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Integrating HIV and palliative care: ending the false dichotomy

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The recently announced UNAIDS 90-90-90 targets have emphasised the need to identify strategies to address the complex psychosocial challenges affecting engagement with HIV care for the 13 million people with HIV taking antiretroviral therapy (ART).¹ In *The Lancet HIV*, Keira Lowther and colleagues² offer compelling evidence from the TOPCare trial, showing that integrating palliative care with HIV treatment and care might be one such strategy. In a randomised controlled trial, they studied the effects of a nurse-led palliative care intervention on patient-reported pain and physical and psychological quality of life for people with HIV taking ART. Implemented in a private HIV clinic in Kenya, the intervention was designed to be feasible and scalable in routine HIV care settings, and combined nurse training and mentorship with standardised assessment of, and holistic palliative care for, patients.² Although pain did not differ between the intervention and standard of care groups, the intervention significantly improved patient psychiatric

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morbidity and psychological quality of life. Patients in the intervention group also had significant improvements in the ability to share feelings and receive help for their family to plan for the future, two factors previously identified as burdensome for people with HIV in sub-Saharan Africa.³ Although TOPCare was not designed to assess the effects of integrated palliative care on HIV clinical outcomes, it does show the feasibility of palliative care integration and its effect on psychosocial wellbeing for patients taking ART.

In moving past the false dichotomy that has long divided disease-modifying HIV care and palliative care,⁴ how can efforts to better integrate the two inform global responses to HIV? First, to achieve the UNAIDS targets, greater investment is needed to sustain ART in people with HIV, in addition to intensifying efforts to expand access to HIV testing and treatment. Integrated palliative care has much to offer in this regard by directly addressing barriers to ART adherence and engagement with HIV care, including pain, physical symptom burden, and depression.⁴⁻⁸ Indeed, people with HIV have many comorbidities and psychosocial issues amenable to palliative care. Anxiety and depression, in particular, are amenable to integrated care in view of the scarcity of dedicated mental health services worldwide and the association between these disorders and HIV progression and poor ART adherence if left untreated.^{9,10}

Second, resource constraints and staff shortages have undermined empathetic treatment and patient-centred care in many HIV clinics, threatening to compromise engagement with care for people with HIV.¹¹ Integration of palliative care into routine HIV care might help reorient clinical services towards patients and, consequently, enhance the quality and patient-centredness of healthcare for people with HIV, supporting long-term care engagement.

Until recently, few studies have assessed the effects of integrated palliative care on health outcomes for people with HIV. As a result, several pressing questions remain unanswered. First, the effect of integrated palliative care on HIV clinical outcomes along the entire care continuum is unknown. Further studies are needed to assess the effects of palliative care integration on ART uptake, retention in HIV care, adherence to ART, and viral suppression to ensure findings are most relevant to people with HIV and HIV care providers and policy makers. Second, the best strategy for service integration is uncertain. Early results from a programme in Malawi suggest that a tiered approach involving lay community health workers is feasible to integrate care at home, in the community, and at health-care facilities.¹² In view of the role that community health workers have had in the scale-up of ART worldwide, this tiered approach warrants further investigation. Last, because of the time it takes for health workers to provide integrated palliative care, new strategies are needed both to quickly identify patients who would benefit most from palliative care and to transition care for asymptomatic patients given ART out of facilities and into communities. If HIV and palliative care are to be integrated in busy HIV clinics, new service delivery models are needed that will efficiently overcome the challenges of insufficient staffing and high numbers of patients in facilities.

Lowther and colleagues' study provides new and important insights into the positive effects of integrating HIV care and palliative care for people with HIV. To achieve ambitious

90-90-90 targets, the international community would be wise to advocate for greater access to integrated palliative care in HIV clinics and to increase investments in strengthening health systems to enable the delivery of comprehensive, patient-centred HIV care.

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