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HA·REACT
JOINT ACTION ON HIV AND CO-INFECTION PREVENTION AND HARM REDUCTION

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.

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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.

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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.

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.

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.

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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