## Models of Care

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</table>

*Indicates presenting author.
Modelling the cost-effectiveness of HIV care in Poland shows clear benefit while transmission risk is considered in the calculations

Justyna D. Kowalska 1, Grzegorz Wójcik 2, Jakub Rutkowski 2, Magdalena Ankiersztejn-Bartczak 3, Ewa Siewasiewicz 4

1. Hospital for Infectious Diseases, Medical University of Warsaw 2. HTA Consulting, Krakow, Poland 3. Foundation of Social Education (FES) 4. Gilead Sciences, Poland

Background

- Cost-effectiveness analyses of HIV treatment are usually based on individual benefits quantified by CD4+ counts and morbidity, but avoided transmission events are rarely considered.
- Here we evaluate the impact of sexual HIV transmission due to delayed cART on the cost-effectiveness of HIV treatment.

Methods

- A lifetime Markov model (1-month cycle) was developed to estimate lifetime costs, clinical outcomes, and cost per quality adjusted life years (QALY) gained for 1 and 3 year delay in starting cART (as compared to starting immediately at linkage to care).
- Health states included >20 illnesses/events into the model grouped as: asymptomatic HIV, AIDS defining condition (mild, moderate, severe) [1], Hodgkin’s Lymphoma, non-AIDS defining condition.
- Mortality rates and utility values were obtained from published literature [2-13].
- Number of new infected persons was estimated based on sexual orientation, number of sexual partners per year, number of sex acts per month, frequency of condom use and use of cART [14].
- For viral suppression we assumed that patients had HIV RNA <50 copies/ml immediately after starting cART and for a lifetime.
- Transmission risk was presented for three scenarios: low, medium, high. (see Figure 1 for definition)
- Costs of care, cART and potential life-years lost were based on estimated total costs and the difference in expected QALY gained between HIV-positive and average person in Polish population.

Results

- Input data were available for 141 patients form TAK cohort.
- Parameters for the model were: female gender 4.3%, mean age 36.1 years (QALY), mean CD4+ cells/µl 4.4 (IQR 3.7-5.0) log copies/ml, transmission mode: homosexual 4.3%, heterosexual 9.9%, bisexual 5.7%, drug use 0.7%.
- Parameters of the model were: age 35.1 years (QALY), mean CD4+ cells/µl 4.4 (IQR 3.7-5.0) log copies/ml, transmission mode: homosexual 4.3%, heterosexual 9.9%, bisexual 5.7%, drug use 0.7%.
- If additional costs of treatment and potential life-years lost due to new HIV infections were not taken into account, initiating cART immediately at linkage to care was not cost-effective irrespective of cART delay.
- When additional costs and QALY lost were included immediate cART initiation was dominant (cheaper and more effective) regardless of the chosen scenario (Figure 1).

Conclusions

- Accounting for HIV transmission in cost-effectiveness analysis provides further evidence supporting immediate initiation of HIV treatment from a public payer perspective.

References:
17. Rak płuc z perspektywy NFZ 2002


1 Infectious Diseases Dep., Ramón y Cajal Hospital, Madrid, Spain; 2 Statistics Dep., Ramón y Cajal Hospital; 3 García Noblejas Primary Care Centre, Madrid

BACKGROUND and OBJECTIVE

Targeted HIV Testing has been proposed as the most efficient strategy to diagnose HIV infected subjects in low prevalence populations.

However, identifying these people at risk of HIV infection can be sometimes difficult and takes many time.

In DRIVE 01 Study we proved that a Targeted HIV Testing strategy, filling a self-administered Risk Exposure & Clinical Indicators (RE&CI) Questionnaire and then testing for HIV Infection only subjects with a positive Questionnaire (≥1 affirmative answer), could identify the same number of New HIV Diagnoses (NHD) as a non-targeted strategy (Routine HIV Testing strategy).

Moreover, this Targeted HIV Testing strategy reduced cost.

CONCLUSIONS

All three tools avoided HIV Tests, but only the RE&CI Questionnaire captured all HIV-infected subjects detected by the non-targeted strategy.

A selection of HIDES list presented a high sensitivity, and was able to avoid the highest number of tests.

Cost of each NHD obtained using RE&CI-Questionnaire compared to HIDES list is low with respect to the benefit obtained.

METHODS

DRIVE 01 Study is a non-Targeted HIV Testing Programme performed in Emergency Department and Primary Care Centre (PCC). All participants were tested for HIV (Rapid Test) and filled out the self administered RE&CI-Questionnaire.

The 3 tools considered were:

- RE&CI-Questionnaire, consisted on 6 questions to evaluate Risk of Exposure to HIV infection and 14 other to asses HIV associated Clinical Indicators (from HIDES Study). One affirmative item was considered as positive (Medicine).
- Denver HIV Risk Score, is a validated tool to target HIV testing to people with the highest risk, included only demographics (age, sex, race/ethnicity), 2 risk behaviors (Injection drug use), and the history of HIV testing, a cut off > 30 was considered (Haukoos et al. 2013;)
- and HIDES Study using 14 Clinical Indicators, one clinical condition is considered (Sullivan).

We calculated Sensitivity (Sn), Specificity (Sp), Positive Predictive Value (PPV) and Negative Predictive Value (NPV) of the three tools, considering the gold standard confirmed cases of HIV Infection with EIA/WB

RESULTS

Accuracy of three HIV Targeted Testing Strategies: RE&CI Questionnaire, Denver HIV Risk Score and 14 IC of HIDES Study

<table>
<thead>
<tr>
<th></th>
<th>Sn</th>
<th>Sp</th>
<th>PPV</th>
<th>NPV</th>
<th>NHD/MHI</th>
<th>Number of test avoided</th>
<th>Number of test to obtain one positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Targeted</td>
<td>100%</td>
<td>49%</td>
<td>0.80</td>
<td>100%</td>
<td>(99.9-100%)</td>
<td>22/0</td>
<td>0</td>
</tr>
<tr>
<td>Strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 IC HIDES</td>
<td>91%</td>
<td>74.4%</td>
<td>1.4%</td>
<td>99%</td>
<td>(99.8-100%)</td>
<td>20/2</td>
<td>3,948</td>
</tr>
<tr>
<td></td>
<td>(70.8-98.9%)</td>
<td>(73.2-75.6%)</td>
<td>(0.88-2.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The cost for one HIV Diagnosis was: 552 € (HIDES), 992 € (RE&CI Questionnaire) and 1,058 € (Denver HIV Risk Score).

INCREMENTAL COST:
The save per HIV Diagnosis was 66 € in RE&CI Questionnaire Strategy and 506 € in HIDES Strategy respect Denver HIV Risk Score Strategy.

This study was financed with two competitive grants: ISCIII (FIS), PI12/00995 parcialmente financiada por FEDER, MINECO EC11/144.
HIV linkage to care:

Impact of a proactive intervention in a Health Area of Spain.

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1. Hospital Ramón y Cajal Infectious Diseases IRYCIS Madrid Spain; 2. Hospital Ramón y Cajal Microbiology Madrid Spain

BACKGROUND

- Early identification of people living with HIV (PLHIV), timely initiation of antiretroviral therapy (ART) and lifelong care are key elements towards achieving universal access to HIV treatment and therefore ending the epidemic.
- The full benefits of HIV Testing are the continuum of care for PLHIV, which extends from HIV Testing through enrollment in HIV care, ART initiation and retention in life-long ART and chronic care. For different reasons many patients are lost in some of these steps, and do not complete the whole cascade.
- We think that linkage to care is one of the essential steps in HIV cascade of care, and failure to retain PLHIV on life-long treatment after treatment initiation is another reason for loss of PLHIV and for the failure to achieve and sustain viral load suppression.

OBJECTIVE

- The objective of this work, is to evaluate the impact of an active intervention aimed to shorten time from first HIV EIA result to first HIV outpatient clinic visit.

METHODS

- This is a first interim analysis of Infectious Diseases and Microbiology Services linkage to care intervention.
- Period of study: From 1st of January to 30th of June 2015 (1st period) and same dates 2016 (2nd period) we identified all first positive HIV EIA (HIV) results obtained in the Microbiology Laboratory Department (MlabD) of Ramón y Cajal Hospital (RyC).
- All Samples came from two main settings: Hospital Departments (HD), or Primary Health Area (PHA).
- In 2015 period, HIV+ results were electronically informed and when possible prescriber physician was alerted by phone, that a second sample needs to be sent to confirm serology. In 2016 period addition to the above mentioned, all HIV + results were weekly identified and we phoned the requesting physician informing the HIV+ result and recommending that the confirmation and the first HIV visit should be done as soon as possible at the HIV outpatient Clinic.
- Number and result of HIV tests, linkage to RyC HIV clinic or other clinic and time (days) to first HIV visit of HIV+ cases where compared between the two periods. Categorical variables were compared with the Chi-squared or the Fisher’s exact test using contingency tables, whereas continuous variables were compared with the Student’s t-test. Regression analysis models, and log-Rank test along with Cox regression models were also used for time to event variables.

RESULTS

Overall 21,049 HIV tests were requested (9,969 and 11,072 in 1st and 2nd periods).

Table 1: baseline and outcome results (overall and according to period)

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>1st PERIOD 2015</th>
<th>2nd PERIOD 2016</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV tests</td>
<td>21,049</td>
<td>9,669</td>
<td>11,072</td>
<td></td>
</tr>
<tr>
<td>NHIVD</td>
<td>108 (0.51%)</td>
<td>60 (0.56%)</td>
<td>48 (0.44%)</td>
<td>0.16</td>
</tr>
<tr>
<td>Sex (Women)</td>
<td>18 (17%)</td>
<td>12 (20%)</td>
<td>6 (12%)</td>
<td>0.3</td>
</tr>
<tr>
<td>Age (years mean RIQ)</td>
<td>36 (28-42)</td>
<td>38</td>
<td>37</td>
<td>0.6</td>
</tr>
<tr>
<td>Setting</td>
<td>PHA 37 (34%)</td>
<td>HD 71 (66%)</td>
<td>65 (65%)</td>
<td></td>
</tr>
<tr>
<td>Linkage to care (yes)</td>
<td>96 (89%)</td>
<td>50/60 (83%)</td>
<td>46/48 (96%)</td>
<td>0.062</td>
</tr>
<tr>
<td>Time to be linked (Mean estimated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>log-Rank</td>
<td>77 (46-108) days</td>
<td>104 (54-157) days</td>
<td>30 (20-39) days</td>
<td>0.410</td>
</tr>
</tbody>
</table>

Figure 1: Time to linkage in the two periods of study.

Figure 2: Time to linkage according to sex.

In a regression model, we found a trend towards a better linkage rate during second period, in an unadjusted model, OR 4.65 95% IC (0.95-22.1), this effect attenuated by sex OR 4.3 95% IC (0.88-20.9), while men have a trend towards a better linkage rate, in an unadjusted model 2.9 95% IC (0.77-11.04), and this effect was also attenuated by the period of observation 2.59 95% IC (0.67-10.13).

Conclusions

High rates of linkage to care were observed in both periods studied, near or higher than UNAIDS objectives. In this preliminary analysis a trend towards a higher rate of and less time to linkage to care were observed in the intervention period, but the effect was attenuated by sex.
EFFICIENCY OF ANTIRETROVIRAL THERAPY IN RUSSIA

Background:
ART is available for free in Russia for PLH, who visit special AIDS centers. According current guidelines ART is eligible for all PLH, but for patients with CD4 <350 cells/ml is priority. At the beginning of the year 2015 more than 200,000 PLH were on ART. The aim of this study was to characterize the basic aspects of antiretroviral therapy among PLH who visited AIDS centers in Russia in order to develop recommendations for new treatment guidelines.

Methods:
Multicenter, open-label study with the inclusion of a retrospective model. We analyzed medical records and questionnaires of 7,000 adult patients, who visited AIDS centers and signed an informed consent form in 27 regions of Russia in April — July 2014. Funding support for this study was provided by Bristol-Myers Squibb.

Results:
3,406 (49%) of all recruited participants were females, 1 was transgender. Mean age — 35, median — 34 (18-79) years. The majority of females were infected through sex (77.4%), more males reported IDU in the past (57.4%). 10% of participants were current drug addicted. 4,445 (60%) of all participants were on ART which was initiated at mean CD4 — 224.6±138.9; median — 216 (1-1400) cells/ml (pic.1).

Termination of therapy in the time of the study was recorded in 10.1% of patients. Brand name ART drugs were mainly used in the period of the study. The most commonly prescribed ART combinations for naive patients in period 2009-2014 years were: ZDV+3TC+EFV (26.6%), ZDV+3TC+LPV/r (21.7%), ZDV+3TC+ATV/(r) (8.9%) — pic.2. The average duration of ART was 34 months [max — 16 years], 18.7% of study participants were on ART over 5 years — pic.3. 52.3% of patients received the first ART combination, 29.1% — the second [max — 9 ART regimens in patient]. The main causes of treatment regimens change were adverse events — 43.3%, simplification [reducing the number of pills and multiplicity] — 27%, pregnancy — 11.2%. The most frequent adverse events of the first ART regimens were: gastrointestinal disorders (33.7%), CNS disorders (22.3%), anemia/leukopenia (14.8%), rash/dermatitis/allergic reaction (10.15%). Virologic failure was the cause of ART change only in 3% of patients. 83.9% of patient in the study reached HIV RNA<1000 copies/ml and 69.1% — less 400 copies/ml at the end of the first year of treatment. Among patients, who have segodiscordant regular sexual partner, only 66.7% were on ART. We noted substantial improvements over time in the proportion of individuals on ART. The proportion of HIV diagnosed patients who received ART increased from 18% in 2011 to 23% in 2013.

Conclusion:
The majority of patients receiving ART in Russia have not yet a very long treatment experience. CD4 level at the moment of ART initiation was low. Though old-fashioned ART combinations were effective and tolerable in a part of the patients, the number of adverse effects were significant. Measures are needed to encourage earlier ART initiation and use drugs with lower toxicity.
Background

• To achieve the ultimate goal of eliminating perinatal transmission, we reviewed and identified gaps of the current public health programme for the prevention of mother-to-child transmission (PMTCT) of HIV in Hong Kong, a region with low HIV seroprevalence of <0.01% in the antenatal population

• The Universal Antenatal HIV Testing Programme (UATP) was introduced in 2001, with an aim to interrupt MTCT through timely diagnosis and management of infected expectant mothers

• The programme was strengthened with implementation of Rapid HIV Testing component in 2008 to offer rapid HIV test in labour wards for women who did not receive testing in early antenatal period

Results

• UATP has high coverage rate of >98% in recent years

• From 2001 to 2014, 3 perinatal infections were identified out of 72 infants born to HIV-infected mothers. All three were detected before 2007, two of which were due to late presentation to antenatal care without participation in UATP. The others was due to failure of intra-partum and post-partum intervention when the mother presented 6 days prior to her pre-term delivery (Table 1)

• The incorporation of Rapid HIV Testing in 2008 had filled the gap for late-presenting pregnant women so that interventions could be offered to HIV-infected women not identified by UATP (Fig. 1)

• Since 2008, the percentage of women with HIV test results known prior to delivery remained above 98.6%; and 97% of HIV positive mothers and their babies had received either 3-part or 2-part ART

• However, five cases of HIV-infected children born to their infected mother who were tested negative by UATP in the early antenatal period were reported in 2009 to 2015. Unprotected sex during pregnancy was the common risk factor. All 5 mothers and all but one of the spouses/partners were either non-Hong Kong residents or originated from Asian or African countries where the HIV prevalence was higher than Hong Kong, highlighting this unique epidemiological pattern.

Methods

• We reviewed the programme performance, and matched with perinatal infections reported

<table>
<thead>
<tr>
<th>Ethnicity of mother</th>
<th>2001</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materinal HIV diagnosed via</td>
<td>UATP (No Rapid Testing before 2008)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasons for failure to prevent MTCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materinal HIV diagnosed after delivery, no timely intervention given</td>
<td>Materinal HIV diagnosed after delivery, no timely intervention given</td>
<td>Late HIV diagnosis during antenatal period + mother received ARV late</td>
<td></td>
</tr>
<tr>
<td>ARV drugs to mother</td>
<td>n/</td>
<td>n/</td>
<td>6 days before delivery (baby delivered premature)</td>
</tr>
<tr>
<td>ARV drugs to infant</td>
<td>n/</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Mode of delivery</td>
<td>Vaginal</td>
<td>Vaginal</td>
<td>Caesarean section</td>
</tr>
<tr>
<td>Outcome</td>
<td>Mother &amp; Infant defaulted follow up</td>
<td>Mother left Hong Kong</td>
<td>Both being followed up in Hong Kong</td>
</tr>
</tbody>
</table>

Table 1. Three cases of perinatal HIV infections due to late presentation to antenatal care prior to introduction of Rapid HIV Testing in labour units

Conclusion

• The gap in PMTCT in Hong Kong lies in the HIV-infected women who seroconverted after they were tested negative in the early antenatal period

• Partner counselling and testing, enhancement of safer sex, targeted HIV retesting at third trimester for pregnant women based on their epidemiological and behavioural risks are options to close the gap
Background
The first of the UNAIDS 90-90-90 aims at 90% coverage of HIV testing and counselling (HTC) [1]. Studies on HTC at the homes of individuals report HTC uptake (individuals tested / individuals encountered at home) of >90%[2]. However, HTC coverage (individuals knowing their status / individuals living in targeted area) remains below 90% because of persons absent during home-based HTC[3]. This study assesses the HTC coverage achieved in Lesotho after two consecutive home-visits in order to achieve maximal coverage and to cover presence during the week and on weekends.

Materials and Methods
The study was conducted in Lesotho, Southern Africa. Data derive from home-based HTC campaigns serving to recruit HIV-infected individuals for the CASCADE-trial (NCT02692027). Assessment of HTC coverage after two home visits is a nested study in the published CASCADE-trial protocol[4]. The primary outcome of interest was the HTC coverage in targeted areas after two visits. Counsellors visited randomly selected villages or urban areas moving door-to-door and offering HTC to all household members. Each area was visited twice, once during the week and once during a weekend day. Household members were defined as spending at least one night at least twice a month in that household. The duration of the HTC campaigns was from February 22 to July 3, 2016. Data were captured on tablet computers and synchronized daily[5].

Results
From February 22 to July 3, 2016 counsellors visited 6429 occupied households with 17,887 household members in 60 rural villages and 17 urban areas; 1988 (30.9%) households were revisited because of persons absent at first visit. Among individuals encountered at home, 1381 (9.5%) were already known to be HIV-infected. Among the 13,193 with unknown HIV-status, 11,268 (85.4%) accepted HTC. HTC coverage after the second visit (figure 1) HTC coverage in visited areas increased from 62.7% after the first to 70.5% after the second visit (figure 1). Table 1 shows HTC uptake and HTC coverage after two visits, stratified by age and gender. HTC uptake was similar among men and women, but coverage was lower among men due to a lower proportion encountered at home.

Conclusion
A second catch-up visit on a weekend increased the proportion of persons knowing their HIV status by 8%, but home-based HTC still fell short of the targeted 90% coverage. Future strategies need to combine home-based HTC with approaches specifically tailored to frequently absent household members, such as testing at the workplace or school-based HTC or self-testing.

Table 1: Logistic regression for endpoints according to age and gender

<table>
<thead>
<tr>
<th>Encounter at home</th>
<th>Total</th>
<th>%</th>
<th>Odds-ratio (95%CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women &lt;15 years</td>
<td>8115</td>
<td>7211 (88.9)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Men &lt;15 years</td>
<td>5209</td>
<td>3668 (70.4)</td>
<td>0.30 (0.27 – 0.33)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>- Children &lt;15 years</td>
<td>4393</td>
<td>3534 (80.5)</td>
<td>0.52 (0.47 – 0.57)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>HTC Uptake</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women &lt;15 years</td>
<td>7211</td>
<td>6204 (86.0)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Men &lt;15 years</td>
<td>3668</td>
<td>3116 (85.0)</td>
<td>0.92 (0.82 – 1.03)</td>
<td>0.13</td>
</tr>
<tr>
<td>- Children &lt;15 years</td>
<td>3534</td>
<td>3048 (86.3)</td>
<td>1.02 (0.91 – 1.14)</td>
<td>0.77</td>
</tr>
<tr>
<td>HTC coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women &lt;15 years</td>
<td>8115</td>
<td>6204 (76.5)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Men &lt;15 years</td>
<td>5209</td>
<td>3116 (59.8)</td>
<td>0.46 (0.43 – 0.49)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>- Children &lt;15 years</td>
<td>4393</td>
<td>3048 (69.4)</td>
<td>0.70 (0.64 – 0.76)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

References
Introduction:
The elevated prevalence of HIV and HCV infections among inmates has been closely linked to intra-venous drug use (IVDU) and the sharing of injection equipment. [1]
The prevalence of HIV in the general population in Portugal is one of the highest of Western Europe (~0.6%), and although the prevalence in IVDU is decreasing in general population, this is not the rule in the incarcerated population. [2]
Approximately 20% of convictions in Portugal are due to drug-related crimes, which emphasizes the expected role of drug injection behavior in the transmission of these infections among the imprisoned population. [3,4]

Materials and Methods:
The HIV and HCV prevalence was estimated among inmates of two male prisons in the center of Portugal (Pinheiro da Cruz and Setúbal), followed in the Infectious Diseases Department between 2014 and 2016.
Data was obtained from the hospital medical records. Collected information included variables such as age, country of birth, transmission risk, serological status, and adherence to consultation and therapy. Patients were considered as refractory to consultation if they had fewer than two consultations per year.

Results:
Approximately 1000 men were incarcerated in those prisons at the time of data collection [4]. 82 (8%) were under follow up in our hospital.

Conclusions:
HIV and HCV prevalence in the inmate population was 5 to 13 times higher than the general population, which represents a major public health issue. Compliance to HAART is higher, probably due to controlled medication distribution in prison facilities.
The prevalence of patients undergoing treatment for HCV is approximately the same as in general population.
National data on HIV and HCV prevalence among inmates, and the characterization of this population, might be a useful measure to study the epidemiological situation, implement prevention interventions and to improve screening and treatment for these two chronic conditions, as well as to implement measures to increase adherence to follow up. Recent studies on this topic are sparse in Portugal and other European countries.

References:
In England people living with HIV (PLWH) can access care at any centre, regardless of geographical location.

Non-UK born and individuals without residency are also entitled to free HIV care at any service.

There is no data currently available on reasons patients transfer their HIV management and care from one service to another.

We aimed to investigate reasons for transfer amongst PLWH transferring their care to one of three London HIV units in London, UK.

### Table 1. Reasons for leaving the previous HIV clinic

<table>
<thead>
<tr>
<th>Location</th>
<th>83 (75%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems at the clinic</td>
<td>12 (11%)</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>5 (5%)</td>
</tr>
<tr>
<td>Services offered</td>
<td>4 (4%)</td>
</tr>
<tr>
<td>Financial reasons</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Employments</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Lost to follow-up</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Other not specified</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

### Results

- 111 patients completed the questionnaire.
- 47% (n=52) transferred from services abroad (see figure 1), 37% (n=41) within London and 16% (n=18) transferred from outside of London.

**Figure 1. Map showing countries patients have transferred from.**

- Reasons for leaving the previous HIV clinic is shown in table 1
- Other services offered include specialist hepatitis C, cardiovascular, neurology and oncology.
- Financial reasons included private insurance finishing and cost of medication being to expensive.

The main reasons for choosing the service patients transferred to shown in figure 2. Other reasons included:

- recommendation by a third party including previous clinic, doctor, charity (n=6);
- service specific to the clinic including specialist clinic, particular doctor, patient representative support, weekend care (n=6);
- previously attending that clinic (n=5);
- via the internet (n=1).

**Figure 2. Venn diagram showing reasons for choosing the service patients transferred to**

- Current BHIVA guidelines recommend a medical summary should be received within two weeks of transferring to a new service.
- 27% (26/95) of patients were aware of the summary being received at the time of their first appointment of whom 10/26 had transferred their care within the UK. 35/95 stated it had not been received and 53/95 did not know. Figure 3 summarises this data.

**Figure 3. Bar graph showing whether patients were aware if their medical summary had been received**

### Conclusions

- Most patients transferred their care to another HIV service for geographical reasons.
- Reasons for choosing their new clinic included a combination of location, reputation or a friend/partner already attending the service.
- Reassuringly a minority cited problems at their old clinic as a reason to transfer care. However, this could have been due to sampling bias, patients with problems may have been less likely to complete the questionnaire.
- In the age of digital media it is also interesting that only one patient found their chosen clinic via the internet.
- Patients seem to base their choice on recommendation.

*Our co-author Duncan Scott died in September 2016. Our thoughts are with his family.*
Atmosphere of Risk or Family-like Relationship?: Alternative Patient Experiences of Decentralized Care in North Central Nigeria

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Background

Decentralization of care and treatment for HIV infection in sub-Saharan Africa aims to make treatment services available in local health facilities, closer to people’s homes. This effort has played a critical role in scaling up treatment services across the region. To better understand the impact of decentralized care from the patient perspective, we conducted a qualitative study that examined how patients experienced receiving care close to their home communities.

Methods

Study data were purposefully collected at one public and government, three faith-based and one private hospitals (N=5). Ninety-three (N=93) male (N=22) and female (N=71) adults receiving decentralized HIV care and ART at the five participating sites took part in individual, open-ended interviews and focus group discussions. The Plateau State, decentralized HIV care program centers on a large tertiary health care facility, surrounded by associated general hospitals. Multiple primary health care facilities are linked to each participating hospital. The entire sample had transferred from the central Plateau State or another large HIV and AIDS care and treatment site. Atlas.ti was used for organizing qualitative data. The interviews covered access to care, services received, and experiences of stigma. Resulting data were content-analyzed with the goal of inductively deriving a set of descriptive categories and linking them together to tell a larger “story” about patient experiences of decentralized care.

Results

For many patients, receiving care at decentralized sites resulted in (a) heightened risk of unwanted disclosure and (b) the development of family-like atmosphere. Factors explaining the negative effect of heightened risk of disclosure include: i) holding the HIV clinic on specific, predictable days of week ii) the physical layout of the clinic, with waiting areas visible to the public, and iii) lapses in patient confidentiality by staff. Factors that contributed to the positive effect of a family-like atmosphere within the clinic include: i) the development of social relationships among patients, ii) the re-enforcement of social interactions among patients by staff, and iii) active efforts by staff to keep patients involved in care by promoting a sense of caring.

Study participants expressed a preference for decentralized care, emphasizing the importance of easy access to care in terms of proximity and lower cost of transportation as reasons for their preferences.

Conclusion

Decentralized clinics embedded within communities can pose the risk of unwanted disclosure. However, with patient-centered staff management, clinics can use local positioning to promote family-like relationships and impact positively on patient perceptions of quality of care, and on retention.

Acknowledgement

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