European Conference on

Hepatitis C and Drug Use

Berlin 23-24 October 2014

Need for action:

End the silence on

Hepatitis C

PROGRAMME

Organisers

The Hepatitis C Initiative

is responsible for the international part of the conference.

The Hepatitis C Initiative is a European Commission funded project (DG JUST/DPIP program) and brings together more than 30 organisations – networks, grass root organisations, NGO's, health institutes and universities – all of them working in the field of infection diseases. The aim of the project is, to contribute to the improvement of knowledge and capacities and to create synergy in order to rise awareness on Hepatitis C and Drug Use. *www.hepatitis-c-initiative.eu*

Aktionsbündnis Hepatitis und Drogengebrauch

The ‚Aktionsbündnis Hepatitis und Drogengebrauch' is responsible for the German part of the conference. The alliance is advocating for awareness rising and improved hepatitis policies in Germany. *www.akzept.org/hepatitis_c_fachtag/index.html*

AKTIONSBÜNDNIS HEPATITIS UND DROGENGEBRAUCH

The international part of the conference is organised with financial support from the Drug Prevention and Information Programme (DPIP) of the European Union.
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Welcome
to the first European Conference on Hepatitis C and Drug Use

Need for action: End the silence on Hepatitis C

On behalf of the organisers of the conference, we would like to welcome you to this unique conference. The conference is organised in the framework of the 'European Hepatitis C Initiative', which is financially supported by the European Commission, Drug Prevention and Information Programme.

Today the hepatitis C virus (HCV) affects an estimated 9 million of European citizens. People who inject drugs, or who injected in their past, are the largest group with estimated prevalence rates in some European countries up to 90%. In other populations such as among „men who have sex with men (MSM)", infection rates are also rising rapidly. Without proper treatment HCV can be a serious and even deadly disease.

The considerable and increasing burden of HCV across Europe is rarely reflected in awareness or attention to the issue. However, this is about to change. Highly effective new treatments are being introduced and there is a growing recognition that truly inclusive testing and treatment policies need to be established now.

The first European conference will bring together key actors on HCV, including drug user community representatives, harm reduction experts, health care professionals, pharmaceutical companies, researchers and policy makers to develop pathways for effective health responses and to open treatment for those who need it.

We would like to thank the European Commission and our sponsors for their support.

We look forward to two days of lively discussion, innovative thinking and a renewed commitment of political action in Berlin.

On behalf of the partners of the conference,

The Correlation team

Conference endorsed by

EASL EUROPEAN ASSOCIATION FOR THE STUDY OF THE LIVER | ENDORSED EVENT

INPUD International Network of People who Use Drugs

HARM REDUCTION INTERNATIONAL

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Programme

Thursday, 23 October 2014

14.30 - 15.00 Opening and welcome	
Video intro - Swedish Drug User Union Dr. Ingo Michels, Head of Unit, Office of the Federal Drug Commissioner of Germany Marco Jesse, JES Bundesverband	Chair: Eberhard Schatz, Correlation Network, Amsterdam
15.00 - 15.30 Keynote speech	
Hepatitis C and Drug Use - turn the page Dr. med. Jörg Gölz, Berlin	
15.30 - 16.00 Coffee break	
16.00 - 17.00 3 national examples of hepatitis policies: Policy-maker - drug user representative	
Scotland: Nicola Rowan, National Coordinator for Viral Hepatitis, Scottish Government Tony Cassidy, Scottish Drug User Representative **France** Prof Daniel Dhumeaux, University of Paris-Est Miguel Velazquez Gorsse, president ASUD **Germany** Dr. Ingo Michels, Head of Unit, Office of the Federal Drug Commissioner Dirk Schäffer, European Network of People Who Use Drugs, Deutsche Aids Hilfe	Moderator: Prof. Heino Stöver, University of Applied Sciences, Frankfurt

Thursday, 23 October 2014

17.00 - 18.30 What do we want for the future: Presenting the Manifesto / Berlin Declaration:

7 stakeholders for the 7 key messages for a better hepatitis C policy and practice:

Moderator: Jose Queiroz, Apdes, Porto

1. **Scale Up Harm Reduction Community Based Programmes:**
   Maria Phelan, Harm Reduction International (HRI)

2. **Access to HCV Testing, Treatment and Care Services**
   Prof. Mojca Maticic, Clinic for Infectious Diseases and Febrile Illnesses University Medical Centre Ljubljana

3. **Access to Affordable HCV Treatments**
   Anya Sarang, Andrey Rylkov Foundation, Moscow

4. **Decriminalisation of People Who Use Drugs**
   Christopher Hallam, International Drug Policy Consortium

5. **Meaningful Involvement of High Risk Communities**
   Efi Kokkini, European Network of People Who Use Drugs

6. **Improved HCV and Health Literacy**
   Magdalena Harris, PHD, Centre of Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine

7. **Effective Targeted HCV Strategies and Action Plans**
   Achim Kautz, European Liver Patient Association (ELPA)

18.30 Reception and buffet

Friday, 24 October 2014

Major session (MS)	Workshop (WS)	Parallell session (PS)	

09.00 - 10.30

Access to hepatitis C treatment in Europe and abroad - the politics on pricing
Chair: Azzi Momenghalibaf, Open Society Foundation

This session aims to unpack and explore the controversy around affordability and access to new hepatitis C treatments in both wealthy and middle-income countries through a moderated multi-stakeholder panel discussion that includes patient advocates and policy makers.

Speakers:
Luis Mendao, European Aids Treatment Group
Chloe Forette, Medicine du Monde
Paata Sabelashvili, Georgian Harm Reduction Network
Gaëlle Krikorian, Advisor on Intellectual Property and Access to Knowledge, Green Party in the EP
Ricardo Bapista Leite, MP Portugal

10.30 - 11.00 Coffee break

11.00 - 12.30

Chair: Dagmar Hedrich, EMCDDA **HCV treatment and care - the way forward**	Chair: Katrin Schiffer, Correlation **HCV in migrants en MSM - challenges and responses**	Chair: Angelos Hazakis, Hep B & C Policy Association **HCV in prison settings**	**Workshop W1** **Demonstration of FibroScan® testing** Dr. Elisabeth Avril, Assoc. Gaia, Paris The mobile FibroScan® : An innovative project of hepatitis screening among people who use drugs in „Ile-de-France“ (Paris region) incl. a FibroScan® demonstration A10 **Workshop W2** **How to create impact on policy making for HCV?** Jose Queiroz, Apdes The workshop will present shortly the Policy and Advocacy strategy developed, establishing bridges with the national realities and reflecting about practical examples. It aims to prepare the field for a sustainable platform in the field of hepatitis C and drug use A11
Amber Arain - Treatment efficiency and safety results of first generation DAA-based regimes A1 Chis Ford - Integrated care for the treatment of Hepatitis C: Ways of improving access to treatment A2 Magdalena Harris - ‘Treatment as prevention‘ for hepatitis C: What does this mean for people who inject drugs? A3	Fred Bladou - SLAM - Drugs by injection in the gay community in a sexual context A4 Mick Quinlan - Hepatitis C and MSM in Ireland – a need for awareness? A5 Luis Mendao - HCV and HIV community testing and linkage to care for migrants A6	Vic Arendt - High recurrence rate of Hepatitis c infection after treatment in prison A7 Heino Stöver - Epidemiology and Prevention of HCV in Prisons A8 Discussion: Recommendations regarding hepatitis C prevention, screening and treatment in prisons A9	

Friday, 24 October 2014

12.30 - 14.00 Lunch

14.00 - 15.30

Chair: Achim Kautz, ELPA **Hepatitis C testing and treatment barriers among active drug users**	Chair: Berne Stralenkrantz, EuroNPUD **Drug User Driven Session**	Chair: John Peter Kools, Correlation Network **Hep C policy between negligence and adaption: Ukraine, Russia and European Union**	Chair: Mika Mikkonen, A klinikka **Reach out to patient groups - what works and what not**
Heike Zurhold - Hepatitis C testing and treatment barriers among active drug users in European cities A12	Miguel Velazquez Gorsse - ASUD's experience: 20 years of peer-to-peer-work to become aware of Hep C A15	Anya Sarang - Hepatitis C in Russia: an epidemic of negligence A18	Marie Debrus - Experience from an Innovative community-based educational intervention among active injecting drug users A21
Ruth Zimmermann - Hepatitis C testing and treatment barriers among active drug users in Germany – results from the DRUCK-study A13	Maria Teresa Ninni - HCV Peer Support: the alliance between practical experiences and professional knowledge A16	Ludmila Maistat- Scaling up access to HCV treatment for PWID's in Ukraine A19	Agnes van der Poel - Case finding and treatment of HCV in addiction care A22
Marie Jauffret-Roustide - Rapid testing and access to HCV treatment among drug users – paradoxical perceptions of health professionals. Results of "ANRS-Cube" research A14	Discussion The Swedish Drug User Union: Liver or die ! A17	Mojca Maticic - Strategies for treatment of hepatitis C in Europe: an overview A20	Alexander Würfel - Lasting improvement in the level of care for patients on substitution treatment with hepatitis C – experiences of AbbVie Germany A23
			Workshop: W3 **HCV prevention skills** Trainer: Danny Morris, Andrew Preston Topics to be addressed: strategies to reduce accidental sharing; the role of foil provision; increasing NPS coverage A24

15.30 - 16.00 Coffee break

16.00 - 17.00 The future of HCV treatment and policy: what's next

Chair: Jeff Lazarus, Rigshospitalet, University of Copenhagen

The closing plenary brings together European hepatitis experts from an array of setting to discuss the future of hepatitis C treatment in Europe and abroad. And what we should do about it

Discussion with the audience

17.00 Closing

Abstracts

A1

HCV treatment and care – the way forward
treatment efficacy and safety results of first generation DAA-based regimes

A. Arain, G. Robaeys, S. Christensen, D. Lucidarme, P. Bruggmann, J. Kunkel, S. Keim, W. Iraqi, M. Jäkel, R. DeMasi, I. Lonjon-Domanec, G.R. Foster

Amber Arain
Contact: amber.arain@uhasselt.be

Introduction:
There is currently a paucity of data on efficacy, safety, or tolerability of direct-acting antiviral agents (DAAs) for chronic hepatitis C virus (HCV) infection in large cohorts of people who inject drugs (PWIDs) or ex-PWIDs.

Methods:
INTEGRATE is an observational multicenter study designed to evaluate efficacy, safety, and adherence of telaprevir administered in combination with peginterferon alfa (PegIFN) and ribavirin (RBV) in ex-PWIDs with genotype 1 chronic hepatitis C in routine clinical practice. Patients included were treatment naïve or relapsers with any fibrosis stage, receiving opioid substitution therapy (OST) and/or being followed in an addiction center. On treatment virological response was determined at week 4 and 12 and Sustained Virological Response 12 weeks after the end of treatment. Adherence was measured by patient questionnaire (M-MASRI) and Health-related quality of life based on patient-reported outcomes.

Results:
The INTEGRATE study enrolled 46 patients at 18 study sites in 6 European countries. 87% were male; 91% Caucasian; median age 43.5 years; median age at first drug use 19 years; 72% reported in their past history use of heroin including 33% daily and 30% reported use of cocaine including 21% daily; 91% of patients were on OST and 89% were followed in addiction center. Nineteen (41%) patients reported alcohol consumption. Forty-two (91%) patients were treatment-naïve for HCV; among patients with liver fibrosis assessment 12/41 (29%) had cirrhosis or bridging fibrosis; 61% of patients had HCV RNA ≥800,000 IU/mL and 80% had HCV genotype subtype 1a.

Conclusions:
INTEGRATE is one of the largest prospectively designed studies to date in people considered as ex-PWIDs treated for Hepatitis C in a real world setting with a first generation DAA-based regimen. On treatment efficacy and safety results up to week 16 will be presented at the congress.

A2

Integrated care for the treatment of Hepatitis C:
Ways of improving access to treatment

Chris Ford
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In Europe people who use drugs (PUDs) have the highest risk of Hepatitis C infection and it is an important cause of morbidity and mortality. Hepatitis C is now a curable disease but less than half the people with the infection have been diagnosed. Treatment has improved dramatically in the last year, and continues to improve, and is successful in the majority of persons treated but it remains unavailable to many.
Treatment is also not equally available to PUDs for a variety of reasons including prejudice in health workers and stigmatization. The majority of patients with chronic HCV infection who are referred for treatment undergo therapy in secondary or tertiary referral centers but only a proportion get offered and complete therapy. Hence alternative approaches to treatment delivery have and are being considered.

In some countries HCV case-finding and treatment in specialist drug dependency services have been shown to be cost–effective and in others open access services. Studies in the UK indicate that a large proportion of patients who are known to have chronic hepatitis C do not access anti-viral therapy care pathways and in studies with selected patient groups primary care led therapy has shown improved up-take of therapy with satisfactory treatment response rates, especially where this is linked with other health care and drug treatment. These findings have led to antiviral therapy being delivered in the primary care setting and discussions regarding the optimal way to manage this approach are on-going.
Providing quality screening, care and treatment for persons with HCV infection requires involvement of appropriately trained individuals as well as facilities suitable for the regular monitoring of patients, especially those on therapy.
This paper will present an overview of integrated care for the treatment of hepatitis C in people who use drugs using UK General Practice as an example. It will be followed by a further two models of good practice in Europe, where hepatitis C treatment is being provided.

A3

‘Treatment as prevention’ for hepatitis C: Addressing the needs of people who inject drugs?

Magdalena Harris
Contact: magdalena.harris@lshtm.ac.uk

Background:
We are in the midst of a changing hepatitis C treatment landscape. New drug developments promise shorter, more efficacious and tolerable regimes, while modelling work illustrates the prevention impact of up-scaling hepatitis C treatment access to people who inject drugs (PWID). Treatment as prevention (TasP) is a concept common to the HIV sector, but new in regard to hepatitis C. While this discourse reflects an increased sense of treatment possibility, particularly in a context of limited treatment access for PWID, critical reflection on its implications are warranted. In this paper I provide an overview of the hepatitis C TasP rationale and, drawing on debates in the HIV field alongside qualitative data, reflect on the potential limitations of this framework and the conditions under which it might be workable.

Methods:
Qualitative interview data from three recent London-based hepatitis C studies are drawn on. Thirty seven PWID were interviewed for the prevention focused ‘Staying Safe’ study (2010=2012); 34 PWID and 13 service providers for the hepatitis C treatment focused ‘Barriers and Facilitators’ study (2011); and 27 people living with hepatitis C, as well as 18 providers and stakeholders were interviewed for the ongoing longitudinal ‘HCV Treatment Journey’ study (2012 – 2016). TasP literature relating to both hepatitis C and HIV inform the analysis.

Findings:
Well evidenced are the multiple barriers to hepatitis C (HCV) treatment access and uptake for people who inject drugs (PWID); barriers rarely reflected on in the emergent HCV TasP literature. Innovations in service delivery, eligibility criteria and drug development hold the potential to ameliorate some of these obstacles, particularly at the individual and clinical level, but many social structural barriers remain pertinent.

Conclusions:
Hepatitis C treatment as a prevention strategy can only be realisable in a context of enhanced harm reduction access, meaningful community engagement, and enabling environment interventions informed by the needs and perspectives of PWID.

A4

SLAM – Drugs by injection in the gay community in a sexual context

Fred Bladou, Daniela Rojas Castro, Guillemette Quatremère, Samantha Tessier, Nicolas Foureur, Vincent Labrouve, Xavier Pascal, Sandrine Fournier, Marie Jauffret-Roustide.

Fred Bladou
Contact: fbladou@aides.org

Background:
In 2011, in France, the emergence of "slam", designating drug injection among gay men in a sexual context was taken up by health stakeholders. As slam is rarely documented, research was carried out by AIDES, a community-based association, in collaboration with other health institutions. The objective was to take stock of this phenomenon regarding definitions, products used, effects, connection with sexuality and harm reduction strategies as well as prevention and medical needs as declared by slam practitioners.
A second research has been directed in 2013 to determinate the number and the specifics of the people using Slam related to the professional health services.

Methodology:
In 2012, a multidisciplinary team (an anthropologist, two sociologists, a dermato-venereologist, a health psychologist and an "insider") conducted a rapid assessment process (RAP). This ethnographic approach insists on the role of the insider, a man practising slam, who ensures the appropriateness of questions and facilitates the rapport researchers-interviewees. The team worked collectively during the whole process (constructing the interview guide, conducting the interviews, analysis and report writing). 23 people from different cities of France were interviewed; 17 current and ex- "slammers" and 6 clinicians, addictologists or members of NGOs.
In 2013, a survey on line has been addressed to more than a thousand services and medical organizations (CSAPA, CAARUD, HIV/HEP B & C hospital services).

Results:
Slam was defined as the injection of products (méphédrone and derivatives, crystal, cocaine) in a sexual context. Most people slamming were HIV+, variable ages (25-59), practising hard sex (e.g. fisting) and were employed. Physical and psychological complications (including addiction) were observed in some of them. They do not attend specialized services because they do not identify as "typical injecting drug users". Interviewees asked for physicians to be at least informed about slam and drug consumption in general, in order to ensure a more effective linkage to care if needed (including just thinking of asking about drug consumption).
The results of the survey in 2013 showed: 92 users has been attending by 20 different structures. 53% of the users are HIV positive. Most of 50% of the professionals discovered injection in a sexual context trough a drug user.

Conclusion:
Although qualitative research regarding injecting drug use among gay men is scarce, it is a rich source of information about this phenomenon and can help develop adequate and appropriate political, institutional and associative responses.

A5

A5 Hepatitis C and MSM in Ireland – a need for awareness?

Mick Quinlan
Contact: mick.quinlan@hse.ie

This presentation will include an overview of services, research and health promotion aimed at MSM in Ireland

1. In Ireland Hepatitis C only became a notifiable disease in 2004. Reports from the Health Protection Surveillance Centre (HPSC) show that of the 9,000 cases reported between 2007 and 2014 where risk factor is known the sexual orientation is not always known. www.HPSC.ie and by email: Dr Lelia Thornton, Specialist in Public Health Medicine, HPSC.

2. A The largest survey ever held among men who have sex with men (The European MSM Internet Survey (EMIS 2010) contained a question on Hepatitis C. Of the 180,000 respondents a small percentage indicated a hepatitis C diagnosis. The EMIS Network. EMIS 2010: The European Men-Who-Have-Sex-With-Men Internet Survey. Findings from 38 countries. Stockholm: European Centre for Disease Prevention and Control, 2013" (ISBN 978-92-9193-458-4).

   B In the Irish EMIS 2010 report Man2Man Report 4 Our Sexua Health twenty men (0.8%)reported a hepatitis diagnosis. http://www.gayhealthnetwork.ie/research

3. The Gay Men's Health Service HSE based in Dublin is the only statutory sexual health Clinic for MSM in Ireland. Hepatitis C testing is part of the service and some information exist of the number tested and diagnosed with Hep C. http://hse.ie/eng/services/list/5/sexhealth/gmhs

4. Since 2011 the Health Services Executive(HSE) and Gay Health Network (GHN) has run the only national HIV and Sexual Health Awareness Programme for MSM in Ireland. The www.man2man.ie promotion highlights various aspects of sexual health presently HIV testing and Condom use.

This presentation will provide an overview of the above and also discuss the growing awareness of the need to impart further information to non-drug using sexually active MSM

A6

HCV and HIV testing and linkage to care for migrants

Diana Silva, Adriana Curado, Ricardo Fuertes, Catarina Barroso, João Santa Maria, Marta Luz, Edna Tavares, Danae Clavijo, Maria João Brás, Daniel Simões, Luís Mendão

Luís Mendão
Contact: luis.mendao@netvisao.pt

Introduction:
In Portugal, Hepatitis C affects mostly people who inject drugs and also on a smaller scale people who were exposed to risk in several contexts (prisons, healthcare facilities, blood transfusions prior to 1992). The HIV epidemic is also concentrated in people who inject drugs, prisoners, migrants from high prevalence countries, specific groups of sex workers, transgender women and men who have sex with men (MSM).
In 2012, GAT started a community-based rapid testing project at the IN-Mouraria centre targeting people who use drugs (PUD) and migrants in a district with high presence of drug use, sex work, migrant communities and a process of gentrification that also attracts other groups (migrants from low prevalence countries, MSM).

Methodology:
IN-Mouraria centre offers HIV rapid testing (Determine) and HCV rapid testing (OraSure). Counselling and testing are performed by a trained nurse and information and referrals by peer counsellors. Opening hours are 5 days/week (2pm to 8pm). All services provided are confidential and free of charge.
HCV rapid test was performed if at least one of the following criteria had ever occurred: injecting drug use; sharing smoking or sniffing material; ever been in prison; men who had unprotected anal sex with men; unprotected anal sex with an HCV positive partner; have received a piercing or tattoo in an unclean environment using unsterile equipment; blood transfusion or organ transplant prior to 1992 or outside Europe or North America; health professional.
People with reactive results or previously diagnosed are offered active referrals to the infectious disease clinic (including migrants in an irregular situation and undocumented people) and a member of staff is available to physically accompany to the first medical appointment.

Results:
Between October 2012 and August 2014, 478 clients were tested for HIV and/or HCV at the community centre IN-Mouraria. Of the 478 clients tested, 227 were migrants, 79 PUD and 172 were from other groups, including the general population. 59% of the clients were male and the mean age was 35 years.
The overall HIV and HCV prevalence was 2.35% and 9.14%, respectively. PUD were the group with higher prevalence for HIV (5.56%) and HCV (29.17%). From those PUD who tested positive for HIV and HCV (n=17), 82% had history of injecting drug use and 41% had been in prison. Among migrants, the HIV prevalence was 1.77% and the HCV prevalence 2.30%. The majority of reactive cases (82%) were from Sub-Saharan African countries.

Discussion:
Our results confirm the high burden of HIV and HCV among people who inject drugs and migrants from high prevalence countries. Providing community-based HCV and HIV rapid testing and linkage to care is a very important strategy to reach vulnerable populations, especially those groups facing linguistic and cultural barriers or high levels of stigmatization.

A7

High recurrence rate of hepatitis c infection after treatment in prison

V. Arendt, P. Hoffman, JH François, L Guillorit, J. Meyers, P. Leider, D. Struck, T. Staub, C. Devaux

C. Devaux
Contact: carole.devaux@crp-sante.lu

Background and aims:
Access to treatment for viral hepatitis for prison inmates remains a debated topic. We conducted a prospective study to investigate access to and effectiveness of treatment for hepatitis C in prison in Luxembourg.

Methods:
All prisoners were offered screening for hepatitis, STIs and tuberculosis. Between January 2003 and December 2012, 665 patients were tested positive for HCV, of which 79 were not aware of their infection before prison. During the study period, the standard of care treatment was daily distribution of Ribavirin and weekly injection of Peg-interferon. Sustained virological response was evaluated 3 and 6 months after the end of the therapy. HCV viral load was measured using the cobas AmpliPrep/cobas TaqMan HCV Test v 2.0,HCV (Roche). Genotype was determined in 482 patients using INNO-LiPA HCV 2.0 (Innogenetics).

Results:
During the study period, 209/665 prisoners (31.4%) started therapy, mainly injecting drug users. Genotype (GT) distribution was: GT1 : 52%; GT3 : 41.3%; others : 6.4%. Overall 42 treated prisoners were lost to follow-up and 45 were treatment failures. On an intention to treat basis, 105 prisoners (50.2%)achieved sustained virological response 6 months after the end of the therapy; 17 patients (8.1%) had an undetectable viral load 3 months after the end of the therapy but no 6 months post-treatment sample was available, giving thus 122/209 (58.4%) cured patients with 61% for GT3 and 53% for GT1. After a mean follow-up of 3.2 years following 6 months of therapy, 20 cured patients exhibited another detectable viral load, giving a reinfection rate of 16.3%.

Conclusions:
A stay in prison is an effective opportunity to treat a group of HCV –infected patients which have otherwise very limited access to therapy. Although a good success rate of HCV therapy wasobserved, the rate of reinfection after discharge from prison was high. Prevention during treatment while patients are in prison should be therefore strongly strengthen.

A8

Epidemiology and Prevention of HCV in Prisons

Heino Stöver
Contact: hstoever@fb4.fh-frankfurt.de

Globally, more than 10 million people are held in prisons and other places of detention at any given time [1]. Due to the high turnover rate in the prison population, it is estimated that more than 30 million people spend time in prisons each year. Drug users in particular often spend relatively short periods in prisons before returning to their communities.
Many people held in prisons have severe problems associated with drug use, together with related health and social disadvantages. Those categorised as problematic drug users constitute a substantial proportion of prison

populations in Europe. Counting only sentenced prisoners with drug offences as the main offence, 15 of 26 European countries for which information is available report proportions over 15% [2]. The number of drug users in prisons is even higher. A systematic review of international studies – with a preponderance of studies conducted in the United States – found that 10% to 48% of men and 30% to 60% of women were dependent on or used illicit drugs in the month before entering prison [3]. In the European Union, it has been estimated that about half of all members of the prison population have used illicit drugs at some time in their lives [4].
Hepatitis C virus (HCV) infection, which is both preventable and treatable, is a major concern in correctional settings. People who inject drugs (PWID) have high rates of imprisonment, largely due to the criminalization of their drug use and to the tendency to fund drug use through crime. The dynamics of illicit drug use, HCV infection and imprisonment are closely intertwined [5] found that in Australian prisons, one-third of entering inmates tested positive for HCV antibodies. The proportion of positive results among entering inmates who injected drugs was 56%. Furthermore, one-third of inmates who were anti-HCV positive were unaware of their infection status.
In general, 80% of HCV-infected individuals develop chronic HCV. Of these, 10% to 15% will develop liver cirrhosis [6]. Three to four percent of patients with cirrhosis develop hepatocellular carcinoma every year [7,8]. Worldwide, 25% of liver cancer cases are attributable to HCV infection [9].
Given the interplay between HCV, drug use and incarceration, HCV has the potential to impose a major disease burden on European prison populations. The purpose of this article is to review evidence and formulate recommendations regarding how to address this situation.

A9

Recommendations regarding hepatitis C prevention, screening and treatment in prisons

Heino Stöver
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In custodial settings, effective and efficient prevention models applied in the community are very rarely implemented. Only approximately 60 out of more than 10,000 prisons worldwide provide needle exchange. Thus, HCV prevention is almost exclusively limited to verbal advices, leaflets and other measures directed to cognitive behavioural change. Although the outcome of HCV antiviral treatment is comparable to non-substance users and substance users out of prison, the uptake for antiviral treatment is extremely low. The re-infection rate after successful antiviral treatment in prisons is low and comparable to re-infection rates outside of prison.
Based on a literature review in order to assess the spread of hepatitis C among prisoners globally and to learn more about the impact for the prison system and especially the staff, recommendations regarding hepatitis C prevention, screening and treatment in prisons have been formulated and will be discussed during the session.

A10

The mobile FibroScan®: An innovative project of hepatitis screening among people who use drugs in “Ile-de-France” (Paris region)

Elisabeth Avril
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Background:
Many infected drug users (HCV) are not treated for fear of treatment, examinations or because they underestimate the severity of the disease. Access to health care is one of the policy priorities for reducing risks. Also, consultations and interviews in street outreach program are opportunities for screening, counselling and care. The FibroScan® is a real new Harm Reduction tool. It measures the liver stiffness (elasticity) and allows the liver fibrosis diagnosis. It‘s non invasive, not painful, rapid (3-5 minutes), gives an instant result. If added to blood tests, can replace the biopsy.
A multidisciplinary team of Gaïa reaches around 25 partner centers (OST centers drop in centers) and offers a half

day of liver fibrosis screening by Fibroscan in each center on a quarterly basis. The intervention is not limited to the medical exam. We also propose to PWUD some awareness activities/sessions on hepatitis (health prevention peer worker). PuD participate in the development of flyers and games around HCV. The team also offers training on hepatitis for health workers of the partner centres.

The results:
Since December 2012 :

- 25 partner centres have been visited on a quarterly basis
- 493 exams: 80% of men, 20% of women => around 1600 exams made since the beginning of the mobile FibroScan project
- Half of the PuD declare to have been in contact with HCV but almost half of them are not medically followed at all and have not began any healthcare process (42%).
- In particular, they face difficulties to access PCR :
- No healthcare coverage
- Extreme damaged veins which can prevent from a classic blood sample
- Reluctance to approach medical workers/facilities
- In average, their last screening are 2 years ½ old (HIV and/or HCV and /or HBV). But almost 50% of them declare having taken a “risk” after this last screening.
- We list the types of risks that can exist in terms of virus transmission and ask them if they faced any situation like sharing materials or unprotected sex. Sharing very small material such as sniff straws, pipes used for smoking crack, withers, cottons, cutters, is very often not known as a very high risk in terms of HCV transmission. We very often take the time to explain those risks and do counselling sessions on how to get and use sterile consumption material
- ¼ of the PuD who have been through the medical exam have an elasticity score above 7 kPa ; 8% present a score above 12 kPa which means a severe liver fibrosis level
- Almost half of the patients have a regular alcohol consumption: more than twice a week and in average 10 units of alcohol per day which is way more the WHO recommendations

Since beginning of 2014 we start the development of screening possibilities:

- TROD (rapid tests for HIV and HCV)
- PCR dried blood tests

Perspectives:

- Develop a harm reduction approach for alcohol
- Work in collaboration with Research National Reference Centre on hepatitis
- Make available hepatology consultations on the field (in the mobile unit)
- Raise awareness activities (creation of specific tools for each type of users that we meet in collaboration with partner teams)
- Develop the training department on hepatitis

Aïi

Workshop
How to create impact on policy making for HCV?

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The workshop will present shortly the Policy and Advocacy strategy developed, establishing bridges with the national realities and reflecting about practical examples. It aims to prepare the field for a sustainable platform in field of hepatitis C and drug use

Ai2

Hepatitis C testing and treatment barriers among active drug users in European cities

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HCV antibody testing of active drug users is a major approach in terms of harm reduction and HCV prevention. The importance for drug users to be aware of their HCV status resulted in recent research and testing activities. Thus, on the European level there is currently a European Initiative on Hepatitis C and Drug Use, and on the German level there is the "Druck-Studie" conducted by the Robert-Koch-Institut.
With regard to the European initiative a short monitoring instrument has been implemented in four European countries to screen active drug users for their HCV testing rates and their need to uptake HCV antibody testing. The monitoring instrument covered questions on risk behaviour, previous antibody testing and test results. Main objective was to identify drug users who are recommended for antibody testing, and in case of being antibody-positive to learn about processes of further diagnosis. The monitoring had been implemented progressively in eleven low-threshold services in the four countries during the period from 1. April 2013 to 31. December 2013. In addition a more detailed questionnaire has been conducted with active drug users which focused on their reasons for and locations of HCV testing and their referral and uptake of HCV treatment – if indicated.
In the session the results of the monitoring and the questionnaire will be presented. There are considerable differences in age, uptake of HCV antibody testing, test results and testing needs between the European countries. Furthermore, the findings demonstrate that there are huge barriers to HCV RNA testing, treatment referral and initiation of antiviral treatment.
The European findings and the German findings will be discussed as to their consequences for improving HCV prevention among both drug users and staff of drug services. The driving question is which approaches are necessary to increase RNA testing in HCV antibody-positive drug users. What should drug and healthcare services provide in order to facilitate access to further HCV diagnosis and potential antiviral treatment.

Remark:
The paper will be presented and discussed in a common session with the presentation of the German "Druck-Studie" conducted by the Robert-Koch-Institut.

Ai3

Hepatitis C testing and treatment barriers among active drug users in Germany – results from the German DRUCK-study

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People who inject drugs (PWID) are at high risk for blood-borne infections, particularly Hepatitis C virus (HCV) infection. In Germany, like in other Western European countries, HCV is hyperendemic in PWID, who represent the group with the highest HCV prevalence and incidence. To generate prevalence and related behavioural data and to enhance prevention against blood-borne infections among PWID in Germany, we conducted a multicentre sero- and behavioural survey. From May 2011 to June 2014 we recruited 2,068 current injectors (PWID aged 16 years+ and having injected within last 12 months) via respondent driven sampling in low-threshold drug services in eight German cities. Dried capillary blood samples of participants were anonymously tested for anti-HCV and HCV-RNA. A detailed face-to-face interview was conducted, capturing data on HCV-related knowledge, former testing, and sexual and injecting risk behaviour. We trained staff in low-threshold facilities to offer voluntary pre- and post-test-counselling (VCT) during the study to evaluate acceptance of VCT in this setting.
Preliminary results show a prevalence of anti-HCV in the eight study cities ranging between 31%-73% and of HCV-RNA between 23%-50%. 66%-93% of participants reported having ever been tested for HCV, most of them

during opioid substitution therapy (OST), and 56%-73% of these reported to be HCV positive. We found that the status “HCV positive” was often not clearly defined for the person, and that a distinct knowledge of test results and own HCV(-RNA) status was often missing. 23-48% of persons with a reported positive HCV status answered that they have had treatment experience in the past, but only in a small proportion was treated successfully. Negative associations with Interferon treatment, fear of adverse events, and missing knowledge on treatment options were reported by a majority of the study population.
VCT and targeted short counselling regarding knowledge gaps revealed during the interview was well accepted by both, PWID and staff of the low threshold drug services. We recommend participatory implementation of these interventions in low threshold settings for PWID. Staff need to be trained to provide detailed information on transmission of HCV, prevention and current treatment options. Short and targeted interventions have shown to be well accepted. Active injectors should regularly be tested for anti-HCV and HCV-RNA, and should be provided advice on their status and the potential consequences. Furthermore, collaboration of low threshold services and treatment centres/ medical doctors offering OST is recommended to link infected persons into medical care.

Ai4

Rapid testing and access to HCV treatment - paradoxical perceptions of health profesionals

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Background:
Despite a high level of HCV testing among drug users (91% but at least once during lifetime), one third of HCV positive drug users are still not aware of their serological status. Tests need to be much more frequent and their access has to be made easier. Even though drug users have access to testing during lifetime, their living conditions can depart them from frequent testing, whereas previous test result is rapidly obsolete regarding repeated risk behaviors.

Method:
A multidisciplinary research on the compliance to HIV, HCV and HBV rapid testing and linkage to care in a medical, associative and community-based context, was settled in 2013-2014. This “ANRS-Cube” research is a combination of an epidemiological interventional study led among 1600 persons (from September 2014 on) and a sociological study concerning the perception of this experimentation. This sociological part started ahead, in December 2013. The targeted population is composed of three sub-groups: drug users, MSM and transgender people (mainly sex workers). The methodology is based on 9 focus groups gathering healthcare and harm reduction professionals (3 before, and 6 during and after the intervention) and on 40 interviews with the beneficiaries of this new device.

Results:
The preliminary results of the study highlight the reluctance of professionals working with MSM to discuss the drug use patterns, considered as a private matter, when proposing the rapid test. Concerning the transgender sex workers, drug use linked to sexual risk behavior in the course of their work is addressed by the professionals working in this field. Harm reduction professionals also emphasize their reluctance to discuss sexual practices with drug users in the same context. Nowadays, drug users’ irresponsibility stereotypes are still present among health workers. Drug users are still perceived as a population with difficulties to follow HCV treatments, because of economic, social and for some psychiatric reasons. Among health workers, this representation is inseparable from an ethical concern on the feasibility of the follow-up of people in precarious situation.

Conclusion:
Post-test counselling training days and focus groups were a valuable space for the professionals, allowing them to express their ethical and logistic concerns on the implementation of rapid testing and access to HCV treatment. They discussed the inadequacies of current missions in their own centers. It also was the space to make a projection of the implementation of the protocol, with several discussions on how to approach sexual risk behavior and rapid testing benefits with drug users in a context of risk exposure. Reluctances and strong expectations exist concerning the benefits of a community based, rapid testing in medical context.

Ai5

ASUD‘s experience: years of peer-to-peer work to become aware of Hep C

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The aim of this speech is firstly to show how the experience accumulated by a Drug Users (D.U.) association as ASUD (Auto-support et Réduction des Risques parmi les Usagers et Ex-usagers de Drogues – Peer-to-Peer and Harm Reduction between Drug and Ex-drug Users) in the fight against AIDS has shown very useful to face the new challenge of HCV, an epidemic called by HWO as a real “ viral time bomb! “ For that reason, we´ll present a brief historical review of how, why and under what circumstances a group of people decided to create ASUD in the early nineties. We’ll expose quickly, among several others topics, why one of the three key populations in AIDS epidemic in France was the D.U. , a point that we have to relate with the dire situation of French D.Us. in as much the prohibition of drugs was, and is still, very strictly applied in this country… We’ll end this first part with the social, health and political consequences of the AIDS epidemic (especially it’s surprising key role in both the born and development of the D.U. movement and the Harm Reduction politics in France…). This last presentation will allow us to explain how the strength of prohibition has very negative consequences for fighting an illness such as HCV and is a real burden for a good harm reduction politics. This particular point can be useful to the current debate of how we can fight HCV, a silent but extremely deadly epidemic, and about the new politics that should be applied to drugs-related problems (this debate took place firstly in Vienna in 2014, but it will continue until 2016, in New York when the UNGASS (United Nations General Assembly Special Section) will examine the question of the appropriateness of a radical change international conventions on drug war…
In the second and last part, we’ll present how ASUD has been involved so rapidly and so early in the fight against HCV, because our experience of AIDS has been essential for this new struggle. In this field, we’ll present the first material we made several years ago onto the most recent ones. It will not be an exhaustive presentation, but one of the different ways we chose to fight HCV: it can be articles about the disease, some with from an insider’s viewpoint (the patient), others from a harm reduction physician’s one but used to D.Us. problems, or about prevention of infection by Injector Drug Users (I.D.U.) , printing posters with funny drawings by a famous artist in the French D.U. community, and finally, presenting brochures enabling readers to acquire a better knowledge of this illness as well as how to make a safe injection, divers advices, and so on.
So, as you can easily see, this paper is an interrelated mix of HIV/HCV fighting experiences along years of a well established drug user association that presents two but narrowly linked sides of this struggle, i.e. the sanitary and the political one.

Ai6

HCV Peer Support Project

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HCV Emergency. To build the alliance between the practical experience and the profession al knowledge is a training project designed for all operators acting in the social and health areas and peer support individuals at various levels involved in the infectious disease and addiction field. This is Section 2 of our training project- Section 1 being devoted to the training of self-help and peer support HCV + individuals –set up within the framework of HCV Peer Support Project promoted by COBS (Piedmont Low Threshold Operators Committee) and Isola di Arran Association. The aim of the plan is to present a formative opportunity to the participants based on a direct comparison between the direct individual experience and the professional expertise of health workers. An update on prevention practices, access to cure and compliance optimization will be contemplated in the training. In addition to that other aspects will be taken into consideration such as the social and health rights of the HCV+ person, how and where the competence of HCV+ subjects can be valued both in the local service system and in the region.

Ai7

Discussion

The Swedish Drug User Union: Liver or die !

Ai8

Hepatitis C in Russia: an epidemic of negligence

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Introduction:
At least 5 million people in Russia are infected with hepatitis C (approximately 4.4% of the adult population). HCV especially affects people who inject drugs (PWID), of whom 1.3 million are estimated to be infected. Despite high prevalence and increasing incidence, access to treatment of hepatitis C in the country remains limited. While the government acknowledges hepatitis C as a socially significant disease and commits to providing free treatment for those in need, in reality, the treatment programs receive minimal funding at the federal and local levels due to high cost of the medications.

Methods:
The study was carried out in 2012¬13 with the goal to describe processes around and barriers to adequate HCV treatment provision. The methods included review of scientific papers, collection of epidemiology data, in¬depth interviews held in three regional centers (Yekaterinburg, Barnaul, Togliatti) and at the federal level with patients who started and/or finished hepatitis C treatment (n=21), with doctors who prescribe and manage treatment (n=5) and experts (n=4).

Findings: The main problems identified during the study were absence of: a Federal Program with targeted funds to HCV treatment; clinical protocols for HCV treatment and of a national registry of patients in need of hepatitis C treatment. While PWUD is the group most affected by the virus they are routinely excluded from treatment and the main “justification” for exclusion of PWUD is doctors belief that PWUD cannot adhere. At the same time, nothing is done in order to build adherence support structures, for example opiate substitution programs that could significantly improve PWUD adherence, are legally banned. While patients with co-infection of HIV and HCV represent a priority group for treatment, less than 10% of them actually get it. High prices of combination therapy and absence of price reduction mechanisms present major barrier to expansion of treatment provision; lack of capacities of the AIDS centers to attend to the adequate level of treatment and complex bureaucracy around medication control inhibits some doctors to start HCV treatment with their patients; patient selection criteria are very subjective, the most common requirement being ‘treatment should be provided only to socially reliable citizens’; an important factor is also low level of patients awareness caused by restricted access to diagnostics, low level or absence of counseling on treatment options and lack of community activism on treatment access.

Discussion and recommendations:
There is an urgent need to significantly expand access to HCV treatment for millions of people in need. In order to achieve this, Russia needs to develop: clinical protocols for treatment of viral hepatitis C; a separate Federal Program for treatment of HCV; standards of outpatient treatment, including detailed description of the procedure and the levels of service provision. PWUD have to be included into treatment programs. This can be achieved by building client management services (social and psychological support, self-help groups), case management and patients schools. Methadone/buprenorphine substitution therapy programs should be urgently legalized in order to safeguard treatment adherence in patience with opioid dependency. Cost reduction of medications procured by the government could be achieved through modifying procurement procedures, negotiating with manufacturers, reducing initial auction prices – or introducing compulsory licensing and local production of medications that have social relevance. Training for medical staff in local policlinics in order to decentralize treatment provision and alleviating the bureaucratic burden from medical specialists is needed. Treatment demand should be scaled up through quality counselling by medical specialists and peers and through patient schools and wider information campaigns. Harm reduction projects have to be expanded to ensure timely diagnosis and involvement in treatment programs. Patient organizations and groups should actively advocate for increased access to treatment, including through strategic litigation and peer education.

A19

Scaling up access to HCV treatment for PWID‘ s in Ukraine

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Background:
1.7 million of Ukrainians are HCV infected (WHO´s data). 56% of HIV positive people are co-infected with HCV. More than 90% of HIV-positive IDUs suffer from HCV (Alliance´s data). HCV awareness level of general population, professional communities and vulnerable groups was very low in 2011. The state did not recognize the epidemic. There was no National Program on viral hepatitis and funds allocated for ensuring accessible HCV diagnostic and treatment for those in need. Most of Ukrainians, in particular, vulnerable groups, could not afford treatment due to extremely high prices.

Description:
In 2012, Alliance started integrating Hep C into its harm reduction programs(funded by GF) implemented in all Ukrainian regions and involving around 120NGOs, activists, experts, medical doctors and patients from all over Ukraine .
The following methods were used:

1. HCV public awareness campaigns among general population, professional communities and vulnerable groups which included:
    - HCV screenings among vulnerable groups (IDUs first of all)
    - trainings for medical doctors on treating IDUs
    - HCV schools and trainings for patients (IDUs)
    - information materials distribution, motivating people to get HCV tested
2. mobilizing communities and involving them in the „Demand treatment!“ advocacy campaign which included:
    - a series of public events all over Ukraine aimed at raising awareness and pushing national and local authorities to approve HCV programs and allocate state and local funds for hep C treatment
    - collecting data and HCV treatment needs (mapping screening results)
    - wide media coverage
3. price reduction for HCV diagnostics and treatment:
    - negotiating prices with pharma and diagnostic laboratories
    - Alliance´s procurements at reduced prices
    - pushing national and local authorities allocate state funds and procure at the same reduced price
    - launch of HCV treatment programs for HIV/HCV co-infected IDUs.

Lessons learned:
Hep C integration in harm reduction programs was crucial for changing situation in HCV area. Mobilizing communities played key role in advocating for HCV National Program and state funds for treatment. Our direct negotiations with pharma resulted in price reduction by2.5 times for treatment for Alliance´s programs and state funded program as well. Price for diagnostics was reduced twice.

Conclusions/Next steps:
Alliance plans to extend HCV treatment programs for IDUs with further price reduction for peg-inf-riba treatment and launching the first ever treatment programs with DAAs (Sofosbunational Hepatitis Program&treatment guidelines and allocating state funds for treatment.

A20

National strategies, plans and guidelines for the treatment of hepatitis C in people who inject drugs in Europe: an overview

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Hepatitis C virus (HCV) infection represents a major global health problem, which in developed countries mostly affects people who inject drugs (PWID). It shows great diversity among European countries, not only in its prevalence in the general population and among PWID, but also in the treatment of hepatitis C. The existence of efficient and safe treatment for HCV has the potential to be used in the majority of infected PWID and prevent the associated morbidity and mortality. It has shown to be as successful and safe among PWID as among other population, with low risk of reinfection (1-5% per year), and has shown to be cost-effective. Besides, opioid substitution treatment (OST), to which some European countries are still reluctant, has proved to facilitate HCV treatment. Sustained virological response also reduces the likelihood of HCV transmission among PWID by eliminating potential sources of infection. Therefore, PWID should represent one of the most important target populations for testing and treatment of HCV infection.

HCV treatment in PWID has been controversial for decades and the treatment uptake in developed countries has been estimated 3-4% only. Historically, the international and national treatment guidelines have excluded PWID, particularly current injectors, from being treated for hepatitis C. Finally, in 2014, the Clinical Practice Guidelines of the European Association for the Study of the Liver (EASL) consider substance users as a treatable patient group at risk provided they wish to receive treatment and are willing and able to maintain follow-up visits on an individual basis, preferably using a multidisciplinary approach.

Barriers to HCV treatment are present on patient (lack of knowledge, financial resources and fear of adverse effects and stigma), provider (adherence and the risk of re-infection) and system level (no national strategies, action plans and treatment guidelines). The extremely varied political, economic and social circumstances of different European countries lead to very different health needs and health outcomes at the national level. Treatment funding, availability of anti-HCV drugs and the settings for HCV treatment in PWID vary immensely among the European countries. Policies, strategies and guidelines for HCV management therefore need to be tailored to the specific national or sub-national context.

In a recent study of 33 European countries data on available national strategy, action plan and guidelines for HCV treatment in general population and in PWID specifically were collected prospectively by means of a structured electronic questionnaire and analyzed accordingly. Twenty-two respondents came from non-governmental organizations, six from public health institutions, four from university institutions and one was an independent consultant. Fourteen (42.4%) countries reported on having national strategy and/or national action plan for HCV treatment, from which 10/14 also reported national strategy and/or national action plan for treatment of HCV infection in PWID. Nearly three-quarters (24/33 or 72.7%) reported to have national HCV treatment guidelines, in the majority (22/33 or 66.7%) PWID were included into the guidelines. Fourteen (42.4%) countries reported to have separate guidelines for treatment of HCV infection in PWID. Almost half of the countries involved in this study reported on having separate guidelines for HCV treatment in PWID on OST.

Starting with setting up or precisely using already existing national strategies, action plans and guidelines for this vulnerable population, management of HCV infection in PWID should become one of the healthcare priorities in all European countries. With the upcoming new direct acting antivirals, there is hope that HCV infection can be cured in the majority of patients in the nearest future. However, the most highly potent medications may remain under-utilised until the group at greatest risk for HCV infection is recognized as urgently needing treatment.

A2i

Experience from an Innovative community-based educational intervention among active injecting drug users in order to reduce hepatitis C transmission, developed since 2011 in Paris and Colombes in France

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Issue:
Following concerns have been documented among people who inject drugs (PWIDs):

- Unsafe injection practices are prevalent among PWIDs.
- Hepatitis C Virus (HCV) prevalence remains at high level among PWIDs (around two thirds).
- Local viral and bacterial infections with negative consequences are frequent (abscesses in particular).
- There are misconceptions about HCV transmission routes and confusion with the HIV ones.
- A wrong self-perception of risks.
- A gap between what people think they do and what they really do are common.
- After more than twenty years of Harm Reduction interventions targeting PWIDs, it seems that distributing sterile injection materials and implementing classical information, education and communication strategies to people who inject drugs is not enough.

Project:
Since 2010, Médecins du Monde – France and two drop in centre (DIC): Sida Paroles and Gaïa Paris, have implemented a pilot program based on an interactive, face-to-face educational approach regarding drug injection related risk behaviours: the ERLI project. ERLI is a French acronym, meaning “Education & Training on Risks and Harms Associated with Injection” (“Education aux Risques Liés à l’Injection”).
After an initial explanation of the project, its context, and its role in listening to each person’s need, the support workers offer to be present whilst the person is injecting. This means that the person does the injection with a substance they usually take, in the presence of two support workers or facilitators, one of whom is always a nurse. The first session allows the individuals’ habits to be observed. They do the injection in the way they normally do, without any intervention from us, except we may ask some details about exactly how they do it. An evaluation of the session is then prepared and points of view of users and support workers are shared, particularly in respect of the concept of risk, and objectives are defined for the subsequent sessions. At a follow-up session, the support workers can, with the individual’s consent, intervene whilst the injection is being done. The aim is not that the injection should be done perfectly, but that the individual’s self-reliance be investigated. Without doing it for them, the issue is to make them aware of the risks they may be taking and to teach them the best way of doing things taking into account their injecting habits, their abilities, and surroundings. It is up to the person concerned to decide and define the risks he/she wishes to take.

Outcomes:
In 2013, the team carried out:

- 637 educational sessions in Paris at the North Station (DIC Gaïa Paris) with 89 different drug users (24 women, 65 men, average age: 34,7 years [20-58])
- 369 educational sessions in Colombes (DIC Sida Paroles) with 39 different drug users (2 women, 37 men, average age: 46,8 years [29-53])

After more than 4 years of experimentation, our first results outline that included injecting drug users showed important risk behaviours for transmission of HCV and bacterial infections. Being able to observe the practices of the users helps to better identify the risks generally underestimated and to highlight other risks than those taken by sharing paraphernalia. Data indicate considerable behavioural changes during follow up after educational sessions. Those preliminary results provide the first evidence for relevancy and efficiency of this interactive educational approach. This strategy should be further investigated, researched and potentially scaled up within common harm reduction services, including safe consumption room.

A22

Case finding and treatment of HCV in addiction care
Making pathways with 'breakthrough' method

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Hepatitis C and drug users
Hepatitis C is a contagious disease that is transmissible through blood. Eighty per cent of infections become chronic, and untreated the disease can lead to severe health damage. In the Netherlands hard drug users belong to the groups with the highest number of HCV infections, esp. among opiate users who ever injected drugs. After the identification of HCV an effective but burdensome treatment is available. However, the infection is not traced or identified for the majority of Dutch hard drug users. Addiction care organisations and hospitals need to work together in case finding and treatment of hard drug using patients.

Breakthrough project: pathways
In the breakthrough project addiction care and hospitals are supported in HCV case finding and treatment. A team of experts in the field (liver specialists, addiction specialists, breakthrough experts) helps local teams to develop a local pathway, as a first step to improve the HCV care for drug users. Working with the breakthrough method means that teams tackle difficulties in Plan-Do-Check-Act cycles, as the teams formulate goals, explore and set up co-creation and support the user/patient as best as possible. Teams come together four times in working conferences to exchange best practices and help each other.

Local team, local pathway
Each team exists of professionals of both addiction care (doctor, nurse, manager) and hospital (liver treatment officer/ specialist, nurse). This local team is responsible for the development of the HCV pathway and for trying out the pathway. Three working conferences took place, the fourth (and closing conference) is in September 2014. A separate conference was organised to inform management about financing the implementation and execution of the pathway.
In 2013 the project started with 11 teams from 6 (of the 11) Dutch addiction care organisations. Two teams/organisations dropped out because of cut backs in staff. In 2014 4 care organisations participate in the project, with 9 local teams. Of the teams 8 are set up around methadone maintenance treatment and 1 around a 24/7 housing program.
The HCV pathways consist of several steps: motivating and screening patients (with swabs or blood test), test counselling, decision on starting treatment, support patients in treatment. One of the success factors is the collaboration between addiction care and hospital professionals. Once they knew each other, they all were enthusiastic to start working together.
Teams set goals on the percentage of patients/users they want to test on HCV. Besides that, they set other goals, e.g. in the collaboration between addiction care and hospital, filing of results in patient files, and information seeking behaviour of professionals. Addiction care and hospital professionals also work together on training and education.
Teams make use of each other's products and results, such as information flyers for patients and tips on blood testing.
Next steps: working with the pathways, broader implementation (more teams in participating organisations). This breakthrough project rounds up in December 2014.

With financial support from:
- Netherlands Organisation for Health Research and Development (ZonMw), dept. Infectious Diseases
- Ministry of Health, through Network of Infectious Diseases & Harm Reduction
- Pharmaceutical companies: Roche, MSD, Janssen-Cilag

A23

Lasting improvement in the level of care for patients on substitution treatment with hepatitis C – experiences of AbbVie Germany

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Current situation

- To improve patients' lives in a meaningful way, AbbVie's approach is holistic, revolving around a profound scientific understanding of the particular disease and the needs of patients.
- AbbVie is currently engaged in developing an interferon-free treatment regimen for hepatitis C patients with genotype 1, which is the most common form of the disease in Europe and the USA.

Contribution of AbbVie - Commitment to improve the level of care for patients on substitution treatment –

- To improve the level of care for patients on substitution treatment in Germany, AbbVie pledges to identify the specific support requirements of patients and their advisors in various areas of life and wants to develop lasting solutions together with strong partners that address those needs.
- These efforts are focused on stabilizing the social setting of the patients concerned, this being a crucial prerequisite for substitution treatment.
- In these efforts, the company intends to work closely with strong partners from the fields of drug addiction treatment, psychological counselling and patient self-help groups. The goal in the medium term is to set up a joint alliance for the improvement of the care situation for patients on substitution treatment also with respect to hepatitis C by involving additional partners and to develop specific end-to-end support programs for Stuttgart, the chosen pilot region.

Presentation

- In his presentation, the general manager of AbbVie Germany will talk about his visit to the Caritas substitution center and Caritas High Noon contact café in Stuttgart Germany and his insights gained into the real-life situation of those involved.
- The reason of his visits: To achieve lasting improvement in the level of care for patients on substitution treatment, it is necessary to have a realistic perception of the actual living situation of the people concerned.

A24

Workshop
Preventing HCV: practical strategies to enhance safer injecting programmes and develop 'best practice'

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Regrettably, achieving comprehensive basic NSP coverage remains the most urgent priority in many parts of Europe – a fact that should not be overlooked. Nevertheless, this workshop will examine a range of opportunities for enhancing NSP beyond the minimum European standards established in 2011 within EQUS (Study on minimum European Quality Standards).
As a workshop, it will be interactive and the focus of the 90 minutes will be shaped by participants as fully as possible; however, the topics for consideration include:
strategies to reduce accidental sharing; applying latest evidence on 'low dead space' syringes;
the role of foil provision in supporting alternatives to injecting and safer drug use; and,
strategies for increasing NSP coverage to vulnerable/special populations e.g. young people, women, specific ethnic/cultural minorities, steroid and other image and performance enhancing drugs (IPED) injectors and, gay men who combine crystal meth injection ('slamming') with high risk sex.

Poster presentations:

Integrated Voluntary Counseling and Testing Program for HIV and viral Hepatitis B and C – A regional program of Baylor Romania

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Peer involvement in scaling-up HCV response among people who used drugs at Therapeutic Communities in Lisbon

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