Health Navigation in HIV Services: A review of the evidence

By Amanda Giacomazzo and Laurel Challacombe

Health navigation is an approach to improving healthcare delivery that helps individuals access the care they need. People called navigators work with individual clients to identify and reduce potential barriers that make it difficult to access quality, timely care. Services are tailored to the needs of the individual and may include activities such as assistance with appointment scheduling, transportation, accompaniment, referrals, health education and counselling.

Since the first health navigation program was established for low-income women with breast cancer in New York City in 1990, navigation programs for other cancers, diabetes, mental illness and HIV have proliferated. Research evidence, especially in cancer, shows that health navigation programs are effective at increasing access to care and improving clinical outcomes.

This review outlines findings on HIV health navigation programs focusing on the following three topics:

1. Programming approaches to health navigation programs for people with HIV and associated activities
2. The target populations for HIV health navigation programs
3. The research evidence associated with the outcomes (e.g., clinical and access to care) of health navigation programs for people with HIV

Further details of the methodology used for the literature review are available near the end of the document.

What are the findings of the evidence review?

Systematic reviews show that health navigation programs, especially in cancer care, are effective at increasing access to care and improving clinical outcomes. In HIV care, the Centers for Disease Control and Prevention in the United States has designated HIV navigation services as a high impact prevention approach. In addition, the International Association of Physicians in AIDS Care’s Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents recommend patient navigators to improve HIV care.

The available research evidence on health navigation approaches and outcomes for people with HIV in high-income settings indicates that health navigation improves patient outcomes:

- There is moderate evidence that health navigation improves clinical outcomes, including achievement of viral load suppression in target populations (although some evidence is mixed, most studies show improvements in clinical outcomes).
- There is moderate evidence that health navigation can improve access to care outcomes (although some evidence is mixed, most studies show improvements in an array of care outcomes).
Additionally, the evidence shows the following:

- Health navigation programs are normally targeted to populations that are specifically at risk for poor HIV treatment adherence and outcomes (e.g., people with HIV who are leaving prison, people who use drugs, people who are newly diagnosed).
- Health navigation programs have similar programming approaches (e.g., strengths-based case management, use of motivational interviewing) but can differ in the specific activities that navigators perform as part of the health navigation program (e.g., appointment reminders, transportation) as well as the type of navigator (e.g., peer, nurse).

See the Strength of evidence section for more information on how the evidence was assessed.

All evidence presented in this evidence review is from the United States. Canadian organizations considering a health navigation program for HIV care may also want to learn from a Canadian jurisdiction that has already implemented one. CATIE has documented three Canadian navigation programs for people living with HIV: Peer Navigation Services in Vancouver, B.C.; the Chronic Health Navigation Program in Kamloops, B.C.; and the Peer-to-Peer Program in Regina, SK.

In addition, CATIE and a national working group have developed national evidence- and practice-based guidelines on peer health navigation in HIV. The guidelines provide agencies with research- and practice-based information and recommendations to develop, implement and strengthen peer health navigation programs. See CATIE’s portal on the Practice Guidelines in Peer Health Navigation for People Living With HIV.

What is health navigation?

Health navigation involves pairing a client with a navigator who supports and guides them through the healthcare system. The work of a navigator includes advocacy, health education, case management and social work components, as well as helping clients to overcome barriers related to achieving their healthcare goals, while facilitating self-management.

For the purpose of this review the following definition of health navigation is used: “A person-centred approach to guide, connect, refer, educate and accompany people with HIV through systems of care. The goals of health navigation are to support people with HIV in their self-determined goals; build the capacity of clients to self-manage their HIV care and navigate systems themselves; and, ultimately, improve their HIV health and overall wellness.”

While the essence of all health navigation programs is similar, there is no standard set of programming approaches or activities that health navigators undertake, as each navigation program targets the specific needs of clients in the local context. Additionally, there are no standard approaches to training, although a variety of resources and tools exist to assist with training.

Why is health navigation for people with HIV important?

Some people with HIV need support to link to and remain engaged in HIV care and treatment to realize the benefits of care. The concept of the HIV treatment cascade (also known as the continuum of care) is one way to determine how well the system is doing to engage and keep people in care and on successful treatment. The cascade is based on the successive steps that are needed for a person living with HIV to achieve and maintain an undetectable viral load, which is an optimal clinical endpoint. Treatment for HIV improves not only health but also quality of life. Additionally, maintaining an undetectable viral load plays a key role in the prevention of HIV transmission.

In Canada, the Public Health Agency of Canada estimates there were 63,100 HIV-positive people in 2016. Their distribution at different points in the treatment cascade is as follows:

- 86% of people with HIV know their status
- 81% of people diagnosed with HIV are taking antiretroviral therapy (ART)
- 91% of people taking ART have an undetectable viral load

As a result, it is estimated that 63% of all people living with HIV have an undetectable viral load. This shows that there is room for improvement in Canada within the treatment cascade.
Health navigators have the potential to play a crucial role in engaging more people in HIV care and treatment by helping to overcome barriers they may be experiencing to optimal care. Navigators can do this by linking clients to appropriate medical care and other social services, supporting clients while in care, helping them to access HIV treatment and when they are ready and supporting clients who are on treatment.

**Barriers to care**

There are two kinds of barriers clients may experience when engaging in the treatment cascade: systems-level barriers and individual barriers. Systems-level barriers are barriers that are caused by the structure of the healthcare system. Lack of insurance and fragmented service delivery are examples of systems-level barriers. Navigators can advocate for reducing these barriers over time, but for individual clients, navigators tend to find ways to reduce the immediate impact these barriers have on that individual’s care by working with the client and other service providers.

Individual-level barriers are specific to each client. A lack of access to transportation, lack of access to adequate food and housing and lack of social support are all examples of individual-level barriers. In the case of HIV care, active substance use and mental illness can also be significant individual-level barriers to care. Navigators can work with clients and service providers to connect people with HIV to needed medical and social services to help to address these individual barriers to care.

There are specific populations that may experience significant or unique structural or individual barriers to care for which there is a lack of research literature, including Indigenous populations, women and youth.

**Who are health navigators and what do they do?**

Health navigators, also known as peer navigators and patient navigators, can share similar approaches to some care coordinators and case managers, and they may be professionals (e.g., social workers, nurse, other allied healthcare workers) or peers (i.e., those with lived experience and an intimate understanding of the circumstances in which many clients live their lives). Whether they are professionals or peers, navigators must have the appropriate cultural knowledge and language skills to work with clients and be able to build trust with clients.

Navigators work with each individual client to identify the barriers they face, find and implement solutions to those barriers and, over time, build the capacity of the client to manage these barriers themselves. By building relationships with each client, navigators may reduce the impact of all barriers on client access to care. This may improve client engagement in care, even in the face of barriers that may make accessing care a challenge.

The specific activities of health navigators are described below in more detail and can include accompanying clients to appointments, creating care plans, connecting clients to medical and social services and providing psychosocial support.

One of the key elements of health navigation is that health navigators cross the threshold of clinical and community-based services, although they could be based in either setting. Another key element is that the work of a health navigator is inextricably linked to, although not limited to, clinical health outcomes (e.g., viral load suppression).

**Who are the populations targeted by health navigation programs for people with HIV?**

Health navigation programs for people with HIV target individuals who are at increased risk of non-adherence or poor retention in HIV treatment or those that have been out of care for an extended period of time. Specific populations of people living with HIV that are targeted as part of the interventions described in this review include:

- individuals being released from prison,
- individuals who use substances,
- newly diagnosed individuals or individuals at high risk for poor access to care/treatment outcomes.
What are the common programming approaches and activities used in health navigation programs for people with HIV?

There is no standard model for health navigation that fits the needs of all populations, settings or systems because navigation programs are built to address the needs of the local context. Navigation may be delivered in different settings (e.g., community, hospital), to different populations (e.g., people who use drugs, people who are newly diagnosed) and by different workers (e.g., healthcare professionals, lay people). The principles of health navigation are consistent across programs in terms of facilitating access to health services through addressing a variety of barriers to care; however, the specific mechanism through which programs achieve this can vary. One common approach is the use of strengths-based models, including motivational interviewing. In a strengths-based model, clients are assisted while acknowledging and capitalizing on their knowledge, skills, capacity and resources. Motivational interviewing assists clients with their readiness for change by helping clients find internal motivation to make changes to their lives.

Other common approaches to health navigation programs for people with HIV include use of:

- nurse health navigators;
- structured educational sessions and topics (e.g., a set number of facilitated educational sessions);
- health navigators as part of a larger clinical and social support team;
- incentives to facilitate engagement in care; and
- peer health navigators.

For more information on peer health navigation in programs for people living with HIV, see the Practice Guidelines in Peer Health Navigation for People Living with HIV.

Evidence included in this review demonstrates a variety of specific tasks associated with the work of a health navigator including:

- transportation assistance;
- appointment reminders and scheduling;
- appointment accompaniment;
- referrals to other community and social services;
- emotional or social support for clients;
- assistance in reviewing health information or coaching;
- use of goal setting;
- development or monitoring of care plans;
- instruction on self-management; and
- outreach.

Outcomes of health navigation programs for people with HIV

Most of the studies included in this review considered the impact of health navigation programs on access to care (e.g., number and frequency of appointments attended, time to first appointment) and clinical outcomes (e.g., viral load suppression). Two qualitative studies considered acceptability or experiences associated with the delivery of health navigation programs.

Access to care and treatment/clinical outcomes

Access to care (i.e., linkage, retention) is critical for improved health outcomes. When in care, people with HIV have better access to medical and other supports that may help them achieve the best health outcomes. Once connected to care, clients can access treatment. Successful HIV treatment is measured by two clinical outcomes: viral load and CD4 count.

Many studies included in this review assessed both access to care and treatment/clinical outcomes. Overall, there is moderate evidence, based on findings from the majority of the studies, that health navigation programs improve
access to care as well as clinical outcomes. Ten studies found positive care outcomes and ten studies found positive clinical outcomes across patient groups.

No systematic reviews focusing exclusively on health navigation for people with HIV were found. The research literature on outcomes of health navigation for people with HIV included here is composed of randomized controlled trials (RCTs; six studies) as well as observational studies (nine studies) and qualitative studies (three studies). While a few studies did not find improvements, these results could be related to a number of factors, including the relatively recent evidence base that has developed on health navigation programs for people with HIV, the lack of a standard approach to health navigation definitions and models, and the fact that comparison groups used case management or other elements of health navigation programming approaches.

**People with HIV being released from prison**

An RCT focusing on people transitioning out of prison in the Linking Inmates to Care in Los Angeles (Link LA) program used lay peer navigators who had had experiences in common with their clients (e.g., prior incarceration, being retained in HIV care, prior substance abuse) to assist clients through the continuum of care and provide assistance with appointments (e.g., reminders, transportation) as well as assistance with goal setting. Participants were randomized to a 12-session, 24-week peer navigation program or a standard transitional case management group. The study found the following:

- There was significantly more linkage within six months in those who received navigation compared with transitional case management (89% versus 77%, respectively). Linkage to care was not different between the two arms at the 12-month period; however, linkage rates were very high, at around 90%, for both groups.
- Significantly more people in the peer navigation arm were virally suppressed (50%) at 12 months compared with those in the usual transitional care arm (36%) (unadjusted).

An RCT of the San Francisco Navigator/Navigation Enhanced Case Management program, which uses intensive case management as well as peer navigators who provide referrals, appointment assistance, outreach and social support to clients, followed participants for 12 months. The study compared navigation enhanced case management (NECM) with treatment as usual (TAU) and found the following:

- NECM participants were significantly more likely to attend medical visits (39%) than the TAU group (28%). NECM participants were also significantly more likely to have non-urgent medical visits for HIV within 30 days of release (44%) than the TAU group (28%). NECM participants were twice as likely to be retained across the 12 months of the project and to be linked to care within 30 days of release.
- There were no significant differences between the groups in achieving an undetectable viral load <50 copies/mL at 12 months (numbers not reported).

An RCT evaluated Project Bridge in Baltimore, Maryland, which randomized HIV-positive people on probation or parole to receive either intensive case management or treatment as usual (TAU). The case manager (i.e., professional navigator) provided appointment assistance, social support, practical assistance and accompaniment, as well as assistance in using social services. The study found no significant differences in access to care outcomes including time to treatment initiation (i.e., intervention participants averaged 27 days between randomization and treatment initiation versus 26 days in TAU group) or in initiation of medication (67% of the navigation group started treatment versus 80% of the TAU group).

An observational study investigated Project Bridge in Rhode Island, which uses intensive case management and motivational interviewing by navigators (social worker) with people being released from prison. The study found that the program was effective in retaining ex-offenders in care. Six months after release, 95% of participants had received medical care in the past six months and at 12 months after release, 96% had received care in the preceding six months.

A qualitative study investigated the COMPASS program in Rhode Island, looking at the use of intensive case management and referral services for people newly diagnosed with HIV in prison, people who are incarcerated with HIV or people with HIV upon their release from prison. Medical and social needs were assessed and services included assistance with linkage to care, substance use treatment and mental health treatment. The study found that 80% of participants reported that they were on HIV treatment and reported high adherence rates (timeframe not stated).
**People with HIV who use drugs**

An RCT of hospitalized participants living with HIV and substance use randomized people to one of three arms: a) professional patient navigation only, b) professional patient navigation with incentives or c) standard care. Participants were recruited from 11 hospitals scattered across the United States. The program used a structured approach to patient navigation with 11 patient navigation sessions and use of contingency management (i.e., a financially based incentive) in one of the intervention arms.\(^{28,29,30}\) Patient navigators provided activities such as coordination of clinical care, help to overcome barriers to care (e.g., transportation and childcare) and psychosocial support.

- In one analysis, no significant differences in viral suppression (<= 200 copies/mL) at 12 months were found (i.e., in the patient navigation only group 36% of participants were virally suppressed; in the patient navigation with incentives group 39% were virally suppressed; in the treatment as usual group 34% were virally suppressed).\(^{28}\)
- In a subsequent analysis, the more sessions attended, the more likely someone was to attain viral suppression regardless of whether they were in the professional patient navigation only or professional patient navigation with incentives group (for those who attended 0–5 sessions 15% were virally suppressed, for those who attended 6–9 sessions 38% were virally suppressed and of those who attended 10–11 sessions 54% were virally suppressed).\(^{29}\)

A quasi-experimental study of Project Bridge Oakland compared professional health navigation services with standard HIV care. The study was conducted in a population of people who use drugs in Oakland, California, to help people with HIV who cycle through the criminal justice system with retention in HIV care. The approach used strengths-based case management and professional health navigation including follow-up and outreach with clients, partnerships with the criminal justice system, accompaniment and the collaboration of a social worker and a physician. The study found significant improvements in viral load suppression: 32% of navigation participants were virally supressed at baseline and this rose to 74% at last follow-up. In comparison, people in standard care did not improve significantly; 45% of participants were virally supressed at baseline and 34% at last follow-up.\(^{30}\)

**Newly diagnosed or generally at risk for poor access to care/treatment outcomes**

An RCT randomized hard-to-reach and ethnic minority (predominantly) participants into an enhanced peer navigation intervention or standard HIV care in three locations in New York, Florida and Puerto Rico. The enhanced peer navigation intervention used a program with one-to-one educational sessions, in addition to activities such as appointment reminders and emotional support for clients, while the standard of HIV care arm included case management and support services. The study found the following.\(^{14}\)

- There was no difference between the navigation group and the standard HIV care group in the time to the first four-month gap in care. However, when looking at the health navigation group only, those in the peer navigation group who completed all seven sessions had significantly fewer four-month gaps in care than those who completed no sessions and those who completed one to six sessions.
- There were no significant differences in viral suppression between the groups at six months (proportion virally suppressed in each group was 52%). Between six and 13 months the standard of care group had a significantly greater proportion of people virally suppressed (65%), as compared with 52% in the enhanced peer intervention group.

An observational study investigated a professional (nurse) navigator program in Washington, D.C., delivered to a group of HIV-positive veterans identified as being poorly engaged in care. The nurse navigator provided HIV education, appointment reminders and adherence support. The study found that:\(^{33}\)

- the program significantly increased the number of clinic visits (from one to two) and rate of medication renewal (from 41% to 81%) after approximately 18 months of follow-up; and
- the percentage of participants with a viral load <200 cells/mL increased from 48% to 69% when followed up approximately one year after enrolment in the program.

Observational studies investigated the HIV Care Coordination program, which uses a multidisciplinary team combined with patient navigation (e.g., appointment assistance, adherence support, accompaniment and health education) for people who are newly diagnosed and those who show poor engagement in care in New York City.
Studies found the following:

- Engagement in care (i.e., having at least two laboratory tests 90 days apart) for people who had been previously diagnosed with HIV (i.e., clients diagnosed more than 12 months before enrolment) increased from 74% at baseline to 91% in 12 months.  
- There were improvements in viral load suppression for people who had been previously diagnosed with HIV, which increased from 32% at baseline to 51% after a year.  
- In an analysis of those with lower mental health functioning, unstable housing or drug use, those previously diagnosed increased their engagement in care from 70% to 91% and viral load suppression significantly increased from 30% to 54% 12 months after enrolment.  
- For people newly diagnosed with HIV, 91% were engaged in care 12 months after program enrolment.  
- For newly diagnosed people, 66% had achieved viral suppression by 12 months.  

An observational study of four navigator programs in Portland, Oregon; Seattle, Washington; Boston, Massachusetts; and Washington, D.C., that use peers and paraprofessionals for people at risk of poor engagement in primary care or at risk for falling out of care compared care visits and viral loads at program entry to 12 months later. The navigators provided many services, including development of a care plan, navigation of the health and social system, accompaniment and referrals. The study found the following:

- The proportion of patients with two or more HIV care visits in the past six months increased from 64% at study entry to 87% six months after working with a navigator. In addition, the proportion of clients with no HIV care in the past six months decreased from 12% at study entry to 5% six months after starting with a navigator.  
- The proportion of clients with an undetectable viral load increased from 35% at program entry to 54% at six months and 53% at 12 months. The program resulted in a 50% increase in the proportion of people with an undetectable viral load.  

An observational study investigated the Louisiana Positive Charge initiative, an HIV navigation program in Louisiana that employs both peer and professional navigators to work with people newly diagnosed with HIV or who have been out of care for more than six months. The navigators help to overcome barriers to care, educate clients, create a care plan, provide referrals and provide emotional support. This study found the following:

- 95% of clients enrolled in the program had a visit with a medical provider after working with a navigator (timeframe not stated).  
- Median viral load improved from 15,607 to 267 copies/mL and median CD4 count improved from 297 to 367 (24% improvement) after enrolment in a health navigation program.  

An observational study from Washington, D.C., compared healthcare sites that were funded by the Ryan White Care Act to provide HIV medical case management (MCM) with sites that were not funded to provide this intervention; however, some of these sites did provide forms of case management or other interventions. Professional navigators provided many services to newly diagnosed clients including intake and assessment, development of a comprehensive care plan, linkages and coordination of services, and adherence support to newly diagnosed clients. This study defined retention in care as a client having two viral load or CD4 tests within 12 months. This study found the following:

- Clinics funded to provide MCM retained significantly more clients, 76% of clients, compared with 60% of clients in the other sites.  
- There was no difference in viral suppression rates between the different comparison sites.  

An observational study from Los Angeles county investigated the impact of paraprofessional navigators with experience in HIV case management and Antiretroviral Treatment and Access to Services training (a navigation program that links people to care) on people who were disengaged from care, newly diagnosed or recently released from prison. The navigation program builds relationships with clients, assesses their needs, links them to resources and transitions clients to more long-term care. The study found the following:

- The program was successful at linking clients to care with 94% of clients linked to care within 12 months of enrolling (68% linked within three months and 85% linked within six months) and retaining them in care with 82% retained in care (defined as attending a second medical appointment three to 12 months after they were
Among those who were linked to care there was a significant increase in the number of clients with an undetectable viral load after 12 months in the program (51% virally suppressed at the time of enrolment compared with 63% between three and 12 months after enrolment).

An observational study on the Barrier to Elimination and Care Navigation (BEACON) Project engaged with people who have been out of care for 12 months in Saint Louis, Missouri. The program uses peer navigators (who perform accompaniment and adherence support), intensive case management, a community HIV nurse and an emergency stabilization fund that could be used for a variety of purposes (e.g., assistance with rent). The study found the following:

- 77% of people engaged in the program were retained in care at six months.
- There were significant improvements in viral load suppression (<200 copies/mL) at six months as compared with baseline among those engaged in care (13% of participants virally suppressed at baseline compared with 71% at the follow-up). Additionally, significant improvements in undetectable viral loads (<20 copies/mL) were found, with 6% of participants having undetectable viral loads at baseline and 45% at six-month follow-up.

Satisfaction and acceptability outcomes

Two qualitative studies considered the satisfaction and acceptability of health navigation programs in women of colour and found favourable results. In a study on the Guide to Healing program at the Infectious Disease Clinic at the University of North Carolina Chapel Hill, participants reported positive experiences associated with the use of nurse navigators who provided orientation to care, care coordination and contact using a strength-based approach and motivational interviewing. The study suggests that nurses could be uniquely qualified to deliver navigation programs. A study on the mPeer2Peer program in Baltimore, Maryland, a program combining peer navigation and a smart phone application, found clients reported that peer navigation was important in assisting them to engage in HIV care.

What does this mean for organizations considering a health navigation program in HIV care?

There is a developing body of evidence that demonstrates the benefits of health navigation programs in improving access to care and clinical outcomes in people living with HIV. Evidence was mixed in some instances, although most studies show positive findings. Consistencies across models point to areas that should be considered when implementing a health navigation program, including the use of motivational interviewing and a strengths-based model of care, although the variance in the components of health navigation programs can make it difficult to determine what is driving improvements. A scoping review considered the factors that impact the success of health navigation programs that link primary care (community health centres, family health teams, etc.) with community-based health and social services. Eleven factors were identified that can impact the success of a navigation program, including (but not limited to) the following:

- Client characteristics: the complexity of client needs, language and geographic barriers and the ability of the agency to provide culturally appropriate services when designing a navigation program
- Navigator recruitment and training: encouraging the growth and development of navigators, training on problem solving for complex cases, fostering collaboration among navigators and orienting navigators to the specific needs of their clients
- Time and resources: adequate human resources, financial resources, physical resources such as space for navigators to work and technological resources such as electronic health record systems
- Community services: whether there are sufficient resources in the community where clients can be referred
- Client uptake: buy-in for the navigation program from clients, use of diverse strategies to recruit to the program, and addressing any potential stigmas that may exist

While the evidence included in this review shows promise for the use of health navigation programs for people with HIV, implementation of specific health navigation program components should be considered in the context of barriers specifically related to the target population, while uniquely identifying barriers to care for individual clients. The fact that health navigation programs offer flexibility in their approach to achieving improved access to care and clinical outcomes should be considered, as well as the target populations and the location of program delivery.
Lastly, the unique knowledge and skills that different health navigators can bring to a program, as well as the training provided to these navigators, are important factors to consider.

Since the strength of the evidence currently available is still of moderate quality, future studies are needed on the use of health navigation programs in more and varied populations and settings. A recent review on health navigation for people with chronic diseases stated that “given the increasing popularity of patient navigators, future studies should use a consistent definition for patient navigation and determine which elements of this intervention are most likely to lead to improved outcomes.” This is consistent with conclusions that can be drawn from the literature reviewed for this evidence review on health navigation programs for people with HIV.

**Methodology**

The purpose of this literature review is to summarize research information on health navigation for those with HIV specifically. The Key search terms were HIV; health navigation; navigation; and intensive case management. Search results were limited to research literature published between January 2014 and March 2018. Relevant literature from before 2014 (e.g., literature on HIV services) from a previous CATIE evidence review (2014) on health navigation was also included. Information related to other conditions (e.g., cancer, diabetes) was considered in the broad context but was considered out of scope for specific outcomes (i.e., access to care, treatment and satisfaction/acceptability outcomes), as well as programming approaches and target population summaries. Articles were identified using PubMed, as well as through the review of reference lists of relevant articles.

While the definition of health navigation intrinsically includes components of linkage to care, for the purposes of this review, interventions that focused on only linkage to care were excluded. Programs that considered linkage to care in addition to components of access to care and treatment outcomes within a health navigation framework were assessed on an individual basis.

**Strength of evidence**

The available scientific literature was reviewed to determine access to care, treatment/clinical and acceptability outcomes of health navigation programs for people with HIV. Descriptions of health navigation programs across studies were also analyzed for approaches and target population studied. Details on the methodology are at the end of this article. All available evidence relevant to the Canadian context came from the United States. Although the evidence rating is flexible (to a certain degree), ratings were based on the following criteria:

1. **Strong evidence**: At least one systematic review or a large body of randomized controlled trials (RCTs) and quasi-experimental studies (with the support of observational research) supports the ability of the intervention to impact the outcome.
2. **Moderate evidence**: Limited randomized controlled trials and/or quasi-experimental studies (with the support of observational research) support the ability of the intervention to impact the outcome.
3. **Limited evidence**: Observational research supports the ability of the intervention to impact the outcome.
4. **No evidence**: No published research exists to support the ability of the intervention to impact the outcome.

The strength of the evidence is based on the quantity and quality of the evidence (type of study design) and not the size of the outcome.

This review attempts to synthesize various approaches to health navigation programs that are described in the research literature to help better understand the more widely used and consistent approaches across health navigation programs for people with HIV.

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Amanda Giacomazzo is CATIE’s knowledge specialist, treatment and prevention programming. She holds a Masters degree in health science with specialised training in health services and policy research and has previously worked in knowledge translation and public health at the provincial level and in the not for profit sector.

Laurel Challacombe holds a Masters degree in Epidemiology and is currently Associate Director, Research/Evaluation and Prevention Science at CATIE. Laurel has worked in the field of HIV for more than 10 years and has held various positions in both provincial and regional organizations, working in research and knowledge transfer and exchange.
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Production of this content has been made possible through a financial contribution from the Public Health Agency of Canada.

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