1. Background and Context

The Lancet Global Health Commission on People-Centered Care (PCC) for Universal Health Coverage (UHC) is undertaking a multi-phase program of work to develop an evidence-informed definition of PCC, an operational framework to guide implementation, and practical recommendations for policy and health system transformation. Central to the Commission's approach is the belief that PCC cannot be defined solely through academic literature or expert consensus. Rather, it must be co-produced with those who experience, deliver, manage, and shape healthcare systems.

To support this objective, the Commission has adopted an iterative program of global engagement known as Participatory Discussion Labs. These sessions are designed as opportunities for collaborative knowledge generation in which participants actively contribute to refining the Commission's emerging concepts, framework, and recommendations. The Participatory Discussion Labs therefore serve as an integral component of the Commission's Discovery Phase, providing opportunities to test evolving ideas against diverse lived experiences and implementation realities.

Following the Commission's inaugural Participatory Discussion Lab at the Prince Mahidol Award Conference (PMAC) in Bangkok in January 2026, AIDS 2026, the 26th International AIDS Conference held in Rio de Janeiro in July 2026 provided an important opportunity to engage a global community that has historically been at the forefront of advancing people-centered approaches to healthcare. Across four decades, the HIV response has pioneered many practices now widely recognized as foundational to PCC, including meaningful engagement of people with lived experience, peer navigation, community-led service delivery, differentiated models of care, shared decision-making, and rights-based approaches to health. The HIV community is uniquely positioned to inform broader discussions on people-centered health systems.

The AIDS 2026 Participatory Discussion Lab was designed both to introduce participants to the work of the Commission and to generate evidence that could inform refinement of the Commission's draft definition and operational framework for PCC. Building on the Commission's participatory methodology, the session sought to examine whether the proposed framework resonated with the experiences of people living with and affected by HIV, healthcare providers, researchers, program implementers, policymakers, and civil society organizations working across diverse contexts.

Participants were invited to reflect on the broader conditions that enable or inhibit PCC within health systems. Through facilitated discussion, participants explored examples of care that embodied the principles of people-centeredness, identified implementation strategies that have proven successful in practice, and considered the policy reforms needed to embed PCC within routine health systems. Collectively, these discussions were intended to strengthen the Commission's understanding of how PCC is experienced, operationalized, and sustained across different settings.

2. Objectives

The objectives of the AIDS 2026 Participatory Discussion Lab were to:

1. Introduce the Lancet Global Health Commission on PCC for Universal Health Coverage, including its objectives, research questions, and participatory approach to evidence generation.
2. Present the Commission's evolving definition and operational framework for PCC as the foundation for discussion and critique.
3. Examine the extent to which the draft definition and framework resonated with the lived experiences of people receiving, delivering, managing, and shaping healthcare.
4. Identify practical strategies, implementation mechanisms, and system-level reforms that enable PCC to be successfully translated into routine practice.
5. Generate evidence that would inform refinement of the Commission's definition, operational framework, implementation guidance, and future research priorities.

3. Methods

3.1 Rationale for Session Design

The design of the AIDS 2026 Participatory Discussion Lab reflected the Commission's commitment to "walking the walk" of PCC. The program combined a brief plenary introduction with extended facilitated discussion. This structure allowed participants first to become familiar with the Commission's objectives, conceptual framework, and emerging definition of PCC before contributing their own experiences and perspectives through small-group discussions. The three discussion laboratories were designed to examine PCC from complementary perspectives:

- Lived experience and empowerment, exploring how PCC is experienced by individuals and communities and how relationships influence care experiences.
- Implementation opportunities and leverage points, identifying practical mechanisms that enable PCC within healthcare services and organizations.
- Policy translation and systems change, examining how health systems and policies can better support people-centered approaches at scale.

3.2 Participants and Representation

Potential participants were identified through the networks of the session co-organizers (IAS – the International AIDS Society, PATH, and Harvard Medical School (HMS). Many invitees were also active participants in the IAS Person-Centred Care Programme Based on the session design and room capacity, approximately 35 participants were invited and confirmed attendance, with about half ultimately participating in the session. A detailed participant list is provided in Appendix 1.

3.3 Session Agenda

Time	Activity	Lead
13:15 - 13:20	Arrival and Welcome	**Marlène Bras,** IAS
13:20 - 13:35	Plenary - Introduction to Commission, PCC working definition and framework	**Todd Pollack**, Program in Global PHC at Harvard Medical School (PGPHC)
13:35 - 13:50	Commissioner Reflections	**Kim Green**, PATH **Maureen Luba,** AVAC **Florence Riako Anam,** Global Network of People Living with HIV (GNP+)
13:50 - 13:55	Orientation to Discussion Labs	**Emma Williams**, IAS
13:55 - 14:55	Discussion Labs 1. Lived experience and empowerment 2. Implementation challenges and solutions 3. Policy translation and systems change	Facilitated by Commissioners: **Todd Pollack**, PGPHC **Kim Green**, PATH **Maureen Luba**, AVAC Supported by: **Emma Williams**, IAS **Davina Canagasabey**, PATH **Loena Le Goff - Gestin**, IAS
14:55 - 15:10	Synthesis	Table Facilitators
15:10 - 15:15	Closing	**Davina Canagasabey**, PATH
	Group photo	

3.4 Documentation and Analysis

Facilitators documented discussions through detailed written notes during each discussion laboratory. These notes were supplemented by participant flip-chart summaries and, where available, audio recordings and transcripts that captured illustrative examples and participant quotations. Notes from each discussion group were subsequently reviewed and synthesized to identify recurring themes across participant groups. Illustrative quotations have been selected to highlight representative participant perspectives while preserving participant anonymity.

3.5 Commissioner and Advisor Reflections

Commissioners and advisors offered brief reflections on the relevance of the Commission's work to the current global health context and the particular importance of PCC at a time of significant health system and financing pressures.

Florence emphasized that this is an especially important moment to be discussing PCC. She noted that the relevance of PCC extends well beyond the HIV response to health systems more broadly. In a period of considerable uncertainty, she argued that there is a need to examine what health systems must preserve, what must change, and how they should move forward. Echoing the theme of AIDS 2026, *"Rethink, Rebuild, Rise,"* she suggested that the Commission's work is particularly timely in helping health systems reconsider how care should be organized and delivered in the current environment.

Maureen reflected on her own reasons for participating in the Commission, drawing on a career centered on communities, HIV and TB, and the integration of services. She emphasized the continuing gap between the principles of PCC and what routinely occurs in practice. Translating PCC into practice requires attention to provider training, adequate financing, and access to appropriate services. She therefore highlighted the importance of moving beyond conceptual discussions to more clearly define what PCC actually looks like in practice. She also underscored the particular relevance of this work to the current HIV response, where integration and breaking down traditional service silos are increasingly important.

Kim situated the Commission within the changing global health environment. Reflecting on the timing of the Commission's initial convening alongside major shifts in U.S. global health funding and challenges to longstanding commitments to inclusion, she described the Commission as an *"act of resistance"* grounded in the realities facing health systems and communities. With fewer resources available for health, she noted that integration is increasingly discussed as a way of doing more with less, but cautioned that efficiency alone should not define the response. She emphasized the importance of connecting the Commission's work to universal health coverage and retaining explicitly inclusive language and principles. In this context, she stressed that the Commission should not become another academic exercise, but should help identify a practical and principled way forward.

Taken together, these reflections reinforced both the urgency and practical orientation of the Commission's work. Commissioners and advisors emphasized that the current moment requires not simply articulating the principles of PCC, but determining how those principles can guide difficult choices about integration, financing, workforce capacity, equity, and access while ensuring that people and communities remain at the center of health system transformation.**Results**

4.1 Lived experience and empowerment

Across the lived-experience discussions, participants described PCC primarily in terms of how people are treated and how power is exercised within care relationships. Respect, dignity, confidentiality, listening, transparency, and compassionate communication strongly shaped whether participants felt seen and supported. Conversely, seemingly routine interactions could undermine trust when providers disclosed confidential information, failed to obtain consent, communicated dismissively, or treated people as diagnoses or tasks rather than individuals.

Examples included an HIV clinic where separating people waiting for ART refills effectively disclosed their HIV status; an ICU experience in which information was shared with family members against the patient's wishes; and childbirth experiences in which provider language, body language, and failure to involve the person in decisions made them feel objectified. Positive experiences were characterized by providers explaining what was happening, seeking consent

even under urgent circumstances, providing emotional support, and maintaining communication with patients and families.

Participants also repeatedly framed people-centeredness as a question of power and decision-making. Experiences were described in which people knew their own bodies, needs, or health histories but their knowledge was discounted because of professional hierarchy.

Participants therefore viewed shared decision-making as more than provision of information. It required providers to recognize lived experience as legitimate knowledge and to create a more horizontal relationship in which both parties contributed expertise. Importantly, some participants questioned the language of *"empowerment,"* because it can imply that providers possess power and then bestow it on patients. Instead, they suggested thinking about power as flexible, relational, and capable of moving in both directions.

These experiences led to several specific recommendations for the Commission's definition. Participants felt that shared decision-making, agency, and the active role of the person receiving care should be more explicit. They suggested that psychosocial support should extend beyond the current language of being "emotionally supportive"; that well-being should be included alongside health outcomes; that "lived experience" should be explicitly recognized; and that the definition should encompass health promotion as well as treatment and prevention for people already interacting with health services.

4.2 Implementation opportunities

Across all three implementation groups, co-design emerged as one of the clearest enabling strategies. Participants argued that people and communities should be involved from the beginning of service design wherever possible, rather than being consulted after models have already been established. Where services already existed, continuous feedback and adaptation remained important.

"When the people are involved in designing of the provision of service, the health outcome is good because… people design things that work well for them and with the lived experience as well."

Co-design was closely linked to personalization. Participants argued that care should begin by understanding what a particular person needs, knows, values, and may find difficult rather than assuming that a standardized service will work equally well for everyone. Personalized care was seen not only as more respectful but as potentially improving engagement and outcomes:

"When clients feel that their care is very personalized, they are more receptive to it."

A related point was that assessment should begin with the knowledge and experience the person already brings. As one participant put it:

"We need to start treating people not as empty boxes. We all have knowledge about something."

Participants described several concrete strategies for putting these principles into practice. Educational guides, videos, peer navigators, and other decision-support tools could provide information before the clinical encounter, allowing limited face-to-face time to focus on questions, preferences, and decisions rather than attempting to deliver all information during a single appointment. One participant described providing simple illustrated information about

hormone therapy before a specialist appointment so that the consultation could focus on what mattered most to the person. Another participant described an mHealth approach that allowed people to learn about different HIV prevention options beforehand:

"When they go there, they're ready to go with the questions… because… it's too much information, even to choose the method you want to use."

Participants consistently linked information to agency and shared decision-making, rather than viewing education as an end in itself:

"By the time you get to a decision, it is a shared decision because we have all understood what it is about."

Flexibility and reducing friction in accessing care

A second major implementation theme concerned making the system adapt to people's lives rather than expecting individuals to organize their lives around the health system. Participants proposed flexible appointment times and lengths, extended hours, mobile services, alternative service locations, telehealth, and differentiated models of care. One participant described the importance of choice even in something as basic as scheduling:

"If you give me one date, one time, one option and I still have to work… [we need to be] giving people the option and flexibility. I think the system needs to adapt to the reality as well."

Mobile HIV prevention services in Brazil provided another example. A participant described a bus operating at different times and locations to reach people who were not accessing conventional public services because of factors such as work schedules, transportation barriers, stigma, and discrimination. The broader principle was described as reducing the "points of friction" that people encounter while trying to receive care:

"Most industries have figured out how to reduce the point of friction to engage their consumer, but… [in the] healthcare system, there's a level of frustration just interacting with the healthcare system."

Coordination and navigation

Participants also highlighted the burden that fragmented systems place on individuals and families, particularly those with multimorbidity or complex needs. Multidisciplinary teams, coordinated appointments, home-based diagnostic services, reminders involving family or other support people, and care navigation were suggested as ways of reducing this burden. One participant described the difficulty of navigating even a comparatively well-resourced health system:

"Sometimes you have no idea who you should be speaking to… it feels like you're somehow to blame for the fact that you haven't been able to figure out this very complicated system."

Importantly, participants questioned whether adding navigators should always be the solution; in some cases, the better response may be to redesign unnecessarily complicated systems themselves.

Every interaction contributes to people-centeredness

Participants emphasized that the experience of care begins before a person meets a clinician. Receptionists, cleaners, administrative personnel, security staff, and others can either reinforce or undermine dignity and trust. One participant gave the example of a sex worker entering a public facility and encountering stigma from a member of the support staff:

"The first person I'll meet is not a healthcare provider… I'll meet a cleaner… and there is where stigma starts. And most of the time, that person might make the client never to come back again."

This experience had led the participant's programme to extend sensitization beyond clinicians to all facility staff, informed by client feedback surveys.

Representation, trust, and pluralistic health systems

Workforce diversity and representation were also seen as mechanisms for building trust. Participants described the value of people seeing themselves reflected among clinicians, peer workers, and educators. A transgender clinician described how shared lived experience could create a safer space for transgender clients, while another participant argued for a workforce that was genuinely representative of communities being served.

At the same time, participants cautioned against defining people-centeredness entirely within the biomedical health system. Indigenous, ancestral, and traditional systems of care also shape where people seek help. Trust, kinship, social norms, language, and culture therefore need to be understood rather than assuming that the formal health system is the natural starting point for everyone. One participant characterized the challenge as fundamentally reciprocal:

"We always ask the traditional healers or midwives to… adapt to the biomedical health system, but then we don't ask health providers to understand [traditional or Indigenous systems of care]."

The discussion connected this to power and the decolonization of knowledge—challenging assumptions about who possesses legitimate expertise and who is expected to educate whom.

4.3 System and policy change

Policy discussions strongly reinforced the view that PCC cannot be achieved through interpersonal skills alone. Participants identified human rights, gender transformation, equity, ethics, stigma, and criminalization as policy-level conditions that can either enable or undermine PCC. They emphasized that clinically effective technologies remain insufficient when social, legal, and economic conditions make those technologies unsafe or inaccessible.

Community and peer workers as part of the health system

One of the strongest policy recommendations concerned the status of community health workers, peer providers, navigators, and other lay providers. Participants argued that these workers have been central to the success of the HIV response but too often remain peripheral to formal systems, poorly compensated, or dependent on voluntary labor. The recommendation was not simply greater appreciation but formal recognition, sustained financing, meaningful participation in decision-making, and accountability commensurate with their responsibilities.

Participants also emphasized that professional status should not determine whose knowledge is valued. Community participation was meaningful only if community perspectives could genuinely affect policy and service decisions, rather than being invited after decisions had effectively been made.

Workforce conditions and provider well-being

Participants repeatedly noted that health workers cannot consistently deliver individualized, compassionate care if workloads, staffing, financing, and working conditions make doing so impossible. Implementation discussions described clinicians seeing very high daily patient volumes and emphasized that workforce adequacy is a prerequisite for flexible, personalized care. This extended to the mental health of providers:

"As we design or as we push the person-centered care… the healthcare provider has also to be in a very good mental health state to offer the services."

Participants therefore recommended both pre-service and continuing education in PCC, but cautioned that training cannot compensate for systems that are fundamentally under-resourced. Education should also focus more explicitly on communication, open-ended questions, stigma, community knowledge, and power.

Accountability should accompany empowerment

Accountability emerged as another important addition to the Commission's framework. Participants argued that empowerment should apply not only to patients and communities but also to community providers and other members of the workforce; and that increased authority should be accompanied by appropriate responsibility and accountability.

"The one that is missing is also delegating the accountability together with the empowerment… [while] giving due respect to their capacity."

Participants also discussed community-led monitoring and the ability of communities to hold ministries, institutions, and providers accountable. This led to a recommendation for the PCC Framework that accountability be represented explicitly and that the model recognize multiple levels from the interaction between a person and provider through organizations and the national health system.

Policies need to be implementable under real-world constraints

Finally, participants cautioned against aspirational policies that assume levels of workforce, infrastructure, and financing that are not available in many settings. Policies should offer practical guidance adaptable to different levels of capacity; for example, minimum versus gold standards, clear referral points, and differentiated options based on available personnel, tests, and infrastructure.

This complemented the broader point that resources are not peripheral to PCC: staffing, time, financing, training, and organizational capacity determine whether people-centered principles can actually become routine practice. The discussion identified manpower, financing, workforce training, community health-seeking behavior, and trust as central enabling conditions.

5. Discussion: Major themes across the Discussion Labs

PCC is fundamentally about relationships and power

The clearest synthesis is that PCC is not simply better bedside manner. Dignity, empathy, communication, confidentiality, and trust mattered greatly, but participants repeatedly linked them to who has authority, whose knowledge counts, and who is able to influence decisions. The lived-experience group described this in clinical relationships; the implementation groups translated it into co-design and shared decision-making; and the policy groups extended it to community governance and accountability. This suggests that power-sharing may deserve greater prominence in the Commission's conceptualization of PCC.

Individual interactions and system design cannot be separated

Across all three laboratories, participants resisted locating responsibility for PCC solely with individual providers. A compassionate provider can still be constrained by a 15-minute visit, 120-patient workload, inaccessible appointment system, inadequate financing, fragmented referral pathway, or discriminatory policy environment. Conversely, relatively modest system changes (e.g., flexible scheduling, transparency about delays, multidisciplinary care, mobile services, pre-visit information) can make respectful care substantially easier to deliver. The discussions therefore strongly support conceptualizing PCC simultaneously at the interpersonal, organizational, and system levels.

Community participation is a mechanism through which PCC is produced

Co-design was among the most consistent findings in the implementation discussions, while policy discussions emphasized genuine community influence, community-led monitoring, and the formal recognition of peer and community providers. Taken together, participants described communities not simply as recipients of care or stakeholders to be consulted, but as co-producers of services, sources of expertise, members of the workforce, and actors in governance and accountability.

Personalization often means flexibility, not necessarily greater intensity of care

An important practical insight was that person-centeredness does not always mean providing *more* care. It can mean providing the right type, timing, amount, and location of care for a particular person. Some people need longer consultations while others need five-minute appointments; some benefit from specialist visits while others may prefer self-care; some need mobile or home-based services; some require intensive navigation while others simply need a less complicated system.

The workforce is both an enabler of PCC and a population whose needs must be considered

Providers, peer workers, community health workers, navigators, and support staff emerged repeatedly across the groups. Participants emphasized training, representation, sufficient staffing, mental health, working conditions, compensation, and professional respect. One particularly important implication is that the framework should perhaps identify consequences of PCC for providers as well as for people receiving care. Participants explicitly asked what would “pull” providers toward PCC and argued that being enabled to provide high-quality care can itself generate professional satisfaction.

Equity requires contextual and pluralistic approaches rather than a universal delivery model

Participants repeatedly warned against treating PCC as a standardized model that can simply be transferred between settings. The needs of transgender communities differed within Brazil; traditional and Indigenous health systems coexist with biomedical services; health-seeking behavior reflects trust and kinship; and structural barriers related to stigma, criminalization, poverty, transportation, housing, and food insecurity affect whether technically effective care is usable. The implication is that the Commission may need to distinguish more clearly between universal PCC principles and context-specific ways of operationalizing them.

6. Acknowledgements

The Commissioners gratefully acknowledge all participants who contributed their time, experiences, and expertise during the AIDS 2026 Participatory Discussion Lab. The openness with which participants shared both positive and challenging healthcare experiences provided invaluable insight into the realities of delivering and experiencing PCC across diverse contexts.

The Commission also thanks IAS – the International AIDS Society for providing the opportunity to convene this participatory session during AIDS 2026 and recognizes the longstanding leadership of the global HIV community in advancing approaches that place people, communities, and lived experience at the center of healthcare.

The Commissioners are especially grateful to the facilitators, note takers, and organizing team whose efforts enabled the discussions and documentation that informed this report.

Appendix 1. Participants

Given Name	*Family name*	*Organization*
Anaclara	*Firpo*	*Ministerio de Salud Publica, Uruguay*
Angela	*Leon Caceres*	*Women4GlobalFund*
Brenda	*Hoagland*	*INI/FIOCRUZ*
Brian	*Minalga*	*Fred Hutchinson Cancer Center*
Clarice	*Pinto*	*World Health Organization*
Daisy	*Kwala*	*Bar Hostess Empowerment and support programme*
Gastón	*Devisich*	*Fundación Huésped*
Ines	*Aristegui*	*Fundación Huésped*
Lillian	*Okui*	*Bummhi*
Maria	*Medeiros*	*Casa da Pesquisa CRT DST/AIDS São Paulo*
Marie-Claude	*Lavoie*	*University of Maryland, Baltimore*
Rodenie	*Olete*	*Sustained Health Initiatives of the Philippines (SHIP)*
Tristan	*Barber*	*British HIV Assocation*
Zoë	*Mullan*	*The Lancet Global Health*
Todd	*Pollack*	*Program in Global PHC at Harvard Medical School*
Maureen	*Luba*	*AVAC*
Kimberly	*Green*	*PATH*
Davina	*Canagasabey*	*PATH*
Emma	*Williams*	*IAS – the International AIDS Society*
Loena	*Le Goff-Gestin*	*IAS – the International AIDS Society*
Marlène	*Bras*	*IAS – the International AIDS Society*
Lina	*Golob*	*IAS – the International AIDS Society*
Florence	*Riako Anam*	*Global Network of People Living with HIV (GNP+)*

Appendix 2. Discussion Questions

Discussion Lab 1

Lived Experience and Empowerment

1. Think of a moment in care when you felt truly seen, respected, and supported—or clearly not. What happened, and what made it feel that way?
2. Looking at the Commission's draft definition and framework, what does it capture well from those experiences, and what feels missing?

Discussion Lab 2

Implementation Opportunities and Leverage Points

1. In your experience, where have you seen PCC successfully implemented?
2. What made implementation possible?
3. What practical changes would most improve implementation?

Discussion Lab 3

Policy Translation and Systems Change

1. What policy or systems change would most improve everyday experiences of care?
2. How well does the Commission's framework support those policy choices?
3. What is still missing?

Appendix 3. Commission DRAFT PCC Definition and Framework

Definition and Framework

People-centredness is an approach to providing the continuum of care that incorporates the needs, values, and preferences of individuals in the context of their communities.

It promotes respectful, empathetic, dignified and collaborative relationships between persons and all those who contribute to healthcare, ensuring that care is not only clinically effective but also emotionally supportive and trustworthy.

People-centred care is a foundation for implementing the right to health and to achieving wellbeing outcomes, and a good care experience. It is achievable when there is a shift to collaborative and co-created health and care systems.



Antecedents

Conditions needed for people-centred healthcare to be enacted

Health system

Integrated health systems that are adequately resourced, managed and organized around people's' needs, cultures and contexts, and are underpinned by a commitment to staff training, education, and positive safe working conditions.

Societal factors

Social governance and community structures, cultures and norms that promote equity, social participation, accountability and culturally-safe practices, to address structural and social determinants of health and well-being

Characteristics

The defining features of people-centred care that distinguishes it from other modes of healthcare delivery

Clinically effective care that ensures technical, evidence-based quality of prevention, promotion, diagnosis, treatment, rehabilitation and palliation across the continuum of care

Care that empowers individuals and communities to meaningfully participate in health promoting behaviours, individual care and service/system design

Emotionally-responsive and affirming care mediated through respectful, trustworthy, compassionate, collaborative relationships with providers, families and the care team

Holistic and inclusive care that promotes wellness, is safe, responds to diverse personal and community preferences, cultures and contexts, including the SDoH and is rooted in lived experiences

Care that is easy to access, affordable and which maximises continuity of experience, as well as health system efficiency, utilisation and effectiveness

Consequences

What we expect to achieve when people-centered care is enacted

Personal Agency & Self-Efficacy: Growth in individuals perceived control and capability to influence their health and care

Engagement in Care: Active participation in care processes and decisions, leading to more consistent health behaviours

Access & Continuity of Care: Improved ability to obtain services and maintain ongoing, coordinated care over time

Wellbeing: Improved physical, psychological and social outcomes through affirming and trusting relationships

Cultural Safety & Equity: Care environments and practices that are respectful, responsive, and safe for service users and service providers

Collective Empowerment: Communities exercising decision-making authority and influence over health priorities and services through inclusive governance.