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TITLE: Integrating HIV and substance misuse services: a person-centred approach grounded in human rights

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Key Messages

Abstract

Integrating HIV-related care with substance use disorder (SUD) treatment provides an opportunity to better meet the needs of people living with HIV (PLHIV) and people living with SUDs, the latter rendered especially vulnerable by prevailing policies, structural inequalities, and stigmatisation. Using an integrated care framework, we draw on existing literature and empirical evidence from scoping reviews we conducted in 2017 and 2021 of HIV and SUD integration designs to better understand barriers and facilitators to care integration and map ways forward. We reflect on the ways approaches to integration address two core gaps in current approaches: a failure to consider human rights when incorporating the perspectives of PLHIV and those who use drugs, and a failure to reflect critically on structural factors that determine risk, vulnerability, health care seeking, and health equity. We argue that for integration to work requires a person-centred approach, grounded in human rights, that treats both concerns holistically and reconnects with underlying social, economic, and political inequalities.

Introduction

From its early days, the healthcare response to HIV, often organised as a series of vertical programmes, has evolved continuously in ways that seek to meet the full range of needs of those living with HIV.[1,2] Much progress has been made, underpinned by commitments to health, gender equality, human rights, employment, and social protection, ideas now taken up in many other areas of health policy. Yet there is still much to be done and the most recent Global AIDS strategy explicitly commits to a 2025 target to provide 90 per cent of people living with, at risk of, and affected by HIV (PLHIV) with people-centred, context-specific, and integrated services for HIV.[1] In particular, it includes goals to support those who seek care for use of alcohol and drugs, a goal that is complicated by the frequent presence of punitive policies.[3]

The rationale for linking HIV and substance use is clear; those who use drugs are at higher risk of exposure to HIV, either through their use of injectable substances[4], or commonly associated activities.[5,6] It is estimated that one in eight people who inject drugs (PWIDs) also live with HIV.[7] In 2020, approximately ten per cent of new HIV infections globally and nearly 50 per cent in Eastern Europe were among PWID.[7,8] These risks have been amplified by the COVID-19 pandemic, which has hampered global health initiatives, including those aimed at ending AIDS as a public health threat.[9] The pandemic has also been associated with initiation or increased use of substances by those seeking to cope with the consequences of measures necessary to reduce COVID-19 spread, while harm reduction and care services for people who use drugs and people living with or at risk of HIV have also been disrupted.[10,11]

In these circumstances, integrating HIV-related care with SUD treatment provides an opportunity to better meet the needs of PLHIV and people living with SUDs.[12] Yet, such integration is complicated because of the need to take account of cultural and contextual specificities.[13-15] There are constellations of individual practices, often driven by the particular circumstances in which they are embedded, while systems of oppression can increase the risk of both HIV and SUDs and impede access to care. Importantly, each condition (and population group) may be stigmatised in different ways and requires services that reflect their particular context.[16] The challenges faced by those who are simultaneously living with HIV and using drugs are exacerbated by HIV-related stigma, stressors, systems of oppression, and overlapping syndemics that create barriers to care.[17-19] These barriers are even more pressing for women, non-binary, gender non-conforming, trans people, and racialised groups living with HIV/AIDS and substance use disorder (SUD), who are at greater risk of having also experienced gender-based violence, racism, or other trauma and who have important and specific care needs.[20,21] The intersectional nature of structural racism and gender inequality further increase barriers to care and stigma experienced by individuals who are historically racialised and marginalised, as well as those in the criminal justice system where drug use, sex work or same sex relationships are criminalised. People who use drugs, in particular those with HIV, are often excluded from care services by punitive laws, underfunded harm reduction services, and pervasive discrimination, which impact both access to and quality of care and are contrary to the concept of health as a human right.[22-26]

So far, HIV services are often offered through siloed or vertical programming or otherwise offered separately from other health services, including care for SUDs.[30,31]The quest for new, integrated approaches has generated calls for a greater understanding of the relative strengths or weaknesses of different integrated approaches towards care for HIV and SUDs.[32,33] Based on evidence generated through a systematic review we conducted in 2017,[29] an updated version (unpublished), and a conceptual framework of determinants and models of integrated care, this paper provides a detailed overview of integration designs and analyses the evidence for future pathways. Through a review of the literature and empirical evidence, we reflect on the ways that approaches to integration address two core gaps in current approaches: a failure to consider human rights when incorporating the perspectives of PLHIV and those who use drugs, and a failure to reflect critically on structural factors that determine risk, vulnerability, health care seeking, and health equity[34].[29]

Conceptual Framework: Models of HIV and SUD service integration

We extend a definition of service delivery integration proposed by Briggs, Atun, and Legido-Quigley whereby managerial or operational changes to health systems bring together inputs, delivery, management, and organisation of particular service functions in ways that are contextually appropriate and person-centred with the aim of improving coverage, access, quality, acceptability, and/or (cost)-effectiveness (Figure 1).[35-37] There are many forms of service integration: this term may refer to a package of preventive and curative health interventions for a particular population group, a combination of different disease control programmes, or for specific diseases. The latter is the case when diseases co-exist, termed multimorbidity, such as HIV and SUD, or the clients of one service need services of the other like mental health and SUD[38,39] or mental health and HIV.[40] Care and funding integration have been prominent for combining certain vertical diseases programmes, such as HIV, sexual and reproductive health, tuberculosis and hepatitis B/C, for example. However, integration offers the promise of more holistic approaches including towards strengthening primary healthcare systems by providing essential care under one roof. The idea is not new; the Alma Ata Declaration in 1978 already envisaged the integration of essential health care into primary healthcare and intersectoral action, and the notion of 'health in all policies' and later One

Health seek to integrate health across other domains.[41] These various concepts highlight that integration must be understood as a spectrum, which has a long history in health and healthcare debates.[42]

However, integration, broadly defined, faces several foundational challenges. They include fragmented health service coverage, especially in low- and middle-income countries (LMICs) and rural areas, physical and financial inaccessibility of services, and a hesitancy of funders to invest in horizontal healthcare. This is particularly pertinent for HIV and SUD care; treatment gap estimates for SUDs in LMICs range from 75–95%, with the gap being greater in rural areas.[43-46] This highlights that poor treatment coverage is set against the challenge of developing more (cost-)effective models of integrated care.

To better understand the spectrum of HIV and SUD care integration and treatment options, we draw on a conceptual framework of determinants and models of integrated care for HIV and SUD. The framework describes three models of care defined by client entry point: HIV care site, substance use care site, and other sites.

Figure 1. Conceptual framework of determinants and models of integrated care for HIV and SUD

The first model captures SUD services integrated into services at HIV care sites, including anti-retroviral treatment (ART) clinics, HIV clinics, and infectious disease clinics that provide HIV care. The second captures the integration of HIV services at SUD care sites, including SUD-focused clinics, drop-in facilities, safe injection sites, and syringe exchange sites. Treatment options for SUD patients usually range from behavioural therapy, psychotherapy, to pharmaceutical treatment. The latter most often focuses on buprenorphine or methadone treatment for opioid use disorder and naltrexone for alcohol use disorder. The third captures situations where HIV and SUD services are integrated at other sites, including detention facilities, mobile care sites, and community sites. At each site, different elements of care may be integrated, including pharmaceutical or behavioural interventions and complex interventions that combine different treatment modalities, approaches to care, providers, or delivery methods. Integrated care can be delivered by diverse health workers, including physicians, nurses, social workers, and counsellors. In some cases, integration is facilitated by technology, including e-Health modalities. Peer support can also feature in these models. Additionally, facilitators and barriers to integrated HIV and SUD care can be categorised around micro (patients and providers), meso (facilities and programmes) and macro levels (systems and policy).

The framework allows consideration of how integrated care for HIV and SUDs is impacted by health systems organisation, noting how both require ongoing long-term care. It also recognises how access may be determined by prevailing substance use policies, including criminalisation, as well as various social determinants of health. It also includes consideration of human rights and the extent to which care is designed, implemented, and evaluated with meaningful participation of those with HIV and SUDs.

Integration of SUD services at HIV care sites

A first step towards integrated HIV and SUD care is for health workers in HIV clinics to screen for substance use, embedding it within routine care. Those who engage in substance use may be at increased risk of non-adherence to HIV medications[47] so it is important to consider it, in addition to the opportunity to intervene with what is a risk factor in its own right, with counselling or pharmaceutical interventions.[48] Panel 1 offers illustrative examples.

A Screening, Brief Intervention, and Referral to Treatment (SBIRT) model is often employed, delivered individually or in groups.[49-51] Such interventions can include motivational interviewing, motivational enhancement therapy and cognitive behavioural therapy,[50,52-58] often delivered by physicians or nurses and combined with pharmaceutical support.[59,60] However, they can also be delivered by other staff, including social workers, mental health workers, and physicians assistants.[51,57,59,61-64] Several of these models, in particular motivational interviewing, can reduce substance use by PLHIV receiving care at HIV clinics[48,52,65] but researchers have called for more work to understand which components are most effective in different contexts.[52] There is also growing evidence of the potential of peers and eHealth interventions to provide or augment counselling services. Patients may prefer engaging with a lay counsellor or peer, especially if it is someone from their community with similar lived experiences and who is non-judgmental.[66,67] There are also studies finding that eHealth interventions can be acceptable to patients and effective in reducing drug use and drinking when used at HIV care sites.[49,52-54,65,67]

Pharmaceutical support for SUD provided at HIV care sites includes on-site buprenorphine plus naloxone treatment, naltrexone, or methadone. These can be prescribed by the HIV clinician, by a co-located substance use specialist, or a specialised pharmacist within a team.[59,68-70] However, the ability to deliver these services in LMICs is challenged by uncertain and inadequate funding and weak delivery systems[60] and by legislation on substitution therapy in some jurisdictions.[71]

Stepped care is another way to bring together HIV and SUD care, where the scope or intensity varies according to the patient's needs,[56] with the option to refer to specialist services (e.g., intensive outpatient or residential treatment), often following assessment by a psychiatrist specialising in addiction. However, the findings of evaluations have been mixed, at least where the aim was reduced alcohol consumption and where the target population was difficult to reach.[55,56] However, this model shows greater evidence of benefits for individuals with alcohol use disorder and moderate alcohol and liver disease than those with at-risk alcohol use. More holistic models seek to span the health, social and economic needs of PLHIV and SUDs.[72] One report described a model staffed by teams that included health care, housing support, employment counselling, resources for interpersonal violence, access to social services and disability supports.[73] However, this model is likely to require a permissive approach to substance use, with supportive harm reduction policies such as legalisation of safe injection sites.

Integration of HIV services at SUD care sites

Integration of HIV testing, treatment, or care at SUD sites often involves bringing HIV services into existing pharmaceutical treatment programmes for opioid use disorder, such those offering methadone or buprenorphine, and often linked to offers of HIV testing.[74-78] The same members of staff deliver both services so, in practice, this usually means physicians, physician assistants, and nurses. It can also mean provision of initial counselling to HIV-positive PWID, [62,79-83] with possible referral to specialised therapists and psychologists, as well as to HIV services. Panel 2 offers illustrative examples.

There are several reports of models adopting a more holistic approach, with HIV services provided by multidisciplinary teams of medical staff, including specialist physicians, counsellors, nurses, case workers, and social workers.[84-87] Some also help patients to access medical insurance or social benefits and other services. Such multidisciplinary teams have been associated with better communication between service providers and specialists on the one hand, and better patient-doctor relationships on the other.[84]

Much of the existing literature has a clinical focus, with assessments focusing on quantitative measures, such as numbers of HIV tests undertaken, adherence to treatment, toxicology measures, rates of viral suppression, or CD4 cell count. There is rather less on how factors such as class, racialisation, stigmatisation, or gender influence design or performance and very little on stakeholder perspectives, although there are some that examine patients' [88] or prescribers' perspectives.[74,89] Such studies could offer important insights as to who uses, or does not use, services. For example, in some drop-in clinics in Kenya, stigmatisation of HIV has led patients to use separate sites.[88] Another study found that buprenorphine prescribers did not feel comfortable talking about sexuality with their patients and so avoided including HIV-related activities in their services.[74]

Integration of services at other health service sites

People living with HIV and SUD often face many barriers to accessing mainstream facilities. Consequently, there have been some attempts to develop innovative models that are not based on existing SUD or HIV services including patient navigation services, as well as primary and community care interventions. Panel 3 offers illustrative examples.

Where there are high numbers of people with both HIV and SUD, community health workers (CHWs) are well placed to provide culturally appropriate HIV and SUD prevention and referral to further care. This will often require training to give CHWs HIV/addiction-related service knowledge and skills. There are accounts of how CHWs in some settings have significantly increased their interaction with other providers, as well as improved their confidence in providing HIV/addiction-related health services.[90] However, task-shifting must not become 'task-dumping' and models of care should respect all those involved.[91] An alternative integration design is based on community outreach centres or mobile drop-in clinics, offering services such as HCV testing, immunizations, rehabilitation, mental health services, care co-ordination, and syringe exchange programmes.[92,93] Mobile drop-in clinics are likely to be especially valuable in remote areas. Network-based contact tracing programmes that target and service PWID recently infected with HIV, can provide a combination of HIV testing, provision of ART, links to other HIV care, counselling, and social support.[94] Trained multidisciplinary staff, including social workers, case managers, and medical professionals, are key to holistic care delivered in a contextually and culturally appropriate manner.

Barriers and facilitators to integrated HIV & SUD care

There are both advantages and disadvantages to these models of integrated HIV and SUD care. Integrated models, regardless of site, offer the opportunity to detect HIV and SUDs at point of care. They can also provide structure, continuity of care, and in some cases holistic support for care needs beyond the biomedical and include social, employment and housing supports. Yet, many focus solely on testing or screening and counselling, with fewer examples of integrated pharmaceutical care. Indeed, some studies suggest that those managing SUDs may feel hesitant to engage with providers of HIV care, a challenge to integration unless providers have well-functioning referral mechanisms to specialist care and social services.[98,99]

Exploring these barriers and facilitators by looking at the intervention allows a deeper engagement with the ways integrated care may be realised. At the micro-level, patients' and providers' experience or perception of the stigma associated with HIV or substance use poses a significant barrier to accessing care services and high-quality service delivery.[100] Thus, peer navigators who share the same lived experience offer one way to connect with and retain PLHIV and SUDs in the care process.[67] There is also a need for greater gender and cultural concordance between providers and people seeking care to better ensure approachable and culturally appropriate care environments.[90,101] Besides the barrier of stigma, physical barriers play an important role in access to HIV and SUD care. Distance to care influences transportation costs, and adequate sick-leave policies can negatively impact patients' ability to seek care.[101-103] Programmes to cover transport costs or offer medicine delivery services are promising ways to bridge gaps in access.[101,103,104] Such initiatives should be complemented by strategies to reduce out of pocket costs for medication and treatment, which can be prohibitively expensive.

At the meso level, providing integrated HIV and SUD care requires a health workforce that feels supported. Health workers must be adequately trained to offer integrated care and provided with opportunities to expand their skills and competencies.[64,97] The allied health workforce, including CHWs and peer counsellors, must be compensated for their time, appropriately trained, and provided with opportunities for career development. Training can be facilitated by standardised training protocols and train-the-trainer models offering skills such as motivational interviewing or screening activities. These efforts should be locally adapted and contextualised and ideally developed in partnership with PLHIV and SUDs to ensure interventions are tailored to community needs and preferences.[97] Regardless of how effective integration may be, health workers providing HIV or SUD care can be overstretched by the additional work needed to deliver some models of integrated care. Task-shifting or task-sharing protocols between health workers, including paraprofessionals, is a key strategy towards sustainable interdisciplinary team-based care.[105] The health workforce can be further supported to deliver integrated care by providing adequate financial compensation to providers for additional workload.[103,106]

Strategies to integrate care must also consider the physical space and systems through which care is delivered. Given that many interventions include a counselling component, both scarce private space for sensitive discussions and the absence of common space for group therapy modalities, limit the type of integrated care provided.[50] Similarly, interoperable information systems that permit the flow of patient data across care interfaces is crucial to supporting integrated care and onward referra.[92] Ideally, such systems would link both health and social care services to better meet the needs of people receiving care. Linked systems could prevent duplication of services, promote co-ordination of care between providers, as well as facilitate program evaluation purposes through more seamless tracking. However, any exchange and storage of patient data must be approached with care, especially where substance use or other HIV risk-behaviours are criminalised.

Importantly, the provision of integrated services should not discriminate nor stigmatise based on ability to pay for health coverage. Some programmes highlight that case managers assist patients in applying for insurance or co-payment assistance programmes.[76] However, financial barriers ultimately have to be addressed at the macro level. To that end, governments need to offer both typologies of services to populations without inflicting catastrophic financial expenditure. This can be achieved by integrating such services into national insurance schemes. Furthermore, policies that restrict government fiscal resources from channelling into substance programmes, such as Syringe Service Programmes, need to be overturned and a harm reduction approach embraced.[76] In addition, national guidelines should reconsider policies whereby a certain level of clinical threshold are required to initiate services.[104]

[Table 1. Barriers and facilitators to integrated HIV & SUD care]

Foundations and enablers of integrated HIV and SUD care

Our review of efforts to integrate HIV and SUD care highlights two foundational gaps in current debates. The first is a lack of attention to understanding the perspectives of PLHIV and people who use drugs and building integration with a human rights focus. The second is the failure to reflect critically on structural challenges, politics and policy, and the determinants of risk, vulnerability, health care seeking, and health equity.

Foundations of integrated care: human rights and meaningful participation of PLHIV/SUDs

Integrated care for HIV and SUDs means more than providing a site where separate services are delivered. It reflects and is determined by the ways human rights norms and principles are embedded (or not) in the way people experience care. A human rights approach requires that PLHIV/SUDs are fully engaged in development, implementation, and evaluation of integrated service delivery. Yet, in reality, the literature reveals that HIV- and substance use-related care outcomes are too often measured in quantitative terms; through viral load suppression, patient numbers or visits, decrease in substance use, or number of referrals, rather than measures that reflect the patient’s lived experience.[60,61,65,66] This concentrates attention on schemes that are short-term (up to one year), typically simply combining several vertical programmes into a single vertical intervention. [74-78]

The foundational gap becomes clear when looking at who designs these interventions. Few studies describe models initiated by local stakeholders or even taking a participatory approach.[56,76] Design ought to be grounded in understanding how communities and local stakeholders can be enabled to create programmes and interventions that best meet their needs given the prevailing context. Service delivery and integration must be sensitive to systematic structures of marginalisation, racism, and provide deliberative spaces for all groups to be represented, in particularly those made most vulnerable by oppressive systems, including women, non-binary, gender non-conforming, and trans people. This also extends to people who have experienced incarceration and/ or homelessness, which are disproportionately burdened by the syndemic, while at the same time falling through the cracks of healthcare systems. While researchers pick specific population or stakeholder groups to participate in interventions, very few public health studies critically reflect on representation and community participation. The challenge is to listen to those voices who are often absent from debate because of structural marginalisation, including stigmatisation, their social and legal status, gender norms, or workloads. The narrow bio-medical focus diverts attention away from the need for co-production and participation by promising quick technoscientific fixes. In so doing, it also blurs the structural challenges that prevent such engagement and work against human rights and social determinants for health.

Enablers of integrated care: Politics, policies & social determinants of health

Besides the need for co-production and meaningful participation, if integration is to be grounded in human rights principles and the lived realities of the people affected, research must take a step back to understand structural challenges that lead, and have led, to fragmented health care delivery. Research must critically reflect on the role of politics and associated policies as enablers for meaningful participation and human rights centredness. Ultimately, integrated care is determined by the health systems in which care is organised, financed, and delivered, as well as the policies, and national and international political climates that shape approaches to SUDs. In addition, the literature further suggests the importance of social determinants of health, such as inclusive work environments, the promotion of income opportunities and education, access to transportation and infrastructure, or food security.[107]

Ideological and social mores, political incentives, power dynamics, and contestation at all levels determine the successes, failures, and opportunities of integrating health service delivery. For a long time, HIV’s exceptional political status led to the ‘golden age’ of donor funding and determined its prominence on global health and development agendas. At the same time, exceptionalism has driven the high degree of fragmentation seen in vertical programming. Reversing this trend has proven challenging over the past decade. While some political discourse encourages integration, horizontal/diagonal programmes, and a ‘normalisation’ of the HIV/AIDS agenda and services into wider health systems, ensuring sustainable integration requires efforts to address the structural determinants of health and shortage of funds for outcomes that are not immediately measurable. While our review focuses on approaches to integration using the example of HIV and SUD care, these must be understood as a constellation of models with wider applicability. In this sense, rather than exclusively focusing on HIV, a positive development would be to promote the integration of blood born virus treatments (e.g., HIV and Hepatitis C), which often co-occur and require similar service delivery, with SUD or even mental health disorders more broadly.

HIV and SUD remain highly stigmatised health challenges. In addition, punitive drug policies and the continued criminalisation of gay sex and sex work routinely prevent care seeking and undermine efforts to prevent HIV as well as deaths due to SUDs. Care for SUDs has been shaped by a global drug policy landscape focused on criminalising behaviours, punitive measures, and a stigmatising view of people who use substances and of sexual behaviours, preferences, sex workers, or those who survived sex trade.[108] Indeed, the international framework of prohibition, prevailing for at least sixty years, continues to provide the main frame for drug policies across the globe. Most national legislations fail to distinguish between substance use and substance misuse, thus enabling measures grounded in paternalistic enforcement.[108,109] Many calls for harsh drug punishments are couched within a 'pro-health' agenda. Such an approach ultimately leads to greater stigma and less care, particularly for PLHIV. Criminalisation of illicit substance use, sex work, sex trade survivors, and/or gay sex limits the availability of possible treatments as well as undermining care seeking and increasing other health risks, such as intimate partner violence among drug-using populations.[29,108]

Similarly, the excessive use of incarceration as a drug control measure only fuels the crisis. People who use drugs are overrepresented in prisons, where drug use takes place but is denied by authorities so that treatment and prevention of SUD is unavailable. It was only in 2016 at the United Nations General Assembly Special Session on drugs (UNGASS) that countries agreed to recognise SUDs and "drug addiction as a complex, multifactorial health disorder,"[110] which are treatable and preventable, rather criminal behaviour.[108,111] It marks the beginning of a shift from a punishment approach towards a public health approach.[108] However, there is still a need for a new approach to policy in many countries, one that supports global health efforts. Preventing SUDs requires lessons to be learned from the HIV/AIDS response. A more person-centred understanding of substance use and misuse, as well as greater efforts to organise care around shared risk-factors, behaviours, and the needs of PLHIV and SUDs are urgently needed.[9]

Similarly, policies must also recognise and reckon with the social determinants of health that shape the effects and effectiveness of care and care integration, particularly for oppressed groups. Individuals are affected differently by HIV and SUDs according to gender, income and education level, class, and race. In 2018 in the United States, for example, Blacks/African Americans represented 13% of the US population, but 41% of PLHIV.[112] In 2019, girls accounted for 75% of new HIV infections among adolescents, globally.[113] These figures provide a snapshot of the unequal burden of HIV/AIDS, which is partially produced by socially determined barriers.[114] To reflect this, policies must provide mechanisms and incentives to prevent and counteract structural barriers. This needs to include post-rehabilitation support and the adoption of workplace policies in the formal and informal sectors to provide income opportunity while taking into consideration gender-based and racialised disparities.

Ways forward: Implications for future research and policy

Integrating HIV and SUD care requires renewed commitment, both financial and operational, to community-led, person-centred, and participatory research and service delivery, particularly for PLHIV and people who use drugs. Such an approach requires transformational research approaches and better understanding of pathways from evidence to policies on substance use and on to governance, management, and delivery of services. At the most basic level, research questions must be posed by the communities impacted by policies and interventions must be co-designed to meet their care needs. Past research with PLHIV across the AIDS response offers lessons learned towards strengthening equitable research partnerships. These must be supported to scale up successful interventions from pilot stages to more sustainable long-term service offerings. Crucially, this means developing and funding integration designs in countries and areas that are most affected by the syndemic. Currently, interventions largely focus on high-income countries with well-developed and specialised healthcare delivery.

Building the evidence base also demands research leverage on novel trial designs to assess effectiveness that are well suited to health services research, such as stepped-wedge or platform trial designs with specific attention to including PLHIV and people who use drugs across the research project lifecycle.[115,116] The current evidence base is dominated by small-scale pilots and traditional RCT designs, with many reporting challenges in recruitment, retention and embedding in ongoing care. Innovative trials must be accompanied by economic evaluations, prospective policy analysis on political palatability, as well as implementation science work, including qualitative research, to better evaluate what interventions work for whom, in what context, and why.[117] National and regional networks of people who inject drugs now advocate for them to be part of the design and implementation of studies in the field. Similarly, research must be open and attentive to novel interventions, such as novel injectable medications, for example. Once scaled up, programmes must be monitored and evaluated over the long term with robust and people-centred indicators including patient reported experience measures (PREMS) and patient reported outcome measures (PROMS).[118]

Ultimately, however, the evidence base must be made relevant to health system decision makers and national policymakers. Again, the AIDS response offers many examples of bringing evidence to action that can be leveraged for integrated care. While a discursive shift towards integration has occurred, policymakers must now enable and support the operationalisation and implementation of integration based on evidence and patient experience. As such, there is heightened need to decriminalise substance use and destigmatise HIV and AIDS such that affected populations are better able to seek needed care at integrated delivery sites. Beyond UNAIDS' call to end AIDS by 2030 and the SDG's implicit support for health-in-all policies, COVID-19 has placed the spotlight on population health as more than the absence of diseases and as delivered by more than healthcare systems. Hence the soil may now be more fertile to nurture the seeds of the long-standing calls for integration.

Panel 1. Examples of SUD services integrated at HIV care sites

Counselling provided by trained counsellors: A culturally adapted six-session gender-stratified group cognitive behavioural therapy intervention offered at a large HIV outpatient Kenya was associated with significant decreases in alcohol use in the group receiving therapy compared to usual HIV-outpatient care.[51]

Peer counselling: Project Khanya in Cape Town, South Africa is a task-shared, peer-delivered behavioural intervention using behavioural activation, problem-solving, motivational interviewing and mindfulness-based relapse prevention. Implementation was associated with a significant increase in ART adherence, and lower alcohol use and substance use.[64]

eHealth counselling: A two session Computerized Brief Intervention for PLHIV with heavy/hazardous alcohol use delivered in two HIV primary care clinics in Alabama and Washington. Intervention enrolment and engagement were associated with both a reduction in the number of drinking days per week and in the number of drinks per drinking day.[49,53]

Pharmaceutical treatment: Experience with integration of on-site buprenorphine plus naloxone treatment into HIV care treatment models in six clinics in different regions in Viet Nam suggested that scale-up in middle-income countries might require enhanced support for buprenorphine adherence.[60]

Stepped-care: The STEP Alcohol Use Disorder Trial, which was conducted in five Veterans Affairs-based HIV clinics in the USA, includes three steps of care. Step 1 – Addiction Physician Management (APM), which focused on providing medication management along with alcohol treatment medications.[56] Step 2, APM plus four sessions of psychologist-delivered Motivational Enhancement Therapy (MET). Step 3 includes referral to a higher level of specialty services (e.g., intensive outpatient, residential treatment) at the Addiction Psychiatrists' discretion. The intervention increased receipt of alcohol treatments without changes in drinking behaviours at week 24. An implementation study found that providers valued tools and processes that improved patient motivation but sought greater flexibility in implementation.[55]

Holistic approach: Dr. Peter Centre (DPC) Vancouver, Canada, is a non-profit integrated care facility offering a comprehensive harm reduction approach, including a supervised injection room and the provision of harm reduction supplies (e.g., sterile syringes, alcohol swabs) for PLHIV who experiencing multiple barriers to social and health services.[73] A marginal structural modelling analysis estimated a 1.54 greater odds of achieving viral load suppression among DPC clients compared to highly active antiretroviral therapy (HAART)-exposed people with HIV who use illicit drugs.[72]

Panel 2. Examples of HIV services integrated at SUD care sites

Pharmaceutical treatment: HIV care was integrated into a methadone maintenance programme at the Irish National Drug Treatment Centre.[78] However, a small study (n=19) found no significant change in substance use or methadone adherence but a significant increase in the proportion receiving directly observed antiretroviral therapy, and in the CD4 cell count.

Clinical setting with multidisciplinary staff: Patients admitted to a low-threshold mobile harm reduction unit (LTMHRU) in Madrid underwent testing for HIV. Those testing positive continued to be cared for by addiction specialists but received ART from HIV specialists, working with clinical pharmacists who assessed risk of drug interactions. After a median follow-up of 252 (IQR 107.8-866.0) days, 73 of 79 individuals were virologically suppressed.[77]

Holistic approach: Antiretroviral therapy was initiated at an outpatient drug treatment centre in Barcelona, staffed by a multidisciplinary health team, including psychiatrists, an infectious disease consultant, social worker, psychologist, and nurses. It achieved high rates of virological suppression amongst HIV-1-infected active drug users.[82]

Panel 3. Examples of HIV and SUD services at other sites

Patient navigation in hospitals: A multi-site hospital based RCT conducted in eleven hospitals across the USA introduced patient navigation. [95] Treatment success rates for navigation was 35.7%; navigation plus incentives was 38.6%; and usual treatment was 34.1%. The authors conclude that this intervention is not appropriate for the setting as patient navigation with or without financial incentives did not demonstrate beneficial effects of viral suppression relative to non-suppression or death verses treatment as usual. The sample included a high proportion of patients with stimulant disorder and lack of treatment options that may have impacted the findings.

Primary care interventions: A cohort study in the USA provided comprehensive care for opioid use disorder among patients infected with HIV or with high risk of HIV. 265 patients enrolled in the FAST PATH Program, a primary care-based addition treatment received services such as substance use assessment, counselling, pharmacotherapy, case management, and mental health care. This study was effective in increasing addiction treatment-related utilisation with 64% participants engagement to addiction care.[96]

Training to increase care in communities: A clustered RCT study conducted across four provinces in Vietnam (Bac Giang, Hai Duong, Nam Dinh, and Nghe An) provided 60 CHWs in the intervention group with in-person and online training to enhance their HIV/addiction-related service knowledge and skills for a length of 12 months. [90] Capacity building of CHWs with training intervention was considered effective as CHWs in the intervention group reported significant increase in their interaction with other providers as well as improved their confidence in providing HIV/addiction-related health services.

Holistic interventions in communities: In a study conducted in Philadelphia, USA, the primary care clinic “Clínica Bienestar” was established, where medical providers and bicultural case managers (who spoke Spanish) used culturally appropriate approach to provide services such as HIV testing, linkage to HIV care, referral for SUD treatment, patient navigation, mental health referral, case management and social support (free lunch, transportation support, legal support etc.). Linkage to care, retention in care and viral suppression were found to be significantly higher at Clínica Bienestar compared to in Philadelphia in 2016.[97]

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