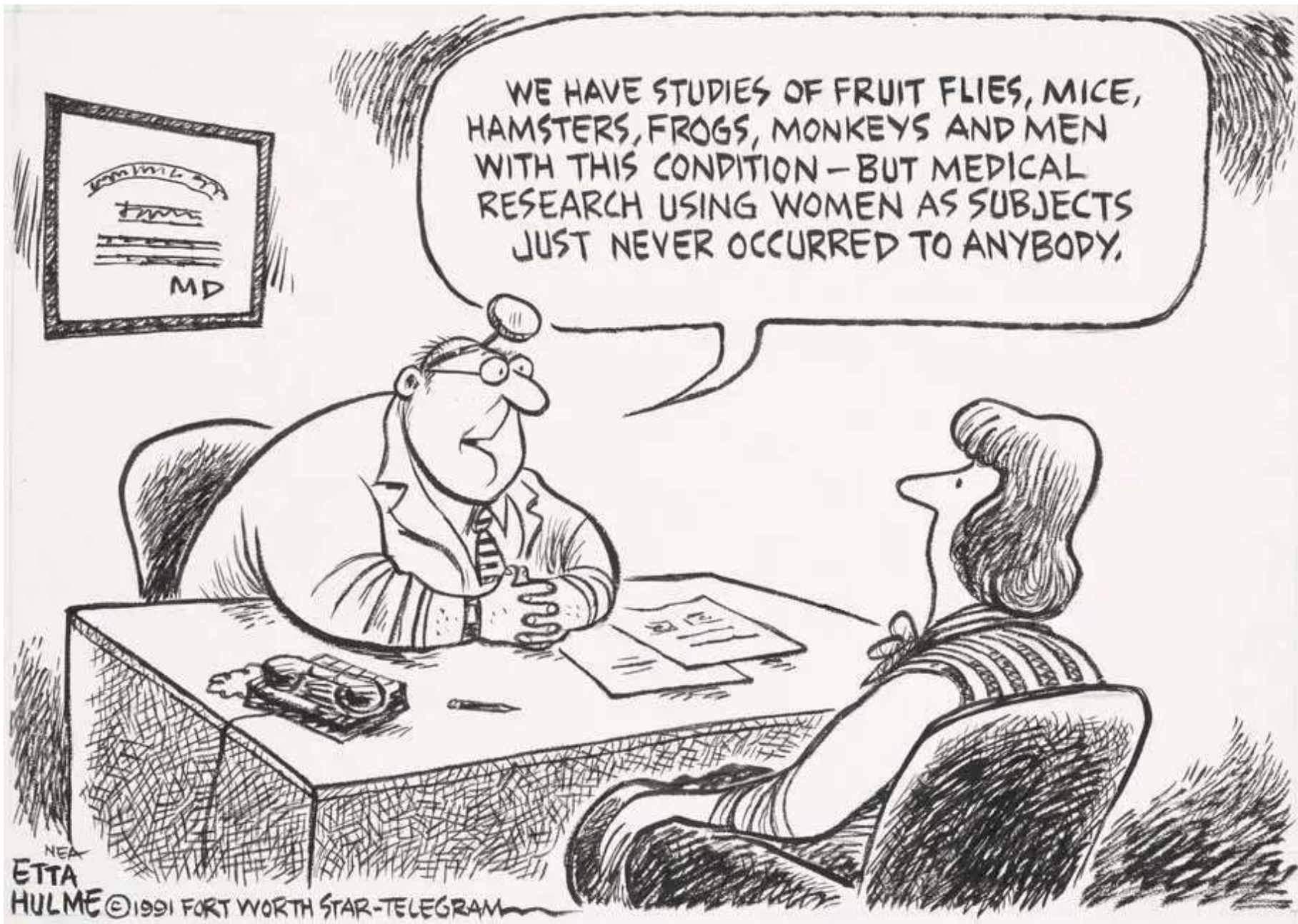
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Summary

- The majority of people living with HIV are women
- Women may experience different comorbidities as they age
- We need more evidence to ensure women's care can be optimised
- New models of care can provide the holistic approach women need
- Proper assessment is essential to promote healthy ageing
- Research Research Research!
- Thank you

Research to Reality: Interventions for Frailty, Depression and NCDs at AMPATH

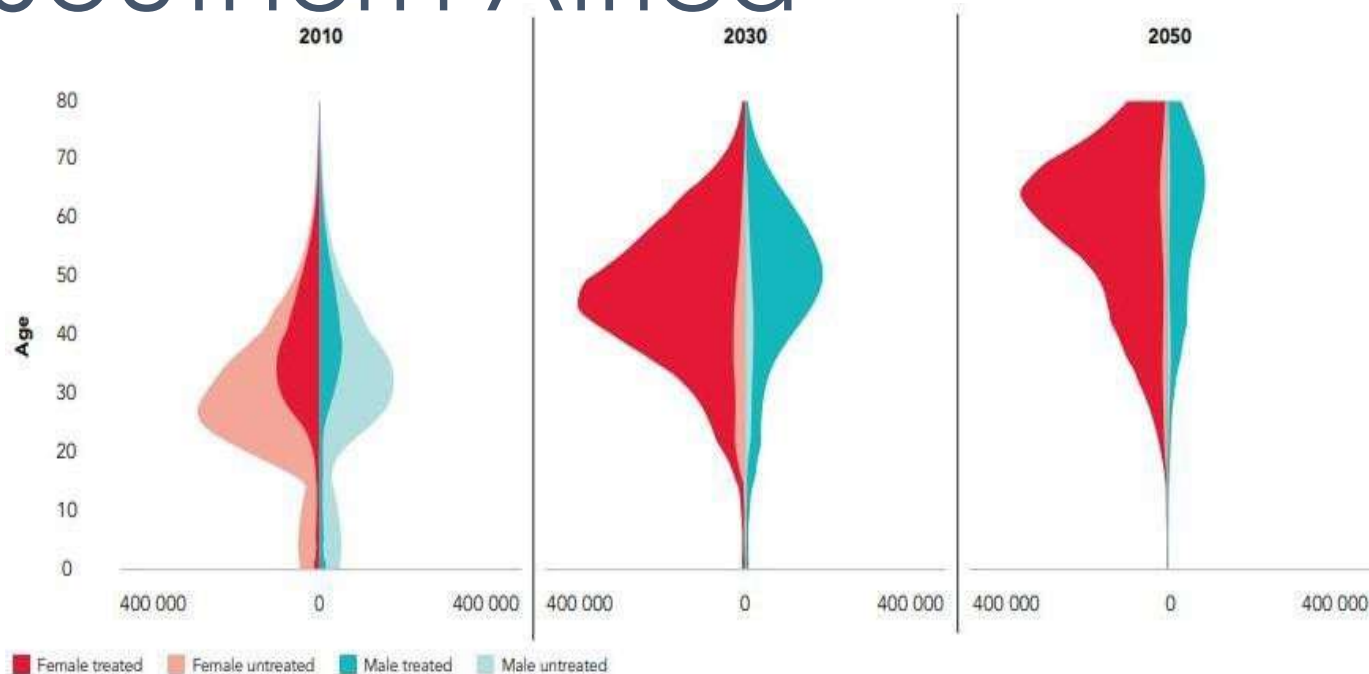


Jepchirchir Kiplagat, PhD
Lecturer, Department of Epidemiology and Medical Statistics
Moi University, School of Public Health

International AIDS Society Meeting
November 20, 2025



Projected age of people living with HIV and on treatment in Eastern and Southern Africa



Median age of people living with HIV will shift from the low thirties in 2010 to the high fifties in 2050

Source: UNAIDS epidemiological estimates, 2023 (<https://aidsinfo.unaids.org/>); Eaton J, Stover J. Describing the end of AIDS as a public health threat. Technical consultation, 20–21 July 2023, Boston, MA (<https://jointswg.unaids.org/publication/describing-the-end-of-aids-as-a-public-health-threat/>).

Why Models of Care Matter



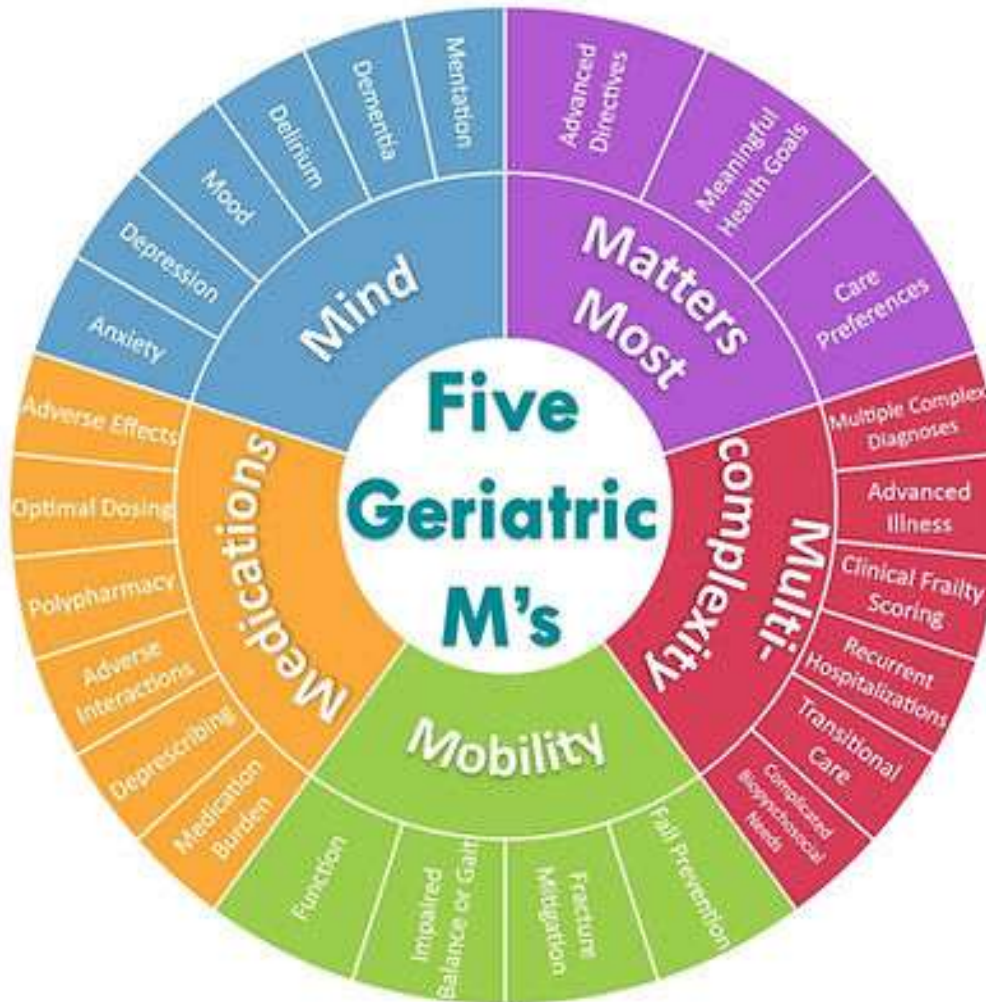
Traditional HIV clinics vs. realities of older adults

- Single-disease focus vs. multimorbidity, polypharmacy, geriatric syndromes
- ART Focused; Opportunistic infections vs. complex older adult needs such as social determinants: stigma, poverty, caregiving roles



Models of care should offer a frameworks to deliver

- Integrated care
- Patient-centered
- Holistic approach to care
- Sustainable services



- **Mobility**
 - Optimizing functional status
 - Maintaining safe mobility
- **Mind**
 - Addressing cognition and mental health
 - Mitigating sensory impairment
- **Medications**
 - Tailoring medications to meet goals and preferences
 - Avoiding high-risk medications
- **Multi-complexity**
 - Navigating health care settings and transitions
 - Balancing multiple chronic conditions
 - Addressing equity and social determinants of health
- **What Matters**
 - Current care planning: Identifying health goals and healthcare preferences
 - Advance care planning

<https://www.geriacademy.com>: Molnar et al. Can Fam Physician 2019

AMPATH Clinician perform CGA prioritization using adapted WHO ICOPE tool

Age Friendly prioritization Tool

Client ID: _____ Age (years): _____ Sex: ☐ Female ☐ Male



Priority Conditions associated with decline in intrinsic capacity	Tests	Asses fully any domain with a checked circle
Cognitive decline	1. Remember 3 words: Chicken, Flower, Shop 2. Orientation in <u>time</u> and <u>space</u> : What is the day today? (Day, Month, Year) Where are you now? (Clinic, Hospital, Home <u>etc</u>) 3. Recalls the 3 words in Q 1 above?	Wrong to either question Correct on both questions Can recall 1 Can recall 2 Can recall all Cannot recall any
Limited Mobility	Chair rise test :Rise from chair 5 times without using arms Did the person complete 5 chair rises within 14 secs? Have you fallen in the past 6 months?	Yes (4 and above rises) Partially (1-3 rises) No Yes No
Malnutrition	1. Unintentional weight loss more than 3 kg in the last 3 months (Check patient chart) 2. Have you experienced loss of appetite?	1. Weight loss less than 3 kg, 2. Weight loss more than 3 kg 3. Not lost weight at all 4. Has gained weight in the last 3 months Yes No
Visual Impairment	Do you have any problems with your eyes; difficulties in seeing far, reading or have eye disease	Yes No

CGA Tool Cont...

Hearing loss	Hears (Finger rub test)	Fail on Right ear, Fail on Left ear, Fail on Both ears , Fail on None
Depressive symptoms	Over the past 2 weeks have you been bothered by 1. Feeling down, depressed? 2. Little interest or pleasure in doing things	Yes No Yes No
Polypharmacy	Are you taking any other medication other than the HIV medication? If Yes, How many tablets?	Yes, No 1-3, 4-5, more than 5
Comorbidities	Do you have any other illness other than HIV? List them <u>e.g</u> Hypertension, Diabetes	Yes, No Hypertension Diabetes Mental Health CKD Cancer Other specify.....

Assess if an older person with HIV needs help with

Activities of Daily Living

- Ambulatory
- Bathing
- Eating
- Dressing
- Grooming
- Toilet

Instrumental Activities of Daily Living

- Finances
- Food preparation
- Housekeeping
- Laundry
- Medication
- Shopping
- Telephone
- Traveling

Frailty



Frailty is modifiable and can be delayed if we implement a person-centered care that employs the above interventions

- Multicomponent exercise
 - aerobic + resistance + balance
- Adequate protein and nutrition support
 - vitamin D Correction
 - Nutritional Counseling
- Early identification of declines
 - Use WHO ICOPE to screen and identify these declines early
- Medication review
 - Identify polypharmacy
 - Assess for appropriate prescriptions
 - Deprescribe where possible
- Manage reversible contributors
 - Assess for sensory loss, sleep, mood, pain
 - Refer for appropriate interventions where necessary
- Control chronic conditions
 - Viral load control
 - Hypertension and Diabetes control
 - Lifestyle modification

Depression

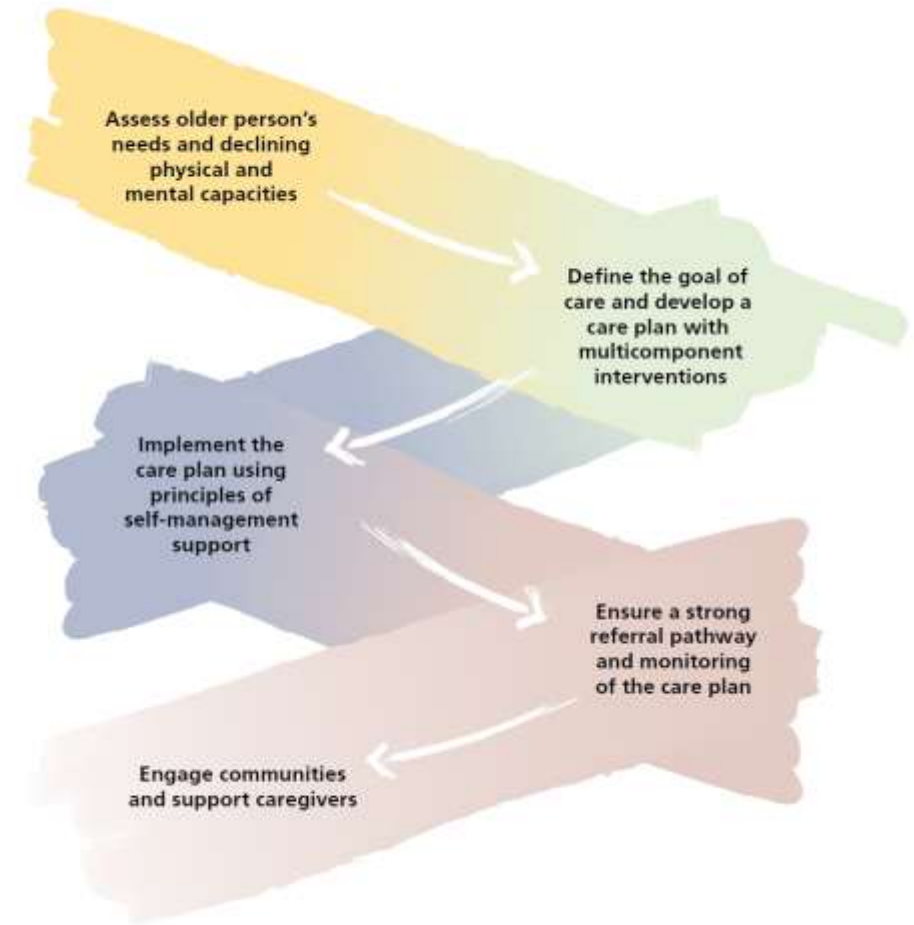
- Psychotherapy
- Group therapy
- Anti-depressant medication
- Peer support including home visits



In Summary

- Provide patient-centered care for older PLHIV
 - with a focus on maximizing physical and cognitive function
 - reducing unnecessary medications
 - coordinating complex care, and
 - ensuring that care is provided according to what matters most to the patient
- Let us purpose to make our clients feel heard, seen, and respected

Fig. 2: Delivering ICOPE in an integrated way



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Community Person-Centred Care (COMPERC) Interventions for Integrating HIV and Non- Communicable Disease Care in Delta State, Nigeria

PCC Research Collaborative November Meeting



Bonaventure Ukoaka

Excellence Community Education Welfare Scheme, Nigeria

Background



1

ART widespread >>
longevity >> comorbid
conditions such as NCD

2

Delta, Southern Nigeria, with
ECEWS as the IP, jointly
provided ART-associated
services to over 52,000
PLHIVs in the state with
support from the US CDC

3

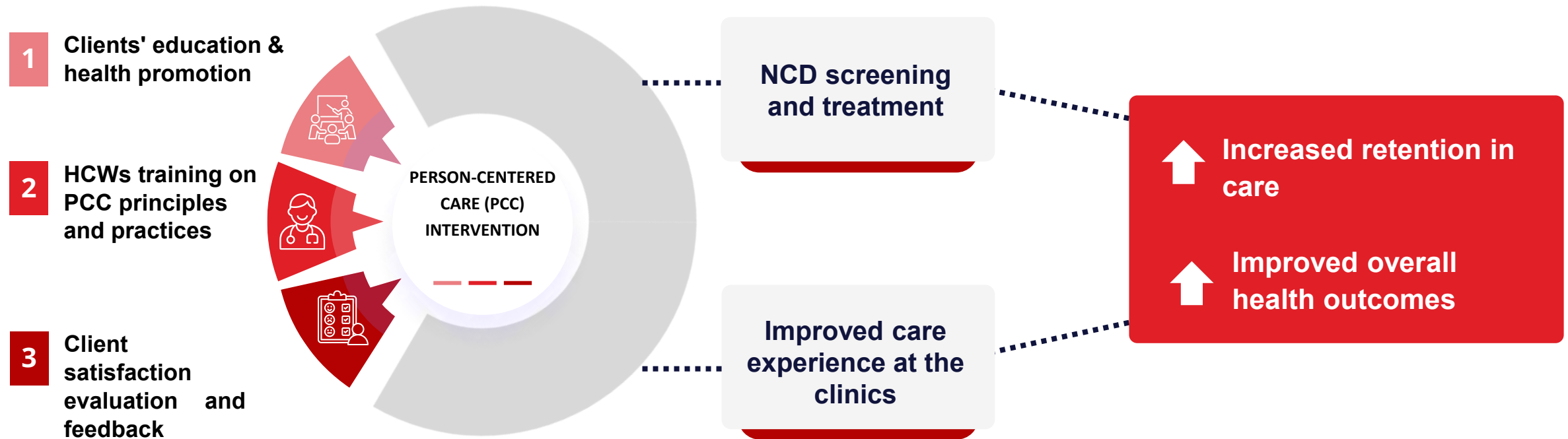
Piloted an NCD project across five
sites in our project and noticed
increasing numbers of clients with
hypertension, diabetes have been
on the low prevalence (in line with
global data); however, the
consequences are usually
devastating. Mental health care is
provided in the program; however,
prioritised on the key population
program

4

COMPERC project: aimed to integrate
PCC principles to improve NCD
diagnosis and treatment for PLHIV,
improve their care experience, and
overall ART retention using a DSD 2.0
care model, focusing on screening
and treating hypertension, diabetes,
and MHD among the ageing and
elderly population. Younger at-risk
persons will be screened

Intervention **model**

PCC model was developed around 3 core components:



NCD integration into HIV services,



Integrated and decentralised community and facility-level NCD screening and care leveraging existing ART service models

- ➔ **Hypertension:** prioritising the elderly (60+) and the ageing (45 - 59) populations
- ➔ **Diabetes mellitus:** screened individuals using preset risk stratification criteria for developing diabetes
- ➔ **Mental health and psychosocial disorders:** conducted mental health screening at the clinics using an adjusted mental health screening tool

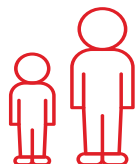
prioritizing:

Who we have reached



Population type:

Interventions were delivered across two regions with adjoining communities; clinic care conducted at two general population sites (non-key population sites)

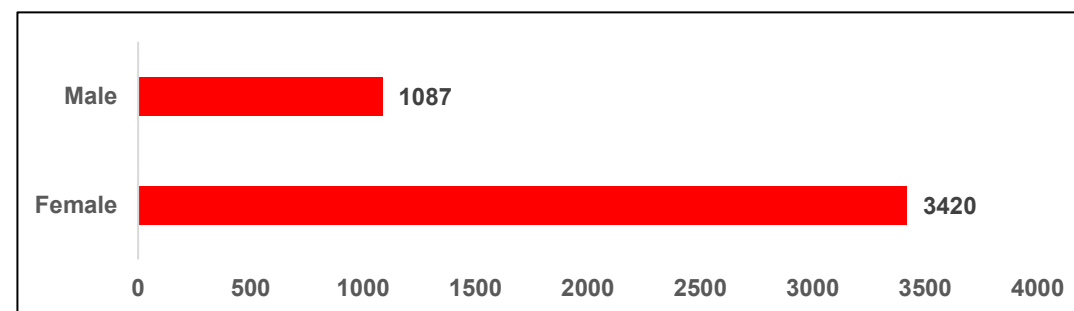


Age band:

14-19	Adolescents and young persons	35
20 - 29	Young adults	378
30 - 44	Adult males and females	1632
45 - 59	Middle-aged	1825
60 - 64	Aging	262
>65	Aged	353



Gender numbers:

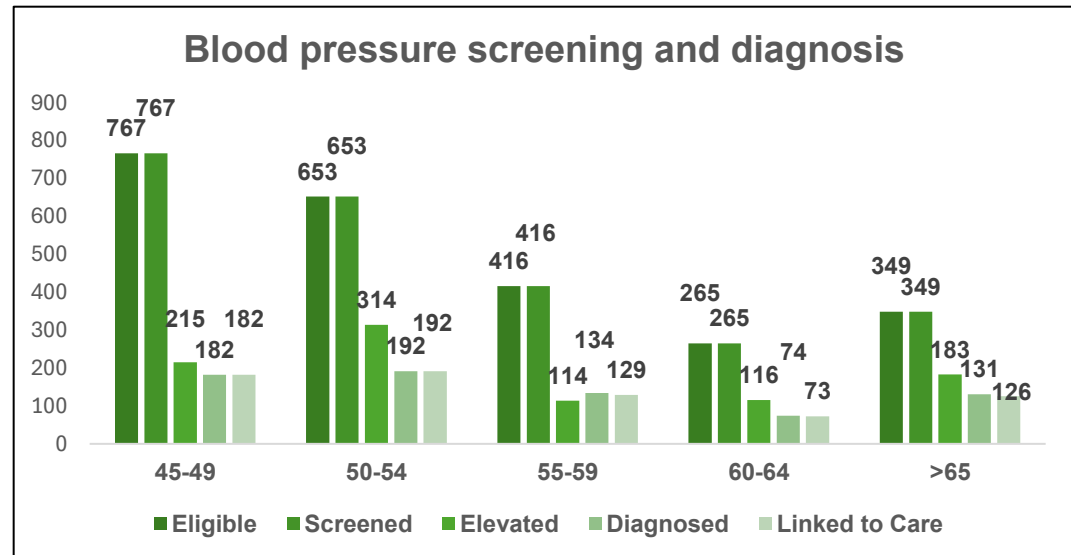
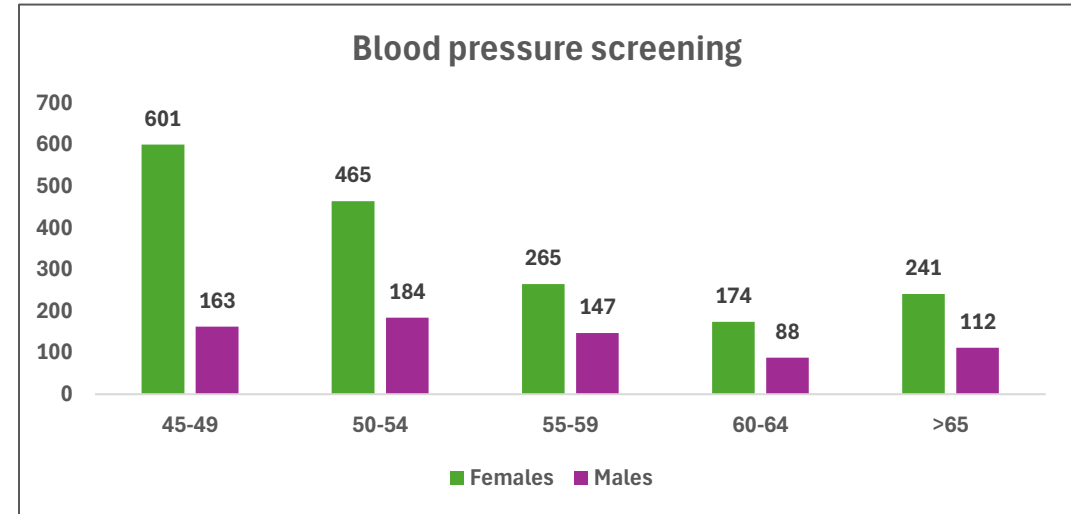


Results

Blood pressure screening outcomes

Blood pressure screenings were conducted for all individuals aged 15 years and above who presented to the facility for ART services or were provided these services (including NCD screenings) in the community.

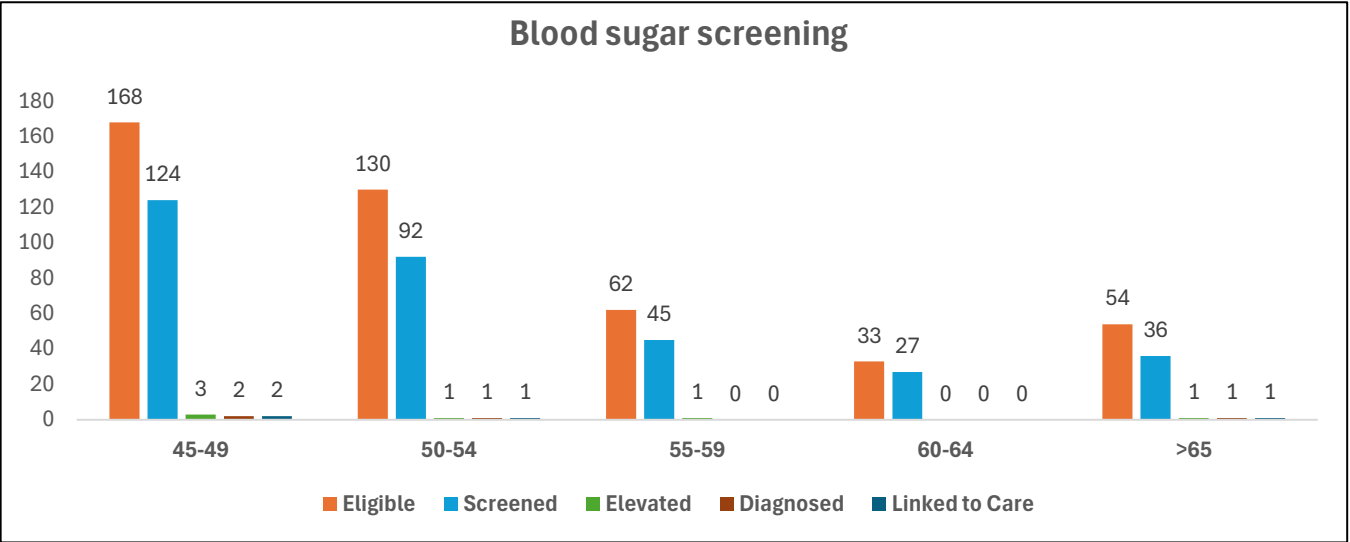
Screening coverage	100%
% elevated blood pressure	38%
% diagnosed	76%
% linked to care	98%



Blood sugar numbers

A preset risk stratification criterion was used for blood sugar screening. Eligibility included:

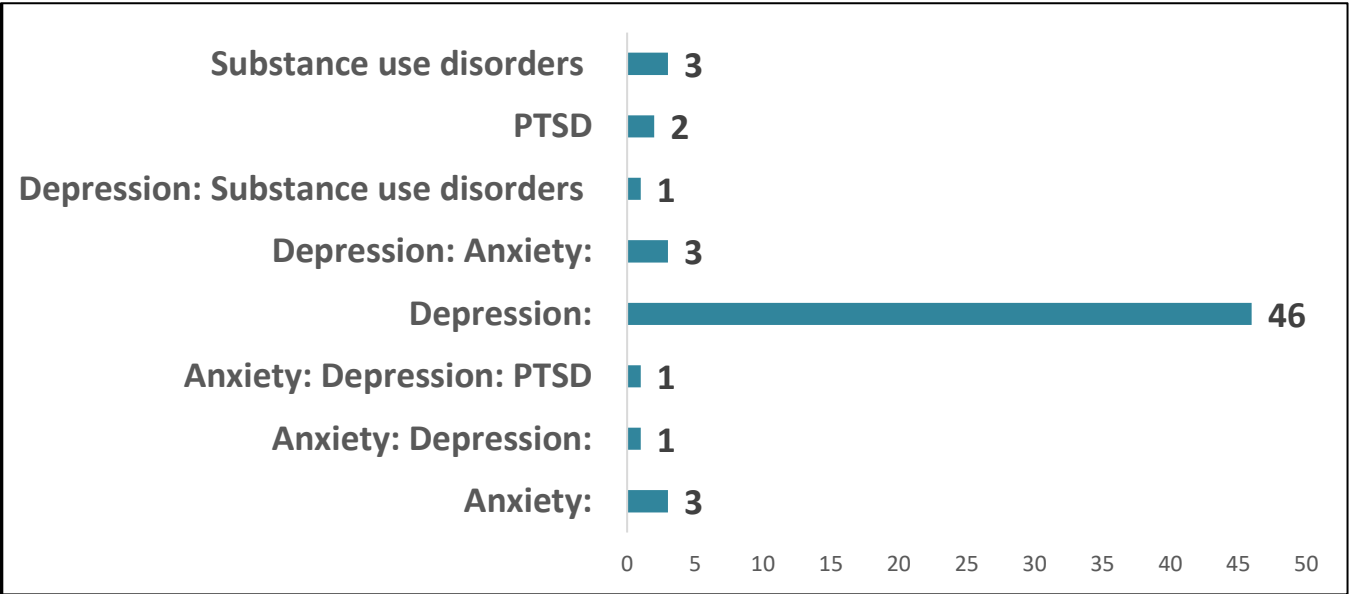
- Aged 15 years and above, who had:
- A body mass index (BMI) >= 30 and/or
- A history of diabetes in a first-degree relative, and/or
- Presence of any diabetic symptoms (polyuria, polydipsia, nocturia, or polyphagia) at clinic visit



Mental health & psychosocial disorders

All clients who presented to the facility were eligible for mental health screening.

A validated 5-item adjusted mental health screening tool integrated into the PLHIV NCD checklist national tool was used to screen clients for mental health disorders.



MENTAL HEALTH SCREENING FORM

Topic	Question	Yes	No
Major depression and medication	In the last 12 months have you ever been so sad and tired of life that you felt like harming yourself?		
	If your answer is yes did you take any medication to calm yourself?		
	Do you know what depression is? (HCP should provide clarity on meaning of depression)		
	If yes have you ever had an episode of depression lasting more than 2 weeks in the last 1 year?		
General Anxiety Disorder	In the last 12 months, did you ever have a time when you felt worried or anxious for no specific reason?		
Panic Disorder	In the last 12 months, did you ever experience a time when your heart started to race or pound and you felt afraid or anxious even when there was no reason?		

Client should be considered positive for symptoms of mental illness if he or she responded yes to any question. Refer to a mental health professional. If a mental health professional is not available, refer the adolescent to the most qualified health or community care provider. This may include lay counsellors, peer support groups, spiritual care-givers, or other sources of support that exist in your community.

Date: _____

Positive screen: ☐ Yes ☐ No

References: adapted from USAID - toolkit for transition of care and other services for adolescents living with HIV.

Unmet Needs

- ➔ **Need for subsidised medication access:** As global health and HIV funding contracts, there is an urgent need to expand sustainable domestic financing mechanisms. Strengthening local platforms such as the Delta State Contributory Health Insurance Scheme (DSCHIS) becomes imperative.
- ➔ **Stigma towards life-saving and health-promoting HIV services:** As observed, fear of stigma limited the provision of decentralised screening services to PLHIVs who experienced one or more challenges to accessing care in the facility.
- ➔ **Effective mental health screening and care services** using standardised tools and a coordinated two-way referral system across ART clinics and tertiary institutions providing specialised services.

Research Gaps

Existing studies often fail to adequately consider how contextual factors, such as cultural norms, health infrastructure, and socioeconomic conditions, influence the effectiveness of integrated care models. Future research should incorporate these factors into its study designs.

Few studies have evaluated the cost-effectiveness of integrated care models. Future research could focus on evaluating the economic implications of these PCC HIV-NCD integrated models.

Comparative studies of different integrated care models could provide valuable insights into the most effective models for implementing a PCC model for disease care for the population.

1

Most studies are cross-sectional, providing a snapshot of results at a specific point in time. There is a need for more longitudinal studies to understand the long-term effectiveness of NCD integrated models for diverse populations, including the elderly.

2

3

There is an emerging need to explore how effectively integrated care models can be implemented in various settings across Africa, particularly in light of declining global health budgets.

4

5

6

While screening, diagnosis, and treatment initiation have been prioritised in most programmes, reporting on follow-up and control outcomes for common NCDs among PLHIV is limited. This gap may be linked to barriers such as the high cost of essential medications, extended multi-month dispensing schedules, and the pill burden associated with combining multiple antihypertensive drug classes needed to achieve optimal blood pressure and blood sugar control. Researching to bridge existing care gaps.

Next Steps

1

Continue care provision to other sites and communities yet to be reached so to expand our coverage and reach

2

Strengthen MHPSS across these intervention sites and those planned for the next phase

3

Continuous advocacy to address unmet needs - treatment cost, program flexibility to accommodate clients' preferences in aligning both ART-related and NCD care, which may include shorter multi-month dispensing (adherence and ultimately suppression concerns)

4

Outcome monitoring: as most patients screened and commenced on treatment present for ARV pickups, control monitoring and treatment outcomes will be assessed and data collected for this cohort

Appreciation



Thank you!

Questions and feedback...

Title

- Person-Centered Care for Men Aging With HIV
- From Clinical Observation to Co-Creation in a Resource-Limited Setting
- Dr. Vanessa Fozao Mbi: IAS PCC Fellow & Seed Grantee



Why This Topic Matters

- Aging + HIV + multiple comorbidities = complex care needs
- Men have lower engagement & viral suppression
- Clinic spaces often feel feminized
- PCC re-centers care on people



How the Research Question Emerged

- Born from clinic observations
- Men 45+ with HIV + HTN + diabetes + ED
- High stigma, loneliness, poverty
- PCC required listening first

Study Approach

- DISCOVER – DESIGN
– DELIVER
- 288 aging men
interviewed
- 36 healthcare
workers + FGD
- Clinical review: VL,
BP, FBS, ED
- Co-creation through
PCC training



What Men Told Us

- Care model not designed for men
- High comorbidity burden
- Communication gaps: many not asked about concerns
- Low viral suppression literacy
- Structural barriers: insecurity & transport

What Providers Told Us

- Strengths: Teamwork & understanding PCC
- Provider-driven scheduling
- Breaches in respect under pressure
- Limited disability inclusion
- Reactive; not proactive; DSD

PCC in Action

- 6-Session PCC capacity-building series
- Effective communication & client voice
- DSD adaptation + disability inclusion
- Integrated HIV/NCD linkage
- Psychological first aid for service providers
- Client journey mapping



Early Signals of Change

- Improved provider empathy
- Better client perception of care
- Interest in tailored DSD options
- Plans for longer refill intervals
- Strengthened HIV–NCD integration



What This Work Teaches

- Start with the person, not the disease
- Co-create solutions with clients
- Empower providers & clients
- PCC improves retention & outcomes



Conclusion

- “Aging men want to be seen; not just managed.”
- PCC transforms stories into action
- In resource-limited settings, PCC is essential

Stakeholders & Contributors

- IAS PCC Team
- Men aging with HIV
- UPEC staff – Bamenda Regional Hospital
- District & regional health partners
- CCBID Consultancy

Acknowledgments

- International AIDS Society
- Bamenda Regional Hospital
- PCC Fellowship Team
- All study participants



PCC MAKES HAPPY HEALTHCARE PROVIDERS

THANK YOU.

The Lancet HIV Commission on Ageing and HIV

Planned Release:
AIDS 2026 Rio de Janeiro, Brazil

Commission Goals

What is a Commission? The Lancet Commissions address a wide range of global health challenges, aiming to generate evidence, raise awareness, and catalyze action for positive change.

Goals of this Commission:

- Recognize the universal importance of ageing with HIV and the urgent need to appraise the global situation.
- Offer globally actionable recommendations for research, clinical care, and policy to improve the healthspan and reduce disparities among people ageing with HIV.

Community Representatives



A collage of 20 individual portraits of people, arranged in three rows. The top row has 10 portraits, the middle row has 8, and the bottom row has 2. The portraits are set against a light purple background. The people in the portraits are of various ages and ethnicities, and are dressed in a variety of casual and semi-formal attire. The portraits are arranged in a grid-like fashion, with some rows having more portraits than others. The overall composition is a diverse representation of individuals.

Community Representatives



Andrew Tan

Kuala Lumpur AIDS Support Services Society (KLASS)
Malaysian AIDS Council Executive Committee
Advocates for HIV treatment and literacy



Daniel Ochieng

Kenyan public health specialist
Runs psychosocial support programs
Facilitator/trainer of health care workers



Nicoletta Policek

Executive Director European AIDS Treatment Group
Chairperson UK-Community Advisory Group
Community representative British HIV Association



Yvette Raphael

South African human rights activist
Global health advocate
Speaks all 11 recognized South African languages



Vanessa Johnson

United States co-founder of Ribbon
Capacity builder (training, tech transfer, education)
Facilitator/trainer of health care workers



Oageng Moseki

Botswanian Communications Officer
Coordinates HIV prevention programs
Partnerships with media outlets and stakeholders



Javier Hourcade Bellocq

Latin American
HIV, Sexual Health and Human rights
Activist, social communicator, and journalist



Dorothy Onyango

Chief Executive Officer Women Fighting AIDS in Kenya
International community of women living with HIV
Founded Pan African Positive Women Network



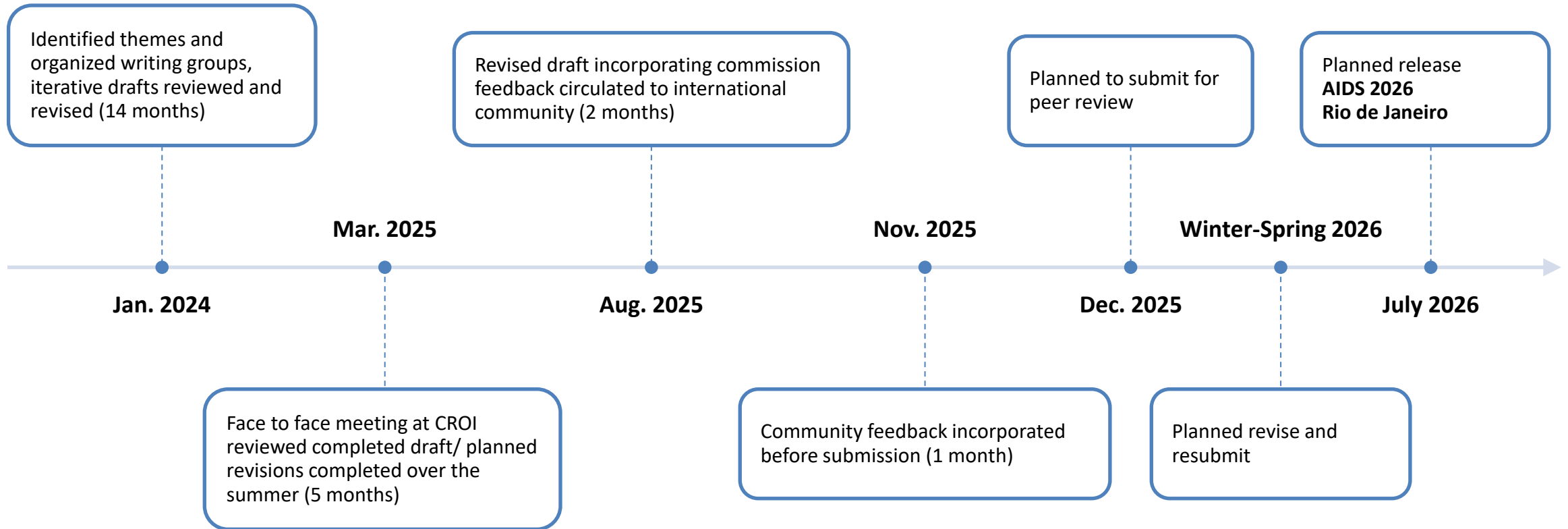
Stephen Watiti

Ugandan physician with HIV
Member 10th Uganda AIDS Commission
Facilitator/trainer of health care workers

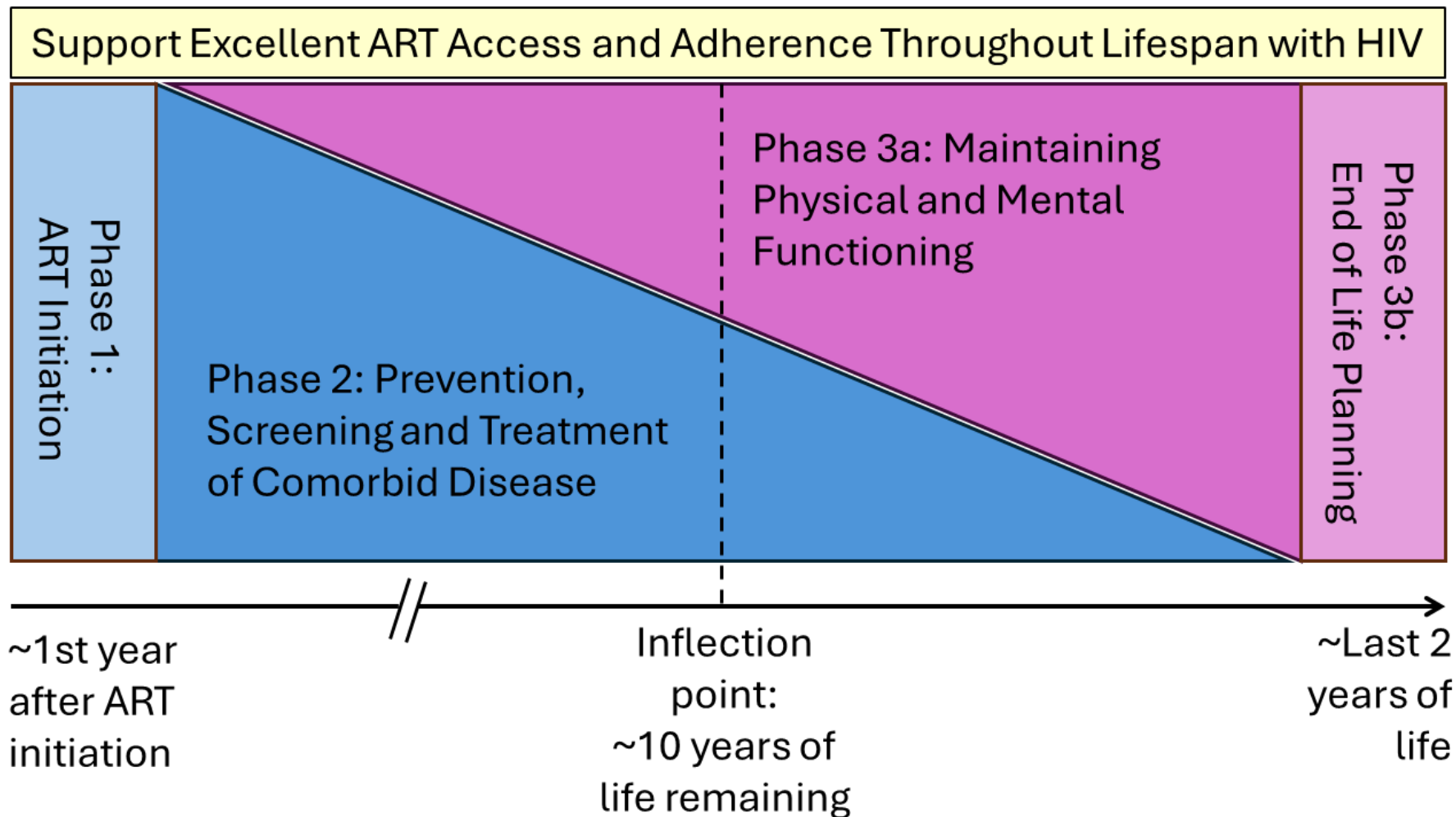
- Selection of Community Representatives
 1. Co-chairs invited Core Members to lead each written section
 2. Co-chairs and Core Members invited Community Representatives to serve on the Writing Groups

- Involvement of Community Representatives
 1. Attendance during regular Writing Group meetings
 1. Co-chairs created space for active involvement and input from Community Representatives during the meetings
 1. Active discussions and solicitation of opinions
 2. Review and revise drafts from Writing Group

2.5 Year Timeline



Phases of Care and Their Emphasis to Optimize Ageing with HIV



Key Conclusions

- Health is not the sole purview of healthcare providers or their institutions.
 - People ageing with HIV, their caregivers, their communities, and the larger internet community have essential roles to play.
 - Barriers to be overcome include healthcare silos, internet access, health literacy, the digital divide, HIV and ageing stigma, and a healthcare “checklist” mentality.
- Each individual is unique and must be central in determining goals of care.

Key Observations-Part 1

- More people are ageing with HIV. Their health care requirements differ in important ways from younger people with HIV and from people ageing without.
- Older individuals are more likely to be diagnosed late. Prevention and screening need to be better tailored to this population.
- Despite viral suppression on ART, people ageing with HIV experience a greater burden of multimorbidity and physiologic injury at earlier chronological ages than people without HIV. This excess burden is in part driven by HIV itself.
- No matter the age at HIV diagnosis, the excess burden of multi morbidity and physiological injury over the lifespan can be mitigated with timely and effective health care, decreased substance use, diet, exercise, social integration, and community engagement.

Key Observations-Part 2

- Once an effective ART regimen is started, healthcare should focus on maintaining viral suppression and minimizing other causes of chronic inflammation.
- Chronological age is a poor proxy for physiological age.
 - Guidelines should specify the survival time necessary to benefit.
 - Once people have <10 years of expected survival an increased focus on what matters most to the individual is indicated.
- Minimize adverse effects of polypharmacy by considering individual priorities, choosing non pharmacologic treatments, and avoiding potentially inappropriate medications.
- An adaptable approach, supported by digital innovations, offers a pragmatic way to shape healthcare for people with HIV.

Today's panelists



Andrew Tan,
Kuala Lumpur AIDS
Support Services Society
(KLASS), Malaysia



Linda-Gail Bekker,
Desmond Tutu Health
Foundation, South Africa



Genie Siegler,
Weill Cornell Medicine,
United States

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- The Person-Centred Care programme of IAS – the International AIDS Society – is implemented with financial support from, and in collaboration with, Gilead Sciences.
- Gilead Sciences has nominated Megan Dunbar, Executive Director, Gilead Sciences to participate in the PCC research collaborative.
- The IAS has full control over all the activities and decisions relating to, and forming part of, the Person-Centred Care programme.