

A rapid assessment of the quality and accessibility of integrated TB, HIV and harm reduction services for people who inject drugs in Portugal

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WHO European Region Technical Expert Meeting

Chisinau, September 27th-29th 2011

Aim and Objectives

Aim: Assess the accessibility & quality of TB and integrated TB-HIV services and delivery systems for PWID in Portugal

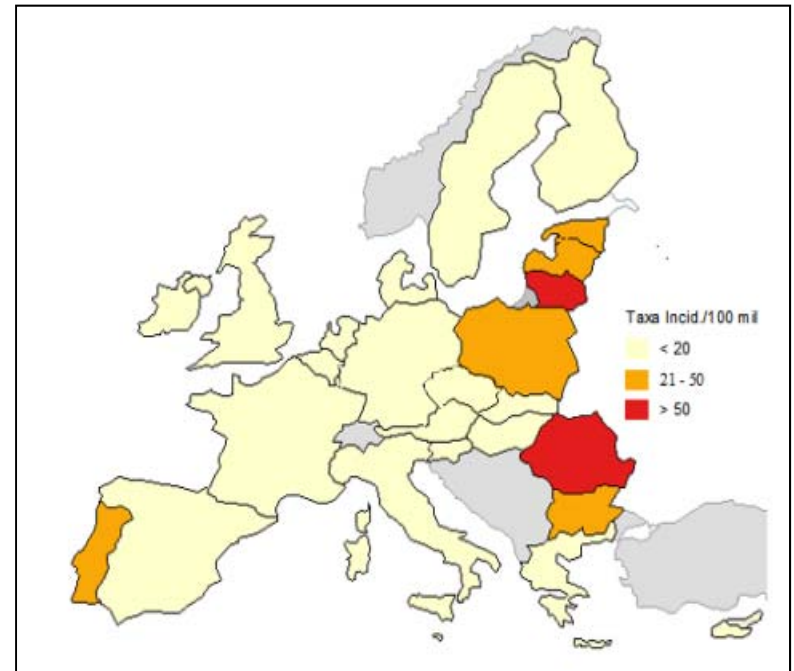
Objectives:

- Examine patterns of service use among PWID: *TB, HIV, harm reduction, prisons*
- Describe experiences of treatment access and delivery (PWID, providers)
- Explore contextual factors influencing treatment engagement and adherence
- Assess relationship between treatment systems: *coordination, referral, integration*
- Describe treatment-related social support and care needs, and role of CBOs
- Develop guidance on 'best practice' on integrated TB & HIV services for PWID

Case study: Porto area (including Vila Nova de Gaia)

Portugal as a case-study

- Among highest rates of TB in Western Europe (22/100,000 pop.)
- IDU important driver of local HIV epidemic
- OST widely available - drug treatment centres, outreach, pharmacies, prisons, hospitals
- In 2001, personal drug use decriminalised - reduction in drug-related morbidity, mortality and injection (Cato Institute, 2009)
- Integrated approach to HIV, TB and drug treatment



(ECDC/WHO-Europe, 2011)



Methods

Rapid assessment: multi-method, triangulation, action-oriented

1) Review of existing data

- Routine services and surveillance data; surveys; treatment protocols
- Informed by WHO M&E guide for collaborative TB/HIV activities (WHO, 2009)

2) Semi-structured interviews, PWID & experts

- 30 PWID with HIV/TB/HCV, 7 service providers
- Recruitment - treatment centres & outreach programme
- Topics included drug use, treatment/integration, social support
- Interviews in Portuguese (audio-recorded), transcribed & translated
- Thematic, iterative and inductive analysis

3) Mapping of HIV, TB & harm reduction services for PWID



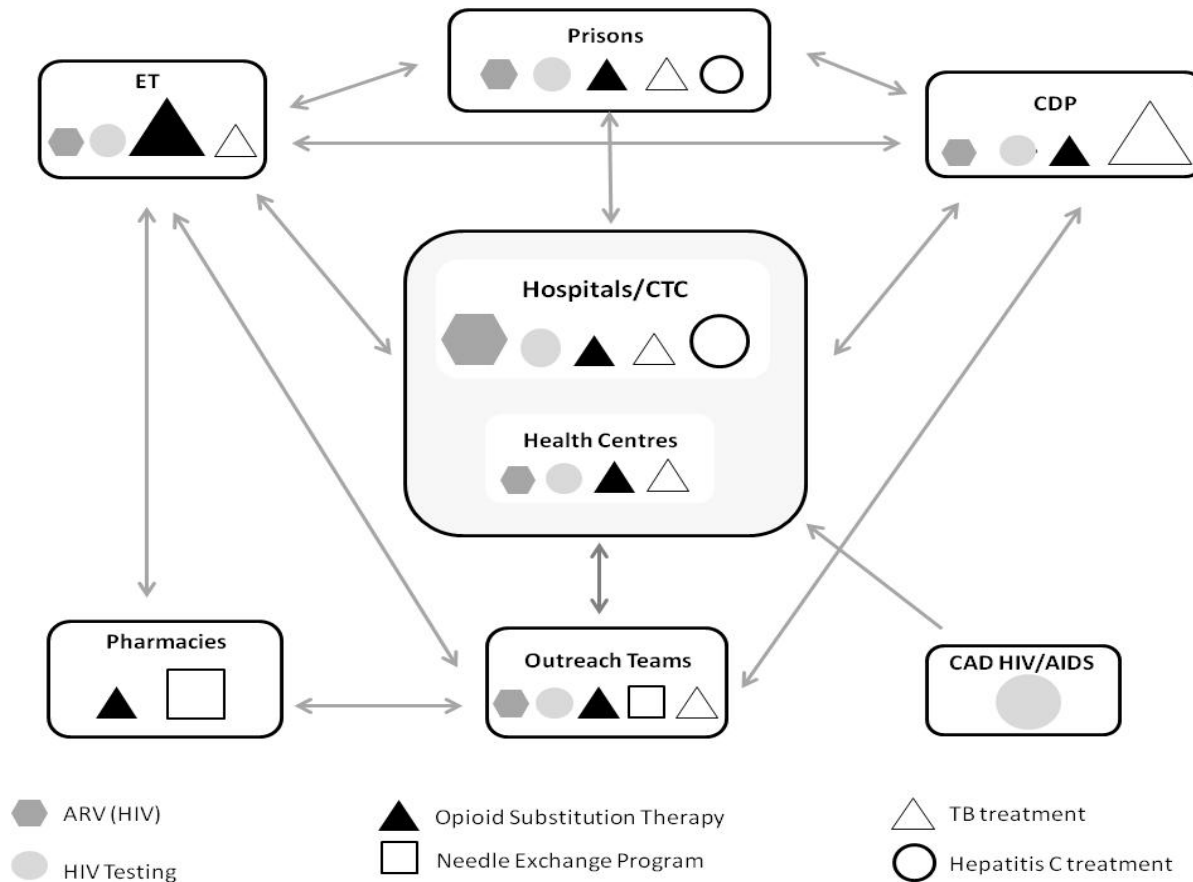
Key Findings



HIV, TB & harm reduction services in Portugal

- **Drug treatment centres ('ETs')**
 - OST – onsite or other healthcare/community settings
 - HIV & HCV screening - rapid HIV testing since 2007
 - Referral for TB screening, and HIV/TB treatment (can be supervised onsite)
- **Pharmacy & outreach:** community-located OST & NSP
- **TB treatment centres ('CDP')**
 - TB screening; routine HIV testing & referral for treatment
 - Active TB treatment via DOTS (1st two weeks home-based/hospital)
 - IPT based on: risk of active TB, anticipated adherence, co-morbidities
- **Hospital-based HIV clinics**
 - Monthly take-home ART from hospital pharmacy ($CD_4 < 350$), 3-9 monthly consults
 - Routine TB screening, referral for treatment
- **HCV treatment** - hospital-based; take-home treatment

Referral network and service integration, Porto



Two models of integration

Combined therapy centre ('CTC'):

Co-located OST, HIV, TB & HCV treatment

Individually-tailored care:
Inter-agency collaboration,
treatment in one
healthcare / community
setting

Drug services a 'way in' to HIV and TB services

- Although typically accessed for social support or OST, ETs and outreach programmes were a key route into TB/HIV services
- Social networks important source of information and encouragement re. accessing drug-related care (ETs – family, community; outreach – peers)
- Contacts within 'system' → circumvent bureaucracy, expedite access
- ET/outreach teams' help navigating services vital to access & adherence - particularly for those with reduced capacity for self-care

"It was this street team that accompanied me to all of the tests I went to do. The street team, CAT [ET], the house, all of them were always with me ... I was in a very bad way, I was dying, I was on my last legs and that street team ... they picked me up because I didn't have enough strength to get myself to hospital. I would either die in the neighbourhood, there where I lived, or they would take me to hospital. So that's what they did."

(Ricardo, male)



Timing of screening & treatment

Service-level

- Once care sought, access to testing & treatment typically prompt (esp. TB)
- Improvements in HIV treatment access in recent years -> ~1 month
- Some missed opportunities re. HIV testing in mainstream services – lengthy referral
- Access to HCV treatment less immediate & requires abstinence from substance use

Individual-level

- Feeling healthy and 'distancing' -> delayed HIV treatment until critically weakness
- Visibility and immediacy of TB prompted care-seeking with support from networks, but often at late stage of illness

"I'd already been at home for 3 months, a very strong cough and I had fever ... the girl I was living with, she said, 'Ó, 'Miguel', go to the hospital', and I [said], 'I won't go to the hospital, I don't like it' ... I reached a point that I've been at home for 3 months like this. I got up, took my brother's car and ... went to the hospital, I was immediately hospitalized there ... the doctor told me I had tuberculosis, if it [had] lasted kind of, a week [longer], I would pass away."

(Miguel, male)



TB and HIV screening data

HIV

- Dramatic decrease in IDU-associated HIV: >1000 → ~200 (2001 -> 2009)
- Rapid testing targeting PWUD increased coverage: 33% → 89% (ETs, 2007)
- Prevalence among PWID (ETs, nationally): 3% HIV-reactive, 1.2% confirmed

TB

- People who use drugs ~ 17% TB cases nationally
- Multi-drug resistance over twice national rate: 2.3% MDR, of which 61% XDR
- Routine TB screening at ETs apparently low: 6% new/existing clients (2010)
- Prevalence among PWID (CDP, Gaia): 19% LTBI, 12% active TB (2005-2007)

HIV-TB

- 94% drug users with TB aware of HIV status; 57% HIV-positive (nationally, 2009)
- *No equivalent data available re. HIV patients' TB status*



TB and HIV treatment uptake data

- 23% HIV-positive new ET clients receiving ART (2009)
- 182 ET clients receiving co-located ART at drug treatment centres (2010)
- 105 ET clients receiving OST and DOTS at ETs nationally (2010)
- $\frac{3}{4}$ (440) drug users with active TB completed treatment (2009)
 - 4% still in treatment, 8% interrupted therapy, 4% lost to follow-up, 9% died
- Following development of collaborative care model at CDP:
 - ~ 4-fold increase in TB screening
 - Reductions in non-adherence (48% -> 24%) and mortality (18% -> 14%)
(Duarte, 2011)



Treatment literacy

- Information on relative benefits of HIV-TB or preventive TB treatment facilitated timely initiation of treatment
- TB treatment widely viewed as mandatory, underpinned by awareness of preventive role and public health benefit:

"I had to take preventative medicine. There were five pills... on an empty stomach in the morning, they actually made me quite ill but I had to take them ... I followed the medication, I could have not couldn't I? ... They advised me to take it because it's like this, while I was taking it I had no problems of catching it [TB], you see, or developing it, but if I hadn't taken ... something could have happened ... it would've be well worse, I would have had to be treated for a lot longer."

(Marcelo, male)

- Perception of HCV as 'normal' and ubiquitous, however, coupled with accounts of painful side-effects, deterred treatment uptake

Integration

- What are the key components of integration, and what influences their relative success?



Collaboration & Communication

- Collaboration between treatment centres, ETs and outreach teams key to effective TB/integrated care - cross-specialty training and meetings
- Recognition of outreach teams' potential to facilitate prompt, active referral
→ move away from restrictive fixed-site treatment delivery
- Good rapport with known colleagues facilitated timely and flexible access – essential to coordinating OST and other medications

"Collaboration at CDP is great ... 'How is tomorrow looking? Are you very busy? Can I send a patient over that I think needs to be tested ... the patient takes this dose [of methadone] ... do me a favour...' Ah, because we stock up CDP with methadone...'If you can, colleague, will you give him the dose tomorrow so that he doesn't have to come here to take it and that way he only goes to one place?'"

(ET provider)

- Formal referral hindered by bureaucratic channels and absence of shared protocols, BUT phone-based contact and up-to-date information on referral network facilitated prompt referral of TB patients to HIV services



Flexibility over treatment location

- Concurrent home-based TB and methadone treatment critical to adherence – especially if physically weak, living far from centre

"They bring it [TB treatment] to my home. If I had to come here I wouldn't do it, and I would have to take two types of transport ... She [the nurse] brings the tuberculosis one and the methadone ... [before] I rarely came here to take it ... I came when I saw that I had to come or when I felt alright, because there were many times when I would take the medication and I would get outside and vomit it all up."

(Maria, female)

- Individually tailored ART delivery outside of HIV services more 'sporadic'
- In case of centre-based treatment, some frustration at need to attend daily and lack of trust to manage own treatment – particularly re. OST



Recognition of agency

- Incentives (travel, meals) → reducing financial and logistical barriers to access
- However, engagement in multiple treatment services ultimately seen to depend on individual desire and action → importance of recognizing clients' agency
- Patient-provider relationship key to engagement in services – particularly for those with limited social support/rejected by family
- Tailored TB 'adherence strategies' involving clients and providers

"If I have a patient who needs tuberculosis treatment ... I give them everything they need, if they want to go to the substitution treatment they get substitution treatment, if they want food, we give them food, teeth help a lot ... a dentists appointment, because by taking drugs they lose their teeth, to be able to get them that makes a huge difference."

(CDP provider)

- However, little mention of user involvement in wider service planning



Wider health & social care needs

- Considering broader health & social care needs critical to engaging clients in HIV and TB services - housing and social security increasingly difficult to access
- Limited involvement of primary care, and discrimination, a concern
- Absence of discrimination in services working with PWID highly valued

"I was here not long ago [Joaquim Urbano], the nurse [said], 'I know you, weren't you hospitalized here?' ... We go there after so many years and people know me. [They say], 'Hi, how are you, everything alright?' ... It's these little details ... do you see? ... They don't look at us as sick people ... We're not treated like sick people there, we're treated like people. They look at us. They have their lives outside, they have their friends outside, right, but they look at us like we look at them. There's no distinction."

(Jacinto, male)



Recommendations & conclusions

- Improve health information systems, particularly re. TB among PWID
- Prioritise TB/HCV screening at ETs, similar to national HIV screening in place
- Renew focus on HCV treatment – challenging ‘normalcy’ and improving integration
- Develop national integration guidelines building on informal experiences of client-centred care - focus on collaboration, communication, flexibility and client agency
- Continuation of outreach programmes critical to ensuring access for most socially marginalised PWID
- Facilitate greater involvement of clients in service planning and delivery
- Work with mainstream care providers to improve understanding of PWIDs’ health and social care needs, and to challenge discrimination

Limitations

- Scarce prevalence and service use data specific to PWID → recommend improved M&E
- PWID interviewed mostly former injectors, all in contact with services – BUT recruitment via outreach teams included marginalised, current users with complex health needs
- Interviews with providers - distinct services agreeing to participate – BUT purposive inclusion of experts from services representing different modes of service delivery

Acknowledgements

- Interview participants and key informants
- National AIDS Coordination, TB Control Programme and other services providing information for existing data review
- Interview, transcription and translation team
- Advisory group
- Smiljka de Lussigny and Susana Silva, for commenting on presentation/rapid assessment report
- WHO-Europe/EC: funding and steering the study

References

- European Centre for Disease Prevention and Control/WHO Regional Office for Europe (2011). Tuberculosis surveillance in Europe 2009. Stockholm.
- Greenwald, G. (2009). Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies. Washington DC, US., CATO Institute.
- World Health Organization (2009). A guide to monitoring and evaluation for collaborative TB/HIV activities, Stop TB Department and Department of HIV/AIDS. Geneva.
- National Institutes of Health Dr. Ricardo Jorge (INSA). *HIV/AIDS: The Situation in Portugal - December 31, 2010*. 2011, Department of Infectious Diseases.
- National Programme to Fight Tuberculosis (PNT). *Point of the Epidemiological Situation and Performance*. 2011.
- Medical School of University of Porto (FMUP). *Programme for Early Detection and Prevention of HIV/AIDS in Drug Users (Klotho) - Monitoring Report (2007-2008)*. 2009.
- Institute for Drugs and Addiction (IDT). *Activities Report 2010*.
- National Programme to Fight Tuberculosis (PNT). *Point of the Epidemiological Situation and Performance*. 2010.
- Duarte, R., et al., *Involving community partners in the management of tuberculosis among drug users*. Public Health, 2010. **125**: p. 60-2.