



A PRACTICAL
TOOLKIT

IMPLEMENTING

INTEGRATED CARE MODELS

FOR PEOPLE WHO INJECT DRUGS



2019

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This toolkit was developed within the EU-funded programme, Joint Action on HIV, Viral Hepatitis and Tuberculosis among People Who Inject Drugs in Europe (HA-REACT).

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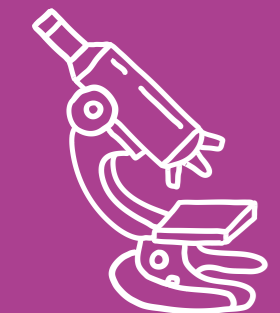
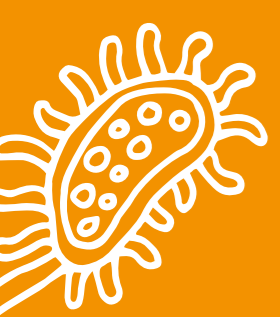
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ABBREVIATIONS

- Ab** • antibody
- ART** • antiretroviral therapy
- DOTS** • directly observed therapy, short course
- DAA** • direct-acting antiviral (medicine)
- ECDC** • European Centre for Disease Prevention and Control
- EMCDDA** • European Monitoring Centre for Drugs and Drug Addiction
- HBV** • hepatitis B virus
- HCV** • hepatitis C virus
- HIV** • human immunodeficiency virus
- IHRA** • International Harm Reduction Association
- IPT** • isoniazid preventive therapy
- MDR-TB** • multidrug-resistant tuberculosis
- NGO** • nongovernmental organization
- NSP** • needle and syringe programme
- OST** • opioid substitution treatment
- PLHIV** • people living with HIV
- PWID** • people who inject drugs (in this toolkit, adults who inject opioids or stimulants)
- PWUD** • people who use drugs
- STIs** • sexually transmitted infections
- TB** • tuberculosis
- UNAIDS** • Joint United Nations Programme on HIV/AIDS
- UNODC** • United Nations Office on Drugs and Crime
- USA** • United States of America
- WHO** • World Health Organization



INTRODUCTION



“After all, the goal is not just to keep people who are addicted to drugs alive, but to give them a real chance. We must give them back the first snow, school holidays and World Bank indexes. We must give them back their lives.”

Erik Moora, Eesti Ekspress journalist



According to the World Drug Report 2018 almost 11 million people worldwide injected drugs in 2016, one in eight people who inject drugs is living with HIV and Every second person who injects drugs is living with HCV. WHO estimates that there were 450,000 deaths attributable to drug use worldwide in 2015. In most cases these deaths are attributable to opioids. People who inject drugs experience some of the most severe health-related harms associated with unsafe drug use, including a high risk of non-fatal and fatal overdoses, and a greater chance of premature death.

People who use illicit drugs, especially people who inject drugs (PWID) are at high risk of contracting HIV or other infectious diseases, such as hepatitis B and hepatitis C or tuberculosis. As drug use is still criminalized in many countries PWID often face stigmatization and have poor access to health care and social services. Even when the services are available, they are often fragmented and hard to navigate. This can lead to delayed diagnosis, poor treatment outcomes and preventable deaths. PWID are in need of an integrated and effectively coordinated approach to care that focuses not only on curing disease, but also on addressing drug use by providing needs based harm reduction and addiction treatment.

Harm reduction services play a key role in making health and social services more accessible to PWID as they have a unique insight into their clients’ complex needs and can provide other specialist valuable knowledge that is essential to early detection of infectious diseases and providing supportive services during treatment.

This toolkit has been developed in the framework of the Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT) that addresses existing gaps in the prevention of HIV and other co-infections, especially tuberculosis (TB) and viral hepatitis, among people who inject drugs. HA-REACT partner organizations are working together to prevent HIV, viral hepatitis and tuberculosis among PWID in Europe. Jointly they strive to to improve countries’ capacity to respond to HIV and co-infection risks, improve provision of integrated HIV, HCV and TB treatment and harm reduction measures, focusing specifically on PWID.

The aim of the toolkit on Implementing Integrated Care Models for People Who Inject Drugs is to provide information on core recommendations and guidelines on how HIV, HCV and TB prevention and treatment activities could be integrated and combined with harm reduction measures to be effectively included in the work of different organizations with people who inject drugs. It includes examples of models of care and good practices as well as references to relevant international guidelines. The toolkit is not a new guideline, but rather a practical tool for specialists to help them to find the most suitable strategy for integrating care on national and local level. We hope that this material will be helpful to wider audience of specialists and organizations working with people who are or have been injecting drug users and who should receive good quality care and support they need.

The European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) have listed the most prevalent infections for which PWID may be at increased risk: HIV infection; hepatitis A, B, C and D infections; tuberculosis (TB); skin and soft tissue infections; severe systemic sepsis, such as Clostridium novyi or Bacillus anthracis infections); STIs such as chlamydia, syphilis and gonorrhoea); respiratory infections such as pneumonia, diphtheria and influenza; wound botulism; tetanus; and human T-cell lymphotropic virus (HTLV) infections. The greatest share of morbidity and mortality among drug users is due to the illicit use of opioids – mainly heroin (whether injected, snorted or smoked) and synthetic opioids such as buprenorphine, methadone and fentanyl.



The risk of HIV, viral hepatitis and TB among PWID is many times greater than that of the general population. For PWID, delivering integrated care and improving linkage to care can reduce costs; improve quality of care, health outcomes and quality of life; and ultimately save lives. It is essential to combine health and social services with harm reduction and ensure that services are provided where PWID spend time. Providing integrated people-centred health services that include treatment for substance use disorders, harm reduction and PWID support services can be challenging for any country's health system. However, this approach is an important way to empower patients and deliver health services that are better aligned with people's needs.



1.1. THE RISKS OF HIV, TB AND HEPATITIS C VIRUS (HCV) AMONG THE PWID



Among the global population of PWID, 1.6 million are currently living with HIV, 6.1 million with HCV and almost 900 000 are living with TB, while 1.3 million are coinfecting with both HCV and HIV. People dependent on opioids are more likely to die from a drug overdose or the other mentioned infections.



FACTS AND STATS

HIV prevalence in Europe

According to WHO Regional Office for Europe, in 2017 159 420 newly diagnosed HIV infections were reported in 50 of the 53 countries of the WHO European Region, which corresponds to a rate of 20.0 newly diagnosed infections per 100 000 population. This number includes 55 018 new diagnoses reported by 49 countries to the joint ECDC and WHO Regional Office for Europe surveillance system, including 25 353 from the EU/EEA, while information about 104 402 new diagnoses in the Russian Federation was published by the Russian Federal Scientific and Methodological Centre for Prevention and Control of AIDS. Continuing a decade-long trend, nearly 80% of newly diagnosed people were from the eastern, 17% the western and 4% the central part of Europe.

In total, an estimated 2.4 million people were living with HIV in Europe, among whom more than a quarter are estimated to be unaware of their infection. Sharing of used injecting equipment makes PWID particularly vulnerable to HIV.

Hepatitis C prevalence in Europe

According to the European drug report, the national infection levels of HCV among PWID in Europe ranges from 14% to 84%. Among the countries reporting their data to EMCDDA during 2006–2013, only Norway has seen a decline in the incidence of new HCV infections, while the other countries have all observed an increase.

TB prevalence in Europe

In 2016, 58 994 new cases of TB were reported in 30 countries of the European Economic Area. Multidrug-resistant TB (MDR-TB) was reported for 3.7% of cases and continues to be highest in the three Baltic states (Latvia, Lithuania and Estonia), where it exceeds 10%. Estimates suggest that there were around 323 000 new TB cases and 32 000 related deaths in Europe in 2015, mostly from eastern and central European countries. In the WHO European Region, an estimated 74 000 cases of MDR-TB occur every year, but only 43 000 of them are diagnosed and begin treatment. The treatment success rate in MDR-TB patients was somewhat higher in 2015 than 2011, increasing from 49% to 51%, though it remains far below the 75% target.

According to global estimates, 80% of HIV-positive PWID are also infected with HCV. Between 2.3 million and 4 million people are estimated to be living with both HIV and HCV, about half of whom (an estimated 1.3 million to 2 million) are PWID. Eastern Europe and central Asia are responsible for more of this total than any other region, with an estimated 610 000 cases, or 27% of the coinfecting PWID globally. Coinfection with HIV adversely affects the course of HCV infection, and coinfecting persons have a significantly accelerated progression of liver disease to cirrhosis. Various health issues caused by injecting drug use can mask the real effects of HCV infection on HIV disease progression. Hepatitis B virus (HBV) and HCV coinfection is commonly found in HBV-endemic countries in Asia, sub-Saharan Africa and South America. In some areas, as much of 25% of HCV-infected people may be coinfecting with HBV.

Data on HIV/TB coinfection remain incomplete. Of TB cases with a known HIV status, 4.5% are coinfecting with the virus. The number of TB/HIV coinfections in the European Region rose from 13 000 to 34 000 between 2007 and 2016, representing a 260% increase. This situation is driven by the spread of HIV in the Region. Infection with HIV increases a person's lifetime risk of developing TB to between 5% and 10%, and the latest studies show that drug use is closely associated with the growing epidemic of MDR-TB. The Reference Group to the United Nations on HIV and Drug Use pointed out that TB among PWID is a public health priority, and that strategies to prevent and treat TB among PWID are needed. The Reference Group emphasizes that injecting drug use should not be a reason to deny or delay TB treatment for PWID, and those receiving treatment for TB should also be provided with psychosocial support and treatment for co-occurring conditions, including drug dependence, mental health problems, hepatitis C, HIV and other infections. Exposure to prison settings have a negative impact on TB/HIV morbidity and mortality in drug users. For example, imprisonment increases the risk of TB by 10- to 50-fold because overcrowded prisons with inadequate air circulation and poor health services serve as reservoirs for the disease.

See also
Annex 1

1.2. CHALLENGES IN CURRENT HEALTHCARE SYSTEMS: BARRIERS TO EFFECTIVE TREATMENT

Numerous studies have been conducted to explore the barriers faced by PWID when accessing HIV, HCV and TB services. These barriers can have important consequences not only for their health and the lives of their families, but also for their communities and for the public health in general. Frequent delays in receiving appropriate care mean higher prevalence of HIV, TB and other infections, as well as higher healthcare costs.

For example, in Spain the estimated annual cost of HIV treatment per patient is €11 638; in Germany it is €32 110, in France €14 821, in the United Kingdom €25 340 and in Italy €6399. Lifelong treatment can add up to substantial expenses that would be better used on prevention or noncommunicable diseases.

In analysing the varied list of barriers to healthcare that PWID face, it becomes obvious that a more coordinated response to drug users' needs is required in order to provide universal access to prevention, treatment and care services at all points of entry into the healthcare system.



MAJOR BARRIERS THAT PWID FACE WHEN ACCESSING TREATMENT

Social issues and stigmatization

Fear of stigma can cause PWID not to seek help or share details about their behaviour.

Poor relationship between healthcare providers and social workers

A lack of coordination between medical staff and social workers can mean that PWID are not offered essential services.

Lack of information

PWID are often not informed about their treatment and treatment options, particularly with respect to hepatitis C. The situation can be compounded by incomplete patient databases.

Inadequate training of healthcare professionals on treatment and care

Treatment providers often lack sufficient training on addiction, which can lead them to regard PWID as troublesome. Providers

frequently lack sufficient cross-training in other relevant specialities.

Testing and treatment not tailored to the needs of PWID

Testing and treatment sites and systems often require PWID to visit many different clinics and pay additional fees. Although integrated sites are now more widespread, treatment discharge as a result of active drug use or HIV infection has also become more common.

Lack of support and counselling for patients who test positive for HCV

Difficulties with treatment compliance

Compliance problems can be exacerbated by restrictive guidelines for the care and treatment of PWID, the use of outdated medical procedures, and regulations that require that PWID be admitted as inpatients in order to receive medications. For example, when facing withdrawal symptoms,

PWID may find it impossible to remain in a hospital where treatment for drug dependency is not offered, leading to discontinuation of treatment and medication. Abstinence from alcohol and drugs is often a prerequisite for treatment.

Long treatment waiting lists, informal fees and additional fees for tests, medication and physician care

These issues all constitute substantial barriers for drug-dependent PWID.

Frequent referrals for coexisting conditions

For example, PWID with TB/HIV coinfection may be required to visit separate clinics with separate health services and specialists for the two diseases.

Confidentiality issues

Some countries require healthcare workers to report people who use drugs to the authorities, often resulting in arrest, forced detoxification and prison sentences.

1.3. KEY ASPECTS OF INTEGRATED HEALTHCARE SYSTEMS

In 2007, the director-general of WHO stated, “We need a comprehensive, integrated approach to service delivery. We need to fight fragmentation”. But what is actually meant by integrated care and integrated health services?

For the first five characteristics of integrated services presented in Box 3, WHO emphasizes that they should be seen as continua, and that fully integrated services may have different forms of management support systems. For instance, management support (of areas such as finances, human resources, logistics and supplies) may apply to all services, or a separate management support system may apply to a particular area that is funded externally. However, some studies show that although the one-stop shop approach is often regarded as the ideal model of integrated care it requires considerable resources that may not always be feasible, including more staff, better infrastructure and broad political commitment. An alternative solution involves the collaboration several existing health and social care services, with facilitated referral mechanisms and effective co-located treatment for various healthcare and community settings. The main idea of integration is to provide services that are not detached or separated for clients, services that they can easily navigate. It does not mean that everything has to be integrated in a single “package”.

It is also important to clarify that integration should not be undertaken just to save money. Integrating new activities into an existing system may provide some savings, but the main goal should be a better overall system. Integration efforts should primarily focus on practical questions of how to deliver services to people who need them at different service levels. For PWID, it is essential to note that integrated health care cannot be provided outside harm reduction programmes.

The International Harm Reduction Association (IHRA) describes the harm reduction approach as evidence-based, practical, feasible, effective, safe and cost-effective. Keeping people who use drugs alive and preventing irreparable damage to their health is regarded as its most urgent priority. The approach acknowledges the significance of small positive change that individuals make in their lives, as IHRA states: “Small gains for many people have more benefit for a community than heroic gains achieved by few. People are much more likely to take multiple tiny steps rather than one or two huge steps”.



KEY CHARACTERISTICS OF INTEGRATED HEALTH SERVICE

The WHO technical brief on integrated health services describes them as having six overlapping characteristics.

1. **An integrated approach** can be a continuum of many interventions, frequently directed to a particular population group. The aim of such an approach is to offer all appropriate interventions at a “one-stop shop”, ideally from the client’s perspective. For example, TB services should address the fact that many of their clients may be HIV-positive, malnourished, smoke or have diabetes.
2. **Integrated health services** are a range of services provided under a single manager at one location, which serves as a multipurpose service delivery point for a given population. These services may include different levels of care with their own functions and staff (for example, a multipurpose clinic and an outreach programme).
3. **Integrated services** aim to provide continuity of care over time, for example life-long care for a chronic condition such as HIV infection.
4. **Vertical integration** of different levels of service is most frequently used in health centres and district hospitals. For the clients, vertical integration requires well-functioning procedures for referring patients up and down the levels of the system, as well as between public and private providers. There is usually one manager in charge of this kind of network of facilities and services who has a broad strategic vision of which services to provide at which levels of the system.
5. **Integrated policymaking and management** bring together decisions about different parts of the health service at different levels.
6. **Working across sectors** involves the coordination of health and social services, such as long-term elder care or health promotion campaigns in schools. Such integration usually relies on institutionalized mechanisms for cross-sectoral funding.

The most important harm reduction strategies, in their effect on both personal and public health, are probably NSPs and OST. NSPs help prevent the sharing of injecting equipment and provide PWID with methods for safely disposing of non-sterile injecting paraphernalia in several ways:

- raising awareness and knowledge of the risks of infectious diseases;
- distributing sterile injecting equipment;
- providing information on how to disinfect needles, syringes and other equipment, as well as how to inject safely; and
- disposing of non-sterile injecting equipment safely.

A systematic review of the effectiveness of NSPs in reducing HIV transmission among PWID showed that increasing the availability of sterile injecting equipment and encouraging its utilization reduces HIV infection. The review also found that NSPs are cost-effective and can increase recruitment into drug treatment, possibly into primary care too. However, these programmes should be combined with other interventions, as they are not sufficiently able on their own to control HIV infection among PWID. WHO accordingly recommends combining NSPs with OST, which can guarantee continuity of drug treatment and which may also help increase adherence to treatment for comorbid infections such as HIV and HCV.

There is evidence associating OST with reductions in illicit opioid use, reported risk behaviour drug-related harms and mortality, as well as with better retention in treatment. In European Union 69% of OST clients are prescribed methadone and 28% buprenorphine. Other substances, such as slow-release morphine or diacetylmorphine (heroin), are prescribed fairly rarely – about 3% of the time. According to the EMCDDA, more than 50% of Europe's problem opioid users still do not receive OST, and there are large national differences in OST coverage, with the lowest estimates (of about 10% or less) being reported for Latvia, Lithuania and Poland.



HARM REDUCTION STRATEGIES

Low-threshold opioid substitution treatment (OST) is a pharmacological intervention that reduces the risk of contracting and transmitting HIV and other blood-borne diseases by substituting non-injecting drugs for the injected substance.

Needle and syringe programmes (NSPs) aim to prevent the sharing of injecting equipment. NSPs also educate drug users about the risks of injecting drug use and sharing needles and syringes, and about how to disinfect and dispose injecting equipment.

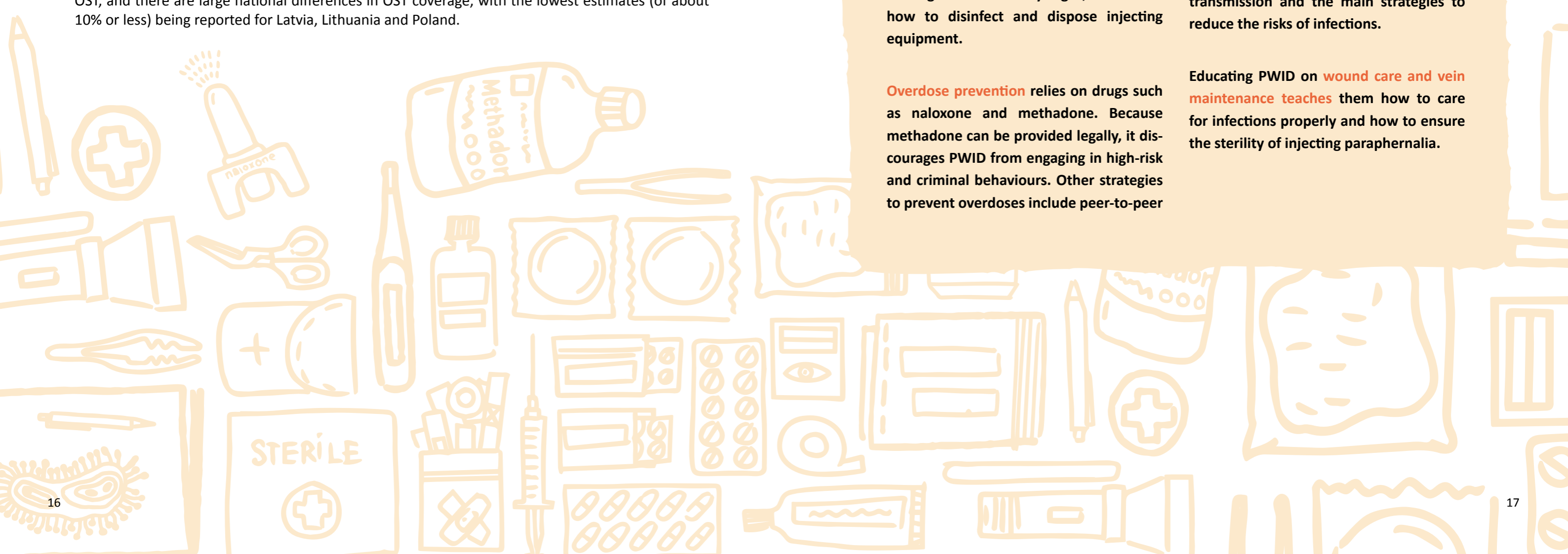
Overdose prevention relies on drugs such as naloxone and methadone. Because methadone can be provided legally, it discourages PWID from engaging in high-risk and criminal behaviours. Other strategies to prevent overdoses include peer-to-peer

education and encouraging PWID to seek help when an overdose is suspected.

Voluntary HIV counselling and testing aims to improve the early detection of HIV and enables people who are infected to begin antiretroviral treatment.

Sexually transmitted infection (STI) prevention and treatment services can educate drug PWID about the risks of HIV transmission and the main strategies to reduce the risks of infections.

Educating PWID on **wound care and vein maintenance** teaches them how to care for infections properly and how to ensure the sterility of injecting paraphernalia.





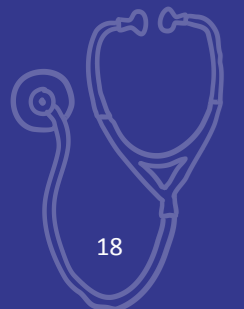
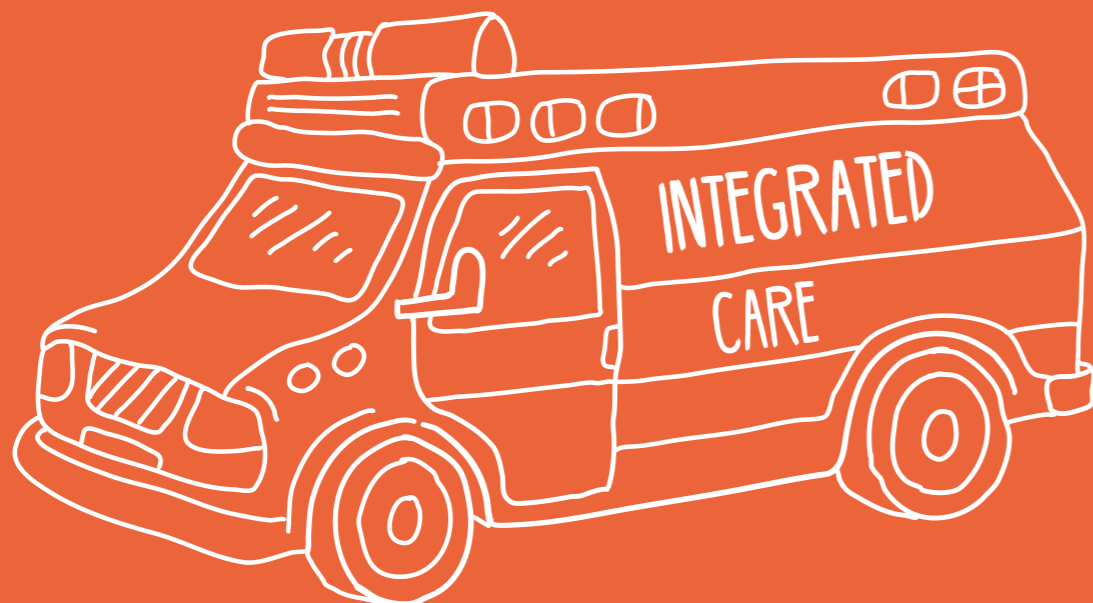
2.

HOW TO DELIVER INTEGRATED HEALTHCARE SERVICES TARGETING PEOPLE WHO INJECT DRUGS



Integrated care should not be a goal in itself. Instead, it should be considered an invaluable tool that can address the complex care needs of people who require a systemic approach involving professionals from the healthcare, long-term and social care sectors. The design of services should reflect the relationship between the level of needs and the degree of integration.

—Blocks: tools and methodologies to assess integrated care in Europe



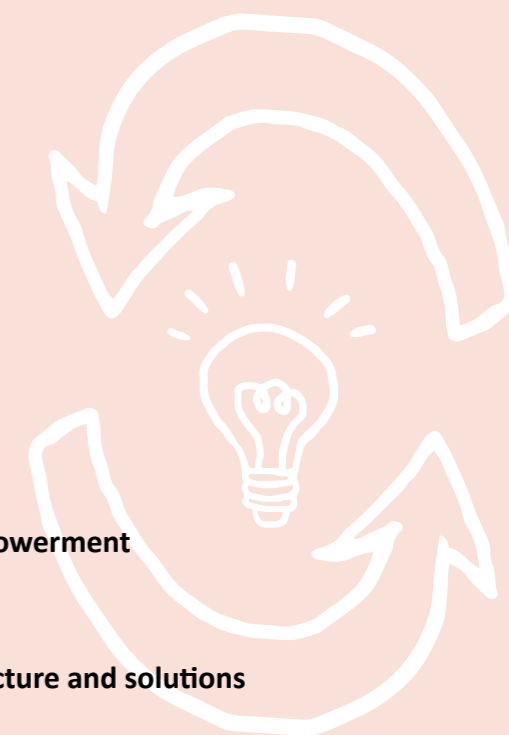
The transition to integrated care is a highly complex process at every stage – design, implementation and assessment. Integrated care models have to be carefully designed and implemented to fit local conditions and needs. At present, most recommendations on providing integrated healthcare address only a few particular elements, settings and patients, focusing chiefly on people living with chronic illnesses, such as diabetes, rather than people with broad health and social care needs – like people who use drugs. Some studies and papers propose key building blocks and strategies for integrated care (see for instance the WHO example below), but there is still not much available that supports the process of implementation.

Although planning and managing the implementation of integrated healthcare services will very much depend upon the organizational structure involved – i.e., whether they are being carried out by a nongovernmental organization (NGO), a primary care service provider, a drug treatment centre, a local government or a local community – the issues they will face and the principles they should follow are the same.



KEY FACTORS IN PROVIDING EFFECTIVE INTEGRATED CARE

1. Political support and commitment
2. Governance
3. Stakeholder engagement
4. Organizational change
5. Leadership
6. Collaboration and trust
7. Workforce education and training
8. Patient-centred approach and patient empowerment
9. Financing and incentives
10. Information and communications infrastructure and solutions
11. Monitoring and evaluation systems



— Blocks: tools and methodologies to assess integrated care in Europe

THE EUROPEAN FRAMEWORK FOR ACTION ON INTEGRATED HEALTH SERVICES DELIVERY

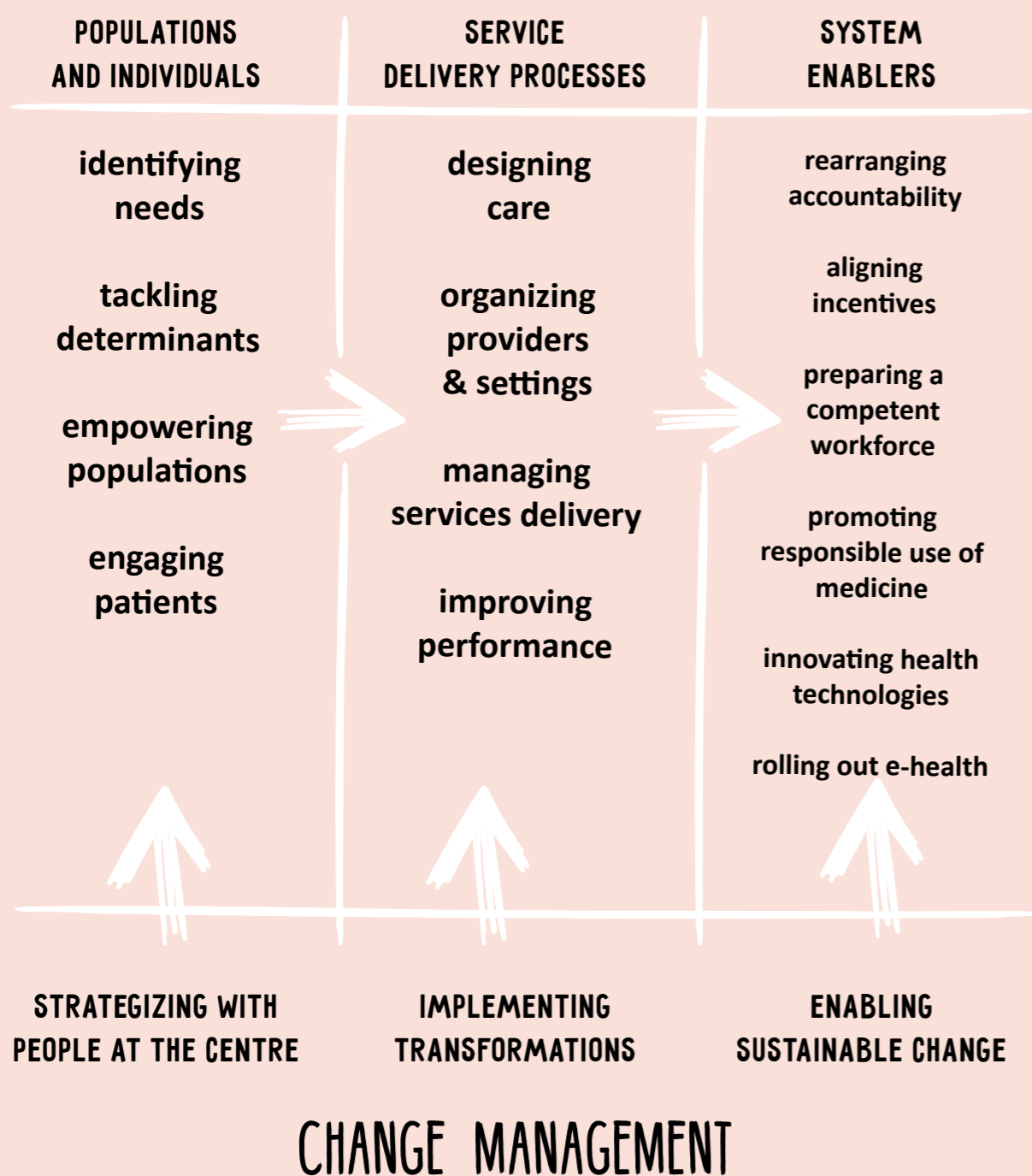


Fig. 1. The European Framework for Action on Integrated Health Services Delivery



STRATEGIES TO FACILITATE INTEGRATED CARE FOR PEOPLE WITH ALCOHOL AND OTHER DRUG PROBLEMS: A SYSTEMATIC REVIEW

In 2017, a systematic literature review on strategies that improve integrated care for people with alcohol and other drug problems had several key findings, as follows. Ensuring that integrated care is adequately funded and specified in the service specifications of commissioning bodies was critical to effective integration. Cultivating positive interagency relationships underpinned and enabled the implementation of most strategies, and staff training in identifying and responding to needs beyond clinicians' primary area of expertise is important at the service level.

Sharing of client information (subject to informed consent) was critical for most integrated care strategies, while case management was a particularly good approach for responding to clients with multiple and complex needs. At the clinical level, screening in areas beyond a clinician's primary area of practice was a common strategy for facilitating referral and integrated care, as was joint care planning. The review also highlighted several strategies that could be useful at multiple levels. (need to redraw the diagram for better quality) (Also: change "Organisational" to "Organizational" and "Inter-agency" to "Interagency").

FUNDING	ORGANISATIONAL	SERVICE DELIVERY	CLINICAL
System investment	Inter-agency relationships	Staff training	Screening
Inter-departmental collaboration	Common agency goals	Information sharing	Joint care planning
Integrated working in service specifications	Co-location	Case-management	Staff supervision
		Referral	
		Professional networks	

2.1. UNDERSTANDING THE TARGET GROUP



It is essential to keep in mind the following factors that affect PWID access to health services.

- **SOCIAL NETWORK SUPPORT.** Reluctance to attend health services can delay treatment to a critical point. Practical advice and psychological support from friends and relatives can motivate clients to seek treatment and care. The sharing of experiences among professionals in the health system can also enable them to help patients navigate bureaucracy more quickly.
- **CLIENT INDIVIDUALITY AND AUTONOMY.** It is important to adapt health services to individual needs and recognize that clients who are actively using drugs tend to prioritize withdrawal avoidance over less immediate health and social care needs.
- **PATIENT-PROVIDER RELATIONSHIPS.** Acknowledging clients and giving them the sense that they are being treated equally helps them feel accepted in specialist treatment centres. The fear of discrimination in general healthcare services remains a concern. Outreach workers have observed that, when they refer clients or accompany them personally, the reception of clients in treatment services improves (see Box 9).
- **TIMELY TESTING AND TREATMENT.** Access to OST and other drug treatments, as well as HIV, hepatitis C and TB care should not involve long waiting lists. In Portugal, for instance, it took significantly longer to initiate hepatitis C treatment when clients were required to abstain from substance use, which is a major barrier for active drug users.
- **TREATMENT LITERACY.** Treatment literacy is important for clients of HIV and TB treatment. “Feeling healthy” can delay treatment until a client is critically weak. TB treatment is widely viewed as mandatory, and few people are aware of its preventive role or its other benefits. Peers’ negative accounts of treatment side-effects can deter or delay uptake.
- **ADDRESSING BROADER HEALTH AND SOCIAL CARE NEEDS.** It is important to address broader health and social care needs of PWID to facilitate treatment adherence. Cuts in government funding can make it increasingly difficult for them to secure housing, social security benefits and other care. That highlights their growing vulnerability and the extent to which they depend on the support of drug treatment and outreach services.

2.2. PLANNING YOUR SERVICE DELIVERY PROCESSES

When planning to deliver integrated care, a good starting point is to think about three key elements: early detection, infrastructure (location of services and staff management) and cross-training of specialists.



FACTS AND STATS

WHO estimates that in 2014, approximately 150 million people in 129 low and middle-income countries received HIV testing services. Nonetheless, an estimated 54% of people living with HIV still remain unaware that they are infected. The growth in service accessibility rates is mostly due to better implementation of provider-initiated testing and counselling, the introduction of more community-based testing services, and the ability to provide same-day test results (and often diagnoses) using rapid diagnostic tests. WHO recommends that, in areas with very high prevalence rates among PWID, HIV testing and coun-

selling services be provided in primary care clinics, harm reduction services, OST and other drug dependence treatment services, STI services, TB services and other health services for key populations. These testing and counselling services can also be provided through mobile and other outreach services for PWID. When recommending HIV testing and counselling, service providers should give people sufficient information to make an informed, voluntary decision to be tested; maintain patient confidentiality; perform post-test counselling; and refer them to other appropriate services.



2.2.1. EARLY DETECTION OF COMORBID CONDITIONS

See also Guideline 4, Good Practice Examples 1, 2 and 7, and Box 2 below.

The first step towards integration is to develop screening and testing services for each condition by integrating them into existing programmes (see Box 1 and Good Practice Example 1). In settings where testing facilities are limited, screening for HIV and other infectious diseases (such as hepatitis B and C) can be provided at health clinics and rehabilitation programmes for people who use drugs. Substance use treatment sites can offer both patient- and provider-initiated HIV voluntary counselling and testing. It is relatively common for TB clinics to offer HIV counselling and testing, for drug treatment programmes to offer HIV counselling and testing and tuberculin skin testing, and for HIV care sites to offer drug use services and screen for TB.

The major issue with screening drug users for TB is their frequent failure to return for reading of their tuberculin skin tests. To increase their return rate, financial incentives have been used, as has linkage to other daily treatment programmes, for example methadone treatment, which can increase uptake because of physical dependence on the methadone.

2.2.2. THREE STRATEGIES TO IMPROVE THE QUALITY AND EFFICIENCY OF TESTING SERVICES

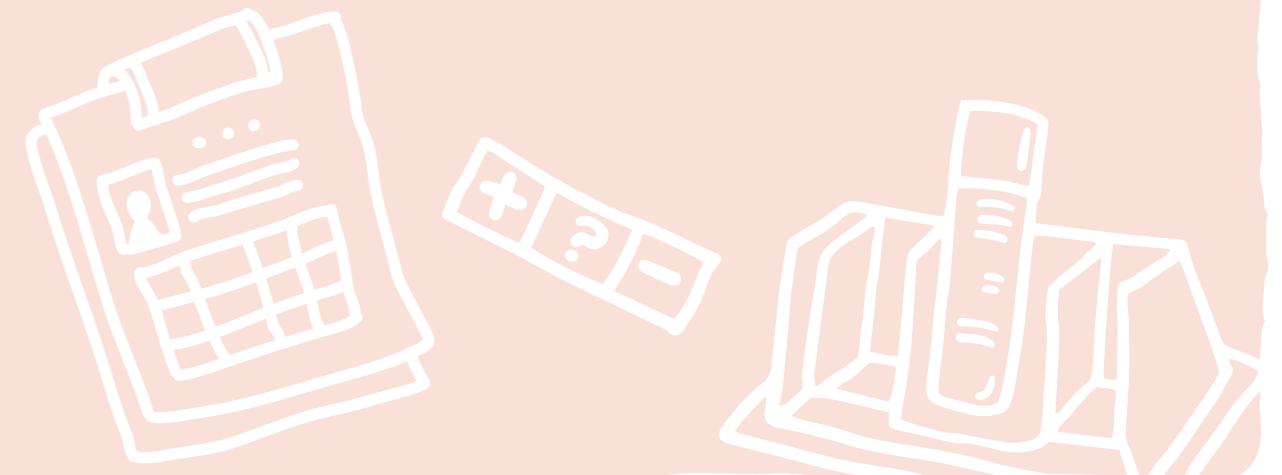
- 1. Integration** is the co-location and sharing of services and resources from different disease areas. In the context of HIV, for instance, integration may mean providing HIV testing, prevention, treatment and care services alongside services for TB, sexually transmitted infections (STIs), and hepatitis B and C, as well as screening and care for other conditions, including noncommunicable diseases.
- 2. Decentralization** means providing testing and other services in locations other than health facilities. Locating services closer to where people live can reduce transportation costs and waiting times, thus increasing uptake. Decentralized services may not be appropriate or acceptable to all potential users, as in some settings, centralized HIV services may provide greater anonymity for key populations or people who fear stigma and discrimination. In some low prevalence settings, decentralizing testing services may be inefficient and costly.
- 3. Task sharing** between healthcare providers and other lay workers can help address the needs of key populations and other groups that are reluctant or unable to access testing services in health facilities, linking them to services and providing ongoing care and support. Services led by trained lay providers, including peer-based interventions, can be a welcome and thus important means of delivering services, providing information and teaching skills that promote safer behaviours. Beyond providing services, lay workers who are peers of their clients can act as role models and offer non-judgmental and respectful support that helps to reduce stigma, facilitate access to services and improving their uptake.



NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE) RECOMMENDATIONS FOR HEPATITIS B AND C TESTING IN DRUG SERVICES

Drug services should undertake the following actions to provide effective hepatitis B and C testing.

- **Designate** a hepatitis lead for the service. This lead should have the knowledge and skills to promote hepatitis B and C testing, treatment and, for hepatitis B, vaccination.
- **Offer** and recommend hepatitis B and C testing to all service users.
- **Offer** annual testing for hepatitis C to people who test negative but remain at risk for infection.
- **Ensure** that people diagnosed with hepatitis B and C are referred to specialist care. For hepatitis C, that may involve offering treatment in the community for people who are unwilling or unlikely to go to hospital appointments, and whose treatment can be integrated with ongoing drug treatment.
- **Provide** access to dried blood spot testing for hepatitis B and C.
- **Make sure** that staff who undertake pre- and post-test discussions and dried blood spot testing have proper training and skills.
- **Make sure** staff have the knowledge and skills to promote hepatitis B and C testing and treatment.
- **Provide** information to women with hepatitis C about the importance of testing any children born after they became infected.
- **Provide** information to PWID about the importance of vaccinating sexual partners and children against hepatitis B.



2.2.3. CO-LOCATION OF SERVICES

See also Good Practice Examples 3, 4, 5 and 6.

When multiple medical and psychosocial services are located in the same facility, they are often integrated under the supervision of a single clinical team. Yet it is important to keep in mind that clients who use drugs are less likely to utilize conventional health services, while those who do not use drugs may regard integrated harm reduction, drug treatment, HIV and TB services unfavourably. In addition, HIV and TB medical providers may not wish to engage in drug use management, or they may not be comfortable working with people who use drugs. It is therefore worth considering integrated outreach services instead (see Box 9). Studies suggest that implementing integrated services in existing drug rehabilitation services or syringe exchange programmes could solve these issues (see Good Practice Example 3). Studies of integrated drug abuse treatment have shown that programmes integrating buprenorphine and HIV treatment have achieved improved clinical outcomes in the France, Ukraine and the United States.

A comprehensive review of data on the integration and co-location of different health services for PWID revealed that the current health policy paradigms for managing PWID services are fragmented, with financing and service provision often separated at the international, national and community level. There are three different location models of integration:

1. **SEPARATE HEALTHCARE SITES**, where frequent communication and coordination between the staffs is essential;
2. **PARTIAL INTEGRATION**, which primarily involves collaboration among different programmes for screening, testing and referral; and
3. **FULL INTEGRATION**, which provides “one-stop shopping” by utilizing an integrated team to provide comprehensive screening, testing, treatment and management services for each comorbidity (1).

While the full integration approach is considered ideal, it should be viewed as a goal to be achieved over time. Potential barriers include insufficient funding and organizational and political constraints that delay the implementation of integrated services.



“I was walking with one of my outreach colleagues in a park in central Helsinki and came across a group of Roma people. They had just injected in the park. After brief introductions, one of the men started throwing his arms about and describing how hepatitis virus can be caught from the air. We were able to tell him about hepatitis and how it’s transmitted, and at the same time refer the whole group to the nearest health advice point for drug users for hepatitis B vaccinations”.

—Outreach worker in Helsinki



GUIDELINES FOR PROVIDING INTEGRATED OUTREACH SERVICES

There are two main reasons to provide outreach. Either existing services are not reaching the target group effectively, or they are not offering interventions based on the group’s needs.

The chief aim of outreach work is to provide more accessible social and healthcare services to people in need.

Types of outreach

- **Detached outreach** is work undertaken outside of any agency contact and can take place on the street or in bars, cafés, clubs, squats, “shooting galleries”, railway stations and so on. Detached outreach aims to facilitate behavioural change, either directly or indirectly.
- **Domiciliary outreach** is undertaken in the homes of a target population. It is undertaken through regular visits to the homes of project clients, as well as the homes of dealers and home-based shooting galleries.
- **Peripatetic outreach** is undertaken in community-based agencies or organizations, such as prisons, housing projects, hostels, syringe exchange sites, brothels and schools. Instead of focusing on individuals, it focuses on organizations where target populations can be contacted.

Managing and leading outreach work

The managers of an outreach project should seek to internalize the ideological foundations of outreach work. They are responsible for obtaining adequate resources for outreach work (such as funding, workers, training and supervision), looking after workers’ safety and well-being, and promoting the professionalism of the work as a part of the service continuum, as well as organizing, leading and steering the work. For a complete understanding of the nature of outreach work, it is recommended that managers have personal experience doing it. That is not a necessity, however, and a lack of practical experience may make it easier to focus on management and maintain an overview of the work. Managers should be able to get information they need from their employees. Outreach work can sometimes provoke resistance and even attacks from people in the surrounding community. Outreach managers are responsible for justifying the work to the public and protecting their workers.

2.2.1. CROSS-TRAINING OF SPECIALISTS

See also Good Practice Example 8 and Box 11.

Comprehensive cross-training of healthcare specialists in the fields of drug use, HIV and other infections is required to provide effective management of multiple health conditions (19). Several challenges need to be addressed when training specialists.

- Lack of motivation and possible reluctance to put effort and time into learning new skills.
- Balancing work cultures. For example, there is a well-established standardized system of care for TB, including strategies for directly observed therapy, short course (DOTS), while HIV care tends to be more patient-centred.
- Lack of coordination among services, which can also become a barrier to treatment. Studies show that if there is not one clinician who coordinates the overall care of the individual patient, certain conditions may not get resolved properly due to providers expecting that someone else is dealing with them.

Case management by a group of specialists who meet regularly to coordinate their activities can help guarantee the rational organization, timely response and greater effectiveness of treatment. It is important to remember that in order to be integrated, co-located services also need to be coordinated; simply providing services at a single location does not ensure they will be integrated. Effective integration requires ongoing coordination of all aspects of service provision, including scheduling, patient turnover, equipment supply and information exchange.



SUMMARY: KEY ASPECTS OF SUCCESSFUL INTEGRATION PROGRAMMES

- Provision of screening and testing for each disease
- Co-location of services for the convenience of the target population
- Training of outreach workers, case managers, mid-level practitioners and physicians
- Enhanced monitoring of drug-drug interactions and adverse side-effects

2.3. SETTING UP MONITORING SYSTEMS



Monitoring is an essential part of successful integrated care programmes. Monitoring is the process of collecting and systematizing data on key programme indicators. Its purpose is to enable the evaluating and modification of activities to ensure rational use of resources and continuity of service provision, in order to achieve programme goals and identify opportunities for improvement.

Routine monitoring of integrated care programmes may include the following elements and indicators:

- **linkage to care** (number of referrals from other healthcare providers, outreach teams, NGOs, etc.);
- **diagnoses** (number of new tests conducted, number of new cases detected); and
- **service provision** (percentage adhering to treatment, percentage lost to follow-up, medication supply and stock-outs, number of newly trained specialists, feedback on service delivery from key populations).



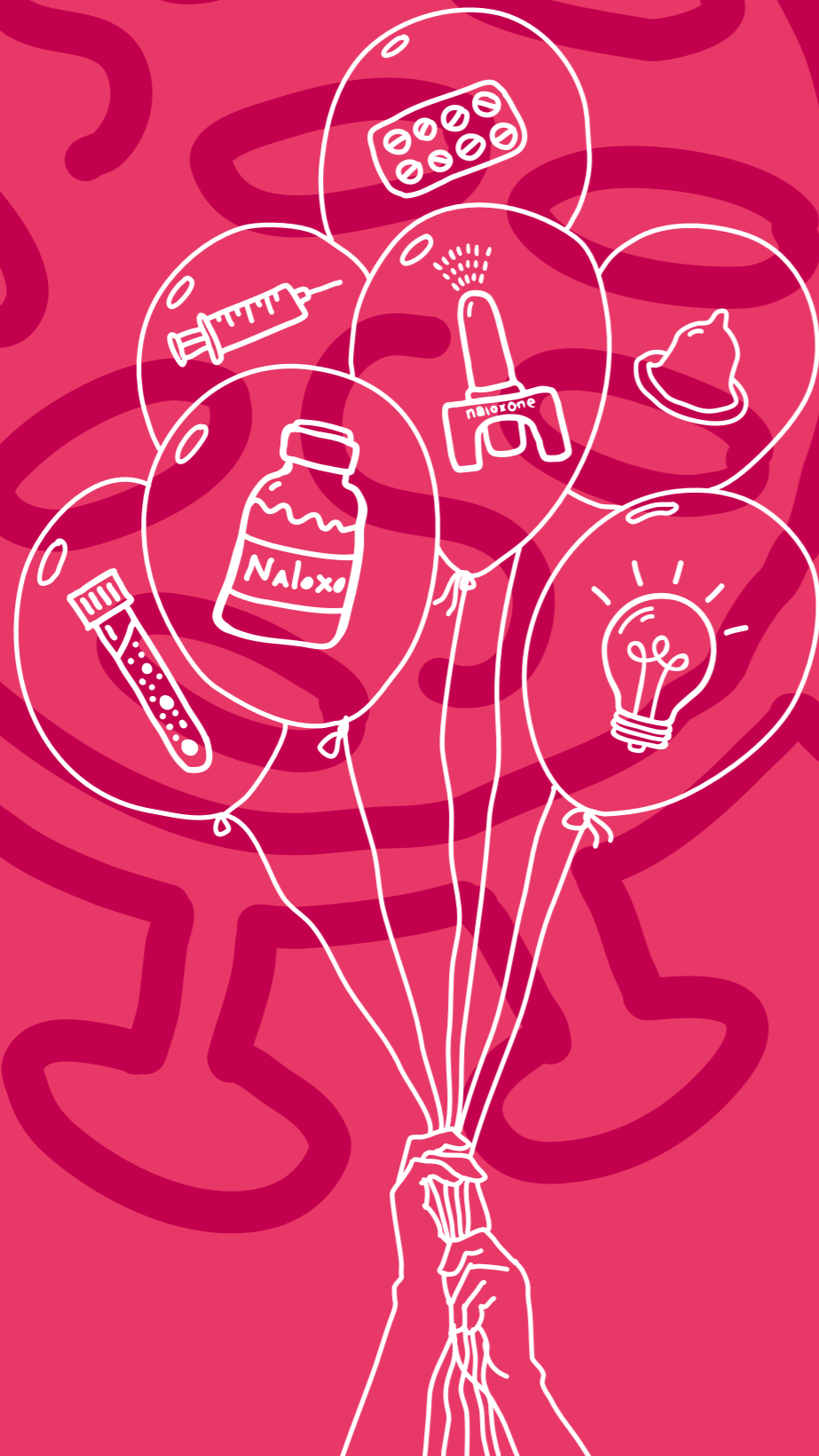
RECOMMENDATIONS FOR STAFFING OPTIONS WHEN INTEGRATING HEALTH SERVICES FOR PWID

A physician and a nurse are usually the key staff components for managing the delivery of integrated services, along with a psychologist and social worker. If any of the key service providers are unavailable, other options can be explored.

Alternatives for involving a physician, nurse, psychologist and social worker

- Introducing a new position to the staffing list
- Changing specialization within the existing staff
- Introducing part of a position to cover some part-time duties
- Arranging for workers from a different service provider to work certain hours
- Changing the job description an existing position
- Providing additional training for a specialist from a different specialty if their area of expertise permits
- Consulting with a specialist from a different health or social facility
- Contracting an external consultant

EXAMPLES OF INTEGRATED HEALTHCARE MODELS



3.1. INTEGRATED TREATMENT MODELS FOR DRUG USE, HIV AND TB



One of the reasons why PWID are in need of an integrated approach to TB treatment is that drug use is associated with worse health outcomes and lower rates of TB treatment completion than the general population. The differences are largely due to chaotic lifestyles, addictive behaviour and other psychological and social factors associated with addictive drug use. Irregular treatment also increases the risk of developing resistance to TB drugs. Early detection and treatment of TB in people living with HIV (PLHIV) is crucial to the control of both epidemics. PWID should be informed about their risk for TB and how they can be screened regularly.

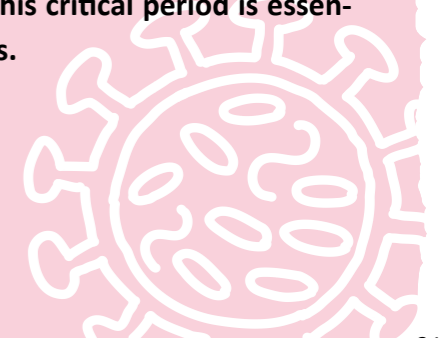
HIV and TB coinfection among PWID can have a negative impact on treatment adherence, as simultaneous treatment requires the consumption of large amounts of drugs. Drug interactions can negatively affect clients' physical well-being during treatment, so the additional support, treatment observation and counselling offered to all TB patients by healthcare facilities are critical to ensuring positive treatment outcomes. Integrated HIV/TB care has been shown to be an effective strategy in efforts to control both epidemics. Active referral pathways between TB, HIV and PWID services are very important.



FACTS AND STATS

While PWID may have an increased risk of acquiring TB independent of their HIV status, HIV infection further increases this risk. TB is one of the leading causes of mortality among PWID living with HIV. With early diagnosis, TB (including MDR-TB and extremely drug-resistant TB) can be cured in PLHIV, assuming that the treatment regime is adhered to properly. Isoniazid preventive therapy (IPT) and antiretroviral therapy (ART) are associated with reduced TB incidence in PLHIV, and IPT is currently recommended for all PLHIV where TB is prevalent.

According to research, HIV changes the clinical presentation of TB from a slowly progressing disease to one with a high mortality rate. TB-related mortality in HIV-coinfected patients is particularly high during the first months of TB treatment and intervening effectively during this critical period is essential to saving lives.



3.2. FIVE MODELS FOR ENTRY TO SERVICES FOR HIV/TB COINFECTION (5)

See also
Fig. 2

ENTRY VIA TB SERVICE AND REFERRAL FOR HIV TESTING AND CARE (“TB REFERS” IN FIG. 2).

MODEL 1

In this model, TB services refer patients to services providing HIV testing, whether or not they receive subsequent HIV care. It requires minimal extra logistic and financial input and can be achieved through joint training of healthcare workers from both programmes, modification of existing record-keeping systems and referral forms, and regular meetings of staff from both services to strengthen referral linkages. The strengths of this model include the simplicity and low cost of introducing the required measures. The key weakness is loss of patients if referral fails (e.g. due to lack or cost of transportation). This model may not be the best option in high HIV-prevalence settings, where both services should be as close and as integrated as possible.

ENTRY VIA TB SERVICE AND REFERRAL FOR HIV CARE AFTER HIV TESTING (“TB TESTS AND REFERS”).

MODEL 2

In this model, TB clinics offer HIV testing on site and refer people found to be HIV positive for HIV care. Depending on the HIV testing policy of the country and local HIV prevalence, this model may require additional HIV testing and counselling space as well as additional staff. Regardless of the test results, people who are tested for HIV should be provided with HIV prevention information. If referral for HIV care fails, the possible consequences include additional HIV transmission to partners and delays in initiating life-saving HIV care and treatment. The main barriers to integration are the additional financial and human resources needed to implement it.

ENTRY VIA HIV SERVICE AND REFERRAL FOR SCREENING, DIAGNOSIS AND TREATMENT OF TB (“HIV REFERS”).

MODEL 3

In this model, HIV services refer PLHIV for TB screening, diagnosis and treatment. Appropriate referral criteria and system are essential to the effective functioning of this model. Failure of the referral process can lead to ongoing TB transmission and progression of TB disease. This model requires relatively little additional logistical or financial input. The referrals are implemented by measures such as joint training of health workers from both programmes, use of existing record-keeping systems and referral forms and regular meetings between staff members of the two services.

ENTRY VIA HIV SERVICE AND REFERRAL FOR TB DIAGNOSIS AND TREATMENT AFTER TB SCREENING (“HIV SCREENS AND REFERS”).

MODEL 4

In this model, PLHIV are screened for TB and referred for TB diagnosis and treatment based on the outcome of the screening. The infrastructure needed for this model varies considerably, depending on whether the HIV clinic offers additional interventions on site, such as IPT or sputum sample col-

lection, which requires heightened infection control measures. There is no need to provide separate space for TB screening. The symptom-based screening algorithm recommended by WHO should be used, and PLHIV who are unlikely to have active TB should be given IPT.

The biggest challenge specific to this model is systematizing TB screening as part of routine HIV care. The WHO recommendations on intensified TB case finding – based on the presence of cough, weight loss, fever or night sweats – have helped increase screening coverage.

TB AND HIV SERVICES PROVIDED AT A SINGLE FACILITY (“SINGLE FACILITY”).

MODEL 5

This model includes patient-centred care provided by the same trained healthcare provider at the same visit, a “one-stop service”. Examples include a TB clinic providing HIV treatment, an HIV clinic providing TB treatment, a primary health centre providing integrated diagnosis and treatment for TB and HIV in one or two rooms, and a hospital providing integrated diagnosis and treatment for TB and HIV in one or two rooms. This model can be particularly efficient in settings with high HIV prevalence where most TB patients have HIV, as well as settings where the availability of human resources is an issue, as it avoids the need for referrals and offers patients better coordinated care. One concern with this model is the risk of nosocomial spread of TB. It should be noted, however, that the risk of TB transmission is not unique to this model, as it exists in general waiting areas of all health facilities with a high burden of TB, i.e., wherever coughing patients with undiagnosed pulmonary TB present regularly. Thus, implementation of proper infection control measures is crucial for all health facilities in high burden settings to minimize the risk of TB spreading nosocomially to immunosuppressed PLHIV.

One of the biggest challenges in the single-facility model involves the different cultures in the management of HIV and TB programmes and the differences in nurse roles in the two kinds of programme. Each type of programme can learn from the other about how to improve patient care; for example, the more patient-centred approach of ART programmes could be replicated in TB programmes. Other challenges in the single-facility model of integration involve over-rigorous adherence to ART programme guidelines. Such guidelines include requiring patients to attend adherence training sessions, even if very sick, or requiring that a “treatment buddy” accompany the patient, which may result in postponed treatment.

The single-facility model of care requires implementing several elements to work effectively, including training, linking providers within a facility and throughout its referral network, and maximizing access to existing support services. Nonetheless, this model appears to be preferable for patients, particularly those who are less well-off and will benefit from reduced travel costs. It should also overcome the problem of losing patients when referrals between separate services fail.

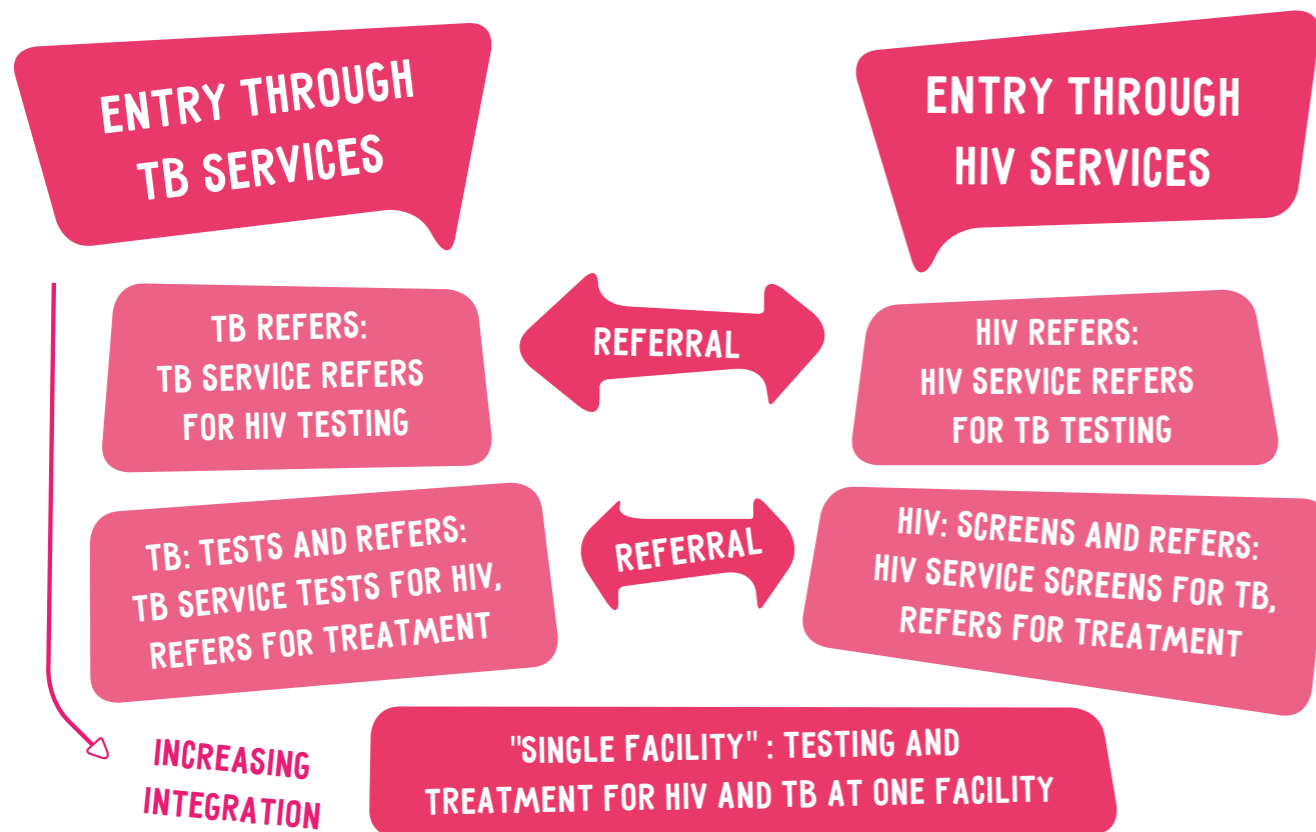


Fig. 2. Five-model framework

FACTS AND STATS

Studies suggest that ART can significantly reduce the risk of TB in PLHIV. Full TB/HIV care integration can lead to a 60% increase in the number of coinfecting patients who start ART, while reducing time to ART initiation by an average of 72 days. WHO recommends that ART should be started in all

TB patients who are also living with HIV, and that TB and HIV prevention, treatment and control activities be integrated to improve treatment outcomes and the quality of patient care. Research also shows that integrating ART with OST and TB treatment increases peer engagement in treatment.

3.3. INTERVENTIONS FOR IMPROVING ADHERENCE TO ART THAT ARE IN GLOBAL USE

DEVICES TO AID ADHERENCE.

Mobile-phone alarms and wall-chart reminders are used to increase ART adherence in China and in the United States, 76% adherence was achieved with electronic paging devices and medication event monitoring system pill caps. Also, in the United States, a combination of preloaded pillboxes, peer counselling and case management was associated with an undetectable viral load in 86% of patients who had previously not adhered to ART.

PEER COUNSELLING AT THE ART POINT OF CARE.

In 10 regions of the Russian Federation, peer counselling led to a 95% ART adherence rate retention among people who use drugs. As mentioned, a combination of peer counselling, case management and preloaded pillboxes improved ART adherence in the United States.

CASE MANAGEMENT.

In France, patients who had three counselling sessions with nurses in a 6-month period showed increased adherence and decreased viral load. In the United States, clinic visits and patient retention increased by 15%–18% as a result of case management and mental health or chemical dependency counselling.

INTEGRATED TREATMENT.

Ukraine integrated ART, TB and buprenorphine treatment, resulting in undetectable HIV viral loads, increased CD4 cell counts, and sputum-negative TB in many patients after 6 months. In the United States, integrating NSPs with ART resulted in undetectable viral load in 54% of clients, while 69% of clients chose to enter drug treatment.

DIRECTLY OBSERVED TREATMENT.

In the United States, direct administration of ART along with drug treatment counselling resulted in 76% adherence among people who injected cocaine, heroin or both. Among PWID receiving directly observed ART at their methadone maintenance site, 56% achieved an undetectable viral load, compared with 32% of those on methadone who administered their own ART. In the Russian Federation, PWID receiving directly observed community-based TB treatment achieved cure rates similar to those of people who do not inject drugs.

USE OF INCENTIVES. In the United States, PWID who were offered monetary incentives adhered to treatment at higher rates –71% with active outreach and 68% without it, compared to just 13% for those with active outreach and no incentives (see Box 9). In other study patients who were offered vouchers for adherence to ART or methadone achieved 78% adherence, compared to 56% among those who were not offered vouchers.

3.1. PRINCIPLES OF INTEGRATING HEPATITIS B AND C CARE

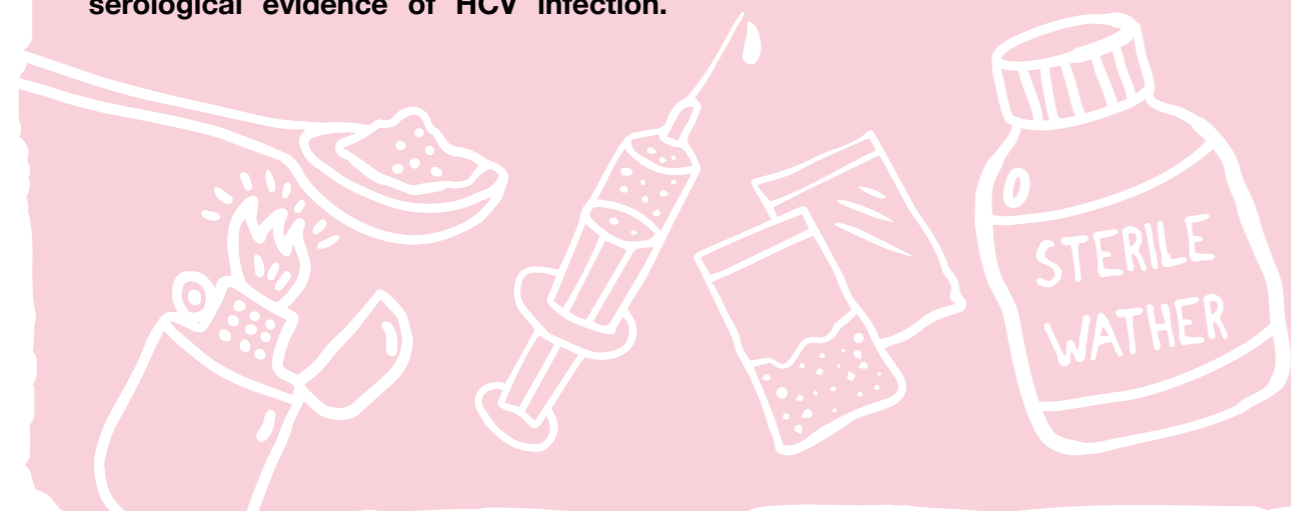
Among PWID, HCV is estimated to be transmitted 10 times more efficiently than HIV. HCV infection can result not only from the sharing of syringes, but also from the sharing of other injection equipment, such as “cookers” (such as bottle caps, spoons and other containers used to dissolve drugs) and “cottons” (filters used to remove particulate matter while drawing up the drug solution into a syringe). Studies have shown that screening and testing for HCV antibodies should be accompanied by client-centred counselling based on individualized behavioural risk assessments. HCV services should be available either on site or by referral in all public programmes and institutions serving people who use illicit drugs, including public health clinics and hospitals, NSPs, HIV prevention programmes, substance abuse treatment programmes, correctional institutions, programmes for high-risk youth, HIV counselling and testing sites, STI clinics, mental health clinics and psychiatric hospitals.



FACTS AND STATS

In middle- and high-income countries, most HCV infections occur among people who use unsterile injecting equipment and contaminated drug solutions. Of the estimated 16 million people in 148 countries who actively inject drugs, 10 million have serological evidence of HCV infection.

PWID infected with HCV are at increased risk of all-cause mortality, reflecting the combined role of injecting drug use, low socioeconomic status, poor access to healthcare and environmental factors.



A growing number of programmes are successfully integrating HCV care into a variety of healthcare settings, including primary care, methadone maintenance treatment, other substance abuse treatment programmes and infectious disease clinics. For example, among HIV/HCV coinfecting patients on highly active ART, enrolment in OST is associated with reduced heroin use, improved adherence, HIV-1 RNA suppression and CD4 cell count response. Healthcare managers need to address the specific challenges faced by PWID in terms of adherence, adverse psychological effects and the risk of reinfection. As DOTS has proven to be highly effective in improving the adherence rates for TB treatment in PWID, a similar approach may be successful for HCV treatment in PWID, especially in combination with OST.

The following strategies to address barriers to adherence have also proven to be effective.

- **Tools** such as electronic reminder systems and cash incentives for attending scheduled medical appointments have been shown to improve adherence.
- **Weekly peer support** coupled with multidisciplinary care (including treatment for HCV infection) is an effective strategy to engage people who use drugs in HCV care.
- **Better education of physicians** and other healthcare providers on drug use, addiction and harm reduction approaches is needed to improve their understanding of problem drug use as a treatable disorder. It is important to improve the ability of hepatitis specialists to manage care for people who use drugs, and of addiction specialists to manage treatment of HCV.



See also
Guideline 5.

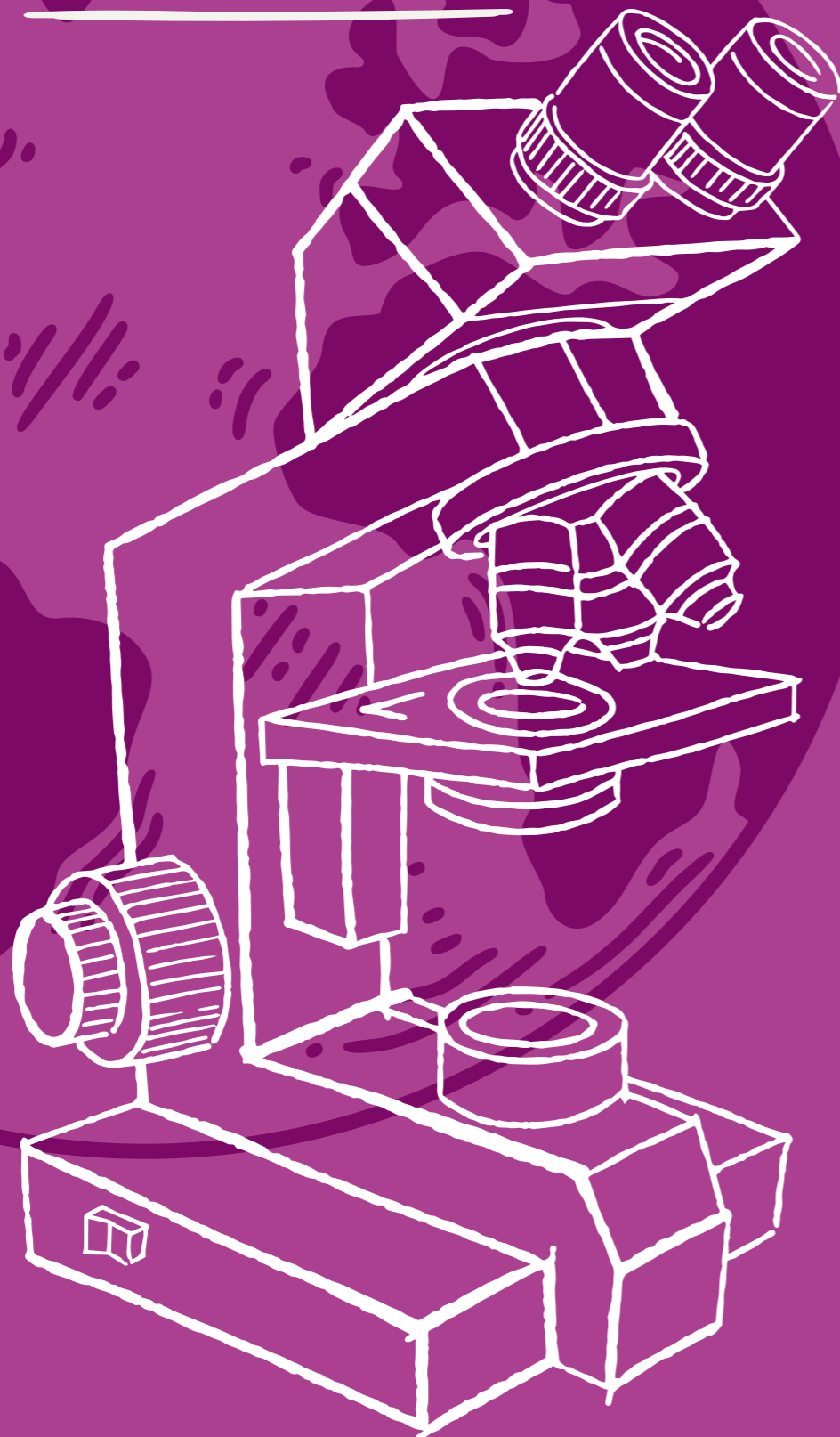
GUIDELINES ON HCV TREATMENT

WHO recommends offering treatment to all individuals diagnosed with HCV infection who are 12 years of age or older, irrespective of disease stage. Also, WHO recommends the use of pangenotypic DAA regimens for the treatment of persons with chronic HCV infection aged 18 years and above. It is generally cost effective to treat

HCV-infected PWID, but cost-effectiveness is influenced by the potential for preventing new infections and by the risk of reinfection. Effective HCV treatment requires collaboration among experts in hepatitis, drug use and addiction, and mental health to create treatment models specifically designed for PWID.



LESSONS LEARNED AND EXAMPLES OF GOOD PRACTICE



4.1. LESSONS LEARNED FROM INTEGRATING HEALTHCARE SERVICES FOR PWID IN PORTUGAL



Collaboration and communication among treatment centres is crucial in order to achieve effective HIV, TB and drug dependency care. It is important to organize cross-specialty trainings and meetings. Formal referrals between HIV clinics and other treatment centres can often be hindered by bureaucracy and a lack of shared protocols. Informal professional networks can be more flexible and provide access to appointments, which has proven particularly important in getting clients referred by outreach teams into services. Good rapport with colleagues produces timely and effective access to services – something that is especially important when coordinating OST with other medications.

The central role of outreach services (see Box 9). Outreach teams working in collaboration with drug treatment centres, hospitals and HIV clinics are able to improve treatment adherence and attendance at follow-up consultations. Outreach teams can perform several useful actions:

accompany clients to services;

- provide support for clients with financial difficulties and reduced capacity for self-care;
- alleviate client fears of withdrawal due to the perceived difficulty of securing OST; and
- communicate with drug treatment centres and treatment providers and facilitate monitoring of treatment – something that is essential when trying to engage PWID in concurrent HIV, TB and drug dependency care.

Flexibility of treatment locations. Co-located services, whether achieved through a combined or collaborative model, is valued highly by clients in Portugal. The possibility of attending a treatment centre near one's home and of transferring to a more conveniently located service improves HIV and TB service attendance. The opportunity to receive home-based DOTS and OST in combination is critical to adherence for immobile or physically weak clients.

Acknowledgment of clients' agency. Incentives such as travel reimbursements and meal coupons reduce financial and logistical barriers to accessing services. Engagement in multiple treatment services depends primarily on individual motivating, making it crucial to recognize clients' agency. A good client-provider relationship is key to clients' engagement in services – particularly for those with limited social or family support.

Recognition of the broader health and social care needs of PWID. Consideration of broader health and social care needs, such as housing and social security, is critical for engaging with clients. The limited involvement of primary healthcare specialists and discrimination are still concerns. The absence of stigma in treatment services that work with PWID is valued highly.



4.2.

GOOD PRACTICE EXAMPLES OF INTEGRATED CARE SERVICE PROVISION FOR PWID



GOOD PRACTICE EXAMPLE 1. Early detection services in Portugal

Drug treatment centres in Porto and Vila Nova de Gaia, Portugal, offer HIV, TB and HCV screening to new clients. The services they offer include the following.

- Rapid on-site HIV testing is offered routinely, free of charge and anonymously at designated testing centres in each district. Clients with a positive result are referred to a contracted private laboratory for confirmatory testing and, if the result is confirmed, to HIV clinics for care.
- HCV screening is prescribed on site, but clients must select a private laboratory at which to be tested.
- For TB screening, clients receive a written referral form and are asked to attend a pulmonary diagnostic centre before bringing their results back to the drug treatment centre at their next appointment.
- Clients who entering a detoxification unit or therapeutic community are screened for HIV and HCV. The blood samples are collected on site and sent to a private laboratory, and the patient is accompanied to the nearest pulmonary diagnostic centre for TB screening.



GOOD PRACTICE EXAMPLE 2. Prison health services in Portugal: OST, on-site screening and treatment referral

All new prisoners are screened for HIV, TB, HBV and HCV and referred as needed to civilian treatment centres, accompanied by prison guards. Treatment is administered via direct observation in the prison setting. All prisons can offer OST on site. In 2007, a pilot NSP was implemented in two prisons, but since 2012, no prisoners have used this service



GOOD PRACTICE EXAMPLE 3. Integrated health service models for PWID in Ukraine

Ukraine is a country where HIV treatment outcomes are comparatively poor and HIV transmission rates still rising (31). In a cross-sectional study, 296 HIV-positive opioid-dependent PWID were randomly selected from two HIV-endemic regions in Ukraine. Three different healthcare settings were studied: integrated, fully co-located services; services that were not co-located; and harm reduction and outreach sites. The majority of Ukraine's 141 OST sites are not co-located. Harm reduction and outreach sites have been available in Ukraine since 2001. In 2008, three pilot sites that were integrated and co-located were established, in Kiev, Dnipropetrovsk and Simferopol, with 20 additional sites being added later.

The services provided in these settings in addition to OST are as follows.

- The integrated, co-located settings provide free on-site treatment and screening services for HIV, TB and opioid dependence.

- Non-co-located services provide substance abuse treatment counselling only with OST.
- Harm reduction and outreach sites provide syringe exchange, case management, referral to additional services (including HIV and TB services), and psychosocial counselling without OST.

OST is provided free of charge. Enrolment in OST requires opioid dependence, at least two years of drug use and governmental "registration", which is often linked to the loss of a driver's license and employment restrictions. OST requires on-site daily observed administration, as distribution for home use is not allowed.

The study (31) showed that integrating multiple services into one setting helps HIV-infected PWID on OST to access ART better, even compared to those receiving OST at the sites that are not co-located. The study also showed that OST reduced injection frequency and increased abstinence, regardless of the service delivery strategy. These results are in line with previous findings from North America, where methadone and buprenorphine treatment increased the likelihood of ART prescription and retention.

As TB is the leading cause of death among PLHIV in Ukraine, there is a national requirement that all OST clients have to be screened for it annually. TB screening in this study sample was extremely high – 89%. The results show that the clients in both the integrated and the non-co-located groups were equally likely to be screened for TB, but those in the integrated group were significantly more likely to receive IPT. Further reductions in morbidity among clients of the non-co-located services could be achieved by providing them with integrated, co-located services.

A health-related quality of life score was used to assess perceived individual well-being and function when participating in OST. The findings confirmed that OST in itself is associated with improved general, physical and mental health, regardless of how services are organized (31). Quality health-care indicator scores were used to represent the percentage of the recommended indicators met for HIV, addiction and TB treatment. The results suggest that receiving care in integrated settings can improve this score, as these indicators were significantly higher in patients receiving integrated care. These findings provide empirical data showing that integrated care for HIV-positive PWID has the potential to improve the individual health of PWID as well as improving public health outcomes.



GOOD PRACTICE EXAMPLE 4. Clinic-based treatment versus referral in the United States

A randomized controlled trial was conducted among opioid-dependent PLHIV to compare HIV clinic-based treatment with buprenorphine to case management and referral to an opioid treatment programme.

After a two-day buprenorphine induction, the HIV clinic participants received BUP doses at the clinic three times a week for 2–4 weeks until they were stabilized. At each clinic visit, they also received unstructured individual counselling, provided urine samples, took buprenorphine doses under observation and received take-home supplies of buprenorphine to last until their next visit. A treatment team of the met weekly to discuss treatment progress.

The results show that the management of HIV-infected, opioid-dependent patients with clinic-based buprenorphine improved the outcomes of substance abuse treatment. Over the 12-month assessment period,

- the clinic-based participants had significantly more visits with their primary HIV care provider than the referral group (median 3.5 visits vs. 3.0 visits, $p = 0.047$);

- the clinic participants were significantly more likely to participate in drug treatment than the participants who were referred to treatment (74% vs. 41%, $p < 0.001$);
- the average estimates of opioid use were significantly lower among the clinic participants than the referral participants (44% vs. 65%, $p = 0.015$) (36).



GOOD PRACTICE EXAMPLE 5. Pharmacy-based TB care in Valencia, Spain

In Valencia, Spain, PWID who were TB patients were referred to the nearest community pharmacy for their TB treatment. Trained pharmacists supervised DOTS, emphasized the importance of adherence, reminded patients of upcoming TB appointments and followed up on non-attendance. In collaboration with a hospital-based social worker, the pharmacists also supervised access to OST and assistance with travel, food and housing. Compared to a retrospective cohort of demographically similar patients receiving self-administered TB treatment, adherence was three times higher (66% versus 22%).



GOOD PRACTICE EXAMPLE 6. Integrated treatment system in Porto and Vila Nova de Gaia, Portugal

The cities of Porto and Vila Nova de Gaia in Portugal have several outreach teams that provide mobile needle exchange and OST, as well as screening, treatment referral and psychosocial support. Additionally, there are four treatment teams/drug treatment centres, two pulmonary diagnostic centres, one HIV testing centre, and four hospitals providing HIV and HCV care.

TWO MODELS OF INTEGRATED DRUG TREATMENT, HIV AND TB SERVICES

A **combined model** was implemented in the combined therapy centre at Joaquim Urbano Hospital. It was set up in 1998 to provide integrated outpatient HIV, TB, HCV and drug dependency care in a dedicated facility.

OST, ART and TB treatment are delivered daily under direct observation, managed by a multidisciplinary team of infectious disease specialists, psychiatrists, psychologists, social workers, nurses, and “social mediators” under combined care protocols, enabling co-located, integrated care from the outset. HCV treatment is also delivered on site, in contrast to the other centres across the country, which dispense medication for home administration. An outreach team provides home-based treatment for those who are physically unable to attend consultations.

The combined therapy centre requires daily visits. Service providers use incentives to encourage HIV and TB treatment adherence, including travel passes, snacks, and the use of informational and recreational facilities offering computer and Internet access, reading materials and sporting activities. Patients who achieve a suppressed viral load, good treatment adherence and a stable lifestyle can be transferred to the hospital’s adjacent outpatient HIV service, where they receive ART supplies each month.

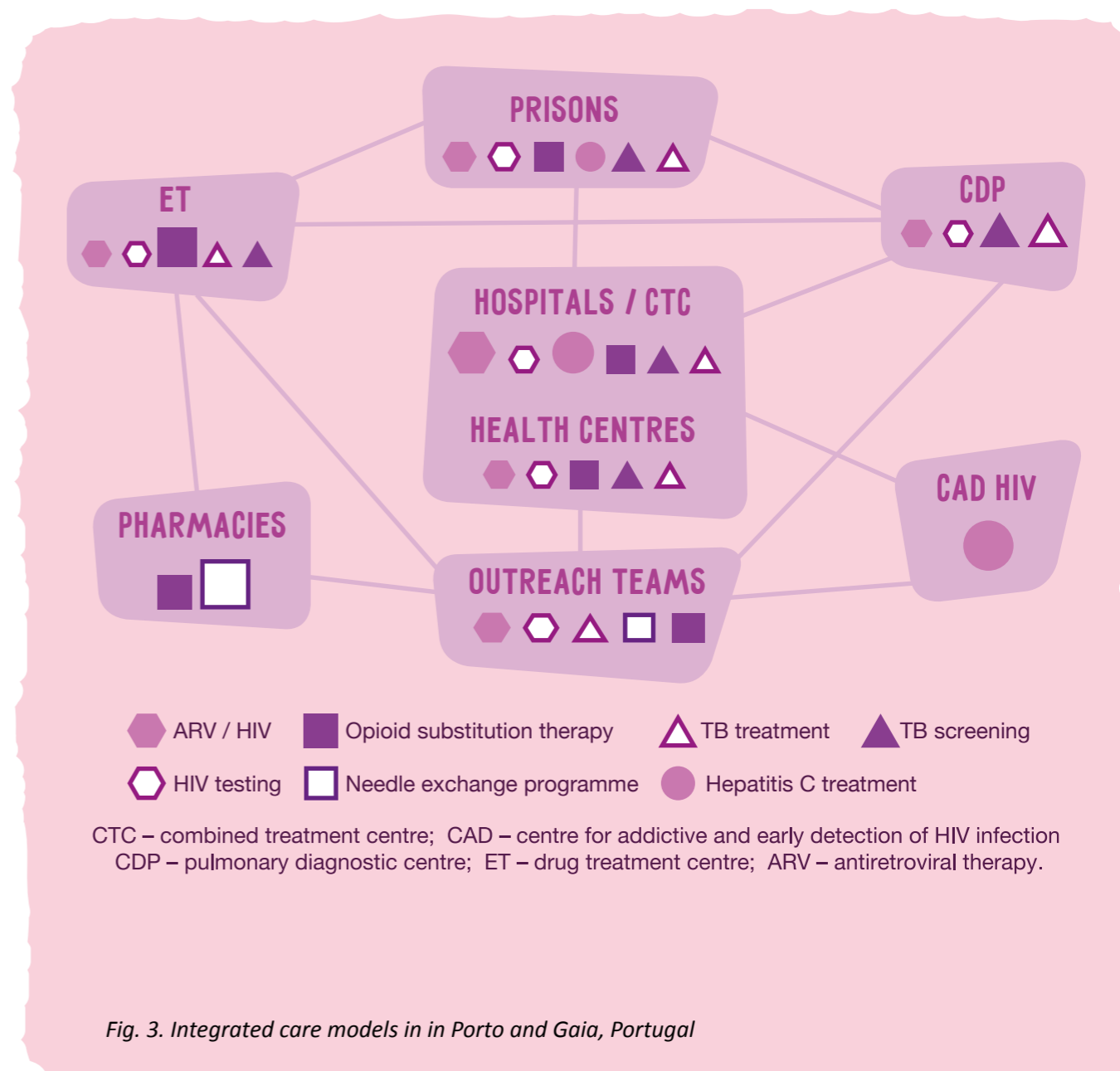
In the **collaborative model**, HIV, TB, HCV and drug dependency care are delivered by separate services, but collaboration among pulmonary diagnostic centres, HIV/HCV clinics, drug treatment centres, outreach teams, sheltered housing and clients permit the delivery of client-centred treatment in a single healthcare or community setting or at home. For example, the NGO-supported outreach program GiruGaia offers a combined therapy programme for PWID who have minimal social support, substantial social care needs and difficulty adhering to OST. It provides daily supervised methadone

therapy, HIV treatment and TB treatment in collaboration with drug treatment centres, HIV clinics and pulmonary diagnostic centres. According to one provider at a pulmonary diagnostic centre, “We have six patients at the day hospital, one in the health centre, ten who receive home treatment and five who basically pick when it is most convenient for them to receive treatment. We don’t have anyone being treated by the street [outreach] teams [at the moment] – we don’t but we could.”

Treatment outcomes

According to WHO estimates, by the end of 2010, a total of 21 000 ET clients were enrolled in OST, with 77% receiving methadone and 23% buprenorphine. Approximately 4800 clients discontinued methadone treatment that year, most of them of their own accord but 14% of them with medical release. A bit less than half of the enrolled pharmacies (226 of 498) were delivering OST and supervising methadone, to 714 clients (compared to 579 clients in 2008). In the community served by GiruGaia, 60 of the 75–80 outreach clients were receiving methadone.

In 2009, around 5400 PWID were receiving HIV care via hospital-based outpatient clinics in Portugal, 33% of them in the Porto district, though data were only available from half of the hospitals. PWID represented approximately a third of all patients receiving HIV care, both nationally and locally.



Of the clients who had acquired HIV through injecting drug use, 23% of those at drug dependence centres and 69% of those at day-care centres were receiving ART. In 2010, 182 clients across Portugal (including but not limited to PWID) were receiving ART at drug dependence centres, while 105 were receiving both OST and DOTS at these centres. In order to improve TB case detection and access to care, a collaborative approach that encouraged referral to drug dependence centres for TB screening was initiated that involved not only the drug dependence centres but also hospitals, the public health department, homeless shelters and outreach teams. The number of PWID screened for TB increased almost fourfold from the period prior to this intervention, and treatment outcomes also improved, with non-adherence falling from 48% to 24% and deaths from 18% to 14%. No data were available on the number of PWID receiving HCV treatment.



GOOD PRACTICE EXAMPLE 7.
TB screening and drug treatment collaboration in Estonia

A small randomized controlled trial among OST centre clients showed that supervised referral to TB services was highly effective. All clients at the centre were offered incentivized screening for latent TB infection, using tuberculin skin tests and interferon-gamma release assays. Those with positive results were randomized to receive either an active referral – in which an OST centre nurse scheduled a TB clinic appointment, provided a reminder and organized transport – or a passive referral – in which the client scheduled their own appointment. Clients receiving an active referral were found to be almost four times more likely to attend TB services, after controlling for age, gender, education, employment status, injection history, incarceration history, previous TB contacts, and the results of skin tests and HIV tests. The active referrals were shown to be cost-effective and popular with clients, and they did not present any major recruitment or referral challenges for the staff.



GOOD PRACTICE EXAMPLE 8.
Integrated HIV/TB treatment model in South Africa

Inadequate training of healthcare professionals involved in integrated HIV/TB treatment can lead to their resisting integration efforts. In a South African township, an HIV/TB team comprised three nurses, one mobile doctor, one TB data clerk and one person responsible for HIV counselling and testing. A nurse-mentor, a counsellor-mentor and a data clerk-mentor were added to the team to develop the skills of the existing staff, provide support for the management of HIV/ART activities and alleviate the staff workload. In the new model, ART initiation and ART follow-up were integrated into TB services as a “one-stop shop” model of care. Both types of services were delivered by the same health professionals at a single-entry point. The integrated approach was implemented at three levels in the health clinic:

- 1. administrative**, in which one facility manager oversaw the provision of all HIV and TB services;
- 2. healthcare provision**, in which the same doctor, nurse, counsellor, pharmacist assistant and clerk attended to all patients, regardless of their diagnosis; and
- 3. monitoring and evaluation**, in which a single health information system recorded data for both diseases in one patient file.

The health clinic provided integrated TB and HIV case management (including pre-ART care, ART initiation and follow-up), STI prevention and management, HIV counselling and testing, and family planning. Once a week, the mobile doctor attended complicated medical cases and initiated ART when indicated. The clinic enrolled patients with HIV and/or TB. Patients beginning ART had three pre-treatment counselling sessions; TB patients received DOTS for the first two weeks. Afterwards, coinfecting patients who were stable, and adherent collected their antiretroviral drugs monthly and TB drugs weekly or monthly from the same pharmacy.

Each patient had his own medical file containing notes, counselling sheets, screening tools and prescription charts. Medical follow-up data were routinely entered into paper registers for ART and TB. The patients who received care through this integrated model were found to be 60% more likely to initiate ART, while the estimated median time from TB treatment start to ART initiation decreased. The study authors concluded that promoting TB/HIV service integration in high TB/HIV prevalence settings can shorten time to ART initiation and will presumably reduce mortality and morbidity rates (12).

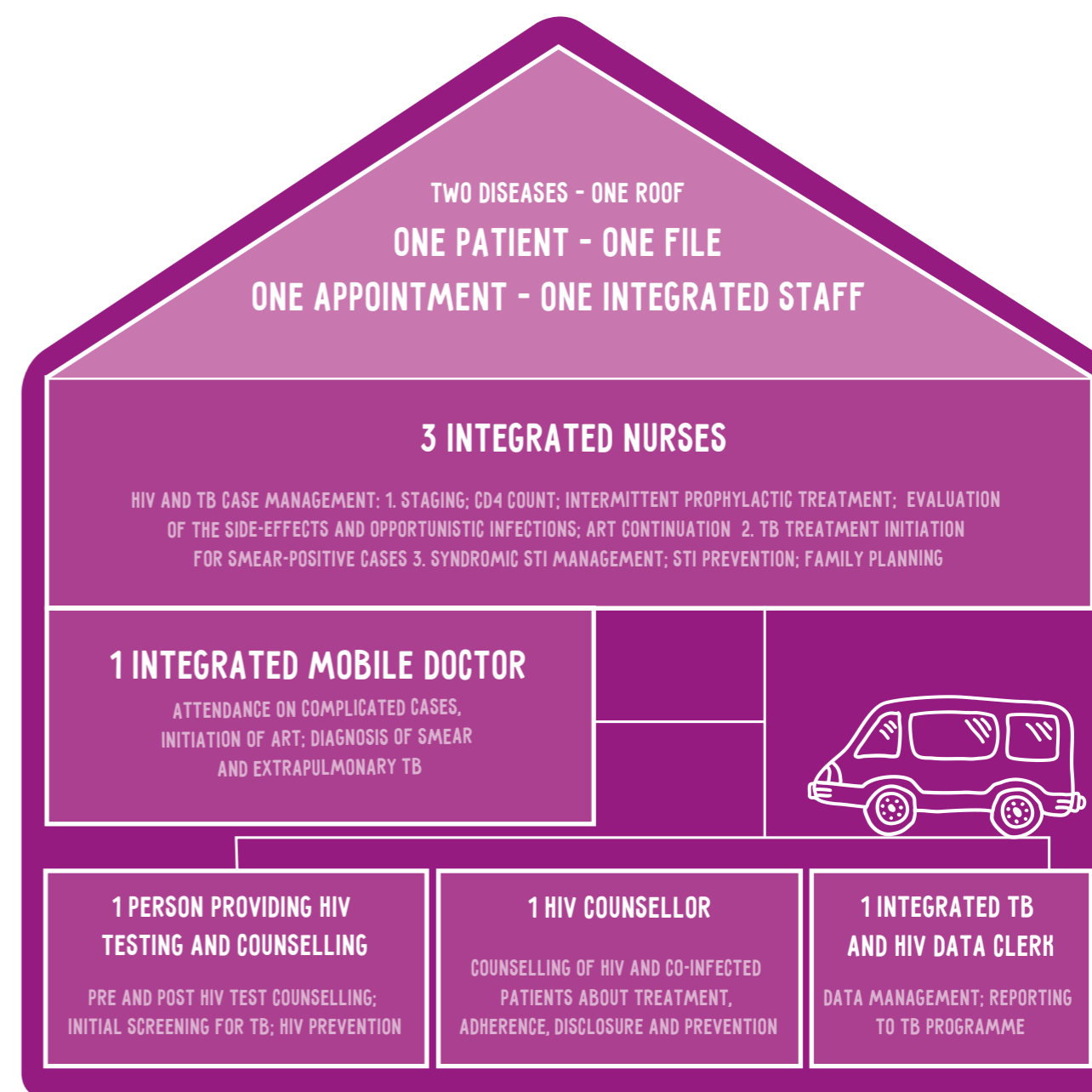
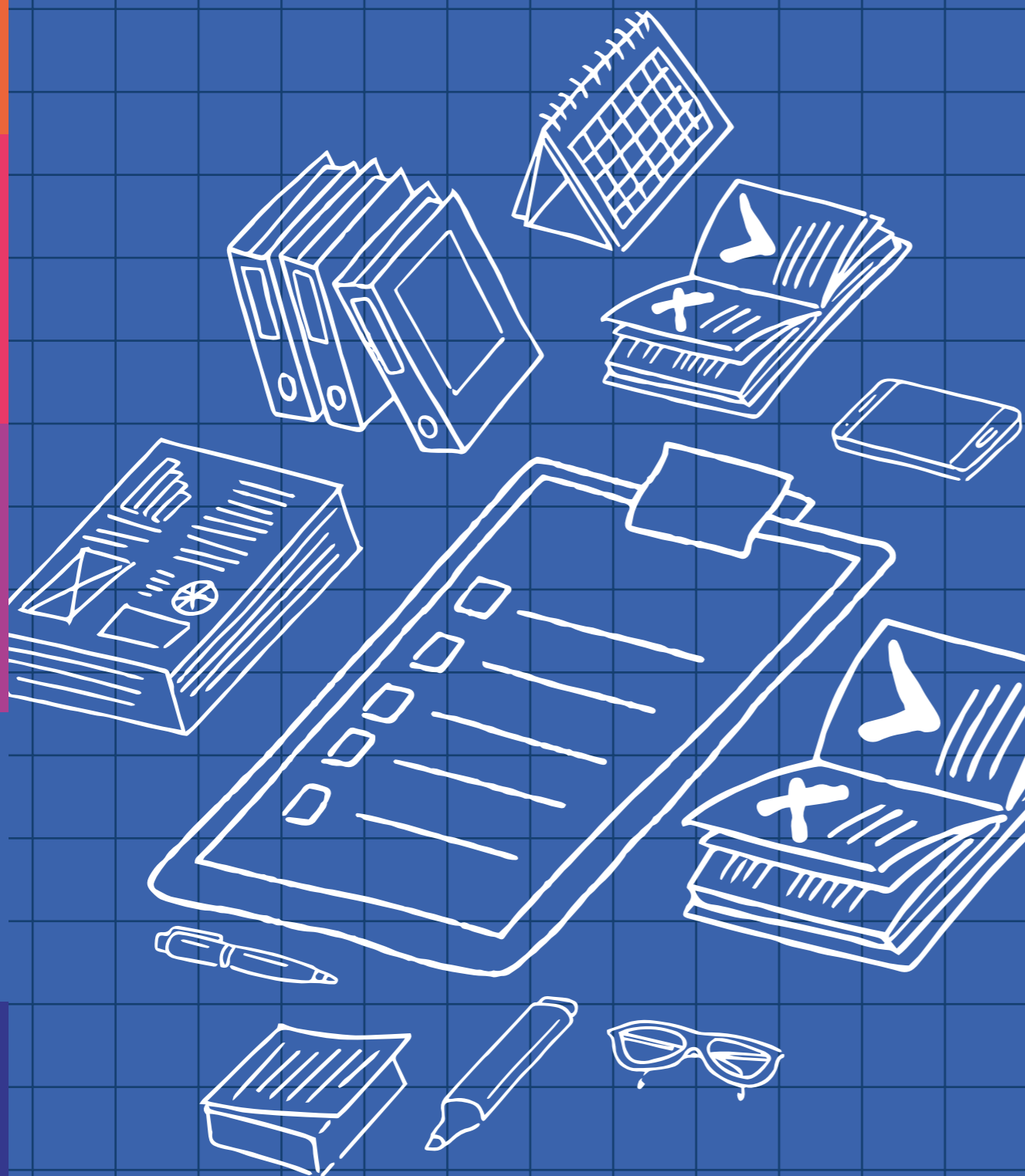


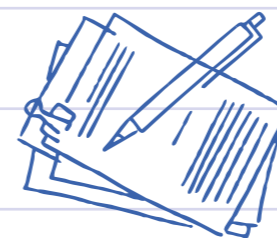
Fig. 4. Model of integrated HIV/TB at a primary care clinic in South Africa

SHORT SUMMARIES OF USEFUL GUIDELINES



5.

ECDC/EMCDDA GUIDELINES ON INFECTIOUS DISEASE PREVENTION AND CONTROL AMONG PWID

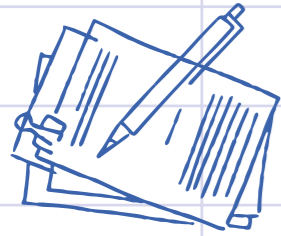


GUIDELINE 1.

ECDC/EMCDDA GUIDELINES ON INFECTIOUS DISEASE PREVENTION AND CONTROL AMONG PWID

The ECDC/EMCDDA guidelines entitled Prevention and control of infectious diseases among people who inject drugs provide a comprehensive overview of the best current practices in infectious disease interventions for PWID. Combining or integrating the following seven interventions can substantially minimize the risk of infections and enhance treatment success:

- 1. injection equipment:** provision of and legal access to clean drug injection equipment, including a sufficient supply of sterile needles and syringes free of charge, as part of a combined multicomponent approach implemented through harm-reduction, counselling and treatment programmes (see Section 1.3)
- 2. vaccination:** hepatitis A and B, tetanus, influenza and, particularly for PLHIV, pneumococcal vaccines;
- 3. drug dependence treatment:** OST and other effective forms of drug treatment (see Section 1.3);
- 4. testing:** routine offer of voluntary and confidential testing with informed consent for HIV, hepatitis C, hepatitis B for those who are not vaccinated, TB and other infections, together with linkage to care for those who test positive
- 5. infectious disease treatment:** ART and antiviral treatment based on clinical indications for people diagnosed with HIV, HBV or HCV; TB treatment for active TB cases and TB prophylactic therapy for latent TB cases; and treatment for other infectious diseases as clinically indicated;
- 6. health promotion:** activities to promote safer injecting behaviour, safer sexual behaviours including condom use, disease prevention, testing and treatment; and
- 7. targeted delivery of services:** combining, organizing and delivering services in accordance with user needs and local conditions, including outreach and fixed-site services for drug treatment, harm reduction, counselling and testing, as well as referrals to primary and specialist healthcare services.

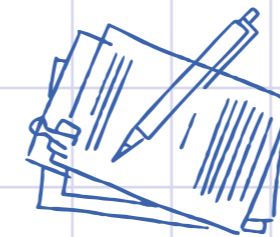


WHO/UN/UNAIDS GUIDELINES FOR COLLABORATIVE TB AND HIV SERVICES

Policy guidelines for collaborative TB and HIV services for injecting and other drug users: an integrated approach includes the following recommendations.

GUIDELINE 2.

- There should be **multisectoral coordination** at the local and national levels to plan, implement and monitor TB and HIV activities for people who use drugs, using existing mechanisms if possible.
- The **national strategic plans** for TB, HIV and substance misuse should clearly define the roles and responsibilities of all service providers who provide services to people who use drugs. These plans should also require the monitoring and evaluation of TB and HIV activities for this target group, including treatment outcomes
- **Human resource planning** should ensure that there are adequate numbers of personnel and that education and training programmes are designed to build sustainable, effective teams, so that all personnel who have contact with people who use drugs have the appropriate skills for dealing with TB, HIV and drug use (40 p. 18)
- All stakeholders in collaborative TB/HIV services for people who use drugs should support and encourage **TB/HIV operational research** to develop the evidence base for efficient and effective implementation of collaborative TB/HIV activities
- All settings where people congregate in the health, drug service and criminal justice sectors should have a **TB infection control plan** supported by all stakeholders that includes administrative, environmental and personal protection measures to reduce the risk of TB transmission
- All services dealing with people who use drugs should have a **case-finding protocol** for TB and HIV so that personnel are aware of the symptoms of TB and HIV and can ensure that people who use drugs have access to appropriate TB and HIV testing and counselling, preferably at the service where they initially present
- TB and HIV services and services for people who use drugs should ensure that this target group has **access to appropriate treatment** by using global, regional and national clinical guidelines. These services should work in collaboration to ensure treatment supervision and to simplify treatment delivery
- All health services should ensure **access to IPT** for PLHIV positive people who use drugs, once active TB is reasonably excluded
- All personnel working with people suspected or diagnosed with TB, PLHIV and people who use drugs should be able to **assess risk factors** for HIV infection and transmission and should provide comprehensive HIV prevention information and services to their clients to minimize these risks. Personnel should also be aware of how to protect themselves from occupational exposure to HIV and TB



WHO GUIDELINES FOR COLLABORATIVE TB AND HIV ACTIVITIES

Policy on collaborative TB/HIV activities is a compilation of WHO recommendations, based on TB and HIV guidelines and policy recommendations that were developed by WHO's Stop TB and HIV departments.

GUIDELINE 3.

The policy recommends using a simplified clinical algorithm for TB screening that relies on the absence or presence of four clinical symptoms – current cough, weight loss, fever and night sweats – to identify people eligible for IPT or further diagnostic workup.

The policy also recommends offering routine HIV testing to patients with presumptive or diagnosed TB, as well as their partners and family members, as a means of reducing the burden of HIV. TB patients who are found to be HIV-positive should be provided with cotrimoxazole preventive therapy. ART should be initiated for all HIV-positive TB patients as soon as possible in the first eight weeks of commencing TB treatment, regardless of CD4 cell counts. TB patients and their family should all be offered HIV prevention services.

WHO states that HIV and TB control programmes “should collaborate with other programmes to ensure access to integrated and quality-assured services for women, children, prisoners [see Good Practice Example 2] and for people who use drugs; this [latter] population should also receive harm-reduction services, including drug dependence treatment in inpatient and outpatient settings.”

RECOMMENDED COLLABORATIVE TB/HIV ACTIVITIES

A. Establish and strengthen the mechanisms for delivering integrated TB and HIV services.

1. Set up and strengthen a coordinating body for collaborative TB/HIV activities that is functional at all levels.
2. Determine HIV prevalence among TB patients and TB prevalence among PLHIV.
3. Carry out joint TB/HIV planning to integrate the delivery of TB and HIV services.
4. Monitor and evaluate collaborative TB/HIV activities.

B. Reduce the burden of TB in PLHIV and initiate early ART

1. Intensify TB case-finding and ensure high-quality TB treatment.
2. Initiate TB prevention with IPT and initiate early ART.
3. Ensure control of TB infection in healthcare facilities and settings where people congregate.

C. Reduce the burden of HIV in patients with presumptive and diagnosed TB.

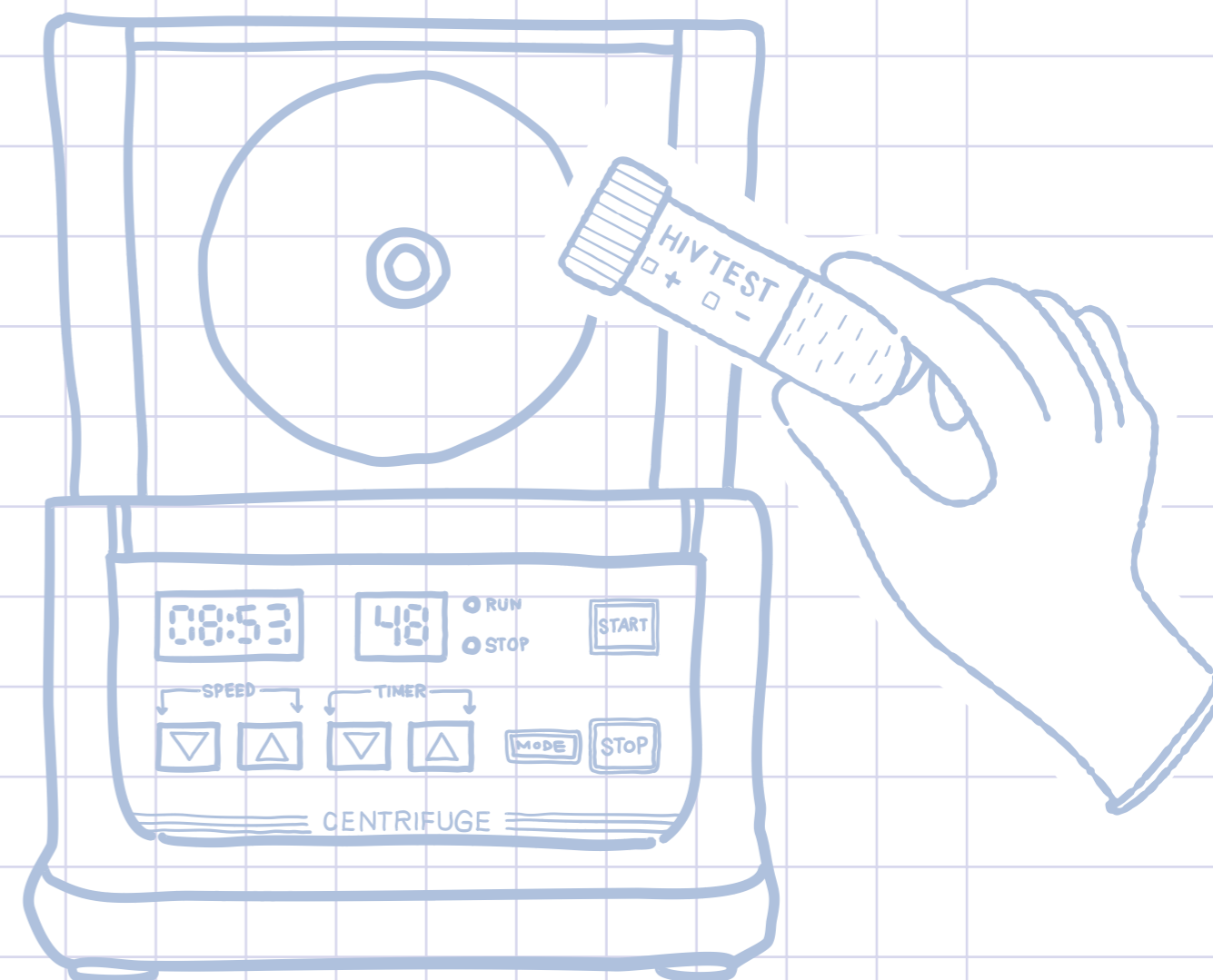
1. Provide HIV testing and counselling to patients with presumptive and diagnosed TB.
2. Provide HIV prevention interventions for patients with presumptive and diagnosed TB.
3. Provide cotrimoxazole preventive therapy for TB patients living with HIV.
4. Ensure HIV prevention interventions, treatment and care for TB patients living with HIV.
5. Provide ART for TB patients living with HIV.

WHO recommends that HIV programmes and TB control programmes devise a joint TB/HIV plan or introduce TB/HIV components in their national plans for prevention, diagnosis, treatment and care. Joint planning should be harmonized with the national strategic health plans and health-system strengthening agenda.

RECOMMENDATIONS FOR JOINT TB/HIV PLANNING TO INTEGRATE THE DELIVERY OF TB AND HIV SERVICES (TAKEN FROM POLICY ON COLLABORATIVE TB/HIV ACTIVITIES)

1. Joint planning should clearly define the roles and responsibilities of HIV and TB control programmes in implementing, scaling up, and monitoring and evaluating collaborative TB/HIV activities at all levels of the health system.
2. HIV programmes and TB control programmes should describe models to deliver integrated client- and family-centred TB and HIV services at the facility and community levels compatible with the national and local context.
3. HIV programmes and TB control programmes should ensure resource mobilization and adequate deployment of qualified human resources to implement and scale up collaborative TB/HIV activities in accordance with the national situation.
4. HIV programmes and TB control programmes should formulate a joint training plan to provide preservice and in-service training as well as continuing competency-based education on collaborative TB/HIV activities for all categories of healthcare workers. Job descriptions of health workers should be developed and/or amended to include collaborative TB/HIV activities.

5. HIV programmes and TB control programmes should ensure that there is sufficient capacity to deliver healthcare (e.g. adequate laboratories, medicine supplies medicines, referral capacity, private sector involvement, and focus on key populations such as women, children, people who use drugs and prisoners) and effectively implement and scale up collaborative TB/HIV activities.
6. HIV programmes and TB control programmes should develop specific strategies to enhance the involvement of NGOs and other civil society organizations, as well as of people affected by or at risk for either disease, in developing and implementing policies, programmes and the monitoring and evaluation of collaborative TB/HIV activities at all levels.
7. Well-designed TB/HIV advocacy activities that are jointly planned to ensure message coherence and targeted at key stakeholders and decision-makers should be carried out at global, national, regional and local levels.
8. Joint communication strategies should ensure the mainstreaming of HIV components in TB communications and of TB components in HIV communications.
9. All stakeholders in collaborative TB/HIV activities, including HIV programmes and TB control programmes, should support and encourage operational research on country-specific issues to develop evidence.





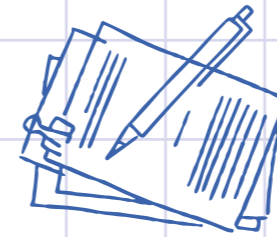
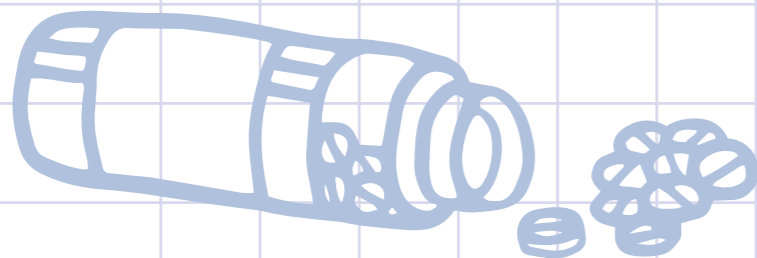
GUIDELINES FOR EARLY DETECTION OF HIV AND LINKAGE TO CARE

WHO has formulated the following “5C guiding principles” that all forms of HIV testing should adhere to

GUIDELINE 4.

- 1. Consent.** People receiving HIV testing services must give informed consent to be tested and counselled. They should be informed of the process for HIV testing and counselling and of their right to decline testing.
- 2. Confidentiality.** HIV testing services must be confidential, meaning that what the testing provider and the client discuss will not be disclosed to anyone else without the express consent of the person being tested.
- 3. Counselling.** Pre- test information can be provided in a group setting, but everyone present should have the opportunity to ask questions in a private setting if requested. All HIV testing must be accompanied by appropriate high-quality post-test counselling, based on the specific HIV test result and status reported. Quality assurance mechanisms as well as supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.
- 4. Correctness.** Providers of HIV testing should strive to provide high-quality testing services, and quality assurance mechanisms should ensure that people receive a correct diagnosis. Quality assurance may include both internal and external measures and should receive support from the national reference laboratory. Anyone who receives a positive HIV diagnosis should be retested to verify the diagnosis before initiation of HIV care or treatment.
- 5. Connection.** Linkage to prevention, treatment and care services should include effective, appropriate follow-up, including long-term prevention and treatment support. Providing HIV testing services where there is no access or poor linkage to care, such as ART, is of limited benefit.

Linkage to other services should be regarded as a key component of effective treatment, care and prevention. A rapid scale-up of HIV testing and counselling must be accompanied by linkage services such as CD4 testing, ART, TB services, STI services and family planning.. According to WHO, the responsibility for linkage to care falls on HIV testing providers. These providers should collaborate with other service providers to ensure that people being tested for HIV are effectively linked to appropriate services. Health programmes should explore appropriate interventions to maximize effective linkages, including text messaging or another follow-up. Testing providers should offer individuals contact details for local networks that support PLHIV. In some settings, peer supporters or community care providers accompany people with HIV to facilities and provide support for treatment literacy and adherence.



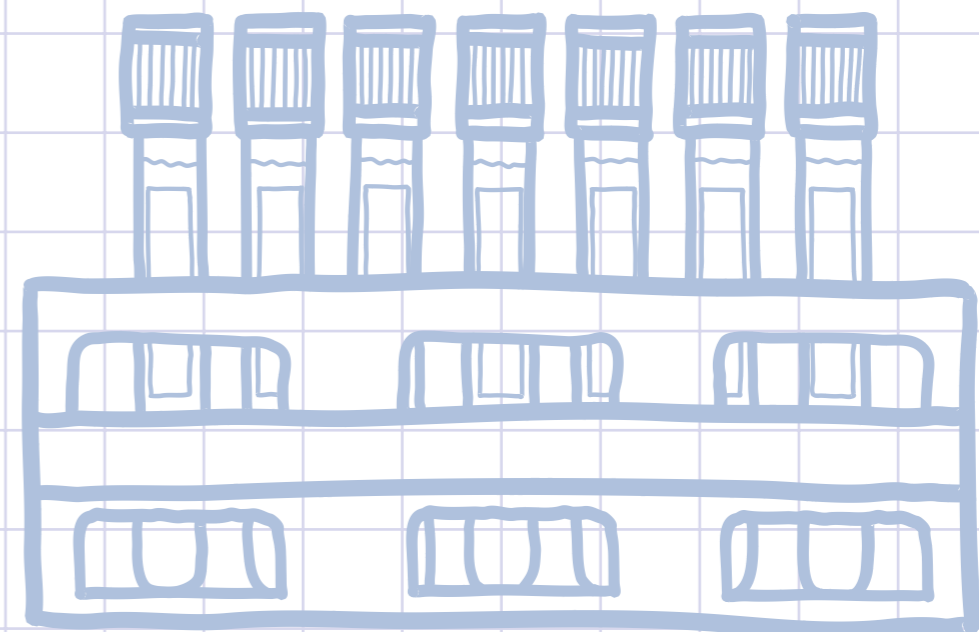
WHO GUIDELINES FOR HCV TESTING AND TREATMENT

In 2017, there were an estimated 15.6 million PWID aged 15–64 years PWID are at risk for infections, including HCV infection, mental health issues, psychosocial challenges, contact with law enforcement agencies and premature death. Fifty-two per cent of PWID (95% UI: 42–62) have serological evidence of past or present HCV infection (anti-HCV positive) and 9% (95% CI: 5–13) have HBV infection (HBsAg positive). However, many infected PWID are unaware of their diagnosis and few initiate treatment, because of criminalization, discrimination, unstable housing and stigma in health-care settings. They require prevention services to reduce the risk of infection and reinfection after a cure.

GUIDELINE 5.

WHO has identified key actions to prevent the transmission of HBV and HCV among PWID.

- 1. Involve PWID** in hepatitis prevention programmes to maximize their impact.
- 2. Offer OST** integrated with hepatitis medical services. In addition to treating opioid dependence, OST reduces HCV risk behaviour and transmission and increases adherence to HCV treatment.
- 3. Distribute low dead-space syringes.** These syringes reduce the risk of HIV and HCV transmission because they retain less blood after use.
- 4. Offer PWID the rapid HBV vaccination regimen,** which takes three weeks to complete rather than six months, along with incentives to increase vaccination uptake and completion.
- 5. Use peer interventions** to reduce the incidence of viral hepatitis.
- 6. Offer testing and treatment to all people who use drugs** to reduce the risk of HIV and HCV transmission. Regular testing for HCV is relevant to uninfected PWID, those cured, and those who had cleared the virus spontaneously. New DAA therapies for HCV can cure the virus in more than 95 percent of people



OTHER TOOLS AND RESOURCES



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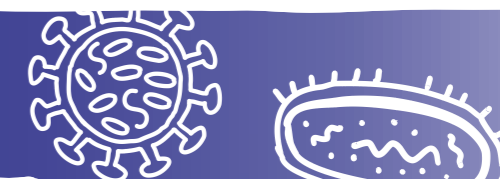
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6.5. OVERVIEW OF INTEGRATED CARE MODELS



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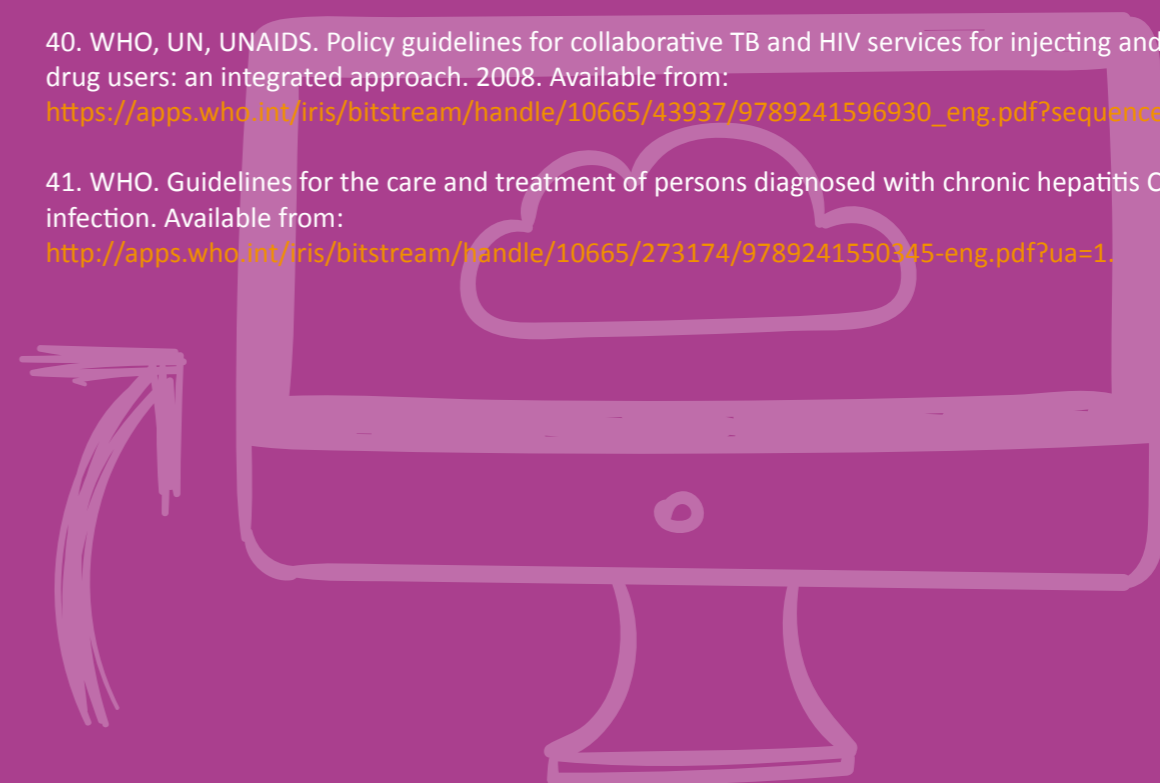
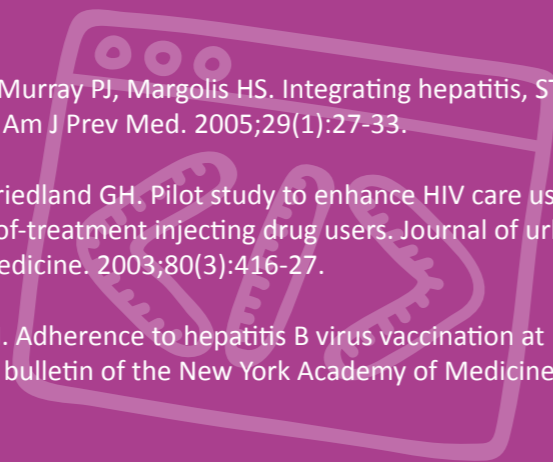
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POLICY BRIEF

IMPROVING THE DELIVERY OF INTEGRATED SERVICES FOR PEOPLE WHO INJECT DRUGS

This policy brief has been prepared within the framework of the Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT).

HA-REACT is co-funded by the Health Programme of the European Union (EU) and brings together **22 partners from 18 EU Member States**. The overall aim of HA-REACT is to contribute to the elimination of HIV and to reduce the number of cases of tuberculosis (TB) and viral hepatitis among PWID in the EU by 2020.

HA-REACT workshops organised in Czechia, Estonia, Hungary and Lithuania have served as a platform for cross-country and cross-organisational exchange on experiences integrating HIV, HCV and TB treatment with harm reduction for people who inject drugs (PWID) at the programme, policy and organisational levels.

The workshops were designed to identify problems and successes related to the integration of services, as well as priorities for policy action on the development of integrated care.

According to United Nations Office on Drugs and Crime (UNODC) estimates, in 2018 there were 2.8 million people who inject drugs (PWID) in Eastern and South-eastern Europe and 700 000 in Western and Central Europe. Worldwide, an estimated 28 million years of life in good health were lost to premature death and disability caused by drug use in 2015. Yet fewer than one in six people with a drug use disorder receives treatment for it in a given year.

Globally, 1.6 million PWID are living with HIV and 6.1 million with hepatitis C virus (HCV), including 1.3 million who are living with both. In addition, almost 900 000 PWID are living with TB.

In Europe, PWID are not only one of the population groups that are most vulnerable to HIV and HCV infection, but also one of them that faces the most barriers to accessing HIV and HCV testing, care and treatment services. Greater efforts need to be made to reach the UNAIDS goal of ending HIV and the UN goal of eliminating HCV as a public health problem.

WHY FOCUS ON PEOPLE WHO INJECT DRUGS?

Drug use, especially injecting drug use, is often criminalized and almost always stigmatized. PWID have less access to disease prevention, social welfare and healthcare services than most other population groups, while also being more vulnerable to illness. That can have a negative impact on not only their health and the lives of their families, but also communities and society in general.

The risk of HIV, viral hepatitis and TB among PWID is many times greater than that of the general population. Delivering integrated care and improving linkage to care can reduce costs; improve quality of care, health outcomes and quality of life; and ultimately save lives. It is essential to combine health and social services with harm reduction and ensure that services are provided where PWID spend time. Providing integrated people-centred health services that include treatment for substance use disorders, harm reduction and PWID support services as part can be challenging for any country's health system. However, this approach is an important way to empower patients and deliver health services that are better aligned with people's needs.

MAIN BARRIERS TO INTEGRATED CARE FOR PWID

HA-REACT ACTIVITIES HAVE HELPED IDENTIFY THREE TYPES OF BARRIERS TO INTEGRATED CARE FOR PWID

People who need health care services the most are often those who are least likely to access them.

In many cases, **health systems are not sufficiently tailored to the needs of vulnerable populations** such as PWID, nor are they adequately linked to social welfare systems. The principal reasons that PWID do not seek health services are related to the organization of health services. These reasons include geographic inaccessibility, poor quality of services, inflexibility, poor coordination of providers and a shortage of skilled staff.

For chronic illnesses such as HIV, viral hepatitis and TB, **successful engagement** of infected individuals in the continuum of care **begins with testing, diagnosis and linkage to care**, followed by treatment and retention in care.

While the initial linkage to care after diagnosis is a crucial stage in the continuum, **many people who are diagnosed are never successfully linked to care**, and thus may never receive the care and support they need. A lack of identity documents, citizenship, a permanent place of residence and national health insurance can all be obstacles in accessing these services.

The skills needed to deliver integrated care often already exist within a workforce. The challenge lies in finding the best way to share and allocate these skills within a system that spans organisational boundaries.

In many countries, there is currently **no legal framework allowing a non-medical worker to perform HIV or hepatitis screening tests or to provide naloxone** to PWID.

Yet pharmacists, **primary care doctors and nurses, and prison staff members** who are able to deliver these services to PWID are not involved in harm reduction.

Moreover, when it comes to providing such services to PWID, **community workers and harm reduction staff members are often more highly skilled than health professionals.**

Such workers **should be allowed to provide** such services to PWID. In particular, **peer workers should be acknowledged as an integral part of the workforce providing PWID care** and given more responsibility.

PWID should be encouraged to identify say what they need and want from services.

The aim of integrated care is **to meet clients where they are**. It should be delivered **by people who understand how drug use impacts** people's lives.

PWID can be strongly affected by the negative views of service delivery staff towards injecting drug use and users. **Stigmatizing attitudes often destroys the motivation of PWID** to be tested or treated, and it is a key factor in preventing them from accessing such services.

Community and peer support are one way to overcome this barrier. **Services developed with PWID can improve health outcomes, decrease stigmatization**, help to create an enabling environment and encourage patients to take responsibility.

PRIORITY ACTIONS FOR BETTER CARE AND ACCESS

THE FOLLOWING 4 AREAS OF ACTION ARE CRITICAL TO IMPROVE THE QUALITY OF INTEGRATED HIV, HCV AND TB CARE FOR PEOPLE WHO INJECT DRUGS AND TO PROVIDE THEM WITH BETTER ACCESS.

PROVIDE POINT-OF-CARE SERVICES WHERE PRACTICABLE AND STRONG LINKAGES TO CARE WHERE THEY ARE NOT

- **Tailor specific services** – including harm reduction, HIV, TB, hepatitis and drug treatment services – **to the needs of PWID**. Ways to do that include establishing more flexible opening hours, opening new sites to increase geographic coverage and introducing alternative methods of service delivery, including mobile solutions, to bring services closer to this population.
- **Recognize that drug use is a social problem and cannot be solved by health-centred approaches alone**, and ensure that, wherever in the health care system a need for substance use disorder treatment is identified, the patient is effectively linked to appropriate social services, such as housing and employment services.
- In addition, **ensure that harm reduction services** have strong linkages to health and social services, and that essential medications are readily available.

OVERCOME BUREAUCRATIC BARRIERS AND UTILIZE NEW KINDS OF CARE PROVIDERS AND TECHNOLOGIES

- **Encourage the involvement of non-medical organizations**, including community-based organizations, in outreach, support and service delivery for PWID.
- **Enable non-healthcare workers to offer testing, distribute naloxone** and provide **other key services to PWID**.
- **Develop new, non-hospital-based technologies** and seek out new partners to help improve the lives of PWID.

COORDINATE THE CARE OF INDIVIDUAL PWID SO THAT THEY DO NOT BECOME LOST TRYING TO NAVIGATE OVERLY COMPLICATED HEALTH SYSTEMS

- **Establish better coordination and communication** between community-based service providers and those based in the health system.
- **Provide services for PWID, including those without identity documents or health insurance**, using a client-centred approach that guarantees their privacy and confidentiality.
- **Provide a full range of harm reduction measures**, as no single intervention can address all PWID needs.
- **Use health information technologies to ensure better communication and collaboration among providers**, to foster the provision of better integrated and more collaborative care while at the same time protecting patient privacy.

TAKE ADVANTAGE OF PEER EXPERTISE AND ENCOURAGE PWID TO TAKE RESPONSIBILITY FOR THEIR CARE

- **Develop services provided by peers**, as such services have been shown to have a positive impact on PWID health outcomes. **Peer advocacy improves client health** by increasing **confidence, knowledge** and the **motivation** to access healthcare and manage one's health proactively.
- **Offer programs that are tailored to patient characteristics** and exhibit gender, ethnic and cultural sensitivity, as they may improve PWID willingness to enter into treatment.
- **Provide PWID with information and counselling opportunities** at every contact point with social, healthcare and harm reduction services. Such support encourages PWID to access care and will help them deal with stigma related to HIV, hepatitis, TB and drug injection.

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