FROM SURVEILLANCE EVIDENCE TO IMPLEMENTATION

Applying the RE-AIM Framework to Integrate Alcohol-Related Interventions into HIV Testing and Harm Reduction Services for PWID in Georgia

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Talk Roadmap

1. What the IBSS data show about HIV testing and alcohol use among PWID
2. Why frequent alcohol use creates an implementation gap
3. Evidence-based practice: integrating alcohol screening and brief intervention into HIV testing
4. RE-AIM framework: how to move from evidence to implementation
5. Barriers, facilitators, strategies, anticipated challenges, and next steps

Problem Statement

- PWID remain a key population for HIV prevention in Georgia.
- Recent HIV testing increased substantially between 2009 and 2022, but coverage remains incomplete.
- Frequent alcohol use was independently associated with lower HIV testing uptake.
- This suggests a missed opportunity within current HIV testing and harm reduction services.

Why Frequent Alcohol Use Matters

Behavioral vulnerability
Alcohol use can increase risk behaviors and reduce planning around health-seeking behavior.

Service engagement
Frequent alcohol use may reduce engagement with HIV testing, counseling, prevention, and treatment services.

Implementation opportunity
HIV testing encounters can become entry points for brief alcohol screening and referral.

Key interpretation:

- The finding does not simply identify a risk factor; it points to a modifiable service gap.
- Harm reduction settings already reach PWID and can potentially integrate brief alcohol-related interventions.
- Implementation science helps ask: what should be implemented, where, by whom, and how sustainably?

Evidence Base: IBSS Data

Design
Secondary analysis of five repeated cross-sectional Integrated Bio-Behavioral Surveillance Survey rounds.

Population
People who inject drugs in Georgia across multiple survey cities.

Period
2009, 2012, 2015, 2017, and 2022 survey rounds.

N = 9,010

Pooled sample of PWID

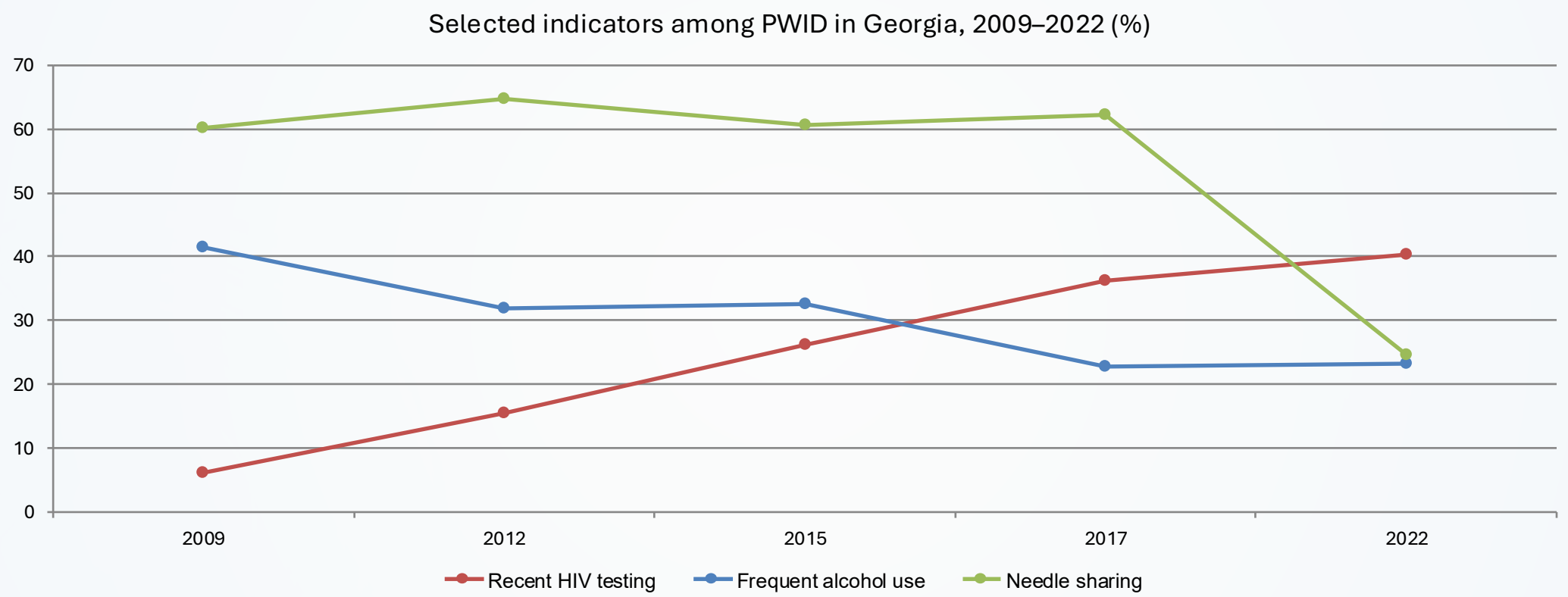
Outcome

HIV testing within the past 12 months

Exposure

Daily or more than once weekly alcohol use

Key Trends: Progress with Remaining Gaps



Source: Submitted manuscript, Table 1.

Main Finding for Implementation

Frequent alcohol use remained independently associated with lower recent HIV testing uptake.

What this means
Existing HIV testing systems may not fully engage PWID who report frequent alcohol use.

Why it matters
Alcohol use is modifiable and can be addressed through brief, low-burden interventions.

aPR 0.72

95% CI: 0.66–0.80

Implementation signal
Surveillance findings can guide service integration inside harm reduction programs.

Implementation Challenge

- HIV testing and harm reduction services may not systematically screen for frequent alcohol use.
- Providers may lack training, time, or referral pathways for alcohol-related support.
- PWID may not perceive alcohol use as relevant to HIV testing or prevention.
- Alcohol-related needs are often addressed separately from HIV prevention, creating fragmented care.

Core challenge

How can alcohol-related interventions be integrated into routine HIV testing and harm reduction services without overburdening clients or providers?

Goal and Evidence-Based Practice

Implementation goal

To explore how brief alcohol screening and intervention can be integrated into routine HIV testing and harm reduction services for PWID in Georgia.

Evidence-based practice to implement better: SBIRT

Screening
Use a validated alcohol screening tool (e.g., AUDIT-C) during HIV testing or outreach encounters.

Brief Intervention
Deliver brief motivational counseling tailored to harm reduction settings.

Referral to Treatment
Link clients with alcohol treatment, mental health, or integrated support services when indicated.

RE-AIM Applied to SBIRT Implementation

Reach	Are PWID with frequent alcohol use being reached through HIV testing services?
Effectiveness	Does SBIRT improve HIV testing uptake and referral to appropriate services?
Adoption	Which harm reduction sites and providers are willing adopt SBIRT.
Implementation	Can SBIRT be delivered consistently and feasibly within existing workflows?
Maintenance	Can SBIRT become part of routine harm reduction practice over time?

Barriers and Facilitators to Implementation

Potential barriers

Stigma and fear of disclosure
Limited time during outreach or testing encounters
Provider training needs for alcohol screening and brief intervention
Limited referral pathways for AUD or mental health services
Low perceived need for alcohol-related support among clients

Potential facilitators

Existing harm reduction infrastructure and outreach networks
Trusted relationships between outreach workers and PWID
Confidential HIV testing platforms already in place
Growing service coverage over time
Surveillance evidence to justify targeted implementation

Pre-implementation assessment could map these barriers and facilitators more formally before pilot implementation.

Implementation Strategies (ERIC-Informed)

Reach	Engage peer outreach workers; tailor messages for PWID with frequent alcohol use
Adoption	Conduct local consensus discussions with NGOs, providers, and policymakers
Implementation	Train providers; adapt workflow; add brief screening to routine HIV testing
Effectiveness	Audit and feedback on screening, testing, and referral indicators`
Maintenance	Develop referral agreements and integrate indicators into routine reporting

Strategies are aligned with ERIC-style implementation strategy categories and adapted for harm reduction settings.

Proposed SBIRT Workflow

1. Routine HIV testing encounter

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2. Alcohol screening (AUDIT-C)

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3. Brief intervention (motivational counseling)

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4. Referral to treatment (when indicated)

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5. Follow-up and monitoring

Pilot setting: selected harm reduction sites in Georgia with existing HIV testing capacity.

Key Considerations for Future Implementation

Acceptability: Will PWID feel comfortable being asked about alcohol use during HIV testing?
Feasibility: Can providers deliver screening and brief intervention within current workload?
Referral capacity: Which services are available for clients who need additional alcohol-related support?
Fidelity: How can we ensure the brief intervention is delivered consistently?
Sustainability: How can the model be maintained after a pilot phase?

Conclusions and Next Steps

- HIV testing among PWID in Georgia improved substantially from 2009 to 2022, but service gaps remain.
- Frequent alcohol use identifies a subgroup with lower recent HIV testing uptake.
- Integrating alcohol screening and brief intervention into harm reduction services is a practical implementation opportunity.
- RE-AIM provides a clear framework to design, test, and scale a future pilot implementation project.

Next steps

Stakeholder consultation → SBIRT adaptation → provider training → feasibility pilot → evaluation using RE-AIM indicators

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Question for discussion:
Have you seen successful examples of integrating alcohol screening into HIV or harm reduction services in other countries, and what lessons from those implementations might be transferable to Georgia?

THANK YOU

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